

Section 1

Review of literature

This component of the Inter-agency Global Evaluation of Reproductive Health Services for Refugees and Internally Displaced Persons was undertaken by Ms Judith O'Heir, Consultant, UNHCR

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Introduction

1. This literature review represents the first component of the Inter-agency Global Evaluation of Reproductive Health Services for Refugees and Internally Displaced Persons (IDPs) and was supported by UNHCR.
2. A brief review of literature describing the reproductive health needs of refugees and populations affected by conflicts is provided as a backdrop to a review of assessment and/or evaluation reports that focus primarily on reproductive health services for refugees and IDPs. Other reports and documents of relevance have also been included, even though they may not describe assessments and/or evaluations of reproductive health services for refugees and IDPs. For example, the global overview on the phenomenon and the prevalence of GBV have been included because they relate to refugee, internally displaced, and post-conflict settings. Several assessments and/or evaluations on the quality of refugee health services as a whole have also been included, as they include findings that are relevant to reproductive health services for refugees.
3. Following the backdrop describing reproductive health needs of refugees and IDPs, the review of reproductive health services is presented under the following headings: family planning; safe motherhood; STI/HIV/AIDS,¹ sexual and gender-based violence,² coordination and collaboration, and general health services. Findings applicable to reproductive health services for adolescents are integrated under these headings, where appropriate. Finally, a summary of the review is presented, together with pertinent conclusions.

Reproductive health needs of refugees and internally displaced persons

4. In 2000, a comprehensive review of data from both published and unpublished sources was conducted to determine if and how reproductive health is affected by refugee or displaced status. Most of the data were from work undertaken in the 1990s, although some studies from the 1970s and 1980s were also reviewed. Refugees living in stable camp settings comprised the population most often studied; caution was therefore advised in applying the findings to refugees during the emergency phase of a crisis or to the internally displaced or other war-affected populations. The review also examined information related to fertility and family planning, safe motherhood, STIs and HIV/AIDS, and sexual and gender-based violence.
5. In terms of fertility and **family planning**, the information reviewed suggests that, among refugees, there is no common fertility pattern. While the nature of an emergency may affect the short-term response, the fertility of refugees in the long term is influenced by social and demographic factors such as age, socio-economic

¹ The term STI replaces the previously used term STD, throughout the literature review.

² The term sexual and gender-based violence (SGBV) is used interchangeably with the term gender-based violence (GBV), throughout the literature review, whereas the term GBV is used in the remaining sections of the report.

status, education, and urban or rural residence, all of which have long since been associated with fertility patterns.³

6. With regard to **safe motherhood**, the review of available data on pregnancy outcomes for both mother and baby suggests that poor pregnancy outcomes are common among many war-affected populations. Nevertheless, although outcomes may be worse during the acute phase of an emergency, the data suggest that, once a period of calm returns, these outcomes may be no more common than in host or home countries. For example, UNHCR's compilation of service and survey data on reproductive health in refugee settings in seven countries indicates that neonatal death rates and estimates of maternal deaths at all sites were lower than estimates for both host and home countries.⁴ The main explanation provided for better pregnancy outcomes was the availability and use of health services. This explanation is supported by a review of the emergency obstetric care (EMoC) available to refugees at eight sites in Africa where some form of EMoC could be accessed. Overall, the emergency health care and other health services available to refugees at these sites were found to be better, both qualitatively and quantitatively, than the services they accessed in their home countries during and, in most cases, before the conflict that made them refugees.⁵

7. The conclusion of a more recent study of reproductive health indicators and outcomes among refugees and IDPs living in 52 post-emergency phase camps in seven countries (Azerbaijan, Ethiopia, Myanmar, Nepal, Tanzania, Thailand, and Uganda) was that refugees and IDPs in most post-emergency phase camps had better reproductive health outcomes than people in their respective host country and country-of-origin populations. For example, four of six groups had lower maternal mortality ratios (MMRs) than their country of origin and five of six had lower MMRs than the host country; four of five groups had lower neonatal mortality rates (NMRs) than their country of origin and six of nine had lower NMRs than the host country; and seven of nine groups had lower percentages of newborns with low birth weights (LBWs) than their country of origin and five of nine had lower percentages of LBWs than the host country. Unlike many of the host country and country-of-origin populations, all refugee and internally displaced populations included in the study had access to health care, including emergency obstetric services, at little or no cost. In addition, all camps had access to referral hospitals providing EMoC within 12 hours, and free transportation and support to the referral hospital was provided by most nongovernmental organizations involved in health services.⁶

8. The data reviewed on **sexually transmitted infections** show a range of STI and HIV/AIDS rates among refugees, although it was noted that this finding is not refugee specific because similar variations in prevalence can be found in other populations not affected by conflict. Some of the critical factors which have been shown to increase exposure to STIs and HIV/AIDS between high- and low-

³ McGinn T, Reproductive Health of War-Affected Populations: What Do We Know? *International Family Planning Perspectives*, 2000, 26 (4): 174-180.

⁴ Batar D, *Reproductive Health in Refugee Situations: Review of Existing Reproductive Health Indicators*. Geneva: UNHCR, 1998 in McGinn, 2000.

⁵ Purdin S, The availability of Emergency Obstetric Care in Refugee Settings, Paper presented at the Global Health Council Conference, Arlington, VA, June 20-22, 1999, in McGinn, 2000.

⁶ Hynes M et al., Reproductive health indicators and outcomes among refugee and internally displaced persons in post-emergency phase camps. *Journal of the American Medical Association*, 2002 288 (5): 595-603.

prevalence populations are related to the displacement resulting from a conflict, and the presence of the military. Data from Rwanda, for example, show that seroprevalence among Rwandans who had lived in refugee camps in Tanzania or Zaire was 9%, signifying a six to eight-fold increase over the rates found in the rural areas of origin.³

9. With respect to sexual and **gender-based violence**, the data reviewed indicate that rape and domestic violence are widespread in conflict situations, although it is difficult to measure the extent to which refugee women are affected, as compared to women living in settled populations. In settled populations, the evidence suggests that most non-consensual sex is committed by men known to the women, which is also the case when refugee situations become stable; however, in the early phases of conflict, unknown militants were thought to be the more likely perpetrators. Other contributing factors in situations of forced migration include disruption of social norms and family composition, the economic dependence of women on men, limited access to basic necessities, and inadequate opportunities for legal help.³

10. A literature review of sexual and reproductive rights of refugee and internally displaced women in 2002 concurs with the findings of the review carried out in 2000, as outlined above. However, the 2002 review, a policy research project for the Belgium International Cooperation, points out that there is very little comprehensive data available on the sexual and reproductive health needs of IDPs. Despite this, it was reported that while national authorities are primarily responsible for the protection and care of IDPs, their attitude toward them is often neglectful and, at times, antagonistic.⁷

Reproductive health services for refugees and internally displaced persons

Family planning

11. The literature review of 2000 on reproductive health programmes in a variety of refugee situations reported that refugees who did not wish to become pregnant often had no choice in the matter because contraceptive services were either unavailable, or method choice and service delivery points were very limited. In addition, where services were available, women would not use them because of cultural traditions or the expectation that those lost in conflict situations should be replaced. Some of the major challenges identified relevant to providing comprehensive family planning services include the establishment of these services as soon as possible following the emergency phase of a crisis; overcoming bureaucratic opposition; maintaining a consistent supply of commodities in the face of inefficient logistics systems; and evaluating programme effectiveness.⁸

12. In 1998 the International Rescue Committee (IRC) conducted an analysis of family planning and reproductive health services for Liberian and Sierra Leonean adolescent refugees in the Forest Region of the Republic of Guinea. Data were

⁷ Bosmans M et al., *Reproductive and Sexual Rights of Refugee and Internally Displaced Women as Cornerstone of Respect for Human Rights*. International Centre for Reproductive Health, Ghent University, Belgium, 2002.

⁸ Krause S, Jones R and Purdin S. Programmatic Responses to Refugees' Reproductive Health Needs. *International Family Planning Perspectives*, 2000, 26 (4): 181-187.

obtained through interviews with administrators, staff and patients and health facilities were visited in both urban and rural areas. The results indicated that it was difficult to determine the extent to which refugees (both adult and adolescent) used these services because available data were combined for refugees and Guineans. In addition, data were not available by age, making it even more difficult to determine the extent to which adolescent refugees were using the family planning services. Nonetheless, the findings suggest that family planning services were under-utilized by adult refugees because they felt that health care services were, in general, of a lesser quality than the services in their home countries. While this was the perception of many refugees, few were able to relate specific personal experiences, as refugees, that substantiated sub-standard care. Adolescent refugees, on the other hand, were found to rely more on contraceptive supplies and services available outside of the formal health care delivery system; for example, many adolescents were aware of, and presumably used, peer educators, animators, Community-based Distribution Agents (CBDA), pharmacies, restaurants and clubs, and Options Santé Familiale (OSFAM) sales points as sources of information and supplies (especially condoms). However, the report emphasized the need to view the results of the analysis in the context of a national health system (the Guinean health system) that had introduced family planning services only six years earlier. The report included recommendations on the collection of disaggregated data on refugees and adolescents within the refugee population, and the launch of a national initiative that would enable the implementation of educational programmes and services that specifically target adolescents.⁹

13. In 1999 UNFPA carried out an evaluation of a reproductive health services project for Somali refugees in eastern Ethiopia. The evaluation focused primarily on the eradication of female genital mutilation (FGM), but also covered family planning and other basic reproductive health services. The results of the evaluation, which involved site visits and discussions with agency staff, health care providers, and refugees, indicated that, while family planning services were available at the camp health centres, the contraceptive mix was limited. In addition, it was suggested that 'family planning acceptance' might have been low because the health care providers were unable to speak Somali. Furthermore, it was reported that some refugee women felt that family planning services were being neglected in favour of activities focusing on the eradication of FGM. The report recommended that literate Somali speakers should be recruited for IEC and family planning services.¹⁰

14. An assessment conducted by UNHCR in 2001 of reproductive health services (RHS) at the refugee camps in Kakuma and Dadaab, Kenya, included visits to camp clinics, health posts and hospitals, a review of supplies, equipment, drugs, and client records and registers, and discussions with health care providers, recipients of care, and the providers and recipients of community education messages on reproductive health. Family planning services were provided over a period of many years in health facilities in both camps in the form of oral and injectable contraceptives and condoms, and intrauterine devices could be obtained at the camp hospital in Kakuma. Camp clinics in Kakuma each had a trained refugee family planning

⁹ International Rescue Committee (IRC), *Analysis of Family Planning and Reproductive Health Care for Refugee Adolescents: The Republic of Guinea Forest Region* (Consultant Report). New York, IRC March 1998.

¹⁰ Luka T, *Reproductive Health Services for Somali Refugees in Eastern Ethiopia*. Addis Ababa, UNFPA/CST, July 1999.

worker, whereas in Dadaab, the same refugee workers who provided antenatal care also provided family planning services. In Kakuma and Dadaab camps, community education on family planning focused on child spacing. RH motivators and CHWs served as a link between the community and camp health facilities in those camps where family planning services were available. However, in spite of community education activities and the availability of family planning services, the use of modern family planning methods was said to be low for reasons touching on cultural and religious beliefs and practises and the performance of family planning providers. Consequently, a recommendation was made to carry out a comprehensive review of family planning services, including the skills and abilities of CHWs, the organization and delivery of services, with particular emphasis on accessibility and convenience to clients, and the socio-cultural appropriateness of IEC/BCC/advocacy activities. Further to this it was recommended that the results of the review be used to improve services and community education activities relevant to family planning.¹¹

15. In 2001, several member organizations/institutions of the RHRC Consortium conducted an assessment of reproductive health services for IDPs in Angola, involving visits to IDP camps in four provinces and one on the outskirts of Luanda, and discussions with health workers and IDPs. In terms of family planning services, the assessment results indicated frequent stock-outs at the health facilities visited. For example, women using contraceptives preferred depo provera injections, but none were available at any facilities that were visited. Lack of resources and transportation difficulties were cited as barriers to consistent and reliable stocks. At one city hospital, nonetheless, all methods were offered, with the exception of male sterilization. In 2000 staff at this facility recorded 2,843 family planning consultations, of which 822 were new acceptors; almost half of the new acceptors chose the pill and 21% condoms. It was reported, however, that the providers of these services did not actively promote family planning, out of respect for the conservative beliefs and attitudes of the population served. Indeed, the assessment report cites a 1999 UNFPA demographic profile which showed that 81% of the 1,422 IDPs interviewed did not know of any method to prevent pregnancy, and only 2.2% were using a contraceptive method.¹²

16. An assessment of reproductive health services for refugees was carried out in Zambia in 2001 to encourage and educate UN agencies, NGOs, donors and others to increase access to a broad range of quality, voluntary, comprehensive reproductive health services for refugees in Zambia. The assessment was conducted by the Women's Commission for Refugee Women and Children, and included meetings with agency staff and health care providers, facility assessments, and focus group discussions with women, men, girls and boys, using the Refugee Reproductive Health Needs Assessment Field Tools.¹³

17. The assessment found that the mostly Angolan refugees were reluctant to use family planning methods because their husbands did not want them to use family planning methods; the religious and traditional belief is that women should have as

¹¹ UNHCR, *How to Guide: Reproductive Health in Refugee Situations – Kakuma and Dadaab, Kenya*. Geneva: UNHCR, 2001.

¹² Meriwether B, Jones R and McGinn T, *Assessment of Reproductive Health for IDPs, Angola*. New York: RHRC, February 2001.

¹³ RHRC, *Refugee Reproductive Health Needs Assessment Field Tools*.
http://www.rhrc.org/resources/general_fieldtools/needs_menu.htm

many children as God gives them; and family planning methods were only suitable for women who already had children; a lack of community-based distribution (CBD) programmes; and the difficulty women have in persuading their partners to use condoms. The contraceptive methods used included pills, injectable contraceptives, condoms, IUDs, and spermicides, but not all methods were available in every health care facility. In most camps, CHWs played an active role in educating refugees about family planning choices, but their work was undermined by the fact that there was no community-based distribution of family planning supplies. The number of family planning users ranged from 13 in Nangweshi camp (population 14,217) to almost 3,000 in Mwange camp (population 23,009); these numbers possibly reflected the extent of the family planning service problems which existed in the various camps. The assessment recommended that demand and supply should be improved through an IEC campaign and community-based distribution of condoms and other contraceptives; that acceptance of family planning services be increased through male involvement, active participation and ongoing training of peer educators and community workers, and the use of appropriate terminology for each community; and that a consistent supply of male condoms be ensured and the possibility of supplying female condoms be explored.¹⁴

18. Also in 2001, several member organizations of the RHRC Consortium conducted an assessment of reproductive health for Colombia's internally displaced. The assessment involved discussions with representatives working with the Ministries of Health and Education, other governmental organizations addressing the needs of IDPs, UN agencies, and international NGOs. Villages, IDP camps and other communities were visited and meetings and focus group discussions conducted with men, women and adolescents. While these activities did not include the assessment of health facilities and the actual services available to IDPs, they resulted in the collection of information about the reproductive health needs and problems of Colombia's IDPs. In terms of family planning, for example, it was found that there was a mixed demand for family planning amongst IDPs, with some wanting more children while others did not. In addition, it was found that IDP women had limited knowledge of family planning and lacked access to contraceptives, either because they were unavailable or were believed to be too expensive.¹⁵

19. In 2002, the JSI Research and Training Institute, on behalf of the RHRC Consortium, conducted an assessment of reproductive health in the Democratic Republic of Congo (DRC), where an estimated two to four million Congolese are internally displaced (90% of them in the Eastern Region) as a result of ongoing civil war. The assessment involved focus group discussions with women (using questions from the *Refugee Reproductive Health Needs Assessment Field Tools*), health facility assessments, and discussions with health care providers and representatives of implementing agencies. Due to time constraints and security issues, the assessment focused primarily on the Kalima Health Zone in Maniema Province and the Goma Health Zone in North Kivu Province. Five health centres and the hospital and principal maternity ward were visited in Kalima Health Zone and five facilities in the Goma Health Zone. In terms of family planning, the findings of the assessment

¹⁴ Krause S et al., *Assessment of Reproductive Health for Refugees in Zambia*. New York: Women's Commission for Refugee Women and Children, September 2001.

¹⁵ Krause S, Morris C and McGinn T, *Displaced and Desperate: Assessment of Reproductive Health for Colombia's Internally Displaced Persons*. RHRC, February 2003.

indicate that few public health clinics had contraceptives available, and in facilities that offered family planning services, stocks often ran out leaving women without a continuous supply of their method of choice. Contraceptives were found in some pharmacies, although they were too expensive for most women, and while the price of contraceptives was lower in the open market, quality was questionable as expiry dates, for example, were either exceeded or changed. Another impediment was that married women needed to obtain the signature of their husbands to receive contraceptives. Not surprisingly, access to family planning services by adolescents was even more restricted. To improve the situation, it was recommended that provision and supply of family planning services, including emergency contraception, should be ensured through a sound contraceptives logistics management system; and that family planning acceptance should be increased through the involvement of men and community education; and that access to family planning services for adolescents should be expanded, including the provision of a range of contraceptives.¹⁶

20. An additional assessment undertaken in 2002 was conducted by Marie Stopes International, on behalf of the RHRC Consortium. The purpose was to assess the reproductive health situation in the areas of Sri Lanka under the control of the Liberation Tigers of Tamil Eelam (LTTE). The assessment team visited the north-eastern districts of Mannar, Vavuniya and Kilinochchi and conducted focus group discussions with women (using questions from the *Refugee Reproductive Health Needs Assessment Field Tools*), health facility assessments, and discussions with health care providers and representatives of implementing agencies. While Sri Lanka has excellent health indicators and a good health system, health services in general, and reproductive health services in particular, were limited in the north and east of the country. For example, in these areas, family planning services were available at the monthly mobile ANC clinics provided by the government. However, in light of poor road conditions and the limited resources available for preventive health services, mobile clinics were unreliable and did not cover all of the north and east of the country. Women had therefore to do without or, if possible, travel long distances to a base hospital or clinic where contraceptives were available. To improve services, the assessment recommended the provision of family planning services through a sound contraceptives logistics management system; training community health promoters in remote areas to provide contraceptives, including injectables, and providing them with supplies; and training the staff at LTTE clinics and providing them with contraceptives.¹⁷

21. Toward the end of 2002, a reproductive health assessment was conducted by the RHRC Consortium in East Timor, involving meetings with key representatives from the MOH, UN and other organizations, discussions with health care providers and community members, and visits to health care facilities. Immediately following the independence referendum in 1999, there was intense fighting in East Timor between East Timorese fighters and the Indonesian army, this led to a massive displacement of the population and the destruction of much of the country's infrastructure, including the near total collapse of the health system. By the end of 2001, many health facilities were functioning once again, including several hospitals, and numerous health centres and health posts. The assessment findings indicated that

¹⁶ Casey S, *Assessment of Reproductive Health in the Democratic Republic of Congo*. RHRC, July 2002.

¹⁷ Casey S, *Assessment of Reproductive Health in Northern Sri Lanka*. RHRC, December 2002 (Draft).

oral and injectable contraceptives, IUDs, and condoms were available at some facilities. In addition, it was found that while UNFPA had supplies of contraceptives, they could not be distributed in a consistent manner. The assessment recommended the provision of district support for contraceptive logistics management; training in family planning counselling techniques for health care providers; piloting of a natural family planning method such as the 'Standard Days Method'; and making emergency contraception available.¹⁸

22. From August 2002 to March 2003, the Women's Commission for Refugee Women and Children conducted an assessment of the availability and accessibility of both the MISP and comprehensive reproductive health services for Afghan refugees in the Pakistani provinces of Northwest Frontier, Baluchistan and Punjab. Thirty-five percent of Basic Health Units (BHUs) and 100% of basic EmOC clinics and referral hospitals, in urban and peri-urban areas of these provinces, were assessed using a data collection instrument based on the RHRC Consortium *Refugee Reproductive Health Needs Assessment Field Tools*. The assessment was supported by UNFPA and was conducted in the context of new influxes of Afghan refugees, as well as a massive repatriation of refugees to Afghanistan. In terms of family planning, the assessment findings indicated that staff required refresher training in contraceptive technology and communication and counselling skills. In addition, the most commonly available modern contraception methods included pills and injectables, but only a few BHUs provided IUDs. Although the number of current users was found to be low and the discontinuation rate very high, actual figures were not provided in the assessment report. Lastly, while all Community Labour Rooms (CLRs) provided some post-abortion care services, little attention was given to post-abortion¹⁹ family planning counselling.²⁰

Safe motherhood

23. During the initial acute phase of an emergency, pregnancy can pose additional health risks for women and their unborn baby; childbirth may take place in extraordinarily unsafe circumstances, emphasizing the need to provide maternal and newborn health services as soon as possible, including referral and services for obstetric emergencies.⁸

24. The 1999 evaluation of reproductive health services for Somali refugees in eastern Ethiopia indicated that safe motherhood services included domiciliary deliveries by TBAs (supervised by midwives), antenatal care, post-abortion care, and referral of obstetric emergencies by ambulance to the local district hospital at Jijiga. However, the report showed that, despite the fact that there was an existing referral system, there were delays in transferring obstetric emergencies from the camps because the ambulance had to be called from Jijiga by radio and that, moreover, this was only possible between 8:30am and 5:30pm. The solution to this problem was to have

¹⁸ Meyers J, *Reproductive Health Assessment: East Timor*. RHRC, September 2002.

¹⁹ Note that in this and the following sections of this report, the term post-abortion care (PAC) refers to the strategy to reduce death and suffering from the complications of unsafe and spontaneous abortion, as described in the *Inter-agency Field Manual*. PAC elements are emergency management of incomplete abortion and potentially life-threatening complications; post-abortion family planning counselling and services; and establishing links between post-abortion emergency services and other RH services.

²⁰ Afzal O, *Assessment of Reproductive Health Services Accessible to Afghans in Pakistan: Advocacy to Action*. Women's Commission for Refugee Women and Children, June 2003 (Draft).

ambulances stationed in the camps so that emergency transfers could be undertaken quickly, although it was not clear from the evaluation report that this solution was going to be implemented. An additional problem was that the midwives working at the camp health facilities were not permitted to manage abortion complications, even though they were often the only health care providers available at the facilities. As a result, it was recommended that the nurses, midwives and physicians working in the camps be provided with training in life-saving skills, including management of incomplete abortion.¹⁰

25. In 1998, UNHCR assessed the safe motherhood services in ten refugee camps in Tanzania to identify strengths and weaknesses and recommend ways to improve services. The assessment involved interviewing health care providers on clinical care, including management and referral of obstetric emergencies; conducting exit interviews with antenatal and postnatal clients; reviewing antenatal, delivery and postnatal records and registers; holding discussions with reproductive health coordinators/focal points, TBAs and women representatives; and assessing the availability of staff, services, clinical protocols/guidelines, drugs, supplies, and equipment. The findings of the assessment indicated that most of the camps had services that were accessible to, and well used, by the women living in the camps, including those for antenatal care, care during labour and delivery and postpartum care. Antenatal care included almost all of the interventions outlined in the Inter-agency Field Manual, with the exception of the development of birth plans and provision of clean delivery kits. With the exception of obstetric surgery, it was possible to manage most of the common obstetric complications in the camp health facilities. One of the ten camps (Lukole A in Ngara) had the capacity to provide caesarean sections for women in the Lukole A and an adjacent camp, while women from the other camps were referred to a district or mission hospital for this procedure. The assessment found that the quality of care needed to be improved, particularly with respect to streamlining the provision of antenatal care (e.g. reducing the number of routine visits per pregnancy from fourteen to a minimum of four and limiting the use of unqualified care providers); and ensuring the availability of a skilled attendant for births on the maternity wards (e.g. putting a stop to the use of inexperienced refugee midwives, workers trained on the job, and TBAs in maternity wards, especially at night); expanding postnatal care (e.g. encouraging at least two postnatal visits and providing care that included the prevention and management of maternal and newborn complications); and providing written clinical guidelines for all aspects of care (e.g. guidelines that provided essential direction to staff, and that standardized care within and between camps).²¹

26. Despite the need to improve safe motherhood services, the numbers of maternal and neonatal deaths in the camps were found to be low, only 11 maternal and 35 neonatal deaths were recorded between January and October 1998. The maternal mortality ratio for this period in seven of the 10 camps (three camps reported that there had been no maternal deaths for this period) ranged from 70 to 199 per 100,000 live births and the neonatal mortality rate from 1 to 8 per 1000 live births. In contrast, the maternal mortality ratio in Tanzania, the host country, was estimated in 1995 at 1,100 per 100,000 live births and 1,900 per 100,000 live births in Burundi, the home country for the majority of the refugees living in the camps.²¹ Consistent with these

²¹ UNHCR, *How to Guide: Strengthening Safe Motherhood Services – Kigoma and Ngara, Tanzania*. Geneva: UNHCR, 1998.

findings are those from a maternal mortality study, conducted in 2001, among Afghan refugees in Pakistan. For example, the maternal mortality ratio and lifetime risk of maternal death was significantly lower than the corresponding numbers reported in Afghanistan; the maternal mortality ratio for Afghan refugees in Pakistan was 291 per 100,000 live births compared to 820 per 100,000 for Afghanistan. However, as was the case at the camps in Tanzania, the safe motherhood services at the camps in Pakistan also needed to be improved. For example, at the conclusion of this study, suggestions to overcome barriers at the first level of care included increasing the number and training of lay midwives; educating women, men, and their families about symptoms and signs expected in healthy pregnancies and those with complications; and seeking antenatal care, and delivery with a trained birth attendant.²²

27. The assessment conducted in 2001 of reproductive health services at the refugee camps in Kakuma and Dadaab, Kenya found that the main components of safe motherhood were in place, these included antenatal care, care during labour and delivery, management of obstetric emergencies, newborn care, and postpartum care. Although many of the recommended interventions for antenatal care were in place, intermittent preventive treatment for malaria and treatment of intestinal parasites were missing in both Kakuma and Dadaab, and birth planning and individual health education were poorly implemented. In addition, syphilis screening and haemoglobin tests were not available for antenatal women in Dadaab. It was also found that the skills and abilities of refugee workers who were trained on the job to provide antenatal care were below the level of the skills and abilities of, for example, trained midwives, particularly with respect to problem identification, response and resolution. These areas of deficiency suggested the need to revise the interventions provided and upgrade the skills and abilities of workers to fill gaps in antenatal care.¹¹

28. Incomplete abortion was managed at the camp hospitals, using MVA. Each of the hospitals had an MVA room containing the necessary equipment, supplies and drugs, and designated staff members had been trained in the procedure of MVA. In the six months prior to the assessment, 45 cases of incomplete spontaneous abortion had been treated using MVA in Kakuma and 20 in Dadaab. It was difficult, however, to ascertain the extent to which post abortion family planning counselling was provided, although the general impression during the assessment was that it was not a particularly strong component of post abortion care, suggesting the need for refresher training for those involved in this care.¹¹

29. The maternity wards in the camps had the basic supplies, equipment and drugs for conducting normal deliveries and for responding to the major obstetric emergencies, with the exception in Kakuma of caesarean section. However, this service was available at Kakuma Mission Hospital, a short distance from the camp. Unfortunately, in Dadaab obstetric surgical interventions were available only during the day because security measures did not permit non-refugee workers to be in the camps between 4:30 pm and 8:30 am. During these hours, refugee workers were responsible for providing services, despite the fact that the skills and abilities of these workers were not at the level of either a trained midwife or doctor. The assessment

²² Bartlett L et al., Maternal Mortality Among Afghan Refugees in Pakistan. *Lancet*, 2002, 359 (9307): 643-649.

found that there was a need to formalize clinic-based PNC care to ensure the provision of basic interventions aimed at preventing postpartum problems and/or detecting and responding to them early, with a view to reducing maternal and newborn mortality and morbidity.¹¹

30. However, despite the deficiencies found in the safe motherhood services in the camps at Kakuma and Dadaab, mortality rates were again found to be low. In 2000 there were four maternal deaths reported in Kakuma camp (maternal mortality ratio 216 per 100,000 live births) and twenty-two maternal deaths in the Dadaab camps (maternal mortality ratio 460 per 100,000 live births); some of these deaths were caused by either malaria and/or anaemia, which reinforced the need to review and revise interventions for antenatal care. The maternal mortality ratios in Kakuma and Dadaab camps were lower than for Kenya as a whole (650 per 100,000 live births); however, because the ratio for the Dadaab camps was more than double that for Kakuma, it was recommended that a formal process be introduced to review each maternal death in order to identify avoidable factors, and determine needed interventions (e.g., staff training, strengthening the referral system) to prevent deaths in the future. In the Dadaab camps the neonatal mortality and stillbirth rates were also double the rates in the Kakuma camp (NMR 8 per 1,000 live births and stillbirth rate 17 per 1,000 total births in Kakuma and NMR 17 per 1,000 live births and stillbirth rate 37 per 1,000 total births in Dadaab). In the Dadaab camps, the absence of syphilis screening (and treatment of positive cases) was cited as a possible contributing factor to stillbirths. Similarly, malaria and anaemia during pregnancy were cited as possible contributing factors for both neonatal deaths and stillbirths.¹¹

31. In terms of safe motherhood, the 2001 assessment of reproductive health of IDPs in Angola painted a very bleak picture. Antenatal care, for example, was available at only some health posts and health centres, although the assessment team was told that few women accessed antenatal care. Some of the possible reasons to explain this was that women were not aware of the importance of antenatal care or that services were not widely available and accessible to them. The majority of women were said to deliver at home with a TBA in attendance; 'home' for an IDP was described as a tent shared with another family or a straw hut with a dirt floor. Some deliveries took place under a tree, in a classroom or in some other structure within the camp. Another issue that was repeatedly raised during the assessment was that women who experienced complications during pregnancy and childbirth left it too late to seek help at a hospital. This was seen as a sign of very low awareness/education on the part of women and that TBAs were poorly-trained. Additionally, the hospitals had very poor sanitary conditions and were poorly equipped and staffed, leading to high rates of life-threatening postpartum infections, among other complications. The recommendations made at the conclusion of the assessment, relevant to safe motherhood (and other aspects of reproductive health care), included the reconstruction and resupply of health facilities, improved referral procedures, more ambulances/adequate transport options, qualified/trained professionals, and essential drugs.¹²

32. The 2001 assessment of reproductive health for refugees in Zambia found that safe motherhood services were better for refugees than for the local population. Antenatal care for refugee women was found to be satisfactory, although there was some variation between camps/locations; for example, syphilis testing appeared to be available at some camps/locations but not at others. Most refugee women

delivered at the health facilities with the assistance of clinical staff, TBAs and/or female family members, and a referral system was in place to respond to obstetric emergencies. The only exception to this relates to refugees living in urban and peri-urban areas, where there was difficulty with transportation for referrals. In most camps, it was found that maternal deaths were rare (only one maternal death was cited by the refugees), whereas neonatal deaths were said to have been more common. In urban and peri-urban areas, refugees noted that a contributing factor to maternal and neonatal deaths was early discharge from health facilities, leading to complications suffered at home. Although services for post-abortion care were not described in the report, it is noted that the use of herbs was a common method for inducing abortion and that the extent of unsafe abortion required additional study. The recommendations for improving safe motherhood services included ensuring the availability of emergency transportation where this was not already possible; ensuring that all pregnant women have access to syphilis testing; and attempting to address problems with supplies at referral facilities.¹⁴

33. The assessment carried out in Colombia in 2001 focused on explicating the reproductive health needs of IDPs rather than on assessing existing services. Nonetheless, in terms of safe motherhood services, the assessment report indicated that IDP women received less antenatal care than did Colombian women as a whole. In addition, because of their inability to pay for services, IDP women who needed EmOC were referred from one hospital to another, delaying the provision of life-saving care. Although the estimated maternal mortality ratio was stated in the assessment report as 71 per 100,000 live births for Colombia as a whole, the estimated ratio was said to be between 207 and 570 per 100,000 live births in areas of the country characterized by significant social inequities, violence, and population displacement.¹⁵

34. The results of the assessment of reproductive health in the DRC in 2002 indicated that, in both Kalima and Goma Health Zones, a safe motherhood programme had been introduced by an international NGO at the beginning of the same year as the study. The programme included training nurses and midwives on safe delivery practises, antenatal care, and newborn and postnatal care. Antenatal care, for example, had been made available once a week at the facilities visited by the assessment team and included health education, tetanus toxoid immunization, intermittent preventive treatment for malaria, and iron/folate supplementation. In Kalima Health Zone, assistance was being provided to rehabilitate maternities at health centres, including the provision of delivery tables. Delivery rooms were found to be in very poor condition. Notwithstanding these problems, most health centres had at least one nurse or midwife living at or near the facility, who could be summoned at night and on weekends. In contrast, the maternity ward at Kalima Hospital, which appeared to have church-related support, was clean and well equipped and provided basic essential obstetric care; women requiring more comprehensive care had to travel three kilometres, either on foot or on a stretcher carried by family members, to the provincial hospital. Further to this, the operating room at the hospital was found to be unclean and poorly equipped. The assessment team was told by the women at four health facilities in Kalima Health Zone that those who lived close by preferred to deliver there, whereas those who lived further away delivered at home with the help of a TBA. Both Goma General Hospital and Charité Maternelle in Goma city performed caesarean sections and offered post

abortion care; however, as was the case in Kalima Health Zone, transportation to the hospital was the responsibility of the woman and her family. ¹⁶

35. The assessment results for both Kalima and Goma Health Zones need to be considered in the context of the DRC as a whole where the maternal mortality ratio doubled from 870 per 100,000 live births in 1995 to 1,837 per 100,000 live births in 1998. Moreover, in some parts of the Eastern DRC, the maternal mortality ratio has been estimated at 3,000 per 100,000 live births. The assessment recommendations aimed at improving this situation included offering free antenatal and obstetric care in Eastern DRC and other insecure areas where the population cannot afford to pay for health services; training health facility staff in the recognition and early referral of women with pregnancy-related problems; training TBAs to recognize and refer pregnant women with problems; and ensuring that comprehensive emergency obstetric care (EmOC) is available at referral facilities and improving the referral system, including community-based solutions to transportation problems. ¹⁶

36. The results of the assessment conducted in Sri Lanka in 2002 indicated that in Vavuniya District antenatal care was provided in four villages by means of monthly mobile Ministry of Health MCH clinics. Tetanus toxoid immunizations, iron supplementation, malaria prophylaxis, and vitamins were provided during these consultations, together with health education talks. Women categorized as high risk were referred to the hospital in Vavuniya where comprehensive EmOC was available. Most of the women interviewed said that they preferred to deliver in hospital and some made their way to Vavuniya ten days before their due date so as to be close to the hospital before labour began. In Mannar District, antenatal care was also provided by the MOH mobile clinic, although it was found that iron supplementation had not been available for four months prior to the assessment. The mobile clinics in both Mannar and Vavuniya Districts were found to be unreliable because of a shortage of human resources and vehicles to conduct the clinics. An international NGO operated a daily antenatal clinic at the Madhu Hospital and a mobile clinic was held four times a month in the IDP camp in Mannar District. Normal delivery care and basic EmOC were available at Madhu Hospital and comprehensive EmOC at Mannar Hospital. The women interviewed in Mannar district reported that they went to the hospitals in Madhu and Mannar for delivery, although some women living near the Adampan clinic said that they called on the midwife, who lived 1.5 kilometres away, to help them with deliveries, while women in the IDP camps delivered at home with the help of traditional midwives. ¹⁷

37. In Kilinochchi District, the assessment team visited a limited number of sites due to flooding and poor road conditions, but were unable to conduct focus group discussions because a suitable translator was not available. The team found that antenatal care was provided through the MOH mobile clinics, although poor roads and a lack of resources reportedly limited these efforts. In addition, basic EmOC was available at the acting district hospital in Akaryankulam, although the road to this facility was poor and often impassable in the rainy season, and women in need of comprehensive EmOC had to travel to facilities in other districts or go to Jaffna. The assessment team recommended that at least one four-wheel drive vehicle be assigned to each MOH area so that mobile clinics can reach remote areas on a regular basis; that public health midwives be encouraged to accept postings throughout the north and east of the country and that they should be provided with clean delivery kits to assist women who cannot reach a hospital; and that, in the interim, community

health promoters should be trained to assist with home deliveries and to recognize and refer women with complications; and that basic and comprehensive EmOC be made available at appropriate referral facilities, together with an improved referral system.¹⁷

38. During the assessment of reproductive health conducted in East Timor in 2002, safe motherhood services were found to be fairly limited. Antenatal care, for example, was generally limited to a check of blood pressure, weight, fundal height measurement, tetanus toxoid immunization, and iron and folic acid supplementation. Many women reportedly delivered at home with the assistance of a family member or, in some cases, with the help of a TBA. In the case of an obstetric emergency, the woman was taken to hospital, either carried by family members or in an ambulance, if available. Two hospitals, one of which was in Dili, were said to provide comprehensive EmOC. While there were said to have been 600 qualified midwives employed throughout East Timor prior to independence, the number stood at less than 200 at the time of the assessment. The recommendations made following the assessment included: strengthening the role of TBAs in support of the services provided by midwives; improving antenatal care through training of the existing midwives; including preparation for emergencies in birth planning; and issuing women with clean deliveries kits.¹⁸

39. The results of the 2002-2003 assessment in Pakistan indicated that, at the BHU level, antenatal and postnatal care were provided by Lady Health Visitors (LHVs). Antenatal care, for example, consisted of 3-4 visits per pregnancy, according to standards set by WHO. Some basic laboratory tests were carried out as part of antenatal care, but more often than not, they were reserved for women identified as high-risk. Clean delivery kits were, however, provided to most women in the third trimester of pregnancy, or to TBAs attending home deliveries. In addition, LHVs conducted normal home deliveries in refugee camps where access to a CLR was not possible. While some CLRs were to have provided basic EmOC, in reality they were inadequately equipped or lacked the staff to provide services 24 hours a day. Additionally, although referral systems were said to have been in place to respond to obstetric emergencies, transportation was not always available and refugee women were often unable to pay for these services. Moreover, staff at referral hospitals complained that women often arrived at these facilities in a critical condition, suggesting the need for community health education on pregnancy-related complications and training for staff at BHUs and CLRs on how to address the needs of women suffering obstetric emergencies. In relation to this situation, the assessment report mentioned that a project was recently implemented by the RHRC Consortium in collaboration with the Averting Maternal Death and Disability (AMDD) Programme aimed at improving EmOC services for Afghan refugee women in Pakistan. Further to this, it was recommended that community education about the danger signs of pregnancy and the need for delivery by a trained attendant for women considered high risk be provided for refugee women, men and adolescents.²⁰

40. In addition to the RHRC Consortium-AMDD project in Pakistan, similar EmOC projects were implemented in eight other countries: Bosnia, Kenya, Liberia, Sierra Leone, southern Sudan, Tanzania, Thailand, and Uganda. However, before the projects were designed and implemented, assessments were conducted in the project countries in 2001-2002 to document EmOC activities in these conflict-affected settings. The assessment tools used included *The Guideline for Health Facilities*

Assessment produced by the Foundation for Enhanced Management of Maternal Emergencies (FEMME) Project, Columbia University's *Design and Evaluation of Maternal Mortality Programs*, and various WHO assessment tools. The facilities assessed served both refugees in camps, such as Afghans in Pakistan and Sudanese in Uganda, and non-camp populations including returnees and IDPs in Liberia, Sierra Leone and Southern Sudan. Some facilities, such as Kibondo Hospital in far western Tanzania, served both local and refugee populations, whereas the Mae Tao Clinic and Mae Sot Hospital on the Thai-Burma border served Burmese refugees and non-refugees, in and out of camps, as well as the internally displaced in Burma.²³

41. While the assessment findings indicated gaps in basic EmOC, the availability of comprehensive EmOC at the hospitals assessed tended to be more complete. Nonetheless, for both basic and comprehensive EmOC, serious problems were found with respect to quality and consistent availability of services. Specifically, at most sites major problems with infrastructure were reported, as were chronic shortages of drugs, medical supplies and equipment. For example, only two facilities out of 26 had magnesium sulphate in stock, and only five had MVA kits. At most facilities inadequate or malfunctioning water systems, unsanitary conditions, and deteriorating buildings were found. In addition, there were critical shortages of staff qualified to provide EmOC, resulting in many facilities being staffed by TBAs, community health workers and medics with various levels of training. Moreover, EmOC standards, guidelines and protocols were not available at most of the facilities assessed. With regard to access to EmOC, transportation and communication posed challenges in both rural and urban areas.²³

42. While many specific recommendations were made following the assessments, the main interventions included the upgrading of physical facilities; provision of necessary equipment, supplies and medicines; improving data collection and record keeping; enhancing staff capacity through training, recruitment and placement; augmenting the means of communication and transportation; improving community outreach through information, education and communication and behaviour change strategies; and supporting cost-sharing mechanisms.²³

STI/HIV/AIDS

43. Once the situation has stabilized, STI/HIV/AIDS interventions in refugee settings are much the same as those used among settled populations, these include: IEC activities; BCC strategies; condom promotion and distribution; use of syndromic case management for STIs; voluntary counselling and testing (VCT) for HIV; and prevention of mother-to-child transmission (MTCT) in host countries providing such services.⁸

44. An evaluation of the syndromic approach to the management of STIs was conducted in the refugee camps in Ngara, Tanzania in 2000, involving a descriptive retrospective survey of data collected from May 1998 to December 2000. The data were collected from patient registers at the four STI clinics in the camps, which comprised one component of a comprehensive STI/HIV/AIDS programme (the other components included the use of universal precautions, safe blood transfusion, condom promotion and distribution, VCT for HIV, home-based care for people living

²³ Meyers J and Friedlander E, *Emergency Obstetric Care: Critical Need Among Populations Affected by Conflict*. RHRC Consortium, January 2004.

with HIV/AIDS (PLWHA), and STI/HIV prevention for young people). Each clinic had an adequate supply of drugs and other consumables and was staffed with a clinical officer and an STI/HIV counsellor. Education and counselling were provided on a one-to-one basis at the STI clinics and condom promotion and distribution were carried out at these clinics. In addition, antenatal syphilis screening was provided at MCH clinics, where positive cases and their partners were treated, and group health education was provided to all MCH attendees. The results of the survey were reported as follows: the incidence of STI showed a steady decline between 1999 and 2000 (syphilis was down by 42.6%, genital ulcer syndrome (GUS) by 15% and UDS by 8%). During the three-year period 6,332 STI syndromes were treated, giving a total cumulative incidence rate of 18 cases per 1000 population per year; 2,888 contacts were traced and treated; and the overall cure rate for all syndromes was reported at 87.6%. It was concluded that the STI services functioned reasonably well in the camps, although it was noted that the continuing influx of refugees would present challenges, as would the interaction between refugees and the local community, particularly in relation to commercial sex activities.²⁴

45. The 1998 analysis of family planning and reproductive health services for adolescent refugees in Guinea found that while information was provided to communities about STI/HIV/AIDS prevention and services, there were few facilities where accurate testing, diagnosis and treatment could be obtained. Health care providers reported shortages of appropriate drugs to treat STIs, whereas patients questioned the cost of drugs and the number and potency of the tablets they were given. In addition, while blood for transfusion was tested for HIV, donors who tested positive were reportedly not informed of the result. Coupled with this was a lack of supplies and equipment (e.g. gloves and sterilizing equipment) needed to practise universal precautions. Hence, it was recommended that the existing STI/HIV programme be strengthened by including standards of practise, adequate supplies and equipment, and training in universal precautions and counselling skills.⁹

46. The 2001 assessment of reproductive health services in the refugee camps in Kakuma and Dadaab, Kenya, found that treatment of STIs, using syndromic case management, was available at the camp health facilities. Some of the recommended drugs were not always available for treatment, but others were. In addition, refugee workers at the health facilities in Dadaab appeared to have only limited understanding of syndromic case management, and partner notification and treatment were poorly implemented at all camp health facilities. Recommendations related to these findings included refresher training for workers involved in STI services, the provision of written guidelines on syndromic case management and partner notification and follow-up, and ensuring the availability of first-line drugs.¹¹

47. The assessment team found that information about the availability and correct use of condoms was provided, but that condom distribution in the camps made it almost impossible for potential users to obtain them anonymously. For example, the main distribution points were at the pharmacies in the health facilities, requiring community members to either ask for a supply or reach through the window and into the box of condoms kept on the counter. Condoms were also available through RH motivators but this, too, required potential users to be identified, suggesting the

²⁴ Norwegian People's Aid (NPA), Evaluation of Syndromic Approach to Sexually Transmitted Infections (STI) Control in Ngara Refugee Camps, Tanzania, 1998-2000. Ngara: NPA, June 2001.

need to consider how and where condoms could be made widely available and more easily accessible. ¹¹

48. In Angola, the 2001 assessment of reproductive health services for IDPs revealed that the lack of supplies and essential drugs prohibited the provision of quality HIV prevention and STI services. Although STIs were believed to be common in Angola, not one of the health facilities that was visited during the assessment had a supply of the drugs recommended for treatment. Diagnoses were based on symptoms and/or physical examination, and the patients then had to buy drugs in the market or at a local private pharmacy. There were no VCT services outside of the capital, Luanda, and although blood for transfusion was tested for HIV at provincial hospitals, the staff at these facilities said that HIV test kits were in short supply. Hence, STI/HIV prevention, diagnosis and treatment were identified as major problems in terms of reproductive health care; to address these problems, reconstruction and re-supply of health facilities, qualified/trained staff, and essential drugs would be required. ¹²

49. The 2001 assessment of reproductive health services for refugees in Zambia, a country with, in 1999, an HIV prevalence rate of almost 20%, found that awareness of STI/HIV/AIDS prevention was good; one example of this was of participants in focus group discussions who were able to cite the main methods of prevention and the facilities at which testing and treatment were available. There were few diagnosed cases of HIV/AIDS and a continuing scepticism regarding the very existence of the disease, but there were numerous suspected cases of HIV/AIDS among the refugee population. Other concerns highlighted during the assessment included self-treatment of STIs (to avoid the embarrassment of being treated at a camp clinic), requests for treatment of sterility (probably related to untreated STIs), and the practise of unsafe (i.e. unhygienic) male circumcision. Although the assessment report did not provide details regarding the availability of drugs for treating STIs, it notes that the availability of male condoms was inconsistent at many of the sites visited. In one camp, users had to obtain condoms from the MCH clinic, which posed a barrier for those who wanted to obtain them anonymously. While voluntary counselling and testing was available in two camps, at some district hospitals and at two centres in Lusaka, these services were not well used, possibly because treatment for positive cases was not available. The main recommendations made based on these findings included ensuring access to condoms for the entire refugee population through community based distribution channels; improving access to STI services by, for example, increasing confidentiality and privacy; monitoring progress of voluntary counselling and testing in Zambia; and targeting the needs of commercial sex workers. ¹²

50. The findings of the 2001 assessment of reproductive health needs of IDPs in Colombia indicated that while the prevalence of STIs among IDPs is unknown, anecdotal reports from the government and UNFPA suggest that prevalence is high. In some indigenous communities, health care workers were unable to reach men to provide adequate treatment for STIs and, as a consequence, have admitted pregnant women to the hospital to reduce the likelihood of reinfection and to prevent MTCT. ¹⁵

51. The assessment of reproductive health conducted in the DRC in 2002 found that most of the facilities that were visited used syndromic management of STIs, but few of them had any condoms and none carried out IEC activities on HIV/AIDS. Population Services International (PSI) undertook IEC activities with truck drivers

and commercial sex workers, in addition to the social marketing of condoms in Kinshasa, Bukavu and Lubumbashi. With respect to HIV testing of blood for transfusion, the National AIDS Control Programme reported that 80% of health facilities providing blood transfusion services did not test donated blood. Nonetheless, the assessment team learned that most NGO-supported health facilities did test donated blood for HIV. While HIV testing was not widely available, MSF-Holland provided VCT in Bukavu and MSF-Belgium did so at two clinics in Kinshasa. One of these clinics offered subsidized STI diagnosis and treatment and VCT to the general population, while the second clinic offered free STI treatment and VCT to commercial sex workers. Both clinics referred clients who tested positive to local NGOs who provided psychosocial support to people living with HIV/AIDS. MSF-Belgium had also recently opened a centre in Kinshasa, which offered subsidized treatment for people living with HIV/AIDS (PLWHA). Finally, the Belgium Red Cross had recently opened a centre in a referral hospital in Kinshasa, which offered HIV/AIDS treatment and counselling to women and children. ¹⁶

52. These limited services need to be considered in the context of a country that has experienced widespread population movement; increasing commercial sex activity (including sex for survival); widespread poverty; low status of women; the presence of troops from countries with high HIV prevalence rates; the use of sexual violence as a weapon of war; the abduction of women for the purpose of repeated rape; and traditional practises such as scarification. In an attempt to improve services related to STI/HIV/AIDS, the assessment recommendations included improving knowledge of STI and HIV transmission and prevention, in both urban and rural areas, through IEC campaigns; ensuring access to male and female condoms through community based distribution; improving access to STI diagnosis and treatment, including partner treatment and treatment compliance; focusing education and income generating activities on commercial sex workers and other women who trade sex for money and goods; ensuring a safe blood supply for blood transfusion; and developing programmes to care for people living with HIV/AIDS. ¹⁶

53. In northern Sri Lanka, the findings of the assessment of reproductive health conducted in 2002 suggest fairly limited services for STI/HIV/AIDS. In Vavuniya North, for example, diagnosis and treatment of STIs was not available and patients with suspected infections were referred to Population Services Lanka (PSL) or to the hospital in Vavuniya; the women who participated in the assessment discussions later reported that they were not asked by hospital staff to bring their partners for treatment. PSL counsellors, on the other hand, encouraged partner treatment, and also provided syphilis testing for pregnant women. Although the Vavuniya hospital was testing donated blood for hepatitis and HIV, VCT was not available in Vavuniya District. The situation in Mannar District was found to be much the same, with no treatment services available in those parts of the district still held by the LTTE; however both the PSL and the hospital in Mannar town provided syndromic management of STIs and syphilis testing, and the base hospital was testing blood for transfusion for hepatitis and HIV. In Kilinochchi District, syndromic case management for STIs was found to be available at the Tharampuran CD/MH and reported to be available at the Akaryankulam hospital. The assessment recommendations relevant to services for STI/HIV/AIDS included: using IEC campaigns to improve knowledge of STI and HIV transmission and prevention, in both urban and rural areas; ensuring access to male and female condoms through

community-based distribution; and improving access to STI diagnosis and treatment services, including partner treatment and treatment compliance.¹⁷

54. With respect to services for STI/HIV/AIDS, very little information was noted in the report on the assessment of reproductive health in East Timor. The assessment showed that laboratory testing facilities were generally unavailable, but that health care providers at some facilities were trained in syndromic management of STIs. VCT services were being established by an international NGO at Dili Hospital around the time the assessment was being carried out. Assessment recommendations aimed at improving the situation related to STI/HIV/AIDS included: community education to prevent the transmission of HIV/AIDS and improve treatment-seeking behaviour for STIs; and community based distribution of condoms.¹⁸

55. The 2002-2003 assessment of reproductive health services for Afghan refugees in Pakistan found that STI/HIV/AIDS services were inadequate and in need of improvement. For example, while condoms were available at all BHUs and urban clinics visited during the assessment, they were not always free to clients and safer sex was not promoted at these facilities. In addition, it was found that at most of the facilities lacked the equipment, skills and supervision needed to implement universal precautions. Beyond these findings, the assessment report contained no other information specific to this particular component of reproductive health services.²⁰

Sexual and gender-based violence

56. Many woman and adolescent girls are subjected to sexual violence, during both the emergency phase of a crisis and following stabilization. It is common in refugee settings for sexual and gender-based violence to be used to debase women and their families; it is equally common for the survivors of sexual and gender-based violence to avoid seeking help, for fear of being blamed for the abuse.⁸

57. In 2000, technical assistance was provided by UNHCR to facilitate the development of a monitoring system for sexual and gender violence (SGV) in the refugee camps in Tanzania. The SGV programme involved four main sectors: the health sector was responsible for examination and treatment; the community sector for counselling and support, socialization/reintegration, and advocacy; the protection sector for protection, police, and the legal/justice system; and the security system for physical safety and prevention. There were international and national NGOs involved in the SGV programme, as well as UNHCR staff, the Tanzanian government, and the refugee communities. Given the size of the programme and the multiple partners and variety of sectors involved, it was not surprising to find that a certain degree of confusion reigned between the roles and responsibilities of the different actors. In addition, there were inconsistencies in the definition of SGV, data collection and analysis, and a general lack of focus on evaluation of outcomes. NGOs and UNHCR had a different method for classifying and counting types of SGV cases differently, leading to variations in monthly reports of SGV incidents from 0 to 50, depending on the camp and the NGO involved. All police reports required a medical evidence form to be completed by a doctor at a health centre, the forms were often incorrectly filled because doctors misunderstood what they were being asked. It was

also unclear who was responsible for returning the form to the police, and completed forms were sometimes lost.²⁵

58. Protocols, practises and procedures were finalized after a series of participatory planning meetings. The definitions of terms for the different types of SGV were agreed upon, including: sexual assault (rape, attempted rape); sexual exploitation/abuse (including sexual harassment); harmful traditional practises (early/forced marriage, FGM, etc.); domestic violence (spouse abuse); and other gender-based violence. The protocol developed for the NGOs involved in health care was clear, comprehensive and, in general, consistent with the guidelines provided in the *Inter-agency Field Manual*. For example, the care involved obtaining and recording a detailed history, general physical examination, assessment of psychological trauma, gynaecological examination, tests/investigations (e.g. vaginal swab, pregnancy test), and treatment (e.g. for common STIs, emergency contraception²⁶). The care for survivors of domestic violence and other forms of gender-based violence and/or assault were similar, with the exception of treatment, which instead focused on physical injuries. However, rather than ensuring that a same-sex health worker provided care, the protocol instead indicated that the examination should be carried out by a medical doctor registered in Tanzania (or other clinicians in the absence of a doctor), with the assistance of a female health worker. Ultimately, however, it was anticipated that by establishing clear systems, roles, and responsibilities for each individual, group, agency, and organization, the prevention of and response to sexual and gender-based violence affecting refugee communities in Tanzania would improve.²²

59. Guinea and Liberia have SGV programmes for refugees using a multi-sectoral approach similar to the ones described above.²⁷

60. With regard to SGV, the findings of the assessment of reproductive health services conducted in 2001 in the refugee camps in Kenya indicated inconsistency between the camps in Kakuma and those in Dadaab. In Kakuma there was no formal mechanism in place for the referral of victims of rape, either from the community to the camp hospital or the reverse. Nonetheless, physical care and counselling were available at the camp hospital and there was a 'safe haven' in the community, run by an NGO, where psychosocial support was provided. In contrast, there was a protocol in place in Dadaab for managing victims of rape, requiring the completion of individual incident forms at the hospital, following examination and treatment of victims. In terms of coordination of services, an inter-agency meeting was held weekly, chaired by the UNHCR Protection Officer, and attended by the SGV focal person from the relevant NGOs and the police force. Community interventions in Dadaab included the provision by GTZ of firewood for women, although the impact of this intervention was not clear as monitoring and evaluation of the SGV programme was inadequate. Nonetheless, there was a widespread perception that the firewood distribution project was the main reason for a decline in the number of reported rape cases, despite the fact that the project provided only approximately 30

²⁵ UNHCR, *How to Guide: Monitoring and Evaluation of Sexual and Gender Violence Programmes – Kigoma and Ngara, Tanzania*. Geneva: UNHCR, 2000.

²⁶ Note that emergency contraception (EC), in this and the following sections of this report, refers to the response to sexual violence, as described in the *Inter-agency Field Manual*.

²⁷ UNHCR, *How to Guide: Sexual and Gender-based Violence Programme in Liberia*. Geneva: UNHCR, 2001; UNHCR, *How to Guide: Sexual and Gender-based Violence Programme in Guinea*. Geneva: UNHCR, 2001

percent of household fuel needs. In both Dadaab and Kakuma, SGV and FGM were topics included in general community education activities for reproductive health. ¹¹

61. One of the issues raised with respect to clinical care for rape victims, in Kakuma and Dadaab, was the lack of female health care providers to examine the woman and provide treatment; observations made during visits to the camp clinics, health posts and hospitals in Kakuma and Dadaab suggested that men provided treatment services. One of the conclusions of the assessment was that there was a need to formalize the process of referral and treatment and ensure coordination between the agencies involved, particularly in Kakuma. In addition, female health workers needed to be made available, as the presence of male health workers at treatment facilities was seen as a barrier for women who might otherwise have accessed these services. ¹¹

62. The assessment of RHS for IDPs in Angola in 2001 found that there were no specific services available for victims of SGV, even though the problem was said to be widespread. For example, in Huambo, Angola's second largest city, hospital staff told the assessment team that sexual violence was so common that victims rarely bothered to report it. The cases of sexual violence seen at the hospital tended to be children for whom families sought medical care as a means of collecting evidence (presumably to take action against the perpetrator). ¹²

63. During the assessment of RHS for refugees in Zambia in 2001, it was found that most of the camps, peri-urban and urban health facilities visited did not have protocols in place for the management of rape victims. Some facilities did, however, have emergency contraceptives available. Although rape was said to be uncommon amongst the refugee population, domestic violence, in the form of husbands beating their wives, was common and was often related to alcohol and drug use/abuse. Assessment recommendations included the establishment of protocols for gender-based violence, training on clinical management of the victims of violence, making emergency contraception available at all camps, and initiating community sensitisation campaigns on gender-based violence. ¹⁴

64. Although the report of the 1999 evaluation of reproductive health services for Somali refugees in eastern Ethiopia did not include information about sexual and gender-based violence in general, it does indicate that there were many groups (e.g. women, TBAs, circumcisers, youths of both genders, men, Koranic and secular teachers, and religious leaders) involved in community activities to eradicate FGM. Nonetheless, while many community members equated the eradication of FGM with the eradication of infibulation, they did not make a connection with other forms of FGM such as clitoridectomy. ¹⁰

65. The findings of the 2001 assessment of reproductive health needs of Colombia's IDPs indicated that the majority of displaced women faced extreme violence related to armed conflict and other physical, emotional or sexual abuse from their partners and/or spouses, strangers, friends, ex-husbands, and fathers-in-law or step fathers. In response to this situation, UNFPA was working on the development of standards in support of an integrated response to sexual violence that addressed protection, justice, and health and medical care. ¹⁵

66. In the DRC, where gender-based violence is rampant, the results of the RH assessment in 2002 indicated that few facilities had protocols for treating rape

survivors, and emergency contraception was rarely available. In addition, fear of stigma prevented some women from seeking medical attention, and many found themselves traumatized not only by the rape experience but also by their family's rejection of them after the event. Based on these findings, the assessment recommendations included training health staff on the clinical management of violence according to *Clinical Management of Survivors of Rape* (WHO/UNHCR); initiating community sensitisation campaigns on GBV; encouraging support for women who have experienced sexual violence; making emergency contraception available at all health centres; and addressing domestic violence and the status of women in the more stable areas of the country. ¹⁶

67. During the assessment of reproductive health in northern Sri Lanka in 2002, it was found that no formal services were available for GBV victims, although some churches provided ad hoc counselling for those seeking assistance. While there is documentation of sexual violence in relation to the Sri Lankan conflict, reports of GBV were rare amongst the women interviewed during the assessment. Domestic violence, on the other hand, was repeatedly reported as a problem. Based on the assessment findings, the recommendations included the implementation of programmes for the prevention of, and response to GBV, including counselling services and assistance with the legal process; initiation of community education programmes to reduce the incidence of domestic violence, particularly in relation to the likely increase in frustration over the lack of services and employment as more IDPs return to the uncleared areas of the country; training of health staff on the clinical management of violence according to *Clinical Management of Survivors of Rape* (WHO/UNHCR); and ensuring the availability of emergency contraception at all health centres and mobile clinics. ¹⁷

68. The findings of the RH assessment in East Timor in 2002 indicate that while GBV was evident, there were few existing services to address the problem. An international NGO had established a GBV programme in four districts, which included workshops on GBV, coordination between the sectors involved in preventing and responding to GBV, and data collection on GBV. In addition, a safe room was established at Dili Hospital, although it had apparently been used a great deal. Recommendations to improve services relevant to GBV included strengthening ongoing efforts to raise awareness at the community level, particularly with respect to domestic violence and gender-biased traditional practises; promoting gender equity in all aspects of health care services; training health care providers on GBV; providing emergency contraception to the victims of rape; disseminating information on the assistance available to women and families who were victims of violence; and promoting research on GBV. ¹⁸

69. During the 2002-2003 RHS assessment for Afghan refugees in Pakistan, it was found that service providers were not trained to prevent or address the consequences of GBV, nor did they believe that GBV was a problem. Additionally, no evidence of GBV programmes was found during the assessment. However, the assessment report notes that UNHCR launched an initiative in December 2002 to establish programmes for the prevention and management of GBV in the refugee camps in Pakistan. ²⁰

70. In 2002, a report was released on gender-based violence in refugee, internally displaced and post-conflict settings. The report was part of a four-year global Gender-based Violence Initiative, lead by the RHRC Consortium, and is composed of

twelve country profiles. Nine of the country profiles, namely those for the Republic of Congo, Rwanda, Sierra Leone, Afghanistan/Pakistan, Burma/Thailand, East Timor, Azerbaijan, Bosnia and Herzegovina, and Kosovo, were prepared on the basis of field investigations that included interviews with survivors, local GBV-related organizations, international humanitarian aid and human rights organizations, local and national government representatives, as well as United Nations personnel. The remaining three country profiles – Colombia, Guatemala, and Nicaragua – were based on desk reviews conducted in New York. One of the primary gaps mentioned in the report is the lack of data on GBV; for example, in none of the countries included in the report were service data collected across the sectors involved in GBV programmes, at either local or national levels. In addition, it was reported that, in many of the twelve countries, little or no research had been conducted on the prevalence of GBV. Other important findings included the tendency of donors and humanitarian institutions and organizations to focus on sexual crimes committed during conflicts. In addition, protection for survivors from all forms of GBV was considered to be weak in every one of the profiled countries.²⁸

71. The report contains recommendations, covering the sectors involved in GBV, for each of the countries profiled. However, a general recommendation relevant to the health sector points to the need for health services protocols that address GBV, standardized training for health workers on all aspects of GBV treatment and response, and respect for the rights of survivors to safety, confidentiality and choice applicable to service provision. In addition, the report mentions initiatives that were underway at the time of publication, such as the development of a GBV assessment design and evaluation manual and the standardization of medical management guidelines for responding to rape, which were being field-tested in 2002. Notwithstanding these initiatives, the report emphasized that the efforts of local communities exemplify the greatest potential for combating GBV in refugee, IDP, and post-conflict settings. Moreover, the report also notes that the “inspiration for change is based in local women’s unrelenting commitment to reducing the violence that has overwhelmed their communities and their lives.”²⁸

72. In 2002, the prevalence of GBV among conflict-affected populations was determined in selected settings in East Timor, Kosovo, Colombia, and Sierra Leone and, while these studies did not involve the assessment of reproductive health services, respondents were asked about access to these services. In East Timor, for example, 68.4% of the women included in the study said that reproductive health services were difficult to access and, in addition, most of these women reported incidents of family or friends being abused either by a stranger or by a family member, rather than to institutional sources of support such as health care providers.²⁹ Similarly, in Kosovo 84% of the women included in the study said that RHS were difficult to access and the most frequent sources of support for these women were family and friends.³⁰ In Colombia, 82.2% of the displaced women interviewed said that RHS were difficult to access and, again, that the majority of

²⁸ Ward J, *If Not Now, When? Addressing Gender-based Violence in Refugee and Internally Displaced, and Post-conflict Settings: A Global Overview*. New York: RHRC Consortium, 2002.

²⁹ Hynes M et. al., *A Determination of the Prevalence of Gender-based Violence Among Conflict –Affected Populations in East Timor*. New York, RHRC Consortium, CDC, IRC, 2003.

³⁰ Hynes M et. al., *A Determination of the Prevalence of Gender-based Violence Among Conflict –Affected Populations in Kosovo* (Draft Report). New York, RHRC Consortium, CDC, 2004.

women either told no one about their experiences or told family and friends.³¹ In Sierra Leone, fewer (44.3%) of the Liberian refugee women included in the study said that they had difficulty accessing reproductive health services.³² However, because the study was conducted in “care and maintenance” camp settings, one would expect even fewer women to be reporting difficulty with access to these services. These study findings suggest that, whether because of difficulty with access or fear of stigma or retribution, the majority of women are not using health services to help manage and/or cope with violence.

Coordination and collaboration

73. While coordination and collaboration between organizations/agencies involved in all RHS components for refugees and IDPs contribute to the successful provision of these services, few of the assessments and/or evaluations referred to in the abovementioned review include this. However, the findings of the assessment conducted in refugee camps in Kenya in 2001 imply that the lack of formal procedures for coordination and collaboration between the NGOs involved in health services in the camps, in both Kakuma and Dadaab, had the potential to undermine the organization, as well as to affect the implementation and quality of these services, including those for reproductive health. It was therefore recommended that the roles and responsibilities of each organization involved in RH activities (i.e. clinical services and community education) should be reviewed and agreed to and, equally, that the role and responsibilities of the respective RH coordinators be reviewed and agreed to, using the sample job description in the *Inter-agency Field Manual* as a guide. It was also recommended that a RH coordination committee be established, representing interests in both Kakuma and Dadaab, and meet on a regular basis for the purpose of discussing issues related to planning, implementation, monitoring and evaluation of reproductive health services. However, at a technical meeting held at the end of the assessment, separate reproductive health coordination committees were formed for Kakuma and Dadaab, and clearly defined terms of reference were developed, including the membership, chairperson, timeframe, date of first meeting, and items to be dealt with.¹¹

74. One of the conclusions of the 2001 assessment of reproductive health for refugees in Zambia was that collaboration amongst implementing partners was crucial to the efficient use of scarce resources and to improving the availability of services for refugees. Therefore, it was recommended that a RH working group be established in Lusaka for implementing agencies (IPs), including UNHCR, UNFPA, relevant NGOs, and refugee representatives. In addition, it was recommended that the presence of an RH coordinating agency and/or coordinator be ensured to lead a reproductive health working group in each camp.¹⁴ A similar recommendation was made following the 2002 assessment in the DRC; that is, it was recommended that reproductive health working groups be established in Goma, Bukavu, Kisangani, and Kinshasa for health implementing agencies to coordinate activities in Eastern DRC.¹²

³¹ RHRC Consortium, *Encuesta de Prevalencia de Violencia Basada en Género en Mujeres Desplazadas por el Conflicto Armado en Cartagena – Colombia* (Draft Report). New York: RHRC Consortium, 2003.

³² Benton A. (Draft Report) *Prevalence of Gender-based Violence Among Liberian Women in Three Refugee Camps*. Sierra Leone: IRC, 2004.

75. In Pakistan, the results of the 2002-2003 assessment of reproductive health services for Afghan refugees indicated a lack of monitoring and supervision relevant to the provision of these services. For example, out of 12 implementing partners in 21 refugee camps in Baluchistan and Northwest Provinces, only six had reproductive health coordinators to monitor and supervise reproductive health services. In response to these findings it was recommended that reproductive health working groups be revitalized to coordinate improvements in the quantity and quality of reproductive health services for Afghan refugees in Pakistan.²⁰

General health services

76. The assessment of refugee camps in Lugufu and Ngara, Tanzania in 2002 was carried out to explore issues relevant to the quality of health care in general, as perceived by the refugees living in these camps. Although the assessment did not include any particular focus on reproductive health, the findings are, nonetheless, relevant to this report. Various participatory methods were used, as described in the UNHCR field guide for assessing refugee perceptions of health care services,³³ including focus groups discussions, free listing, problem ranking, historical narration and transect walks. The health services in the two camps in Ngara, which housed Burundi and Rwandan refugees, were provided through four outpatient and two inpatient departments, and in the two Lugufu camps, which house Congolese refugees, through two outpatient and one inpatient departments. In both the Ngara and Lugufu camps, the formal health services were recognized and accessed; for example, many refugees who participated in the focus group discussions said that it was easier to obtain treatment in the camp health facilities than in their home countries and that the proximity of the health services, and the fact that they were free, facilitated use of the health facilities in the camps. In addition, the work of Health Information Teams was cited as a positive way of providing health education messages to camp residents. In Ngara, for example, the refugees referred to messages about HIV/AIDS counselling and testing services and the gender-based violence programme, when asked to give examples.³⁴

77. Notwithstanding the positive findings reported, dissatisfaction was expressed with the health services because some refugees felt health care providers did not treat them in a professional manner and that, in some cases, their illnesses were mismanaged. A specific complaint was that they had to return more than once to obtain the drug that had been prescribed. For example, the camps in Ngara had a countersigning system that required refugee clinical officers to have prescriptions approved by a Tanzanian clinical officer or doctor, who may or may not have been available at the time the prescription was written. Other concerns voiced included the reluctance of women to go to a maternity ward for delivery because they feared having a caesarean section, and the preferential treatment enjoyed by certain groups such as businessmen, particular ethnic groups, and children.³⁴

³³ UNHCR, *Assessing Refugee Perceptions of Health Care Services: Field Guide*. Geneva: UNHCR, 2002

³⁴ NPA, *Perceptions of Burundian/Rwandese Refugees on Quality of Health Care Services: Findings from a Participatory Assessment, Lukole Camps, Ngara, Tanzania, July 2002*. Ngara: NPA, 2002; and Burke H, Williams H, *Refugee Perceptions of Health Care Services: Summary of Finding from the Lukole and Lgufu Camps in Western Tanzania*. Atlanta: Centers for Disease Control, 2002.

78. Refugee health services were also assessed in Moscow and the Moscow region in 2002 to determine the quality of the services being provided. The assessment involved visits to outpatient and in-patient facilities, a review of medical records, and interviews with health care providers and refugees. Inpatient and outpatient care was found to be available, including consultative specialist care, at multifunctional medical and preventive facilities and at specialized institutions. Preventive and sanitary education was also provided and was aimed at preventing disease and encouraging a healthy lifestyle. Details and/or topics of this education were not reported. The refugee health services were reportedly provided in accordance with the Russian legislative guarantees on provision of medical and preventive care for the population. Although the services relevant to reproductive health were not specifically discussed in the report, it did mention that, at the time of the assessment, there were 60 pregnant refugee women under the supervision of a gynaecologist. Gynaecological monitoring was carried out in conformity with standards adopted in the Russian Federation; however, details of care were not described in the report. The report also mentioned that adolescents were regularly examined when they registered for school or college, although once again details were not provided.³⁵

79. Of the refugees interviewed, an overwhelming majority indicated that they had access to all types of medical care. While only a third of the refugees interviewed spoke Russian, three quarters of them said that they used an interpreter when accessing health services. Sixteen percent indicated that they were denied some type of medical care (e.g. consultations with certain specialists) and some said that they were not always able to obtain free medicines; for example, 51% of the interviewees said they were fully provided with drugs from the medical institution they attended, 41% said they were partially provided (i.e. they had to buy some prescription drugs from a drugstore), and only 6% claimed they were not provided with free drugs at all. Although 87% said that they were satisfied with the medical care they received, some believed that refugees living in Western countries were provided 'much better' medical care.³⁵

80. In 2003, UNHCR and WHO conducted joint evaluations of the health of, and health programmes for, Bhutanese refugees in Nepal, Afghan refugees in Pakistan, and refugees in Zambia (report pending). The evaluations were carried out as part of a three-year initiative to institutionalize health programme evaluations in humanitarian situations.

81. In Nepal, the evaluation was undertaken in six of the seven Bhutanese refugee camps, using informant interviews with the staff of UNHCR and UNFPA, government representatives, NGO staff, and refugees, including health care providers. Focus group discussions were also conducted in the camps with women, men, and adolescent girls and boys. Health and nutrition indicators were reviewed and mortality data verified. A survey of essential drugs, basic equipment and staff was carried out in five camp Basic Health Units (BHUs) and two government sub-health posts. A similar survey was conducted in four camp health posts/centres and one government health centre. In one camp, exit interviews were conducted with mothers of children under five, and a community survey was carried out in every fifth household. The findings indicated that crude and under-five mortality rates and

³⁵ UNHCR, *Assessment of the Quality of Medical Care Provided to Refugees, Russian Federation*. Geneva: UNHCR, 2002.

the maternal mortality ratio for Bhutanese refugees are considerably lower than for the surrounding population (e.g. the maternal mortality ratio for the camps in 2002 was 110 per 100,000 live births compared to 540 per 100,000 live births for the Terai, where the camps are located). In general, access to curative services was found to be better for refugees than for the host population. However, problems identified with respect to the quality of health services included the lack of standard case management (e.g. for Integrated Management of Childhood Illness -IMCI), the absence of appropriately trained staff at facilities below the hospital level, inappropriate management of STIs, and the absence of a programmatic approach to sexual and gender-based violence (SGVB).³⁶

82. In terms of reproductive health services, it was noted that, initially, these services focused primarily on maternal and child health care, but were gradually expanded to include family planning and, more recently, the prevention and management of STIs/HIV/AIDS and SGBV. In addition to community awareness raising activities, clinical services included laboratory tests such as those for STIs and rapid plasma reagin (RPR) tests for antenatal women, and STI case management. Contraceptive methods (i.e. condoms, pills, and injectables) and family planning counselling were available in the camp facilities and IUDs and Norplant at the referral hospital. However, it was found that contraceptives had been in short supply for several months prior to the evaluation. Nonetheless, family planning services in the camps were widely known and accepted both for limiting the number of children and for birth spacing. With respect to antenatal care, it was reported that women go for their first consultation as soon as they know they are pregnant and have an average of ten antenatal visits, even though the target for Nepal is four visits per pregnancy. Coverage of antenatal care was said to be 100% and 99.5% of deliveries were reported to be attended by trained staff or TBAs; 69% of deliveries took place at home attended by a trained TBA. The report did not include information about EmOC or post-abortion care, but in contrast to the positive findings relevant to maternal and newborn care, the services for STI/HIV/AIDS were described as being 'absolutely deficient', especially for men. Therefore, it was recommended that a comprehensive, high quality STI/HIV/AIDS programme was needed in the camps for both adults and adolescents. In addition, with regard to SGBV there was absence of a programmatic approach, despite serious problems related to rape, trafficking and domestic violence. However recent attempts have been made to raise awareness on SGBV and to provide clinical services for the survivors of rape.³⁶

83. The joint evaluation in Pakistan was undertaken in camp and urban settings in Islamabad, North-West Frontier Province and Baluchistan. The methods used included semi-structured interviews with individuals and groups, review of relevant documents, focus group discussions, direct observation, administration of a questionnaire to implementing partners, and an IP rating exercise by UNHCR field staff. In general, it was found that the level of primary health care services for refugees in camps was better than for the host population or in Afghanistan. However, there was a stark contrast between the health services in camps and those for urban refugees, as services for the latter were described as difficult or non-existent. Community labour rooms and RH units offering a wide range of reproductive health services were considered to have been successful initiatives. In

³⁶ UNHCR, (Draft Report) Refugee Health in Nepal: A Joint UNHCR-WHO Evaluation of Health and Health Programmes in Bhutanese Refugee Camps in Nepal. Geneva: UNHCR, 2003.

camps where there were labour rooms within a hour's travelling time away, supervised delivery rates were found to be 20-30%, whereas in camps that did not have a labour room delivery rates were less than 5%. Some camps apparently had 'quite well developed' family planning programmes, although details of the programmes were not provided in the evaluation report. Details of services for the prevention and management of STIs/HIV/AIDS and SGBV were not provided in the report either, although it was noted that health staff were not well trained or informed regarding the management of patients who present themselves following SGBV.³⁷

Summary and conclusions

84. The reproductive health needs of refugees and IDPs living in stable post-conflict settings 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 STIs/HIV/AIDS, and the prevention and response to SGBV.

85. The assessment and/or evaluation reports reviewed in this section present a variety of family planning services for refugees and IDPs, particularly with respect to the availability of methods and the skills and abilities of service providers. For example, at many of the sites where assessments and/or evaluations have taken place, the range of methods available was limited and supplies were inconsistent, even of the most frequently used methods. However, it was also found that at sites where family planning services included the provision of a relatively wide range of contraceptive methods over a period of many years, these services were not well used. Socio-cultural factors were cited as reasons for low acceptance of family planning methods, indicating the need for community education campaigns aimed at changing the attitudes and practises of users and/or potential users. Additionally, there is an obvious need to ensure that the skills and abilities of family planning providers are appropriate and that services are accessible to clients, including adolescent girls and boys. These findings, however, more than likely reflect the situation in the home countries of refugees and, therefore, may not be limited to refugee settings.

86. With respect to safe motherhood, the services for refugees suggest a generally more positive situation, despite variations among the sites where assessments and/or evaluations have taken place. At most sites, however, the services available included those for antenatal care, care during labour and delivery, management of obstetric emergencies, newborn care, and postpartum care. In addition post-abortion care, using MVA, was available in some camps. On the whole, the services were well used, and in the camps in Tanzania and Kenya, for example, maternal mortality ratios were found to be lower than in host and home countries. These findings were supported by those from the maternal mortality study conducted in the Afghan refugee camps in Pakistan and the study of reproductive health indicators and outcomes among refugees and IDPs in post emergency phase camps in seven countries. Notwithstanding the positive findings of the assessments and/or

³⁷ UNHCR, (Draft Report) *The Road to Health and the Road to Afghanistan: A Joint UNHCR-WHO Evaluation of Health and Health Programmes for Afghan Refugees in Pakistan*. Geneva: UNHCR, 2003.

evaluations, at some sites particular services needed to be added or improved; for example, antenatal syphilis screening and intermittent preventive treatment for malaria were needed in some camps, as was better access to emergency obstetric care and post-abortion care. In addition, there was a need to update the skills of health care workers at some sites and provide them with written clinical guidelines covering all aspects of maternal and newborn care.

87. While the findings relevant to safe motherhood services for refugee women were generally positive, this was not the case for IDPs in Angola, where most of the usual safe motherhood services were severely limited and unlikely to improve until health facilities were reconstructed and re-supplied, qualified/trained health professionals were made available, and referral procedures were improved. The situation for IDPs at the sites assessed in the Democratic Republic of Congo was similar, although the safe motherhood programme introduced by an international NGO should help to improve services more rapidly than in Angola. Similarly, the assistance provided by international and other organizations in East Timor should improve the limited services provided for safe motherhood. Nonetheless, as was pointed out in the review of reproductive and sexual rights of refugee and internally displaced women, the attitude of national authorities toward IDPs is often neglectful and, at times, antagonistic.

88. With regard to STIs/HIV/AIDS services, the assessment reports suggested variations relevant to the availability of the drugs recommended for treating STIs and the skills of health care providers, particularly with respect to syndromic case management. For example, in Ngara, Tanzania, syndromic case management had been used successfully, whereas the refugee health workers at the facilities in Dadaab, Kenya, had a limited understanding of this approach. Other shortcomings were related to partner notification and treatment, condom distribution, and the supplies needed to practise universal precautions. A recurring problem related to condom distribution was the inability of users and/or potential users to obtain them anonymously. The recommendations made to overcome the problems identified in the reports appear reasonable and included ensuring access to condoms for the entire refugee community through community-based distribution systems; refresher training for workers involved in STI services and the provision of written guidelines on syndromic case management and partner notification and follow-up; and ensuring the availability of the drugs recommended for treating STIs.

89. For IDPs in Angola, services for STIs/HIV/AIDS were very limited, even though STIs were believed to be common. None of the facilities visited during the assessment had, for example, a supply of the drugs recommended for treatment of STIs; hence, STI prevention, diagnosis and treatment were identified as major problems in terms of reproductive health care. However, these problems were unlikely to be addressed until health care facilities were reconstructed and re-supplied and qualified/trained staff made available to the population at large.

90. Services for SGBV survivors, where they existed, were found generally to lack well defined protocols, practises and procedures. For example, in Kakuma, Kenya, there was no formal procedure in place for the referral of victims of rape, but physical care and counselling were available at the camp hospital and a 'safe haven' had been established in the camp community to provide psychosocial support. However, one of the problems encountered in relation to the care of rape victims was

the lack of female health care providers to examine the woman and provide care. While this was seen as a barrier for women who experience sexual violence, the protocol developed for the refugee camps in Tanzania indicated that a medical practitioner, with the assistance of a female health worker, should carry out the examination. Nonetheless, the establishment of clear systems, roles, and responsibilities for the individuals, groups, agencies, and organizations involved, should help to prevent SGBV affecting refugee communities in Tanzania, as well as improve the response to incidents when they occur. This would also hold true for refugee and internally displaced communities in other countries.

91. In Angola, no specific services were available for IDPs who had suffered sexual violence, which is not surprising given the lack of services for other aspects of reproductive health. Sexual and gender violence were, nonetheless, reported to be widespread. In Zambia, however, rape was said to be uncommon in the refugee population but domestic violence was widespread, which reinforces the need to ensure the availability of services to respond to this problem, not only in Zambia but also for refugee and internally displaced populations in other countries. As was pointed out in the global overview of gender-based violence in refugee, internally displaced, and post-conflict settings, the tendency is for donors and humanitarian institutions and organizations to focus on sexual crimes committed during conflict; however, while establishing services for the victims of rape is essential, it is only one of a number of components of sexual and gender-based violence programmes.

92. Although coordination and collaboration among the organizations and/or agencies providing RHS for refugees and IDPs are important, only a few of the assessments and/or evaluations raised this point. In the refugee camps in Kenya, however, coordination and collaboration among the NGOs involved in health services in the camps was weak and had the potential to undermine the organization, implementation and quality of health services, including those for reproductive health. Consistent with this was the conclusion in the assessment report for Zambia that collaboration amongst implementing partners was crucial to the efficient use of scarce resources and to improving the availability of services for refugees. These findings suggest the need to include coordination and collaboration in future assessments of reproductive health services for refugees and IDPs, with a view to improving these particular aspects of service provision.

93. With regard to the assessment of refugee health services as a whole, the findings of the assessments conducted in Tanzania and Moscow were generally favourable. Although the refugees who participated in focus group discussions in Tanzania expressed some dissatisfaction with the services, most found it easier to obtain treatment in the camp health facilities than in their home countries, principally because of the proximity of the facilities and the fact that the services were free. An important facet of this particular assessment was that it used participatory methods that focused on the perceptions of the refugees living in the camps.

94. To conclude, the assessments and/or evaluations reviewed in this section provide a generally favourable impression of some aspects of reproductive health services for refugees living in stable and secure contexts. While some gaps are noted in family planning services and the use thereof, these findings are very likely to be consistent with those in the home and/or host countries of the refugees for whom the services were provided. This does not, however, suggest that the gaps in the

services for refugees should not be filled. With respect to safe motherhood, the services for refugees were even more favourable, with indicators and outcomes in numerous countries that were better than in the host or home countries of refugees. Nonetheless, there is a need still to improve some aspects of the services provided for mothers and their newborns, particularly with regard to antenatal care and emergency obstetric care. STI/HIV/AIDS services and, to an even greater extent, GBV in refugee settings, were less comprehensive and in need of greater strengthening. However, it is important to note that, in contrast to the services for refugees, those for IDPs appeared to be severely lacking and in need of a great deal more attention if the reproductive health needs of these populations are to be met.

