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RRN
NETWORK paper**Reproductive
health for displaced
populations****by Celia Palmer****Abstract**

The provision of reproductive health (RH) services by humanitarian agencies to displaced populations is relatively new. Until recently, the needs of displaced people in emergency settings were often ignored. During the eighties, attempts were made to address the problem, and in the last few years increasing attention has been paid to these needs in emergency contexts. In particular, recognition of the major threat posed by STDs and AIDS and growing media attention to sexual violence among displaced populations has highlighted the importance of the RH agenda in emergency settings. Alongside changes in RH provision in stable settings, the move to implement RH services for displaced populations was accelerated after the International Conference on Population and Development in 1994. The Conference set reproductive health within a rights framework and highlighted the needs of displaced populations.

However, despite the increased recognition of RH

concerns in emergencies, in reality the agenda has proved difficult to implement. Some aspects raise ethical and moral concerns to which humanitarian agencies have different attitudes. Bilateral agencies, non-governmental organisations and donors are grappling with difficult decisions as to what services they should provide and how to ensure services are safe and effective. This is also happening in stable settings. In the absence of good data on both needs and impact of RH service provision in emergencies, much of the emphasis on safe provision falls to the judgement of field based practitioners, with important implications for training and appropriate resourcing at that level. In this paper available information about reproductive health among displaced populations is presented. Policies of a number of actors are also described and examples of current RH programmes and the issues facing those attempting to implement them are explored.

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Any views expressed in this paper are those of the author and do not necessarily reflect those of any organisation represented.

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Introduction

1.1 Background to the paper

This paper seeks to give an overview of reproductive health (RH) needs and service provision in emergency settings and the implications for those working with displaced populations. This first chapter defines reproductive health for the purposes of this paper. Chapter 2 considers what is known about the reproductive health status of displaced populations and highlights why these populations have particular needs. By *displaced populations* I refer to both refugee and internally displaced populations, (although there is evidence to show that IDPs tend to receive different levels of service provision to refugees, not only in the area of RH). The advice contained in the paper also aims to cover all phases of displacement from emergency to rehabilitation, only distinguishing particular phases where these are relevant to the type of service provided. Current and proposed policies on the provision of reproductive health services in emergency settings are outlined in the third Chapter with existing programmes illustrated by case study material in Chapter 4. Constraints to the implementation of these services are discussed in Chapter 5 and the final chapter summarises the main conclusions of the paper and suggests possible ways forward. We hope, in this way, to both inform aid workers who are new to this agenda and want to learn more about reproductive health in these contexts. We also aim to clarify a number of key issues for those who are already involved in service provision and are familiar with these debates.

The paper is targeted primarily at those working in the health sector with displaced populations, though not exclusively, as the nature of the reproductive health agenda means that workers from other sectors will also be involved. RH service provision may range from education and counselling on sexual violence to condom distribution to obstetrics, involving a range of professional competences.

Prevention of sexual violence may, for example involve the planners/logisticians in the appropriate siting of latrines and water points when planning camps. Steps taken to ensure women-headed households have equal access to food supplies may also be important, helping to minimise the role sexual favours may play in their ability to obtain food and other commodities. Community service NGOs can help empower women and young people through providing opportunities for income generating activities, which in turn enable them to meet and talk together. Legal services will also have a role to play in ensuring that perpetrators of sexual violence are brought to justice.

Unfortunately, although awareness of RH concerns in emergency contexts has increased considerably over the past few years, much of the information we have on reproductive health needs is anecdotal or of poor quality. This lack of data has led to considerable debate amongst policy makers and service providers as to the extent of the need in situations of competing demands for resources and as to the appropriateness and feasibility of providing safe services. There are a number of reasons for this: (i) the difficulty of

collecting data in situations of insecurity where human resources are scarce and there may be rapid population movements; (ii) the lack of priority accorded to reproductive health; (iii) the lack of importance attached to the collation of data; (iv) the perceived need for rapid responses and action. This paper explores these and other barriers to RH provision with a view to shedding light on some of the debates surrounding provision of these important services.

1.2 Historical Overview

What is Reproductive Health? The concept was first developed in the late 1980s but did not gain widespread acceptance until the International Conference on Population and Development (ICPD) (Cairo, 1994). The document that arose from this Conference argued for a move away from population control towards a more holistic view of women's health.

It recognised the role of men in reproduction and the importance of child survival and finally advocated a shift in emphasis from providers to beneficiaries, from population policies to individual rights. As such, it was initially greeted with excitement and embraced by feminists, women's advocates, and policy makers in women's health alike.

The ICPD document defines reproductive health as, "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive health system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so".

This new approach links a variety of services previously offered by providers who traditionally worked apart. As a result, the developments advocated by the Cairo conference necessitate not only a shift in attitudes but also involve structural and organisational change that those working in conventional settings are also battling with. The advantages and disadvantages of the new approach as well as ways of dealing with them are still being learned.

Whilst this shift in emphasis to RH was occurring in the non-relief context, there was an increasing recognition in relief circles that in emergencies, women and their health needs were being

neglected. Evidence that women's needs had been ignored to the detriment of their health and that of their children was beginning to accumulate. Refugee women were often not being registered in camps; were not consulted when services were being planned; were not involved in food distribution or targeted for income generating activities. This was despite the fact that women were often heads of households and in some instances made up 30% of the populations of the refugee population (Eriksson et al, 1996).

At the ICPD conference, the particular problems of refugees and populations affected by conflict were officially recognised. The document referred to, "migrants and displaced persons [who] in many parts of the world have limited access to reproductive healthcare and may face specific serious threats to their reproductive health and rights. Services must be sensitive to the needs of individual women and adolescents and responsive to their often powerless situation, with particular attention to those who are victims of sexual violence." The Women's Commission on Refugee Women and Children were also already drawing attention to the issue of reproductive health services to displaced populations (Wulf, 1994).

In seeking to meet the objectives of the Cairo conference, UNHCR and other international agencies brought the services shown in Box 1 (below) under the RH umbrella - this paper also takes these areas as constituting the principal.

Box No. 1

Reproductive health services for refugee situations as recognised by the Inter-Agency Field Manual

- safe motherhood;
- sexual and gender-based violence;
- the prevention and care of sexually transmitted diseases (including HIV/AIDS);
- family planning and other reproductive health concerns (including gynaecological services and female genital mutilation).

Adolescent health and the involvement of men are also highlighted as needing particular attention.

Source: Inter-Agency Field Manual, Geneva, 1995

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What do we know about the RH status of displaced populations?

2.1 Pre-conflict context

There is general consensus that populations affected by emergencies share some common attributes that can increase their reproductive health needs but there may be important differences in how communities respond to their experiences. Little is known about the impact of conflict on the perceptions, needs and wants of women and men in these situations.

The diverse pre-conflict contexts of these populations will also result in differences in both need, and more particularly, demand for services. It is unlikely that the demand for family planning would be the same among a refugee population from the Former Yugoslavia and an internally displaced population in Sudan for example. Literacy rates, for example, may vary substantially; low literacy rates can affect reproductive health in a number of ways: they may be associated with early marriage, or the lack of knowledge about and utilisation of reproductive health services. Female illiteracy has also been shown to have detrimental effects on health and health seeking behaviour such as a failure to recognise early symptoms of infection and disease. Maternal mortality and morbidity rates vary substantially around the globe and some women entering conflict will already bear a huge burden in this area.

The provision of services before an emergency occurs will also affect demand for services later. Where there have been little or no contraceptive

services there is unlikely, initially, to be a demand for them even if they are offered. Moreover, different populations are accustomed to different contraceptive methods. In the Democratic Republic of the Congo (Former Zaire) in 1990, while the practice of contraception was found to be common in Kinshasa (dominated by the rhythm method), the use of modern contraceptives was limited. 15% of the ever pregnant women in the survey also reported having induced abortion. Both abortion and modern contraceptive methods were used as complementary fertility control strategies (Shapiro, Tambashe, 1996).

The cultural background of a particular population will also affect the acceptability of some reproductive health services. Respect for women is often based upon traditional roles within marriage and the family. Explicit rules for women may involve restrictions of both movement and decision making. If facilities are dominated by male healthcare providers, some women will not seek healthcare at all. For example, Burmese refugee women in Bangladesh constantly complained that they did not feel comfortable talking to or being examined by male doctors (Hilsum, 1994). The movement of Afghan women refugees in Pakistan was severely restricted due to the rigidly imposed practice of Purdah; from marriage until the birth of her second child a woman could not attend the dispensary unless her husband accompanied her (Christensen H). Holck and Cates found that Kampuchean refugees (WHO 1995) arriving at two different camps had very

Table 1: Demographic characteristics of selected refugee populations

Country of Asylum	Females (x1000) years of age			Males (x1000) years of age			Percentage of total population over 18 years of age	
	0-4 yrs	5-17 yrs	18+ yrs	0-4 yrs	5-17 yrs	18+ yrs	Women	Men
Algeria	11.4	24.5	44.9	9.7	23.2	15.4	34.9%	12.0%
Benin	4.1	15.6	19.3	3.9	14.8	12.7	27.4%	18.0%
Burundi	16.0	41.0	50.7	15.2	39.7	44.3	24.5%	21.4%
Cameroon	4.5	4.4	11.1	4.5	4.4	15.2	25.2%	34.5%
C.A.R.	3.9	7.3	9.4	3.8	6.3	8.2	24.2%	21.1%
Côte D'Ivoire	43.1	86.2	61.2	39.5	82.7	46.7	17.0%	13.0%
Djibouti	2.7	6.8	8.1	2.6	6.9	6.3	24.3%	18.9%
Ghana	9.5	23.4	29.2	10.3	22.4	16.9	26.1%	15.1%
Kenya	26.5	51.6	55.9	17.6	42.6	38.2	24.1%	16.4%
Mauritania	8.5	17.0	17.8	7.7	16.2	10.0	23.1%	13.0%
Bangladesh	13.5	20.6	24.7	13.2	20.1	24.1	21.3%	20.7%
Iran	173.7	309.5	307.6	183.8	342.1	424.0	17.7%	24.4%
Iraq	4.8	6.1	7.4	5.3	5.9	9.6	18.9%	24.6%
Nepal	539	16.0	20.3	6.0	16.6	21.3	23.6%	24.7%
Pakistan	136.7	137.2	285.1	121.5	121.7	253.2	27.0%	24.0%
Mexico	3.5	6.9	7.3	3.6	7.1	7.9	20.1%	21.8%

C.A.R.: Central African Republic

Note: statistics dated 1 January 1995. Totals may not add up due to rounding. Countries selected on basis of a minimum sample of 30,000 refugees. Adapted from: *The State of the World's Refugees, 1995. In search of solutions. Annex II. Table 6.*

different fertility rates - ranging from 55 births in one camp per 1000 population to 13 births per 1000 in the other. Those with lower rates had a better nutritional status, higher socio-economic class, and came from urban areas.

Other factors include the use of traditional medicine, religious beliefs, and the level of protection the community is afforded. The level

of use of traditional medicine may affect demand for Western style health services while religious beliefs may prevent potential users from using particular forms of contraception. The level of protection afforded a community or an individual in these circumstances will affect their vulnerability to sexual and gender-based violence. Normally, refugees have better access to protection than IDPs but it cannot be assumed that a refugee

camp automatically affords all the protection necessary. Sometimes the site of a camp leaves people vulnerable to attack from their country of origin, in other cases refugees have been attacked by host country militia and/or members of militia from their home country who had fled with them.

2.2 Characteristics of displaced populations

Populations affected by crisis or upheaval are by no means a homogeneous group. Some have recently crossed an international border and are still suffering the effects of their experiences during flight, while others have been living in camps for many years. The health status, priorities and needs of these populations will vary significantly. The level of insecurity in which a population is living will affect the type of services that can be provided. In more acute emergency settings, health providers are more likely to be international staff with short term contracts and the populations whom they have gone to help may also be there on a temporary basis and may move back to their homes as circumstances change. In these distinct environments different approaches to service provision will be necessary.

It has been assumed that women and children may constitute as much as 70-85% of displaced populations (Cohen, 1995; Forbes-Martin, 1994). This figure is misleading as men together with children will also make up a similar percentage. For example, according to UN figures (UNHCR, 1995), in approximately two thirds of refugee situations the percentage of adult women outnumbered that of adult men. However in approximately a third of countries described in Table 1 (page 7), namely Cameroon, Iran, Iraq, Nepal and Mexico, the reverse was true. In Western Ethiopia 90% of the refugee population were young Sudanese men (Anderson, 1994) and the women had to be organised to teach the men how to cook.

Despite inconclusive figures, it is true to say that women who are on their own may find it more difficult to assure their own safety and that of their children. They become targets of violence from both the opposing army, the armed forces in the country of asylum and sometimes from members of their own community. They may be forced to provide sex in exchange for food, shelter or other necessities for self and family survival (Bissland, 1994; Amnesty, 1995). This will increase women's chances of being in contact with men who have

'high risk' behaviours and therefore of acquiring STDs/HIV (Zwi and Cabral, 1991).

Women may have been separated from their families - split in the confusion that ensues during exodus or short periods of intense fighting, and from their spouses - who may leave to fight, be killed or to seek income generating activities elsewhere. After the Rwandan genocide the female share of the population increased from 52% in 1992 to between 60% and 70% in 1995. The number of female headed households increased from 21% to between 29% and 40% (Eriksson et al, 1994).

Women alone become household heads and often take on new roles with increased economic responsibility. Refugee groups have here again shown remarkable creativity in developing coping strategies, female heads of household being no exception. They have often taken up commerce, collecting wild fruits or making small items to sell. Some women are forced to resort to illegal income-generating activities such as prostitution and beer-brewing (Acha Djibrinne, 1993).

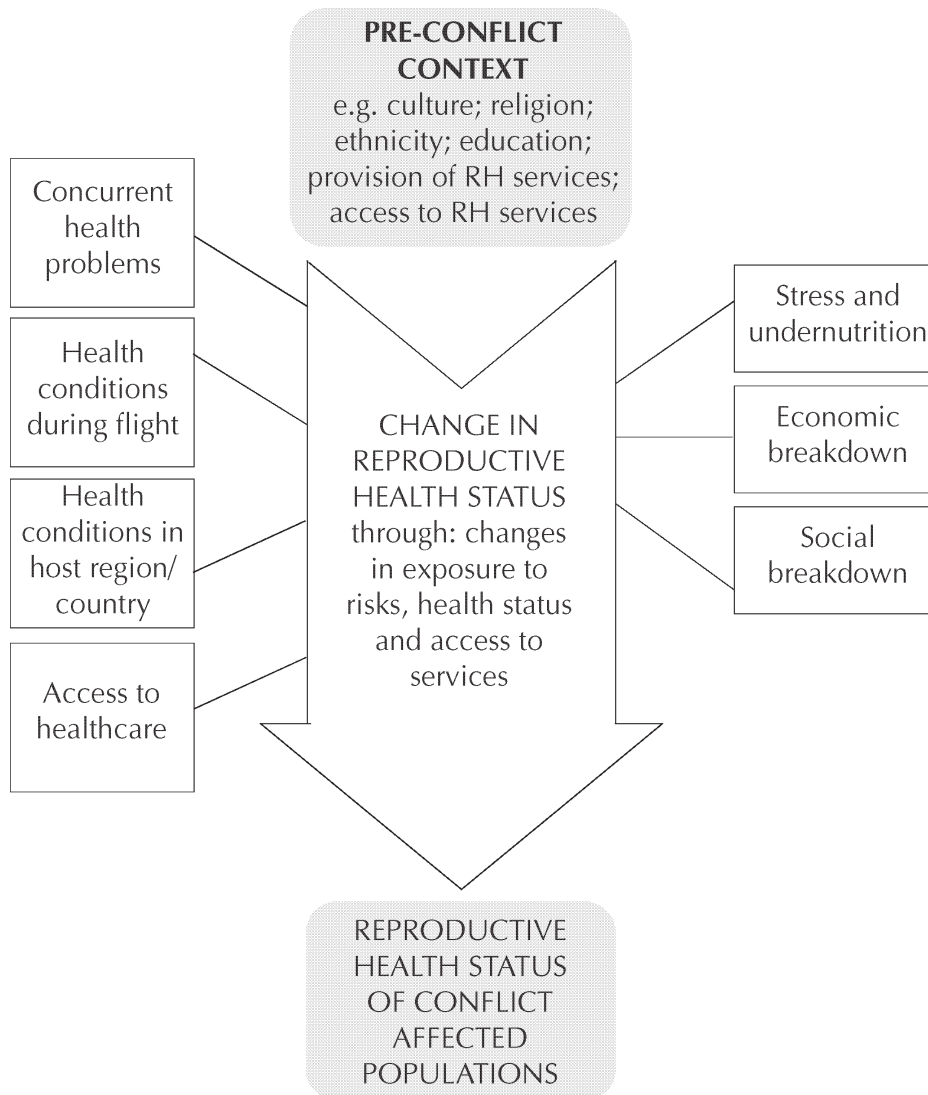
Key factors affecting the reproductive health of such displaced communities are summarised in Figure 1 opposite.

2.3 Specific reproductive health concerns

Safe Motherhood

Maternal and child healthcare has generally been regarded as an essential minimum package for refugee populations. The success of these programmes in reducing maternal morbidity and mortality is difficult to determine. Little research has been done in this field, in part because of the difficulties in evaluating outcomes, but anecdotal evidence raises a number of issues. Displaced populations may have little access to informal transport: mothers who previously relied on the passage of private cars and trucks for transport to hospital are suddenly unable to do so. Breakdown of infrastructure and loss of health service personnel, in these contexts, may contribute to a reduction in the availability and quality of services. However, with the advent of humanitarian relief in this situation, this can be reversed. During the war in Mozambique the percentage of pregnant women vaccinated against tetanus fell by more than half. The lack of health service provision will also make mothers

Figure 1. Community factors affecting reproductive health status



vulnerable to other diseases that will impact on their pregnancy. Malnutrition may be common and can be harmful to the mother and the child. The mere fact of living in high violence situations has also been shown to increase pregnancy complications (Zapata, 1992).

Miscarriage (spontaneous abortions)

NGOs working in Rwandan camps in Zaire recorded that miscarriage rates were very high (De La Rosa, 1995). In Goma, a rate of 90 miscarriages per 1000 pregnancies was reported whilst data from five camps in Bukavu suggested a rate of 139/1000 and in Hugo camp (in the Kivu region) the figures reached 163/1000. Whether these rates were indeed high is unknown as information is required about the length of gestation and secondly the proportion of these miscarriages which were due to unsafe abortion is unknown. For example, 15% of all pregnancies are thought to spontaneously abort before 20 weeks of gestation

and ninety percent of these occur in the first 12 weeks. If many of the miscarriages reported occurred after this period then these figures could represent abnormally high rates. The reason proposed as to why rates may be high are poor nutrition, malaria complications and fatigue. In southern Sudan, high perceived rates of miscarriage were described by health service providers, key informants and the community alike (Palmer, C, forthcoming). STDs were frequently identified as the cause. This may well have been the case as pregnant women with untreated Syphilis of under two years duration transmit the disease to their child¹. Approximately half of the pregnancies in mothers with primary or secondary syphilis result in miscarriage, stillbirth, perinatal death or premature delivery (Over and Piot, 1997).

Infertility

Infertility levels may increase in some circumstances due to the spread of sexually

transmitted diseases and the lack of available treatment for them. This may be a particular problem in sub Saharan Africa where the STD burden is high (Westrom, 1975, Westrom et al 1979). Currently there is no formal data for displaced populations. However, in southern Sudan displaced populations felt that infertility was high and they attributed the small numbers of pregnant women among their community to the high prevalence of sexually transmitted diseases (Palmer, C, forthcoming).

Unsafe abortions

Unsafe abortion is defined by WHO as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking minimum medical standards or both (WHO/MSM/92.5). Globally about 70,000 women are estimated to die a year as a result of unsafe abortion of whom 69,000 are from Africa, Asia, Latin America and the Caribbean (Sadiq, N, 1997). Estimates are often based on health service data with adjustments for access to and availability of services so their accuracy is not known. In addition to the mortality from unsafe abortion many more may suffer infection or trauma. Even in countries where abortion is legal, access to services may be so poor that women continue to rely on unsafe abortion with detrimental effects on their health. There is little objective data on the impact of conflict on the prevalence of unsafe abortion. In Former Yugoslavia however, we know that demand for abortion services rose during the conflict and for most of the war it averaged more than two abortions for every pregnancy going to term (Carballo et al, 1996). See section on termination of pregnancy (page 12).

Peri-natal mortality

Pregnancy outcomes may be seriously affected in other ways. The peri-natal mortality rate in Former Yugoslavia more than doubled during the war. One of the most important underlying factors was the steep increment of low birthweight babies and the difficulties encountered in keeping these babies alive. A key contributor to the increase in low birth weight babies was a change in lifestyle with an increase in levels of smoking. The incidence of congenital malformations rose from 0.7% prior to the war to 2.1% during it. Almost a quarter of the malformations included anencephalus and/or hydrocephalus. Maternal deficiency in specific nutrients and the lack of ante-natal care were implicated (Simic, 1995).

STDs including HIV/AIDS

The conditions of war increase the risk of spread of sexually transmitted diseases. Zwi and Cabral describe low intensity war as having five ways in which populations become high risk: displacement, military activity, economic disruption, psychological stresses and increased migration.

AIDS and civil war have been described as a 'devil's alliance' (Mworozi, E, 1993). Mass movement of populations will result in the mixing of people from high and low prevalence areas. The example of Mozambique is illustrative: the HIV rate began rising when nearly two million refugees, returned home from Malawi, which has a high HIV rate (Hulewicz, 1994). STD infection rates among returnees were almost double estimated rates from nondisplaced populations. 8% of women reported sexual abuse during displacement and 3% reported exchanging sex for money (Cossa, 1994).

The military often have a higher prevalence of HIV than the civilians in their country, so their movement is likely to contribute to the spread of the virus. In Uganda the pattern of recruitment into Amin's army has been linked with the geographical spread of the epidemic (Smallman, 1991). In Rwanda the annual incidence of Gonorrhoea continuously increased among military recruits between 1981 and 1984 (Piot and Carael 1988).

The breakdown of infrastructure that accompanies war and some natural disasters will also reduce access to and availability of health services. Health and maternal units have for example been specifically been targeted in Mozambique and Liberia; between 1975 and 1989 about 900 primary healthcare units in Mozambique were destroyed by fighting or looting. Moreover the health facilities that are available may become overstretched having to treat large numbers of soldiers as well as civilians. Adequate treatment for STDs is rarely provided, with contact tracing and preventative activity often being omitted.

The separation of families that ensues as a result of conflict and displacement may mean that women are without their partners for long periods of time. In this situation they are more vulnerable; women alone may not be as able to protect themselves from violence and may therefore seek new partners. Sexual violence is common in these situations and is another factor increasing the spread of sexually transmitted diseases.

Sexual and gender-based violence

The breakdown of societal sanctions induced by war together with an increase in the number of armed people, and issues of control of food and goods, make the community in general and women in particular more vulnerable to sexual abuse. Aggressors may be soldiers living temporarily in the area, deserters, or members of the opposing force. During flight, there is evidence that women have been victimised by bandits, border guards, army and resistance units. Yet the violence may not end when they reach what they consider to be a place of safety.

Perpetrators of sexual violence include guards and administrators of the camps, military personnel and fellow refugees or displaced people. Abuses include not only outright rape and abduction, but also offers of protection and assistance in return for sexual favours. The structure of refugee camps may further increase the potential for this violence to occur by locating water points far from populated areas and by the provision of communal latrines.

Musse documented 192 sexual abuse cases against refugees (mainly Somalis) over a four month period in Kenyan refugee camps between February and June 1993 (Musse, forthcoming; International Protection of Refugee Women). Nyakabwa and Lavoie describe the problems of single women refugees in Sudan and Djibouti. In Sudan, Ethiopian and Eritrean refugees were reported as using remarriage and prostitution as a means of survival (Nyakabwa, 1995). A refugee survey undertaken in 1983 found that 27% of mothers who were single and heads of households had resorted to prostitution to earn a living. In Djibouti, arbitrary rape against Ethiopian and Somali women occurred. Approximately 22-27% of Burundi women, between the ages of 12-49, reported experiencing sexual violence after becoming a refugee (Nduna, 1997). This trauma has both direct and indirect consequences. Direct consequences may be a pregnancy or acquiring an STD. Indirect consequences include the reaction of the women's family who may consider that she has brought dishonour on them and she may be rejected by her family and even whole community.

Care is needed when discussing sexual violence with women to ensure that social/cultural sensitivities are fully understood and terminology clear: female refugees in Bangladesh felt they had

been 'raped' if their veil had been removed from their faces, not that they had been subjected to forced sexual intercourse.

Family planning

There is considerable anecdotal evidence to support arguments that fertility rates rise as a result of displacement as well as fall (Wulf, 1994). In Sarajevo, the International Organisation for Migration (IOM) reported that the absolute number of deliveries fell from a yearly average of approximately 10,000 before the war to 2,000 during the conflict (IOM 1995). The IOM argue that this massive drop in birth rate could not be explained by population movement alone, but by a number of additional factors. First, most men of military age were conscripted and sent out of the city or away from home for long periods of time. Secondly, many people wanted to postpone pregnancy for fear of both physical insecurity and the chance of additional displacement.

In Pakistan, Afghan women refugees were reported to have high fertility rates. It was estimated that if current age-specific fertility rates were continued, by the end of her childbearing life an average married woman would have had 13.6 children (Wulf, D, 1994). High fertility rates were coupled with high child mortality rates in this population and most Afghan women refugees in Pakistan were estimated to have lost at least one live-born child (Miller, 1994).

Contradictions may exist within the same population, for example, discussions with refugees from Rwanda revealed that some wanted children to replace lost family members while others felt that conditions were too uncertain to have more children. A high prevalence of amenorrhoea may also contribute to low fertility rates. One of the most common problems among women in Former Yugoslavia attending a womens' therapy centre during the war was amenorrhoea (Frljak, 1997). Approximately seven months after the exodus of Rwandan refugees into Goma, according to a report by the UNHCR reproductive health coordinator, birth rates were found to be low (US Committee for Refugees, 1996). One year after the exodus, however, they started to rise rapidly but still had not reached pre-disaster levels (US Committee for Refugees, 1997). These figures should be interpreted with caution as many women may deliver without contact with health services and the denominator in these contexts is very hard to estimate.

However, reports on fertility are few and often limited by lack of age-specific data. Refugee mass movements tend to be from areas of high fertility and there is little firm evidence that fertility rates increase above the pre-conflict levels. There may be a loss in fertility in the initial stages of an emergency due to poor health status and separation of family members, but the data that is available is inconclusive. It is possible that fertility rates may increase or decrease depending on a range of factors including the health status of the displaced population and the duration of the conflict.

Figures for contraceptive use are equally sporadic. Some reports noted a rapid rise in the use of contraception when it became available in refugee camps. In Khao I Dang camp on the Thai-Cambodian border, contraceptive use rose rapidly when services were introduced from a prevalence of zero to two thirds of all eligible women (D'Agnes, T, 1982; Potts, 1980). 95% of acceptors chose the injectable contraceptive. Vietnamese refugees in Hong Kong were also reported to embrace modern contraceptive services when they became available in the camps (Mulley, 1991). In Rwandan camps there was, "an increasing demand for contraception particularly on behalf of former or continuing users". Contraceptive usage during the war in Yugoslavia was found to be low. This was attributed to the low priority accorded contraception by the health providers and difficulties in obtaining supplies.

Termination of pregnancy (TOP)

Termination of pregnancy or abortion is legal under certain circumstances almost everywhere in the world. Most countries recognise a threat to the mother's life as a legal basis for stopping a pregnancy. Approximately 60 percent of countries make some provision for the preservation of the physical health of the mother although the definitions of physical health vary. Induced abortion (as it is also known) is a relatively safe procedure but if it is performed in unsafe conditions it can pose a considerable risk to the mother.

In Latin America termination of pregnancy is the fourth most commonly used method of contraception. Estimates of the number performed range from 2.7-7.4 million per year. Figures from IPPF estimates in the mid 70s implied that between one-quarter and one third of all pregnancies were intentionally aborted (Jacobson, Jodi, 1990). Nearly all of these abortions, with the exception of those performed in Chile, Barbados and Belize,

are unsafe and their sequelae are the principal cause of death among women of reproductive age. A study in Bolivia found that 39% of women aged under 18 years who were hospitalised for complications of abortion had had illegally induced abortions (Baily et al, 1988). One of every three to five unsafe abortions leads to hospitalisation (Paxman et al, 1993). In 1987 worldwide there were between 26 and 31 million legal abortions and between 10 and 22 million unsafe abortions (Henshaw, Morrow, 1990). Of approximately 20 million unsafe abortions, these are estimated to have resulted in 70,000 deaths worldwide of which 69,000 are in developing countries and one third in Africa (WHO, 1994). In emergencies, we have little formal information about unsafe abortion and whether or not the rates increase. In Former Yugoslavia, where termination was common prior to the war, the rate was reported to increase significantly. This was attributed to changes in attitudes to fertility and reduced access to contraceptive services (Carballo, M, 1996). For most of the war the rate was said to average more than two induced abortions for every pregnancy taken to term (Republic Committee for Health and Social Welfare, 1995). The increased incidence of rape amongst displaced populations is also likely to have contributed to the requests for termination. According to estimates in medical studies a single act of intercourse will result in pregnancy between 1% and 4% of the time (Cate, 1984; Tietze, 1960). Elsewhere, as in Rwandan camps, terminations have been reported to take place but no quantitative data is yet available.

Other issues

Female genital mutilation

Female Genital Mutilation (FGM) is estimated to have been carried out on between 85-114 million living women in the world today (World Bank, 1993). According to a WHO definition, FGM comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs. FGM was condemned by the ICPD and in a joint WHO/UNICEF/UNFPA statement as a violation of human rights including the right to the highest attainable level of physical and mental health, and the right of security of the person. The practice still occurs among many ethnic groups, from West to East Africa, in Southern parts of the Arabian peninsula, along the Persian Gulf and among some migrants from these areas in Europe, Australia and North America.

FGM is usually carried out by traditional practitioners using cutting tools ranging from a piece of glass to scalpels or special knives. Instruments are often reused without sterilisation which is rarely available in these settings. Anaesthetics and antiseptics are not used and various substances are used to stop bleeding. Unintended damage is often caused by septic conditions or the struggling of girls or women. It is increasingly performed by trained medical personnel as this is thought to be more hygienic, but medical participation is strongly condemned by WHO. It is not known how emergency situations affect the practice of FGM. Many groups will have practised it prior to the conflict. Whether instability leads to an even stricter enforcement of traditional cultural practices (as for Afghan women in Pakistan) or it provides opportunities for change will probably vary significantly from place to place.

The health of adolescents

Adolescents have a special importance in relation to reproductive health. High rates of childbearing among adolescents are common in some places and have been reported particularly in sub Saharan

Africa. Here adolescent fertility comprises between 15 and 20 percent of total births in 11 countries for which data are available. Teenage pregnancies are associated with significantly worse antenatal care, lower birth weights, earlier weaning and especially during the second year of life, higher child mortality (Legrand, 1993). It is argued that in some areas the deterioration of tribal and rural traditions in the face of rapid urbanisation has led to the continuation of early childbearing in the absence of the traditional support for the young mother. Young people then become spatially and psychologically cut off from their elders who were traditionally responsible for passing on information (Barker, 1992). The impact of emergencies on adolescents is likely to be similar, with many taking on responsibility for themselves and others which they were unlikely to have in stable situations. However we need to learn more about this group in conflict situations. Existing demographic data is not very detailed but suggests that there is great variability in the number of adolescents in a refugee camp. For example, under 17 year olds made up 47% of the refugees in camps in the Cote D'Ivoire but only 24.5% of those in camps in Pakistan (See Table 1).

3

Existing and proposed policies on RH for displaced populations

Traditionally, adequate food, water, shelter sanitation, and rapid immunisation against measles were considered as essential first steps in providing assistance to emergency-affected populations. Where reproductive healthcare delivery has been seen as a priority the emphasis has been on maternal and child healthcare (MCH) (Sandler, 1987). Aspects of RH such as the treatment of STDs would be covered by general outpatient services and the complications of abortion by hospital services.

However, as discussed above, throughout the late 80s and early 90s, due in part to the UN Decade for Women and Safe Motherhood initiatives, women began to be recognised as a significant group among displaced populations whose needs had been ignored. Evidence was accumulating, for example, that family planning services were not being made universally available to refugees² (anon, *Lancet*, 1993) and in 1992, the US Department of Health and Human Services recommended that refugees should receive “counselling in family spacing, provision of contraceptives and education about breast feeding and infant care”.

This chapter looks at existing and planned provision of RH services in emergencies, focusing on the development of policy. Chapter 4 draws on case study material to illustrate specific points and Chapter 5 considers problems in implementation.

The provision of full reproductive health services in emergencies (see Box 3, page 16), is currently backed by both UNHCR, UNFPA and WHO. Dr

Nafis Sadiq, UNFPA Executive Director, stated that, “UNFPA recognise that refugees and internally displaced persons and persons in all emergency situations have the same vital human rights, including the right to reproductive health, as people in any community”.

RH policy, as with the majority of policies in humanitarian situations tend however, to be somewhat haphazard due both to the context in which assistance is provided, often insecure and rapidly evolving, but also because agencies often have their own policies developed to suit their particular mandate, principal funding sources and their employees. There is no official accountability to one body although some agencies often agree voluntarily to take note of policies and guidelines developed by others, such as the UNHCR or WHO. These concerns are by no means unique to the field of RH services, but have contributed to the comparatively little attention dedicated until now to policy development.

3.1 Current initiatives to develop reproductive health policies

In conjunction with a large number of NGOs and other interested parties, UNHCR and UNFPA hosted an inter-agency symposium in June 1995. One product of the symposium was the development of a field manual for reproductive health services in refugee settings (UNHCR, 1995) (see also Box 5 on page 18). In addition, an Inter-Agency Working Group (IAWG), consisting of approximately 32 members and including NGOs,

donors, bilateral agencies, researchers and other groups interested in working on reproductive health (see Appendix) was formed. The field manual is based on technical guidance provided by WHO, who are also finalising managerial guidelines on reproductive health. These guidelines discuss the impact of all the different phases of displacement (from exodus to rehabilitation) on reproductive health status. Despite the range and quality of organisations signed up to the IAWG process, there has recently been some controversy as to the appropriateness of its guidance at field level and as to the evidence on which it is basing some of its recommendations. Some of those concerns are discussed below, one of the principal ones being that the tone and language of the manual suggest it would be more suitable for *health* programme managers. Yet the most recent draft of the manual states that, ‘the primary audience for the manual are field managers of health services’. The final version should be completed as this paper goes to print, in February 1998. One RH programme manager, commenting on the draft manual, remarked that:

“It is useful at the moment at the management level but it needs to be changed if it is for use at the field level. It is too technical. We need another manual which is more practical.” (pers. comm. 1997)

Recognising the difficulties of providing all RH services, in the heat of an emergency, the current draft of the manual recommends the use of a ‘minimum initial service package’ (MISP) see Box 2 below, to be provided as soon as possible (UNHCR, 1995). This package has been developed for introduction without further needs assessment on the grounds that there is enough documented evidence for its justification.

While there appears to be general agreement by agencies operating in emergency settings on the implementation of the MISP, there continue to be areas of concern. One in particular is the supply of emergency contraception also known as the morning after pill³ (MSF 1997). Although this product has been described by the Food and Drug Administration of America as ‘remarkably safe and effective when used as directed’, its administration remains controversial as there is debate as to whether or not its action constitutes termination. The latest version of the inter-agency field manual (December 1997) states that, ‘Cultural and religious beliefs may preclude some providers and women from using this treatment’. This is understandable but it will also be important

Box No. 2

The Minimum Initial Service Package (MISP)

- prevention and management of the consequences of sexual violence
- prevention of the transmission of HIV/AIDS by enforcement of the respect for universal precautions and guaranteeing the availability of free condoms
- reduce excess maternal and neonatal mortality by ensuring clean deliveries and establishing a referral system to manage obstetric emergencies.
- planning for the provision of comprehensive RH into PHC.
- identification of qualified human resources - specifically a RH Coordinator

Source: Reproductive health for refugees: a field manual (1997).

to ensure that those who wish to have the treatment as well as those who are prepared to offer it, are given the option to do so.

The field manual recommends the introduction of full reproductive health services as soon as possible after the acute emergency phase. The recommended full services to be administered are shown in Box No. 3. The following chapters of this paper refer to these services as forming the basis of reproductive health services to conflict affected populations.

Many non-governmental organisations are working with UNHCR to produce common guidelines in this area. However, some also have documents which clarify policy within their own organisations or which deal with particular areas of the RH agenda. MSF, for example, in their book called ‘Refugee Health’ (MSF, 1997) confirmed their commitment to the introduction of the MISP in emergency settings. Healthcare in the emergency phase is seen as one of the top ten priorities, and reproductive health is described as a special issue under this chapter. The authors state that ‘during the emergency phase, resources should not be diverted from dealing with the major killers. However, there are some aspects of reproductive health which must also be dealt with at this stage’. They then go on to outline the MISP as the standard services to implement. AIDS and sexually transmitted diseases are given particular attention. In the ‘post’ emergency phase a full range of reproductive health services are

Box No. 3

**Full reproductive health agenda
(to be implemented once emergency conditions have stabilised)**

- 1 Safe Motherhood
- 2 Sexual and gender-based Violence
- 3 Prevention of sexually transmitted diseases including HIV/AIDs
- 4 Family planning
- 5 Other concerns such as the care of unsafe abortions, and prevention/response to FGM.
- 6 Reproductive health needs of adolescents.

Source: IAWG Field Manual, 1997

advocated.

A number of policy statements from key actors in the field of RH policy development are reproduced verbatim on the following pages. (See Boxes 4 and 5 in particular).

Box No. 4

**The Reproductive Health for Refugees Consortium (RHR)
(Lyndall Sachs, Marie Stopes International)**

During the ICPD (September 1994), CARE, The International Rescue Committee (IRC), John Snow Research and Training (JSI), Marie Stopes International (MSI) and the Women's Commission for Refugee Women and Children joined forces to set up The Reproductive Health for Refugees (RHR) Consortium. This was in response to the international consensus at ICPD that refugees and displaced populations are a notoriously under-served group when it comes to reproductive health services.

Each agency has a track record in reproductive health design, implementation, monitoring and delivery; the provision of technical assistance and training; or a range of other activities including advocacy, resource development and coalition building. Individually and as a group, Consortium members play a catalytic role in the development and implementation of a wide range of activities in the institutionalisation of reproductive health for refugees.

Consortium members play a key role in the Inter Agency Working Group on Reproductive Health in Refugee Situations. The Consortium recognises that food, water, shelter and sanitation are needed immediately and health services must be in place within days of an emergency response. But as the international community becomes more aware of problems relating to gender violence, STD transmission, and maternal morbidity and mortality in emergencies, it is clear that basic reproductive health services cannot wait for the stabilisation phase.

In response to field requests, the RHR Consortium has developed and tested a guide for conducting needs assessment in order to determine appropriate service mix. The Guide contains a core set of needs assessment questions related to the five essential technical areas: safe motherhood, family planning; STD/HIV/AIDS prevention and treatment; emergency obstetrics; and prevention of sexual violence. The questions address: services available and those needed; strategies for service delivery; materials and equipment, training; information, education and communication; and personnel and financial commitments.

In an emergency setting, Consortium members emphasise public health interventions that mitigate or interrupt the disease processes. The specific activities undertaken in the first stages of an emergency response are developed in conjunction with an assessment of the nature, location, circumstances, composition, and conditions of the affected population. In addition to rapid assessments, planning, and response, IRC has an Emergency Preparedness Programme that facilitates a pro-active approach to emergencies by reinforcing IRC's systems of readiness in the area of Program Administration, Financial Administration, Personnel Administration, Material Support, and UN/IO/GO/NGO Coordination.

Aid budgets for refugee programmes remain static, with fierce competition for limited resources. For many agencies, reproductive health continues to be perceived as a low priority area. Yet, recent research indicates that once a refugee setting has stabilised, poor reproductive health is one of the leading causes of morbidity and mortality. Agencies which fail to acknowledge this are denying refugees a fundamental human right as embodied in a range of international law, the most recent of which is the Plan of Action from the International Conference on Population and Development.

Consortium members acknowledge that every refugee setting is unique and few programmes can simultaneously address all the reproductive health issues. Two constraints stand out: funding limitations, and differing community attitudes to reproductive health. MSI's programme in Sri Lanka is a case in point. A needs assessment undertaken in 1995, indicated a huge gap in reproductive health provision among IDPs in four districts in the north and east of the country.

Funding constraints compelled MSI to identify the two most needy areas, with the focus on family planning, prevention and treatment of RTIs and preventative health. In 1997, with additional funding obtained from the EU, and armed with its earlier experience, MSI was able to expand its programme to two additional sites, providing comprehensive family planning services, diagnosis and treatment of STDs, other gynaecological services, ante and post natal care, general health services and childhood immunisations.

MSI recognised that approaches to programming for refugees' reproductive needs may differ in order to meet their special needs. Yet, the end objective remains that interventions should result in knowledge, behavioural change or technical skills that will endure and have lasting advantages within the community. MSI's experience has to date focussed on providing services to refugees in a development type situation. In recognition of this, the agency is currently exploring applying its model of local fund raising and cross subsidy between sites, areas and region. In its programmes in Sri Lanka, Pakistan and Nepal, refugees with means access services on a user pays basis, thereby freeing up funds for those who cannot afford to pay.

Consortium members seek to address a specific range of health problems, and to meet the needs of identified client groups through the provision of quality client oriented services. The Guide to Needs Assessment and Evaluation clearly sets out a series of questions to assist agencies in ensuring quality of care.

Drawing upon widely accepted frameworks for quality of care, MSI's programmes offer information to clients, choice of methods for family planning, technical competence of service providers, inter personal relations between providers and clients, mechanisms for continued care and an appropriate mix of services to address the needs of clients. MSI sets clearly defined project objectives and ensures that teams are properly trained in their respective competencies. Fundamental to the success of the programmes is the participation of the clients themselves in the quality and appropriateness of services.

The past two years has seen a dramatic increase in awareness among policy makers, donors and the general public about the reproductive needs of refugees. The experience of Consortium members has shown that simple preventative programming in the initial phases of a refugee emergency can reap enormous benefits for the health and well being of refugees. As the body of experience grows, agencies will learn from each other how best to maximise these benefits.

The RHR Consortium will continue its efforts to institutionalise reproductive health services in refugee and displaced settings through:

- Advocacy for increased attention and action among policy makers, donors and service delivery groups;
- Expanding the body of knowledge for the promotion of reproductive health in refugee settings;
- Increasing the level of funding for reproductive health in refugee situations
- Encouraging and facilitating research into and development of tools for implementation of reproductive health programmes.

Source: MSI, London. Lyndall Sachs now works for UNA in London. RHR can be contacted through Consortium members: American Refugee Committee, CARE, International Rescue Committee, John Snow, Marie Stopes and the Womens' Commission.

Box No. 5

From advocacy to action — The challenges ahead

(Kate Burns, UNHCR)

Attention to Reproductive Health in Refugee Situations stems from the 1994 ICPD where the Plan of Action states: “Migrants and displaced persons in many parts of the world have limited access to RH care and may face specific serious threats to their reproductive health and rights (ICPD 7.11) Following the Cairo conference UNHCR and UNFPA spearheaded international efforts to address the issue of reproductive health in refugee situations.

The common objective of this initiative on Reproductive Health in Refugee Situations is to promote the introduction or strengthening of *appropriate* reproductive health activities in refugee situations. A series of preparatory meetings culminated in the Inter-Agency Symposium on Reproductive Health in Refugee Situations held in Geneva, June 1995 attended by over 50 UN agencies and NGOs. The outcome of the meeting was the issuing of the field-test-draft version of the Inter-Agency Field Manual on Reproductive Health in Refugee Situations in December 1995.

As stated by Sadako Ogata and Nafis Sadik in the foreword to the Manual “Refugees and persons in refugee like situations have the same right as others to have access, on the basis of free and voluntary choice, to comprehensive information and services for reproductive health...” While provision of adequate food, clean water, shelter, sanitation and PHC *must* remain principal concerns in a refugee emergency, the guiding principle underlying all RH activities asserts that appropriate reproductive health services must and should be integrated into PHC, when feasible, and that these services should be **based on the refugees’ expressed needs and demands with full respect for the various religious and ethical values and cultural backgrounds of the refugees in conformity with universally recognised international human rights.**

The programmes outlined in the Inter-Agency Field Manual replicate internationally recognised guidelines for non-refugee populations - that is to say - guidelines for implementation of comprehensive reproductive health care for people in not in conflict or displacement. All technical recommendations reproduced in the Manual are in conformity with WHO policies on this matter. It is time to demystify the differences in undertaking RH in refugee situations - in fact — the commonalties between refugee and non-refugee populations are far greater than the differences.

The challenge

Introducing or strengthening RH services throughout the various refugee situations world-wide poses a collection of complex challenges - as they do for non-refugee situations. A field manual designed to meet the needs of healthcare providers and managers from as diverse settings as Tanzania to Thailand or Azerbaijan to Angola must be user-friendly and technically sound. Each refugee setting has to take into consideration a magnitude of factors - such as, the refugees’ reproductive health needs and priorities, the type of services provided to refugees before flight and the policies and services delivered in host countries. A field manual of itself cannot prescribe the appropriate specific RH programmes for every setting — it takes dedicated and experienced staff working closely with the community of refugees analysing their own context, and prioritising among competing demands, the major RH problems — and selecting the best interventions for individuals, communities and populations with which they are concerned. Working with national institutions is crucial. The field manual is a resource with broad programmatic guidance which needs to be adapted to each situation.

Assessments must be carried out to ensure that RH programmes not only meet the needs of the refugee population, but which are feasible and practical for partners to undertake and maintain. Material and human resources required for each component area of RH need to be assessed. Careful planning is essential to ensure that all the elements of a programme are in place before initiating any aspect of RH. For example, if management of STDs is identified as a priority,

then skills of staff in diagnosing and treating STDs needs to be assessed, skills upgraded as necessary, protocols for treatment of STDs must be prepared, drugs procured, prevention strategies developed and widely disseminated, and supervision and monitoring of treatment/prevention practices routinely undertaken.

The Minimum Initial Service Package (MISP) (described in Box 2, page 15) is designed to ensure minimum services are available to refugee populations as soon as possible in an emergency situation. The MISP is not just a package of materials and equipment - but a series of activities undertaken by qualified staff - to meet certain objectives. The MISP can be implemented without any new needs assessment as there is sufficient documented evidence for its justification.

Implicit within the MISP is the need to identify and put into place a referral service that can manage life-threatening RH emergencies. This is most often accomplished by strengthening and supporting national health facilities.

The New Emergency Health Kit (NEHK 98), now being finalised under the auspices of WHO Action Programme on Essential Drugs, includes key reproductive health elements. This will ensure that, as soon as the kit arrives, health providers have the equipment, supplies and materials to undertake most aspects of the MISP.

Besides the material needs, reproductive health services require human resources. The Field Manual recommends that a Reproductive Health Coordinator be identified early on in the emergency. This person can take a lead role in assisting actors to implement RH services in a timely and appropriate manner and finding opportunities to mainstream RH into other allied sectors, such as community services, education and protection. Experiences in the Great Lakes and Kenya have proven the important role RH Co-ordinators can play in raising awareness of RH, assisting in refresher training of health care providers to ensure the necessary skills to undertake quality RH services and providing continuous technical assistance to all actors in this important field.

It is important to remember that the majority of health workers working in refugee situations are trained healthcare providers from the refugee population, the host or neighbouring countries. We are not starting from scratch in introducing RH services in refugee situations as trained healthcare providers who provided these services prior to displacement can often be identified. They may need refresher training and certainly need supervision.

The future

Much progress has been achieved since 1994. More than 150 RH projects in some 60 countries have been described in a database on who is doing what where. Technical assistance missions by various UN and NGO actors have been undertaken to strengthen RH activities in more than 15 countries. Over 10,000 copies of the Field Manual have been distributed. It has been field-tested by more than 100 health professionals representing 50 agencies in 18 countries. Results overall, expressed by field-testers, has been favourable to the manual and its contents. It is now being revised incorporating comments from the field as well as any new technical information, from sources such as WHO and UNAIDS. The final field manual will be ready in mid 1998.

It is our expectation that the multitude of actors involved in meeting the health needs and well being of refugees and displaced populations are committed to providing comprehensive and high quality RH services, based on their abilities, to the populations they serve - through programmes which involve refugees in all aspects in a culturally sensitive manner.

Source: UNHCR, Geneva. Kate Burns, Senior Reproductive Health Officer, Programme and Technical Support Section.

3.2 Policies on specific areas of the reproductive health agenda

● *HIV/AIDS*

Combined UNHCR,WHO, UNAIDS Guidelines for HIV interventions in emergency settings were published in 1995. MSF also have a policy specifically for HIV/AIDS indicating priority interventions (see Box 6) in the emergency phase: actions 1-6 are recommended for implementation together with condom distribution to those who ask, as well as symptomatic treatment of AIDS.

Box No. 6

MSF priority interventions for HIV/AIDS programmes

- 1 Rational indications for blood transfusions
- 2 Safe transfusions, when transfusions are really necessary
- 3 Proper sterilisation/disinfection and proper disposal of medical waste
- 4 Reduction of injections
- 5 Reduction of HIV transmission through sexually transmitted diseases control
- 6 Protection of health workers
- 7 Medical Management of AIDS cases
- 8 Promotion of safer sex
- 9 Counselling and social support
- 10 Protection of the patient against discrimination

Source: Blok, L.; Deguerry, M.; Sohier, N. MSF and AIDS Policy Paper. 2nd Version - April 1996. in *Medical News* October 1997.Vol.6 No 3

● *Family planning*

A number of caveats exist in general policy documents to the introduction of family planning services. Before introducing family planning services for example, the IAWG manual states that the situation requires 'stabilisation'. Stabilisation is said to have occurred when the crude mortality rate falls below 1 in 10 000 per day, when there are no major epidemics and when the 'settled' refugee population is not expected to repatriate or relocate over a six month period. MSF agree with the above and state that no family planning programme should be undertaken unless:

- the situation is stable and the emergency phase is over;

- refugees are expected to stay in the camp for at least six months;
- the necessary resources are available;
- there is a demand for contraception within the population and this need has been thoroughly assessed.

MSF also counsel that the acceptability of such a programme by other organisations in the camp should be considered and finally the extent to which continuity can be guaranteed ie. the same service provider should be available for at least six months. Although some caveats are understandable in these contexts, those already mentioned could be interpreted so stringently that services would be excluded in all circumstances. A system needs to be in place which ensures that populations that need and want family planning are able to access it.

● *Sexual and gender-based violence*

Other specific guidance includes UNHCR guidelines on the prevention of and response to sexual violence against women. Statements have also been issued about the response to female genital mutilation in non displaced settings. WHO, UNICEF and UNFPA produced a joint statement on the latter which is reproduced on opposite in Box 7.

● *Termination of pregnancy*

Where guidelines specific to displaced populations is not available, information and guidance established in stable contexts is an essential aid to establishing services. The ICPD statement on abortion, for example, makes the roles and responsibilities of service providers clear. See Box No. 8.

3.3 Difficulties in determining policy

The problems agencies face in developing policy with regard to reproductive health issues are numerous. Some of the issues facing policy-makers are described below.

● *paucity of good data on how emergencies affect reproductive health status*

Biomedical, epidemiological and socio-economic data are needed to assess the need for reproductive healthcare and evaluate interventions, but this data tends not to be widely available (see Chapter 2) in these contexts. Registration systems often fail to provide even basic data on the age and sex

Box No. 7

Joint WHO/UNICEF/UNFPA statement on Female Genital Mutilation.

“All societies have norms of care and behaviour based on age, lifestyle, gender and social class. These ‘norms’, often referred to as traditional practices, originate either from social or cultural objectives or from the empirical observations related to the well being of individuals or the society. Traditional practices may be beneficial, harmful or harmless. Traditional practices may have a harmful effect on health, and this is often the case in those relating to female children, relations between men and women, marriage and sexuality. In presenting this statement, the purpose is neither to criticise or condemn. But it is unacceptable that the international community remain passive in the name of a distorted vision of multiculturalism. Human behaviours and cultural values, however senseless and destructive they may appear from the personal and cultural standpoint of others, have meaning and fulfill a function for those who practise them. However, culture is not static but it is in constant flux, adapting and reforming. People will change their behaviour when they understand the hazards and the indignity of harmful practices and when they realise that it is possible to give up harmful practices without giving up meaningful aspects of their culture.”

Source: World Health Organisation, 1996. Female Genital Mutilation: A Joint WHO/UNICEF/UNFPA Statement. Geneva: WHO.

breakdown of the populations (De la Rosa, 1995). In many places, the issue of registration is being addressed (pers. comm. K. Burns, UNHCR), even if the data is not adequately used at field level. Some reproductive health issues such as unsafe abortion and female genital mutilation are sensitive and therefore difficult to document. Others such as maternal mortality pose technical problems as the relative infrequency of a death means that large studies may need to be done at considerable expense.

● ***lack of information about effectiveness of interventions***

Effective reproductive health interventions can make a significant impact on the health and health status of populations in non-conflict settings: the use of the combined contraceptive pill to prevent pregnancy (Guillebaud, 1993), the use of condoms and the treatment of STD infections to reduce HIV transmission (Pinkerton, 1997; Grosskurth, 1997) and the immunisation of mothers against tetanus (Jamison, 1993) are a few examples. The effectiveness of these interventions is unlikely to vary significantly in conflict contexts. Other services that are currently being provided are of uncertain benefit. Regular prenatal care is needed to help detect and manage some pregnancy-related complications and for health education purposes. However, the most effective timing and content of prenatal care is unknown (World Bank, 1994). The number of prenatal visits may not be important and as few as three may be enough where services are of high quality (Weinstein et al, 1993). Operational strategies to address issues of recent

Box No. 8.

Common position of the international community towards abortion (TOP)

“In no case should abortion be promoted as a method of family planning. All Governments and relevant inter-governmental and non-governmental organisations are urged to strengthen their commitment to women’s health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services. Prevention of unwanted pregnancies must always be given the highest priority and all attempts should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have access to reliable information and compassionate counselling. Any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislative process. In circumstances in which abortion is not against the law, such abortion should be safe. In all cases women should have access to quality services for the management of complications arising from abortion. Post abortion counselling, education and family planning services should be offered promptly which will also help avoid repeat abortions.”

Source: ICPD Programme of Action (1994) Paragraph 8.25

concern, such as the provision of counselling services to address gender violence, are also relatively untested. Concerns about the effectiveness of counselling services have been explored more fully in a previous RRN Network Paper (Summerfield, 1996).

- ***deciding on the importance of needs assessment and on how needs can be assessed***

Traditionally the identification of needs in humanitarian emergencies and among displaced populations have taken the form of rapid assessments (Guha-Sapir, 1991). These assessments often incorporate observation, the collation of health service data and discussion with community leaders. The delivery of appropriate and effective reproductive health services necessitates a more in depth understanding of community knowledge, beliefs and attitudes. Qualitative data collection using, for example, focus groups and in-depth interviews have proved useful (De la Rosa, 1995, IRC, 1997) as have rapid and participatory appraisal methodologies (Palmer, 1998) but will not be adequate for all purposes. Certain reproductive health indicators such as maternal mortality cannot be measured directly and a proxy measure of need will have to be used (Graham and Campbell, 1990). Such measures are being developed in stable settings including the measurement of maternal deaths through asking sisters of the woman who died and the measurement of a set of what have been called 'near miss' indicators (Filippi et al, 1997). Policy-makers in humanitarian aid are therefore faced with a situation where recommendations for services and their measurement are constantly changing.

Other aspects of the RH agenda are sensitive and appropriate skills and specific approaches will be needed to obtain the information required. One approach used to obtain sensitive information is the use of scenarios. Scenarios are hypothetical stories of events that can be presented and then discussed, enabling sensitive topics to be discussed in a less personal way³. More investment to develop further innovative methodologies for assessing need may have to be made.

A vast amount of information on the community and its reproductive health status prior to exodus could and should be made available to providers working with displaced populations. Anthropological, health and socio-economic data

about the population are often available but rarely collated and distributed at field level. Data such as pre-conflict fertility rates, STD/HIV seroprevalence, details of health service provision and the legality of abortion in both the country or region and host country will be useful and could form a baseline to guide further assessments. The RHR Consortium have developed a compendium of tools that could be used in these settings (add quote).

- ***deciding how services should be prioritised***

In the face of competing priorities and diminishing humanitarian aid budgets (World Disasters Report, 1996), it is a difficult time to introduce new services. Many still argue that reproductive health, or some aspects of it, should not be seen as a priority in these contexts. However reproductive health problems have been shown to contribute substantially to the global burden of disease and there is evidence to suggest that some reproductive health programmes represent some of the most cost-effective interventions in the health sector in low-income countries (World Bank, 1993). Many displaced populations come from regions with high fertility and maternal mortality rates (exacerbated by poor prenatal and delivery care and unsafe abortion) and where STDs/HIV are a major cause of disability and death. However, to date, priority among displaced populations have been given to other needs.

- ***ensuring that legal, religious and cultural views of beneficiaries and service providers are respected***

Some areas of the reproductive health agenda, such as female genital mutilation and aspects of contraceptive services are sensitive issues. Both beneficiaries and service providers will have different attitudes towards them depending on the religious, cultural and socio-economic background from which they have come. These different views will need to be taken into consideration and respected while ensuring that those who both need and want services are able to access them. Dilemmas may arise when, for example, services to which a population are accustomed may be illegal in the host country to which they have fled.

4

Case studies of current RH services

It is still rare to find programmes where the full reproductive health agenda is being implemented: in some cases existing services (MCH and STD treatment) may simply be re-packaged and termed reproductive health. A database that is being developed on reproductive health in refugee situations cited approximately 150 programmes which were currently being run on reproductive health issues in refugee contexts, but this figure includes programmes which may provide only one aspect of reproductive health e.g. safe motherhood. Out of the 150, only one programme was listed as comprehensively covering all the major aspects of reproductive health. Instead more piecemeal change is occurring with agencies introducing one or two aspects of the reproductive health agenda into their existing programmes or different agencies may be providing one or other aspects of reproductive health within the same setting.

Much of the impetus for change has come from the emergence and spread of HIV/AIDS and media reporting of the occurrence of sexual violence among displaced populations. Even before the ICPD conference in 1994 some change was occurring. In 1991, for example, a prevention of HIV/AIDS programme initiated by MSF-Switzerland commenced in refugee camps in northern Uganda this programme has been handed over to an indigenous NGO (Madi Aids Community Initiative - MACI) and is still continuing. This chapter looks at some examples of these programmes, which despite the absence

of formal policy guidelines up till now, have been implemented. It is hoped that using examples of actual practice will help the reader to visualise opportunities for appropriate provision. The information below essentially covers work known to the author, and as such it is recognised that it does not give a comprehensive picture.

4.1 Controlling STDs with Rwandans in Tanzania (1994)

In Rwandan camps in Tanzania, AMREF undertook a rapid 8-day assessment of the prevalence of STDs in August 1994 (Mayaud, LSHTM/AMREF, 1997) soon after the arrival of refugees between April and June 1994. Prevalences of STDs were assessed from a survey of antenatal clinic attenders, men from outpatient clinics and men from the community. All groups reported frequent experience with STDs and engaging in risky behaviour prior to the survey. However, during the establishment of the camps sexual activity was said to be low. Over 50% of antenatal attenders were infected with agents causing vaginitis and 3% with Gonorrhoea. The prevalence of active Syphilis was 4% and among male outpatient attenders this figure rose to 6.1%.

A mass education programme was initiated after the assessment. This included the use of eight large mobile exhibition boards bearing messages in the local Rwandan language with cartoons around the theme of HIV/AIDS/STDs. 400,000 STD/AIDS education leaflets were distributed. Health

workers from 13 different organisations were trained to provide medical care using WHO recommended STD treatment flowcharts. Clinics were equipped with essential supplies and STD drugs. Full evaluation results are expected soon but early results suggest that the prevalence of STDs may not have decreased but neither did it rise (personal communication P. Mayaud, LSHTM/AMREF). One of the problems that arose was the difficulty in changing programmes when it was found that some STDs were resistant strains and would not respond to previously recommended drugs. The project collaborated closely with CARE who were concentrating on the provision of education and information. AIDS Community Educators (ACEs) were also recruited from the refugee community to give messages in one to one encounters and group discussions. Trained counsellors also gave education sessions while patients waited to be seen in 'outpatients'. More effective strategies to promote individual action was felt to be both through encouraging self-empowerment, 'the freedom to choose,' through the message, 'treat STDs to protect and ensure future fertility.' (Benjamin, J.A., 1996). A follow up knowledge, attitude and behaviour survey showed that condom use did not increase but there was an overall decrease in the number of people reporting multiple sexual partners and an improvement in knowledge about HIV transmission.

4.2 Using reproductive health kits in Former Yugoslavia (Feb 1994-Jan 1995)

In the Former Yugoslavia, Marie Stopes International (MSI) introduced the first reproductive health kit. The kit was designed in September 1993 and updated following the first phase of distribution (MSI 1995). The initial kit contained supplies, equipment and information/education material necessary for the following: -contraception (oral contraceptive pills, IUCD and condoms), abortion, gynaecological examination and pregnancy testing. It was therefore heavily weighted towards the provision of family planning services. In order to disseminate public information on reproductive health and family planning issues, MSI developed and produced leaflets in the local language for distribution with the kits. Two seminars on family planning were held. Changes in the kits were recommended to incorporate other needs of the community including supplies for cervical screening, the

maintenance of problematic pregnancies and treatment of STDs. MSI, for example reported that "In Zeneca,...statistics show that while the number of deliveries remain constant the abortion/delivery rate has changed from two abortions to every delivery in 1993 to one ...in 1994" (MSI, 1995). In May 1994 an evaluation of the programme raised concerns by team members about the hostility of some of the beneficiaries to the programme and the difficulties this caused for field workers (DFID, 1994).

4.3 Coordinating reproductive health services for Rwandan refugees in Congo (Former Zaire) 1995-6

Where comprehensive programmes have been initiated it has often been through the action of a reproductive health coordinator who has advocated and supported the work of a number of agencies. One of the first attempts to introduce comprehensive reproductive health services occurred in the camps for Rwandan refugees in the Democratic Republic of Congo (Former Zaire). A reproductive health coordinator was appointed for Goma and Bukavu, Lake Kivu region in early 1995, through John Snow Inc., some seven months after the initial influx. Reproductive health working groups were established in every camp in Goma and consultation meetings were held with implementing partners in Bukavu. The programmes initiated in the camps included: evaluation of community needs through focus group discussions; identification of priority needs and programme constraints; implementation of surveys and studies on HIV/AIDS and family planning; collection of data and the development of a reporting and monitoring system for reproductive health indicators; a review of NGO and staff capacity for implementing activities; provision of training in information, education and communication (IEC) activities and training of community workers and healthcare providers.

Agencies provided family planning and safe motherhood services, and STD/HIV prevention and treatment activities. Ante-natal consultation was one of the most popular reproductive health services provided. During the mission there was said to be an increasing demand for contraception by the women especially by former and continuing users. One of the points noted by the RH Coordinator in a final report on the programme was the presence of local capacity demonstrated by the presence of 'competent Rwandan refugees

working with NGOs on reproductive health activities.’ (De la Rosa 1995).

4.4 Advocating reproductive health among Kenyan refugees in Somalia (1995-6)

In 1995, in the Somali camps in North-East Kenya, the National Council of Churches of Kenya (NCCCK) was given the responsibility of integrating the missing aspects of reproductive healthcare into services at Kakuma and Dadaab camps. The reproductive health coordinator found that safe motherhood services were already offered in the camps, treatment of STDs was available and a support programme for the survivors of sexual violence existed. However, family planning services were only established in one camp and no preventive or education programme about AIDS/STDS was available. Training and workshops were then initiated and where necessary supplies provided (Riungu, Mutua, Mohamed, 1997).

In the same camps, the NCCCK also addressed the issue of female genital mutilation with the community. The details of the practice and its origins were discussed with community leaders. They reached some agreement that parts of the practice should be changed. One UN representative stated that

“among men there is still some opposition to the stopping of FGM. Some believe that the clitoris should be bled. They are prepared to reduce the extent of the FGM but not to stop it altogether”.

In addition, attempts were made to reach adolescents. At first leaders were concerned about what the young people would be taught so they attended the youth sessions. The importance of preserving their fertility for the future of their family and clan was emphasised. Later more direct contact with young people was achieved and specific needs were identified. A report on the project (Riungu and Barasa 1997) stated that,

“[young people] owned up to being sexually active ...informing us of the availability of cheap sex in the town.....[and that] exchange of sex for food was common”.

In June 1995 a survey revealed minimal condom use among those who were sexually active. Those who had used them did not know how to use them properly. A group was trained specifically to direct their educative efforts toward the youth. Sessions

for young people were organised on STDs, HIV/AIDS, adolescent crises, school drop out, alcoholism and early marriage. Young people themselves were also trained to teach their peers.

4.5 Addressing violence among Burundian refugees in Tanzania (1996)

The International Rescue Committee had been assisting Burundian refugees in South West Tanzania since the first influx in 1993. A range of reproductive health care services, including family planning, counselling and contraceptive distribution, education on the prevention of STDs and safe motherhood initiatives were taking place within primary care services in Knembwa camp. The refugees were estimated to have suffered a high degree of sexual and gender-based violence both prior to their flight, during flight and within the camps. The ‘countering gender and sexual violence project’ was initiated in October 1996. The aim of the project was to reduce violence and to minimise its consequences. The project was managed by two women one of whom was a Burundian refugee who was an elected community leader from the camp. Involving community members was seen to be crucial for the project to work. Elected refugee women representatives were therefore chosen to counsel and support those who had experienced violence. These representatives were involved in the assessment process which was undertaken at the beginning of the project. The assessment included in-depth interviews, group discussions and a survey (Nduna, 1997). Very high response rates were achieved and were attributed to involvement of the community leaders and representatives. It was noted that ‘participatory methods ...make the community desire change’. The results suggested that approximately 25% of the 3,803 Burundian women between the ages of 12-49 in Knembwa had experienced some form of sexual gender violence. Survivors of violence reported to the Women’s Representatives or members of the project team and a programme of assistance was then offered (See Box 9 overleaf).

4.6 Maternal health education in Afghanistan

Health Unlimited, a British NGO has undertaken some pioneering work using health education media projects (Health Unlimited, 1993). One project is taking place in Afghanistan with the BBC Radio Pashto service using programmes with

Box No. 9**IRC Burundian refugee project for victims of gender violence**

- 1 Counselling in how to continue to live in the community
- 2 Medical examinations for trauma, STDs including HIV and pregnancy
- 3 Material support such as soap and clothes for the most needy
- 4 Referral to camp management through social workers to apply for family separation in cases where women fear continued domestic violence
- 5 Referral to the camp police to investigate in cases where the woman wants to seek prosecution
- 6 Open invitation to return as often as they want to discuss the incident or their feelings.

Source: IRC (1997) Pain too deep for tears. Assessing the prevalence of sexual gender violence among Burundian refugees in Tanzania.

drama, song and comedy to bring health messages alive. Early results, as assessed by a follow up survey, showed significant changes in attitudes and practices in mother and child health. During the project, local warlords used the radio to negotiate a ceasefire to facilitate a mass communication campaign. More recently in Cambodia, similar techniques have been used to educate women about birth spacing.

5

Issues affecting implementation of RH services

Doucement, doucement, je suis pressée'

As discussed previously, the concept of reproductive health is a new one, and despite the rhetoric and activity at an international level, field workers in humanitarian contexts may have little knowledge of the agenda. This is not surprising in some ways as what policy there is has, for the most part, been developed from the top, with little involvement of representatives of international field workers or of the communities (Palmer, C, forthcoming). One reason for this is the fact that humanitarian aid workers are a mobile workforce, often only remaining for a short time in the field, making it difficult to involve them at policy level. Representatives of both the communities affected to date and the host countries also appear to have had little opportunity to influence policy. Perhaps as a result, some humanitarian agencies have been slow to take forward the new agenda because of concerns about prioritisation of the issues and quality of care.

Some of the difficulties facing policy makers in the field of reproductive health have already been outlined in the Chapters above, but other issues face those implementing programmes. At a local level these difficulties revolve around answering the following key questions: (i) how to prioritise reproductive health; (ii) how to obtain an understanding of the needs of the community; and (iii) how to ensure high quality services. These issues are discussed in more detail below.

5.1 Deciding how to prioritise reproductive health services

One of the first problems the advocates of such service provision and RH coordinators have however, is in persuading field colleagues of the importance of RH. Service providers often underestimate the significance of reproductive health to the populations with which they work. This may be because specific needs assessments, where appropriate questions are asked, are not undertaken, perpetuating the perception that demand for such services from displaced populations is low. Unless the right questions are asked, programme decisions will continue to be made on incorrect assumptions. One programme manager responsible for southern Sudan said:

"I .. see if we can make them [displaced populations] aware before it (AIDS) hits them... then it may have minimal damage but ... they all want to have children.... . We realise its a problem and its a priority but... maybe there are more pressing health needs, more immediate health problems for the populations".

and another said,

"At the moment reproductive health is not a priority...abortion is not a problem, they already have good child spacing, ...violence is not occurring in Sudan as the women are treasured."

Yet in research recently undertaken in southern Sudan with Oxfam, a number of beneficiaries were not happy to have so many children;

I don't want many as if you have many they may become thieves and they don't listen to you so its not good to have too many. Another reason for having few children is because the men now divorce you and leave you and your children".⁵

many women talked about the occurrence of induced abortion in their communities:

"Some people don't want to be pregnant especially if they are very young or if they are pregnant by a man other than their husband. They take herbs and chloroquine injections by breaking glass and drinking it. They also take Omo. People die because of this. Some also try with a wire".⁶

child spacing was also easier in theory than in practice,

"...but some women conceive even if their baby is only four months old. While keeping away from their husband he can go and 'steal outside' If you don't allow men to go and 'steal outside' they will make you pregnant in four months time".⁷

and violence in the home was very common,

"The reasons for beating are mismanagement of funds, misconduct, if the woman refuses to have sex with her husband, improper ways of receiving visitors, infidelity, abuse of her husband, rumour mongering and theft".⁸

Health providers may feel concerned about cultural and religious beliefs of the people with whom they are working, and rightly or wrongly, some think it better to ignore an issue and therefore to avoid controversy (pers. comm., NGO Medical Coordinator, Nairobi). Health workers in Somali refugee camps in Kenya were worried about security and felt there may be a backlash from community leaders if family planning services were introduced (Riungu, Muta, Mohamed, 1997). Other service providers have been concerned about the possible abuses, for example, the coercion of women to commence family planning methods in order to reduce fertility (pers. comm. RH field worker). However, an outright refusal to provide services where there is need would be regarded as a refusal of rights as endorsed at the ICPD conference.

Depending on the available resources it may be necessary for field workers to prioritise interventions within the reproductive health agenda. In Former Zaire (Congo) service providers were faced with delays in the provision of condoms and contraceptive supplies. In order to

address these constraints, NGOs prioritised needs in their camps by using four criteria. These were: severity, prevalence, acceptability to the community and feasibility. The reproductive health services were scored in each of these areas and then ranked. Goals and objectives were then set according to these priorities. (De la Rosa, 1995). Collecting data about need was an essential first step in deciding what services to implement (see following section). However more sophisticated prioritisation mechanisms may be needed to ensure appropriate and efficient use of resources. Researchers at Columbia University have drawn up criteria for prioritising international reproductive health programmes which takes account of the following factors:- the views of beneficiaries, the availability of resources, the feasibility of delivery within a given timescale, legal and cultural constraints.

5.2 Assessing the needs of the community

Many NGOs have already signed up to the 1994 Code of Conduct for NGOs working in disaster response programmes (RRN, Network Paper 7, 1994). The Code states that, 'wherever possible, we will base the provision of relief aid upon a thorough assessment of the needs of the disaster victims and the local capacities already in place to meet those needs....in implementing this approach, we recognise the crucial role played by women in disaster prone communities and will ensure that this role is supported and not diminished by our aid programmes.' A number of issues will face international field workers in seeking to fulfill the Code in relation to reproductive health. First, more in-depth needs assessments are often time consuming, both in the methods themselves and the time needed for analysis. Both financial and human resources will need to be made available to ensure the results are as robust as possible. Service providers will need to ensure their staff have the skills to undertake these assessments. Local capacity may be available as some techniques (described earlier) will be familiar to community members. The advantages of these methods of assessment are that they increase the involvement and therefore commitment of the community concerned. IRC used these methods in assessing gender violence (discussed above) and found that their advantage was in giving the community control and making the community desire change. A cautionary note was struck however, indicating that the methods

should only be used if programmes to address the issues of concern to the community are developed (IRC).

Where communities have not been involved in planning it is possible to provide services which do more harm than good. For example, a number of Somali women rape survivors who were transferred to the coastal refugee camps in Kenya subsequently asked to return to their previous camps. The reason they gave was that they had been put in a special area for women who had been raped where they had become isolated and stigmatised (pers. comm., NGO health worker).

Just as it is difficult to assume the priorities of a community it is also difficult to make assumptions about their needs. In Former Zaire up until early July 1995 only one NGO was providing family planning to the Rwandan refugees but they were reported to have informal sources through private pharmacies and refugee medical doctors in one of the camps. These refugees often brought their own supplies (mostly oral contraceptives, injectable contraceptives and Norplant) with them (De la Rosa, 1995). One year later, contraceptives were being provided in all camps and the contraceptive prevalence rate doubled (pers. comm. K. Burns, UNHCR).

5.3 Ensuring a high quality of care

Even if services are made available, beneficiaries will not use them if their quality is poor (Parker et al, 1990). Quality of care has been shown to play a significant role in women's use of prenatal care (Locay et al, 1990), whether in choosing to give birth at home (Sargent, 1989) or continuing contraception use (Mensch, 1993).

There are many aspects to quality of care and in emergency contexts poor quality generally results from lack of continuity, lack of infrastructure, insufficient staff, inadequately trained staff, insensitivity to patients, lack of involvement of the community, shortages of equipment and supplies, and inadequate evaluation. In addition, long waits and lack of monitoring and privacy or confidentiality also reflect a lower standard of care.

The provision of continuity of care is especially difficult in unstable contexts due to short term funding, short contracts of humanitarian aid workers and the unpredictable future of the displaced population. Some RH interventions fit more easily into short term programmes than

others and in some circumstances pragmatic choices will have to be made. In the former Zaire the medical coordinator of UNHCR Goma recommended the provision of only two methods of contraceptives: combined oral contraceptives and injectables. The rationale for this was to keep family planning simple in the beginning due to the difficulty of follow up and poor hygiene in the camps (De la Rosa, 1995).

Concerns have been raised about the availability of financial and human resources to implement quality reproductive health services. There is some indication that there is an expectation from donors that they want to see the introduction of such services at no extra cost (pers. comm., RH programme manager). This is unlikely to be realistic when many agencies are already struggling to provide what was previously considered a minimum service (World Disasters Report, 1996). RH coordinators have already identified a need for extensive training (Obaso-M, 1997). Results of cost-effectiveness studies suggest that money provided for RH services will produce considerable saving in the future and this is a strong argument in making the case for increased funding to ensure they can be provided. The lack of available resources may disproportionately affect those who are internally displaced as there is no single international agency with the responsibility to help them.

The problems of resourcing may be solved to some extent by working collaboratively with local hospitals and indigenous NGOs already established in the area. There are a number of reasons why working closely with the host country or region may be beneficial: it may contribute to the continuity of care, it will ensure that tension does not arise between the host and displaced communities and finally there is an opportunity to enhance local capacity (Toole, 1990).

Local communities are often affected by infectious disease spread from the displaced community and vice versa. When the Rwandan refugees arrived in Tanzania there were concerns about the spread of HIV to the local populations. The refugees were coming from a country with prevalence rates varying between 5-35% whereas the district in which they arrived had low prevalence rates of between 3-8%. If services are only provided for the displaced populations then inequities between them and the host population will rapidly increase. (De la Rosa, 1995). The limitations of the mandate of UNHCR to provide services for the local

population may be a barrier to solving this problem.

Programme monitoring and evaluation will need to be undertaken to ensure quality services are maintained. Where data are available, health service indicators should be used to measure programme impact: changes in the prevalence of neo-natal tetanus for example or the proportion of maternal deaths from obstructed labour.

Indicators will have to be developed in accordance with resources, priorities and needs and in consultation with the host and displaced communities. However resources may be limited and/or where technical measurement of impact may be difficult. In these circumstances field workers may have to place reliance on process indicators. Process indicators measure either inputs or outputs of a programme: an example of an input would be the percentage of staff trained in gender awareness and an output would be the proportion of pregnant women who have received

iron and folate tablets. A subgroup of the IAWG has recommended indicators which could be used in these settings and these are described in detail in the field manual. Involving the community and local health workers in evaluation as well as ensuring they are informed of results and action to be taken will help ensure success. Limiting the number of indicators to those essential to the programme may simplify data collection and ensure more accurate information and timely feedback.

Initiatives are currently under way to both develop a set of minimum standards in the provision of food, health, nutrition, shelter and water/sanitation elements of humanitarian assistance, known as the Sphere Project⁹, and the People in Aid initiative which seeks to ensure the appropriate briefing and training of all aid workers both prior to, during and following their field work. The team working on minimum standards in health will be covering reproductive health in its ambit.

6

Conclusion

“If you concentrate too much on the provision of material aid, on saving lives, you forget about the human dignity you say you want to restore”, Hugo Slim.

Despite the difficulties of implementing the RH agenda, these services have the potential to greatly improve the health of populations yet remain cost-effective. Investments in reproductive health may benefit not only the individual and their family but also the community and the next generation. The first steps in initiating change, through a greater awareness of RH issues, are under way at an international level but a commitment must be made to ensure that such changes take place at field level.

In order to ensure the implementation of high quality programmes a number of investments will be required. First, international field staff will need to understand the reproductive health agenda. They should be informed, for example, about gender issues as well as the social, cultural and psychological aspects of sexuality and reproduction and available methodologies to assess need. Some of the recommended services and techniques will not be familiar to international workers in their home countries. A commitment should therefore be made to utilising local capacity and enhancing it where necessary. Secondly a commitment to evidence-based policy and practice will be necessary; if evidence is available and generalisable it should be incorporated into current guidelines. Further research to address specific issues may be required and efforts should be made to ensure that it takes place. Finally the evaluation and monitoring of programmes will be essential tools that will also need an increase in both human and financial resources in order to be effective.

The introduction of the RH agenda is at a crucial period for humanitarian aid and could create the

opportunity for accelerating more extensive changes in the way relief services are organised. Relief aid is increasingly criticised (Toole, 1993, Macrae and Zwi, 1994) and calls made for more accountability, particularly to the beneficiaries (Macrae, de Graaf, 1997). Some of the critique has centred around what many consider an artificial division between relief and development which is also reflected in funding structures. This model now appears out of step with the reality of situations where populations have no possibility of a fast return to normality and receiving relief becomes a way of life. IFRC, among others, are advocating a new approach they have named developmental relief (World Disasters Report, 1996). It has three specific features: it seeks to communicate with beneficiaries, it looks to sustain livelihoods, not just lives and it aims to build on local realities. The community’s participation in all aspects of the relief effort from planning through implementation and evaluation are said to be key. This has also been shown to be particularly important in the field of reproductive health (Barnett-B, 1995; Zulkifli 1994) and is essential in order to ensure that these services are acceptable, appropriate and sustainable (Robey, 1994). Without this approach suspicion and opposition from the community is more likely and may lead to under-use of good safe services (John Hopkins University, forthcoming).

Donors, policymakers and service providers are now facing crucial decisions about how to integrate the new RH agenda and their greatest challenge may be to ensure that rhetoric about community participation becomes a reality.

Appendix

Signatories to the Inter-Agency Field Manual on Reproductive Health in Refugee Situations

Original Signatories to the Manual

- ♦ Action Africa in Need
- ♦ Action Contre la Faim
- ♦ African Medical Research Foundation
- ♦ American Refugee Committee
- ♦ Andrew W. Mellon Foundation
- ♦ CARE International
- ♦ Centro de Capacitación en Ecología y Salud para Capesinos
- ♦ Columbia University
- ♦ Family Health International
- ♦ Government of the USA
- ♦ International Federation of the Red Cross and Red Crescent Societies
- ♦ International Planned Parenthood Federation
- ♦ International Rescue Committee
- ♦ International Organization for Migration
- ♦ IPAC Flemish AIDS Coordination Centre
- ♦ John Snow Inc.
- ♦ Marie Stopes International
- ♦ Save the Children Fund UK
- ♦ UNFPA
- ♦ UNHCR
- ♦ UNICEF
- ♦ Wellstart International
- ♦ Women's Commission for Refugee Women and Children
- ♦ World Association of Girl Guides and Girl Scouts
- ♦ World Health Organization

Additional agencies : now members or interested parties

- ♦ Centre for Disease Control
- ♦ CONCERN
- ♦ CRED
- ♦ Department for International Development
- ♦ GOAL
- ♦ International Centre for Migration and Health
- ♦ IPAS
- ♦ LSHTM
- ♦ MERLIN
- ♦ Population Council
- ♦ Refugee Policy Group
- ♦ UNAIDS
- ♦ USAID Office of Population
- ♦ VOICE
- ♦ World Vision International

Participants of the Inter Agency Working Group

- ♦ Action Contre la Faim
- ♦ American Refugee Council
- ♦ CARE International
- ♦ Centers for Disease Control
- ♦ Columbia University School of Public Health
- ♦ Université Catholique de Louvain
- ♦ Department of Humanitarian Affairs
- ♦ Department for International Development
- ♦ Family Health International
- ♦ International Centre for Migration and Health
- ♦ IFRC
- ♦ SPHERE Project
- ♦ International Organization for Migration
- ♦ International Planned Parenthood Federation
- ♦ International Rescue Committee
- ♦ IPAS
- ♦ John Snow Inc.
- ♦ LSHTM
- ♦ Marie Stopes International
- ♦ Médecins Sans Frontières – International
- ♦ Médecins Sans Frontières – Belgium
- ♦ OXFAM
- ♦ Permanent Mission of the USA
- ♦ Population Council
- ♦ Save the Children UK
- ♦ UNAIDS
- ♦ UNHCR
- ♦ UNICEF
- ♦ USAID
- ♦ US Department of State
- ♦ WCRWC
- ♦ World Health Organisation

Glossary

Abortion/Termination of pregnancy	These terms are used to describe a pregnancy ended deliberately either by a health professional or any other person including the mother herself.
Anencephalus	A condition where the child is born with part of the skull and brain absent.
Emergency contraception	The administering of a high dosage of the combined pill within 72 hours of sexual intercourse to prevent a pregnancy.
Female Genital Mutilation	All procedures that involve partial or full removal of the female external genitalia and or injury to the female genital organs for cultural or other non-therapeutic reasons.
Gender-based Violence	Any act of physical or psychological violence occurring within the home or the community.
Hydrocephalus	A condition causing the normal flow of cerebral spinal fluid to be obstructed resulting in the accumulation of fluid in the brain.
Subfertility	Assuming normal sexual relations, the inability of a couple to become pregnant after 12 months.
Maternal mortality ratio	The number of maternal deaths per 100,000 live births
Miscarriage	The unintended loss of pregnancy before 28 weeks gestation
Peri-natal mortality	The number of stillbirths and deaths in the first week of life.
Sexual Violence	Any act of sexual violence occurring in the family or within the general community.
Unsafe Abortion	A procedure for terminating unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking minimal medical standards or both.

Acronyms

AMREF	African Medical and Research Foundation
FGM	Female Genital Mutilation
HIV/AIDS	Human Immunodeficiency Virus/Auto-immune deficiency syndrome
IAWG	Inter-agency working group.
ICPD	International Conference on Population and Development
IDPs	Internally displaced persons
IEC	Information, education and communication
IPPF	International Planned Parenthood Federation
IRC	International Rescue Committee
IUCD	Intra-Uterine Contraceptive Device (coil)
MCH	Maternal and Child Health

MISP	Minimum initial service package
MSF	Médecins Sans Frontières
MSI	Marie Stopes International
NCCCK	National Council of Churches of Kenya
NGO	Non-governmental Organisation
RH	Reproductive Health
RHR	Reproductive Health for Refugees Consortium
STDs	Sexually Transmitted Diseases
TOP	Termination of Pregnancy
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Childrens Fund
WHO	World Health Organisation

Endnotes

1. After a period of 2 years, Syphilis may go into a latent phase where it is not infectious.
2. However there are exceptions to this, especially in long-term camps
3. At a biological level, the mode of action is uncertain in that the emergency pill may act to prevent either ovulation and/or fertilisation and/or implantation. Given that different individuals and groups consider abortion to have occurred at different stages, this uncertainty and the fact that abortion is a highly sensitive and politicised issue means that the position of agencies are likely to fall on different sides of the debate, which may hinder implementation, even where there is informed demand.
4. Scenarios involve telling a story of a situation occurring in a similar context to that of the beneficiary and discussing what would happen if the same situation occurred in their community. This has the advantage of making the discussions less personal.
5. Young settled woman speaking at a group discussion in Maridi town.
6. Key informant interview with community leader in Maridi.
7. Group discussion with settled women in Maridi . To ‘steal outside’ meant to sleep with a woman other than your wife.
8. Group discussion with displaced men in Kotobi.
9. SPHERE Project: Minimum Standards in Humanitarian Response. A programme of the Steering Committee for Humanitarian Response and InterAction. Project Manager, Susan Purdin, IFRC.

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RRN

Background

The Relief and Rehabilitation Network was conceived in 1993 and launched in 1994 as a mechanism for professional information exchange in the expanding field of humanitarian aid. The need for such a mechanism was identified in the course of research undertaken by the Overseas Development Institute (ODI) on the changing role of NGOs in relief and rehabilitation operations, and was developed in consultation with other Networks operated within ODI. Since April 1994, the RRN has produced publications in three different formats, in French and English: Good Practice Reviews, Network Papers and Newsletters. The RRN is now in its second three-year phase (1996-1999), supported by four new donors – DANIDA, ECHO, the Department of Foreign Affairs, Ireland and the Department for International Development, UK. Over the three year phase, the RRN will seek to expand its reach and relevance amongst humanitarian agency personnel and to further promote good practice.

Objective

To improve aid policy and practice as it is applied in complex political emergencies.

Purpose

To contribute to individual and institutional learning by encouraging the exchange and dissemination of information relevant to the professional development of those engaged in the provision of humanitarian assistance.

Activities

To commission, publish and disseminate analysis and reflection on issues of good practice in policy and programming in humanitarian operations, primarily in the form of written publications, in both French and English.

Target audience

Individuals and organisations actively engaged in the provision of humanitarian assistance at national and international, field-based and head office level in the 'North' and 'South'.

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Ministry of Foreign Affairs
DANIDA

ECHO

Department of Foreign Affairs,
Ireland

Department for International
Development, UK