

Refugees and reproductive healthcare

Global decade report

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Foreword

This document is the second in a series of reports produced by the Reproductive Health Response in Conflict Consortium (RHRC Consortium), formerly the Reproductive Health for Refugees Consortium (RHRC), charting progress in the field of reproductive health (RH) service delivery for refugees and internally displaced populations. Following the Women's Commission for Refugee Women and Children report *Refugee women and reproductive healthcare: reassessing priorities* (1994), the RHRC produced *Refugees and reproductive healthcare: the next step* (1998). *The global decade report* charts almost ten years of worldwide conflict and its impact on the RH of those forced to flee.

The country chapters provide an overview of the RH status of millions of displaced people. These chapters are intended as a snapshot of the situation on the ground and have been compiled by RHRC Consortium members during an 18-month period. Many of the country chapters have been up-dated more recently based on desk-top research or additional field visits. Full country reports are available through www.rhrc.org

Unlike previous reports, this report is unique as it includes a chapter highlighting many of the innovative global initiatives undertaken by the RHRC Consortium in the areas of advocacy, emergency obstetrics, gender-based violence, monitoring and evaluation, small grants and training.

The RHRC Consortium was founded in 1995 and comprises: American Refugee Committee; CARE; Heilbrunn Department of Population and Family Health, Columbia University; International Rescue Committee; JSI Research & Training Institute; Marie Stopes International; and Women's Commission for Refugee Women and Children.

In order to better reflect the breadth of its work in communities affected by armed-conflict, the RHRC Consortium changed its name in 2003 from the Reproductive Health for Refugees Consortium to the Reproductive Health Response in Conflict Consortium.

The RHRC Consortium:

- is dedicated to the promotion of RH among all persons affected by armed conflict and
- promotes sustained access to comprehensive, high quality RH programmes in emergencies and advocates policies that support RH care for persons affected by armed conflict.

The RHRC Consortium believes all persons have a right to quality RH care and that RH programming must promote rights, respect and responsibility for all. To this end, the RHRC Consortium adheres to three fundamental principles:

- using participatory approaches to involve the community at all stages of programming
- encouraging RH programming during all phases of emergencies, from the initial crisis to reconstruction and development and
- employing a rights-based approach in all of its work, as articulated in the 1994 International Conference on Population and Development Program of Action.

Introduction

Background

Since the end of the cold war, conflicts have become increasingly internal, ethnic or communal in nature making them more difficult to resolve than conventional conflicts between states. In these settings fighting may be prolonged and continue for decades, resulting in the sustained displacement of large civilian populations. Latest figures estimate 25 million people will be displaced within their own countries whilst almost 15 million have crossed an international border.¹ A sizeable proportion of these people will be spending many years in official camps, hastily built settlements or in the slums of major cities. Even in places where peace has officially arrived – Angola, East Timor, Sri Lanka – resettlement is a slow and complicated process.

Communities affected by conflict are often classified by international organisations to fit into categories devised by donor agencies. However, these classifications may often be misleading and cause inequities in access to humanitarian assistance. Refugees, internally displaced persons (IDPs), host communities and people who have remained in the region of conflict may experience barriers to accessing humanitarian assistance, specific to their situation, yet their needs are primarily the same and their access to services is equally adversely affected by the conflict.

As the nature of conflict has changed so has the nature and range of agencies operating in these settings. Although the term “complex political emergency” describes the complexity of the background to conflicts, it also captures the day-to-day reality of activity on the ground where agencies struggle to ensure essential services throughout each phase of these emergencies: from emerging political crises and armed conflict, through to reconstruction and rehabilitation and development.

Despite increased understanding among field-based agencies of the importance of reproductive health (RH), capacity for delivering services remains limited, resulting



Photograph by Peter Barker

in a severe lack of RH programmes. For example, despite the improved availability of commodities to implement the *Minimum initial service package (MISP)*² and increased awareness of the need for co-ordination, few communities have access to these basic RH services that should be available in the earliest days of a crisis.

It is not just during the emergency phase that more attention needs to be paid to the RH needs of displaced communities. As the number of protracted conflicts increases so does the number of people denied access to comprehensive RH services. Even after a situation stabilises, the toll of long-term conflict on basic infrastructure is so high and the reconstruction needs so great that RH is once again marginalised during the return and rehabilitation phase.

Displaced populations, whether in established refugee camps or dispersed within host communities in rural or urban settings, do not always receive humanitarian assistance in a co-ordinated manner. RH care services are no different in this regard and indeed are often provided much less systematically than other services.

Photograph: Internally displaced family in Puttulam, Sri Lanka.

What are the current barriers to the provision of comprehensive reproductive health services?

In 1998, The *next step* report indicated that non government organisations (NGOs) were increasingly undertaking RH programming in conflict settings but service delivery was still inconsistent.³ This was attributed to a combination of residual reluctance on the part of some agencies to provide RH services at all, and a lack of capacity among others to effectively introduce a new range of health services.

Since 1998, much of the overt resistance to prioritising RH in conflict-affected settings has been overcome through education, awareness raising and advocacy. This heightened awareness, however, does not always translate into a change in practice. There remain barriers at headquarter and field levels to effective implementation. Major organisations providing services in humanitarian relief operations have yet to prioritise or standardise RH care as a component of healthcare provision, despite the evidence that doing so saves lives.

United Nations (UN) agencies are increasingly recognising the importance of integrating RH services into their programme planning and implementation, but major donors have not followed this lead. Lack of commitment within donor agencies exacerbates the lack of priority accorded to RH by NGOs. Funding constraints not only prevent direct service delivery but also have a negative impact on potential changes in organisational policy and on steps that could build capacity. Lack of capacity within agencies remains a major barrier to the provision of quality RH services in conflict settings. Short-term donor funding cycles are ill-matched to the reality of protracted situations, often resulting in gaps in information and service provision. In addition, short-term funding does not encourage agencies unfamiliar with RH to integrate these services into their programmes.

Ideological opposition to the provision of RH services in conflict-affected settings has long been a barrier to

effective implementation. Such thinking continues to hinder efforts to improve service provision. Donors to both RH and refugee programmes are becoming increasingly targeted by powerful conservative lobbying groups, often religious in nature, within their countries. For example, restrictions by the US administration on funding for global RH care services are having a harmful effect on refugee and IDP communities worldwide.

As communities flee war and conflict it is essential that the fight to ensure comprehensive quality RH services remains co-ordinated and focused.

Global reproductive health data

In 1998 *The next step* report made the case for better data collection in refugee settings. By 2000, the Reproductive Health Response in Conflict Consortium (RHRC Consortium) was confident that data collection was at a level to justify convening the first ever conference focusing exclusively on RH for refugees and displaced populations. *Conference 2000: findings on reproductive health of refugees and displaced populations* played a vital role in introducing new data from field programmes to the international agenda and demonstrating that appropriate interventions can improve the RH status of refugees and IDP.

Since then, research has increased particularly among camp-based refugee populations. For example, the US Centers for Disease Control and Prevention undertook research between 1998 and 2000 in 52 post-emergency phase camps in seven countries. The study concludes that refugees and IDPs in most post-emergency phase camps had better RH outcomes than their respective host country and country-of-origin populations.⁴ This evidence demonstrates that RH services can be provided in relief settings and are a key element in improving the well-being of people affected by armed conflict. However, data on dispersed populations or populations affected by new and on-going conflicts is harder to find.

¹ United States Committee for Refugees. www.refugees.org/world/statistics/wrs02_table3.htm

² The Minimum initial service package was developed by the Inter-agency Working Group (a group of over 30 academic, government, international and UN agencies formed in 1995) to respond to the needs of populations during the emergency phase of a crisis and to serve as a minimum reproductive health standard for situations that have moved beyond the initial emergency.

³ Reproductive Health for Refugees Consortium. *Refugees and reproductive healthcare: The next step*. 1998.

⁴ JAMA. Reproductive health indicators and outcomes among refugee and internally displaced persons in post emergency phase camps. Vol 288 No. 5 pp595. 7 August 2002.

The RHRC Consortium has encouraged data collection through its monitoring and evaluation programme. In addition, the RHRC Consortium's Global Technical Assistance Project, developed in 1998 to better address the lack of capacity among NGOs, UN agencies and others to implement RH programmes for refugees and IDPs around the world, has gathered considerable data from the field. This data indicates that the environment is steadily being created to promote RH. For example, many people in the field had seen or had a copy of the key inter-agency field manual, *Reproductive health in refugee situations: an inter-agency field manual*. In addition, many countries visited by the Global Technical Advisor had developed or were in the process of developing a RH policy. However, the actual implementation of quality RH programmes in the field is never easy and much remains to be done.⁵

Key findings from global refugee settings

Integrated fully comprehensive RH services are far from a reality in most refugee settings:

- one in three adolescent females displaced by armed conflict in Colombia are already mothers or pregnant with their first child⁶
- in a study conducted among IDPs in Angola, fertility rates were significantly higher than the national average⁷
- approximately 50,000 to 64,000 internally displaced women in Sierra Leone have histories of war-related assault⁸
- RH related causes were the leading cause of mortality (at 22%) among Afghan women of reproductive age in Pakistan⁹
- sexually transmitted infections (STIs) were the problem most consistently identified by community members in a 1999 RH qualitative study conducted in war-affected communities in southern Sudan.¹⁰

Safe motherhood and emergency obstetric care

While there has been a marked improvement in the

attention given to safe motherhood in many settings, maternal and infant mortality is still extremely high in many countries, particularly those affected by conflict. Ante-natal care is now widely available in conflict settings yet postpartum care is still too frequently provided in an *ad hoc* manner. There is a severe lack of skilled providers trained in managing emergency obstetric care (EmOC) as well as a tendency to set up parallel systems in refugee settings rather than improving existing facilities, thus greatly hampering efforts to reduce maternal mortality.

Family planning and emergency contraception

Evidence suggests that the needs of displaced populations for family planning (FP) are not markedly different from those unaffected by conflict. It is, therefore, still essential that the provision of FP services is not overlooked when communities are displaced. For instance, failure to provide quality FP services often results in high levels of unsafe abortion. However, in many conflict settings FP has been neglected. Agencies often lack funds, training and supplies and others have ideological opposition to contraception. Awareness and provision of emergency contraception remains particularly low.

Sexually transmitted infections and HIV/AIDS

Although a great deal of progress has been made in ensuring that HIV/AIDS prevention is part of the healthcare provided to populations affected by conflict, more needs to be done to accelerate access to prevention and care services. All STIs, including HIV/AIDS, thrive under crisis conditions, which coincide with limited access to the means of prevention, treatment and care.¹¹ Conflict-affected populations are disproportionately at risk in terms of STIs including HIV/AIDS.¹²

More funding is needed for innovative, collaborative programmes combining quality research with interventions to prevent the spread of HIV/AIDS. In addition, a dramatic increase in programming is needed to provide comprehensive HIV/AIDS services including voluntary counselling and testing; prevention of mother

to child transmission; and the care, support and treatment for people living with AIDS.

Gender-based violence

Gender-based violence (GBV), particularly in the form of sexual violence against women and girls, is a feature of virtually all armed conflicts, and anecdotal reports suggest that other forms of GBV, such as trafficking, sexual exploitation, and domestic violence may increase in the wake of conflict. Partly because of the global advocacy of RH professionals, the prevention of, and response to, GBV has been increasingly recognised as an important component of humanitarian assistance. However, most local and international NGOs lack the capacity to effectively address GBV in a co-ordinated and effective manner. There is also a shortage of tools and field resources to develop fully integrated multi-sectoral programmes (please see Initiatives section for further information about RHRC Consortium GBV tools and resources).

Adolescents

Within communities affected by conflict, young people are particularly vulnerable as they are displaced from their homes and often separated from their families and communities during the transition to adulthood. While there is widespread recognition that particular attention needs to be paid to the RH care of young people,¹³ quality programmes that truly address their needs are far from a reality.

Summary of findings

- the lack of technical assistance and capacity building continues to prohibit the provision of comprehensive quality RH services
- existing tools and resources need to be better disseminated and integrated into agency programmes in the field
- resources and tools need to be translated into local languages
- linkages need to be made to ensure the transfer

of skills and knowledge from local organisations on the ground to incoming agencies serving conflict affected populations

- the lack of consistent and adequate supplies remains a key barrier to quality service provision
- the implementation of the *MISP* is far from universal and unless the RH services outlined in it have been introduced and planned for from the outset of an emergency their delivery will be less robust as the situation develops
- comprehensive prevention and response programmes for STI/HIV/AIDS and GBV have yet to be institutionalised in most conflict settings worldwide
- the lack of access to EmOC contributes to high maternal mortality rates
- the lack of integrated youth programming continues to contribute to heightened vulnerability of displaced young people.

Critical actions for the next decade

Recommendations

The challenge currently facing the international community is to ensure that RH becomes an integral component of every humanitarian response. Strategic alliances have been formed with and between governments, UN agencies and international and local organisations, including the RHRC Consortium and the Inter-agency Working Group; policies have been put in place and guidelines developed. What is needed now is a concerted drive to transfer progress at the international level to on-the-ground services for communities affected by conflict. This involves much more than the rebuilding of infrastructure and the deployment of medical teams.

As the nature of emergencies has evolved, the traditional categorisation of international agencies as relief or development agencies is also changing. Development focused agencies need to expand their target audience to conflict-affected populations while humanitarian agencies need to ensure that comprehensive RH care is integrated

⁵ International Rescue Committee. Final report: Global technical assistance project. January 2003.

⁶ Profamilia. Colombia survey. 2001.

⁷ UNFPA. Demographic profile and the reproductive health of internally displaced persons in Angola. Unpublished abstract presented at the Reproductive Health for Refugees Consortium conference. Washington DC. 2000.

⁸ Physicians for Human Rights. War related sexual violence in Sierra Leone: a population-based assessment. Boston. 2002.

⁹ Bartlett. et al. Maternal mortality among Afghan refugees in Pakistan. *The Lancet*, Vol. 359. 23 February 2002.

¹⁰ Palmer C. Rapid appraisal of needs in reproductive health care in southern Sudan: a qualitative study. *British Medical Journal*. 319(7212):743-748. 1999.

¹¹ UNFPA. HIV/AIDS in conflict: Consultative meeting. 19-20 April 2002.

¹² Reproductive Health for Refugees Consortium conference 2000. Findings on the reproductive health of refugees and displaced populations. New York. 2000.

¹³ Women's Commission for Refugee Women and Children and UNHCR. Working with young refugees to ensure their reproductive health and well-being: it's their right and our duty. 2002.

into their service delivery. To achieve this, targeted training is required for humanitarian workers and medical staff; RH supplies need to be accessible and available from the outset of any emergency and funding priorities must incorporate RH services through all phases of humanitarian relief. There are specific examples of activities already occurring yet more needs to be done at the policy, implementation, training and research levels.

Policy/funding

Donors should engage in long-term commitments to ensure the protection of, and response to, the sexual and reproductive rights and the needs of communities affected by conflict from the earliest moments of a crisis.

International peace building, peace making and peace-keeping operations should pay special attention to the protection of the RH rights of displaced populations.

Implementation

The components of the *MISP* should be available from the outset of every emergency.

Comprehensive RH services should be established as soon as possible, following a thorough needs assessment.

A RH co-ordinator must be in place to facilitate effective co-ordination among all stakeholders in humanitarian relief.

Specifically targeted RH services are needed for young people; they should also be involved in assessing, developing, implementing and evaluating these programmes.

Men should be included in RH service delivery.

Focus on internally displaced persons

Services need to be made more accessible to dispersed populations, refugees and IDPs.

Where refugees and IDPs live in camps, clinics and outreach programmes should be established within

the camps and a reliable, standardised referral system should be implemented, monitored and supported where necessary.

Where refugees and IDPs live dispersed throughout the community, the capacity of the local health system should be supported and supplemented with additional services as required.

Training and technical assistance

Increased training and technical assistance (TA) to build institutional capacity and leadership are required by agencies at all levels.

Priority must be given to TA and on-the-job support as a follow-up to training activities.

Research

Further evaluation and dissemination of replicable service delivery models needs to be encouraged to improve effective and efficient RH interventions.

Conclusion

Communities affected by conflict have a fundamental human right to quality, integrated RH services at all stages of conflict. The RHRC Consortium will continue to advocate at all levels with governments and other agencies and work with its international partners to ensure that these rights are realised.

In all war-torn countries, the participation of civil society is essential in restoring social services. Education and healthcare, including reproductive healthcare, cannot be restored in a war-shattered country without a great deal of hard work, investment and partnership.

Thoraya Ahmed Obaid, Executive Director, United Nations Population Fund, speaking at the 55th annual conference of non government organisations: *Rebuilding societies emerging from conflict: a shared responsibility*, 10 September 2002.

Angola

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Internal displacement in Angola

Sites visited: internally displaced person (IDPs) camps in Bie, Malanje, Moxico, and Huambo provinces and the Viana IDP camp on the outskirts of Luanda

Date of visits: February 2001 and April 2002

Assessment team: Rachel Jones, the Women's Commission for Refugee Women and Children; Meriwether Beatty, JSI Research and Training Institute; and Therese McGinn, Heilbrunn Department of Population and Family Health, Columbia University

Why are the internally displaced persons there?

After gaining independence from Portugal in 1975, Angola immediately fell into a 27-year conflict between the government's Movement for the Popular Liberation of Angola and the opposition forces of the National Union for the Total Independence of Angola (UNITA). The conflict displaced an estimated one-third of the country's 13.9 million people and sent another 445,000 Angolans fleeing to neighbouring countries for safety.¹ Angolans suffered abuses at the hands of both the Angolan armed forces and rebel troops, including harassment, forced displacement and recruitment, sexual violence and indiscriminate beatings as well as a general neglect of their rights to security, health and education.² During this period more than half a million Angolans died of war-related causes.¹

The death of UNITA leader Jonas Savimbi in February 2002 prompted peace talks that led to a cease-fire agreement two months later, followed by a formal declaration of peace on 2 August 2002. There is great hope that the peace will be lasting despite the overwhelming task of rebuilding the country's decimated infrastructure, reintegrating former combatants safely into society and supporting the efforts of the Angolan people to reconstruct their lives. One concern is that if UNITA soldiers are not provided with adequate aid to support themselves and their families, a new eruption of violence could result.³ In addition, the delivery of



Photograph by Julia Matthews

humanitarian assistance has become increasingly difficult as IDPs are settled in various regions around the country.⁴

Which agencies are assisting the internally displaced persons?

The Angolan Ministry for Social Assistance and Reinsertion (MINARS) is the government agency responsible for IDPs in Angola. MINARS works closely with other government branches, as well as the United Nations (UN) Office for the Co-ordination of Humanitarian Affairs (OCHA), other UN agencies and international non government organisations (NGOs). The UN agencies and international NGOs such as Médecins Sans Frontières (MSF), Marie Stopes International and Oxfam provide financial and technical support to many of the government services. However, the needs of the population are enormous and few agencies are working in Angola due to the high cost and logistical difficulties of operating in the region. Donor fatigue is also a concern.

In anticipation of the new and shifting needs of these people, the United Nations High Commissioner for Refugees (UNHCR) and NGOs active in the region are strengthening their presence and adapting their infrastructure to better address the needs of the displaced population.⁵

Photograph: Moxico internally displaced persons camp.

General conditions

Angolan IDPs tend to move as communities, often staying with family and friends and integrating into host communities. This places additional strains on already-poor families and intensifies competition for meagre resources. "Home" for an IDP is often a tent shared with another family or a straw hut with a dirt floor.

Displaced populations often move from rural areas to state-controlled capitals where they live in rapidly expanding urban slums. Many aid agencies, however, chose not to expand operations to the capital, believing that the government should meet the needs of people there.⁶

Transportation is a particular problem for Angolans making humanitarian assistance difficult and expensive: 60% of humanitarian assistance was transported by air in 2001.⁷ The large-scale presence of landmines is also a major problem; Angola is estimated to have more landmines than any country in the world with one in 400 Angolans having suffered a landmine accident.⁸ Landmines blanket the countryside making it impossible in many regions for people to cultivate food or raise livestock. This has created a dependency on the World Food Programme for food deliveries by air.

General health conditions and services

The Angolan government spends less than two percent of its national budget on healthcare, and after years of neglect the health system is in shambles. The government has committed to increasing its health budget to 5.5% but the increase has yet to take effect and while a sign of progress, this increase does not come close to meeting the country's actual need for health services. In addition, healthcare facilities at all levels are inadequately staffed and lack basic equipment and supplies.



Photograph by Diana Gourvenec

Due to the war, many people have not been able to complete their education, and trained medical and health personnel are in short supply. Many doctors have left the country, and others have relocated to the capital in order to earn more money in private practice. As a result, provincial hospitals are often severely understaffed.

A shortage of medical equipment and supplies is also a severe problem. Healthcare workers complain of drug supplies running out and a lack of equipment. The only facilities to have any medicines or equipment are sponsored or supported by NGOs and so do not rely on the government health system for procurement.

In theory, healthcare should be accessible and affordable for all Angolans, but the reality is quite different. Government staff are severely underpaid and as a result many government health workers do not go to work or attempt to charge fees for their services. NGOs are only able to work in stable and secure areas so there are large parts of the country where people are dependent on the government for services that may or may not be available. Most health facilities are supported or run exclusively by international NGOs.

Photograph: Internally displaced persons camp in Luanda.

¹ United States Committee for Refugees. World refugee survey 2002. http://www.refugees.org/world/articles/wrs02_Africa1.cfm#Angola. December 2001.

² Human Rights Watch report. <http://www.hrw.org/wr2k3/print.cgi?afrika1.html> 2003.

³ Interaction. Urgent aid needed in Angola before the rainy season. <http://www.interaction.org/newswire/detail.php?id=701> 8 August 2002.

⁴ UNHCR World News. Angola. World Food Program concerned over increase in people leaving camps. 27 January 2003.

⁵ UNHCR News updates Angola: spontaneous returns reach 70,000. www.unhcr.ch/cgi-bin/texis/vtx/print?tbl=NEWS&id=3dd4d4527 15 November 2002.

⁶ United States Committee for Refugees. World refugee survey 2001.

⁷ Norwegian Refugee Council. Internally displaced people: a global survey. Second edition. 2002.

⁸ UNDP. <http://www.undp.org/erd/devinitiatives/mineaction/angola/report.htm>

Reproductive health conditions and services

Angola is classified as a chronic emergency, yet basic minimum standards for reproductive health (RH) services are not being met. Even the many NGOs and UN agencies that signed the *Inter-agency field manual for reproductive health in emergency situations*⁹ are not coming close to meeting the minimum standards they committed to by signing this document.

Most Angolans, including IDPs, do not have access to the most basic RH services, including ante-natal care and contraceptives. Many provinces do not have adequate emergency obstetric services, or services are too far away to be accessed by the population. While services in provincial capitals are inadequate, health conditions in the more rural and inaccessible areas of Angola are believed to be much worse. Following the cessation of violence, some areas that had not seen international aid since 1998 have recently become accessible. MSF teams found high levels of malnutrition and neglect, with severe malnutrition reaching 30% in certain areas.¹⁰

Despite great general needs among IDPs and local communities, IDPs have special needs and require special considerations. Health workers claim that awareness of RH issues is lower among IDP than in the local communities and that IDP often wait too long to access



Photograph by Therese McGinn

Photograph: Rural clinic in Huambo Province.

services. There are also complaints that IDPs are not treated well at certain health facilities, and therefore lack faith in a health system that marginalises them.

Although comprehensive RH services are virtually non-existent, there are efforts to increase services in some locations. The United Nations Population Fund (UNFPA) is supporting the national RH programme in four provinces, and NGOs augment the government services in certain provinces. The government is also launching a national AIDS campaign. In addition, the UNFPA and the government are collaborating on a multi-sectoral project called JIRO (Informed, Responsible, and Organised Youth), which aims to prevent sexually transmitted infections (STIs), including HIV/AIDS, and drug use among youth.

Safe motherhood and emergency obstetric care

Angola has one of the highest maternal mortality rates in the world, estimated at 1,300 per 100,000 compared to bordering Namibia at 370 per 100,000.¹¹ This is unsurprising given that fertility rates are high, use of family planning (FP) is low, ante-natal care is not widely available and many women do not have access to emergency obstetric services.

Ante-natal care is offered in some health posts and health centres, but many women do not utilise these services. The majority of women deliver at home and some NGOs are training traditional birth attendants to identify potential risks and refer women to the maternity centre or hospital. Many women in Angola do not have access to emergency obstetric services as they are rare and transportation to hospitals is often unavailable or unreliable. Women with delivery or post-partum complications usually arrive at the hospital too late for their lives to be saved. Even when they do arrive, hospitals generally have very limited equipment, few trained staff and poor sanitary conditions that lead to high rates of life-threatening post-partum infections. Unsafe abortion may also contribute to the high maternal

⁹ WHO, UNFPA, UNHCR. Reproductive health in refugee situations: an inter-agency field manual. 1999.

¹⁰ Médecins Sans Frontières. MSF in the 'grey zones' of Angola. 31 January 2003. <http://www.msf.org/countries/page.cfm?articleid=BC22D7D1-38B2-46A0-8EE0D1C3D3E89E03>

¹¹ UNFPA. State of world population. 2002.

mortality and morbidity rate in Angola. According to a 1999 UNFPA study,¹² 19% of women respondents said that they knew of women who had aborted unwanted pregnancies.

Family planning

The same UNFPA study showed that 81% of the women interviewed had no knowledge of any method to prevent pregnancy, and only 2.2% of the women were using a contraceptive method. The study suggested a significant demand for education and awareness building, as 32.8% of women said that they were interested in knowing how to prevent a pregnancy.

Despite this obvious need, numerous barriers to FP access exist. Often FP services are only available in the provincial capital, and when counselling is offered in a health post or health centre the woman must often then go elsewhere to actually obtain the contraceptives.

Obtaining contraceptives is not easy as facilities frequently run out of them. Although the Angolan Ministry of Public Health, with the assistance of the UNFPA, is supplying the country with contraceptives, a lack of resources and transport problems are barriers to consistent and reliable stocks. Supplies are also often stolen for private use or resale in the market.

Depo-Provera is the most favoured form of contraceptive but it is very difficult to procure. When a rare shipment does arrive, word spreads fast, and the supply is gone almost immediately.

Sexually transmitted infections including HIV/AIDS

A lack of supplies and essential drugs prohibits the provision of quality prevention and care services for STIs, including HIV. STIs are believed to be extremely common in Angola yet very few health facilities have a supply of drugs to treat STIs. People with STIs must go to a local market or to a private pharmacy for drugs, which can prove to be quite expensive as well as ineffective and/or

harmful. People also rely on traditional methods of treatment that can be dangerous, causing miscarriage and/or infertility. As STIs are so common, some people consider obvious symptoms to be normal bodily functions and rather than seeking treatment try to cope with their illness.

The percentage of Angolans with HIV/AIDS between the ages of 15 and 45 is estimated to be 2.23% for males and 5.74% for females.¹³ Due to the lack of testing and the difficulty in gathering statistics, however, the reality is assumed to be higher and rising swiftly. Considering that HIV/AIDS is now the leading cause of death in Africa and that Zambia, bordering Angola to the east, has one of the higher known prevalence rates in Africa at 21.5%, there is potential here for an HIV explosion, if it has not already happened. Already, a worrying rise in HIV prevalence rates has been documented among women attending ante-natal clinics in Luanda.¹³ Though NGOs and the Angolan government are initiating HIV prevention activities and information campaigns, condoms are not always available and voluntary counselling and testing for HIV is non-existent outside of Luanda.¹³

Although Angola's war related isolation and lack of mobility helped the country to avert the AIDS epidemic facing other southern African countries, the emergence of peace will increase trade, migration, and travel – three elements which aid the spread of HIV/AIDS.¹⁴ According to Refugees International, the civil war may have limited the spread of HIV/AIDS, but it also prevented the spread of HIV/AIDS awareness making the population even more vulnerable to infection.

Gender-based violence

According to the 1999 UNFPA study, 69% of the women interviewed had experienced violence from their husband or partner; 21% knew of women forced to have sex against their will, and 12% of IDP respondents knew of men forced to have sex against their will. Cases of gender-based violence (GBV) increase dramatically

¹² UNFPA-Angola produced a report in June 1999 entitled: The demographic profile and the reproductive health of IDP. The findings of this report were based on interviews with 1,422 IDP in Huila, Benguela, Malanje and Zaire provinces. These findings were presented at the Reproductive Health for Refugees Consortium conference 2000: Findings on reproductive health of refugees and displaced populations. December 2000. The presentation abstract is available on-line at: <http://www.rhrc.org/conference/index.htm>

¹³ UNAIDS-Angola: Epidemiological fact sheet on HIV/AIDS and sexually transmitted infections 2002 update. 2002.

¹⁴ Refugees International. The new war in Angola: combating HIV/AIDS. 30 July 2002. <http://www.refugeesinternational.org/cgi-bin/ri/bulletin?bc=00433>

whenever there is an influx of the military or close proximity of IDPs to a military base.

Angola does not have any specific laws protecting women from physical or sexual violence although greater attention is now being paid to this issue through the creation of the Ministry of Family and the Promotion of Women (MINFAMU). Data from MINFAMU and the Angolan Women's Association show that of the 3,550 reported cases of violence against women in Luanda reported between 1997 and 1999, 60% were domestic violence and 30% were attributed to sexual violence by a stranger or acquaintance. While these statistics are not specific to the IDP population, they do indicate that violence is a significant problem in the general population and therefore may be exacerbated in the high stress situation of displacement and conflict.

Adolescents

There are very few programmes designed to address the specific RH needs of IDP adolescents in the provinces. Generally, the limited services that are available to IDPs are not "youth-friendly." Considering the very low quality and availability of services overall, youth-focused programming is considered to be an unaffordable luxury. Though there is not a very strong cultural stigma attached to premarital sex, there is still an embarrassment associated with RH services that discourage adolescents from accessing services in centres where they are likely to encounter family members or neighbours.

The RH problems of the IDP community as a whole tend to be intensified among adolescents. Unsafe abortion is said to be more common among young girls, particularly in and around Luanda, while adolescents are particularly likely to self-diagnose and treat themselves for STIs without visiting a health facility. In addition, health staff said that reported GBV cases tend to involve very young girls (7–12 years old) and incidents of rape and domestic violence are common.

The future

With the declaration of peace in August 2002 there is hope in Angola for a brighter future. Peace provides security to war-ravaged populations; alleviates some of the dangers, if not the logistical problems, of delivering humanitarian aid and it brings the hope of returning home and self-sufficiency for many Angolans. However, the numerous obstacles facing the country will not be easily overcome and the situation requires commitment from the Angolan government as well as from the international community. Political commitment to RH is key to addressing the education, training, supplies and resource issues facing the country.

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Internal displacement in Colombia

Sites visited: Bogotá, Cartagena and Barranquilla, Quibdó, Chocó and Puerto Asis, Putumayo

Date of visit: November 2001

Assessment team: Sandra Krause, the Women's Commission for Refugee Women and Children; Claire Morris, Marie Stopes International; Therese McGinn, Heilbrunn Department of Population and Family Health, Columbia University; and Patricia Ospina, Profamilia

Why are the internally displaced persons there?

There has been fighting in Colombia on some level since the mid 1960s. As a result of the violence, more than two million people have been displaced since 1985,¹ the vast majority of whom are indigenous groups uprooted from rural to urban areas. Many have been uprooted and displaced repeatedly, moving from one urban area to another in search of security and in order to survive. As the war continues to escalate some people are displaced en masse, but the majority flee as individuals or in small family groups. Most do not want to acknowledge their displaced status for fear of retribution.

In 2001, the conflict intensified and expanded into new areas of the country including the largest cities. This caused the new displacement of 342,000 people, although these figures are disputed by the Colombian government.¹

Children are among the primary victims of the conflict. Many young people have been forced to witness horrendous crimes, including the murder of their parents and other family members. Of the 33,000 members of guerrilla and paramilitary groups in Colombia, it is estimated that over 6,000 are children, some as young as ten. Most join these groups voluntarily to escape poverty or to avenge the killing of family members, although some groups also forcibly recruit children. Many families flee conflict-affected areas to safeguard their children from recruitment.



Photograph by Claire Morris

Which agencies are assisting the internally displaced persons?

A number of national and international agencies are currently working with internally displaced persons (IDPs). National agencies include Si Mujer, Serfam, Fundacion Mujer y Futura, Cami, Casa de Mujer and Profamilia while international agencies including Engenderhealth, Save the Children UK, Marie Stopes International and the UNFPA also provide assistance.

General conditions

Those who are displaced in large groups represent less than half of all IDPs; the rest are individuals and small family groups. IDPs are provided with extremely limited emergency assistance by the authorities. Lack of funds, medicines and transport, as well as discrimination by service providers, prevent IDPs from having access to general healthcare as well as reproductive health (RH) services.

The majority of IDPs come from the countryside and prior to displacement most worked in agriculture. Most have moved to urban areas. A high level of insecurity and continuous lack of protection has discouraged IDPs from concentrating in camps, forcing them instead to spread among city slums and to change their location as frequently as they can. Much of the violence is directed

at men, resulting in a high number of female-headed households. In addition, traditional support networks have been broken up by the major socio-economic changes that displacement causes.

The lack of job opportunities in urban areas for people with farming skills – a situation made worse by the current economic slowdown – has forced some men to abandon their families, leaving women with increased responsibilities and a shift in gender roles. However, it has become very difficult for unskilled women, particularly single mothers, to earn money within the formal sector of the economy. Over one million children, of whom 800,000 are under the age of 14, have fled their homes.² Apart from the deterioration in their quality of life, most displaced children have at least one family member who has been murdered or been victim of an attempt on their lives. The number of IDP children going to school is minimal due to high costs, the lack of spare capacity in local schools and stigmatisation. Child labour among IDPs is common, as is prostitution and criminal activity among displaced adolescents.

The Colombian government's laws and decrees addressing forced displacement are inadequate, with government assistance lasting for 90 days only. This limited assistance is only available to individuals and families displaced in the past three years, and involves a bureaucratic registration process. Many choose not to register for fear of reprisals from armed groups and because of their mistrust of the government. IDPs without adequate documents for registration have been asked to return to the village or town from which they escaped to obtain new papers, placing them at serious risk. Furthermore, policies addressing internal displacement often have a strong link to specific presidents, thus affecting the sustainability of such policies across administrations.

A disproportionate number of IDPs belong to minority groups. Although Afro-Colombians make up only 16%

of the country's population and indigenous people two percent, together they account for more than one-third of all displaced people.

General health conditions and services

In the last decade the health system has been restructured and a general social security system has been introduced. However, the public health sector faces major difficulties in reaching much of the population, especially the very poor and IDPs. Responsibility for health and family planning (FP) has been delegated to local municipalities. The system requires municipalities to provide services to IDPs but they are not supported with the adequate resources or technical assistance to do so. In addition, some municipal governments are reluctant to provide services to IDPs at all, fearing that making them feel secure will encourage them to stay.

Reproductive health conditions and services

There are marked disparities in RH status between urban, rural and conflict-affected areas. Some technical areas of RH, such as maternal and infant health status have steadily improved, while others, such as gender-based violence (GBV), unwanted pregnancies, knowledge about sexually transmitted infections (STIs) and the needs of adolescents, remain inadequately addressed. Government FP services are marginal.

The limited general health assistance provided to IDPs does not include RH care. Agencies have not implemented the *Minimum initial service package (MISP)* despite on-going new displacements although the local Planned Parenthood affiliate, Profamilia, has now extended its outreach services to include displaced populations.

Safe motherhood and emergency obstetric care

Safe motherhood services are generally limited and are even less accessible for those who are displaced. Services are over-stretched and IDPs' inability to pay gives rise to discrimination by healthcare providers. Hospitals often

¹ Norwegian Refugee Council. Internally displaced people: a global survey, 2002.

Photograph: Internally displaced persons living in a sports hall, Puibdó Chocó.

² Save the Children: UK. Emergency updates – Colombia. <http://www.savethechildren.org.uk> December 2001.

refer emergency obstetric cases to other hospitals when IDPs cannot pay, delaying life-saving care for women. Basic clean delivery supplies are not made available to pregnant IDP women for home deliveries in rural areas, nor are midwife delivery supplies made available at referral centres and hospitals to address the increased impact of IDPs on these facilities.

IDPs receive less ante-natal care than Colombian women overall. Twenty-seven percent of displaced women who were surveyed experienced either a miscarriage or a stillbirth. Of these, 37% received no treatment or medical care.³

Family planning

Although national records appear to indicate a reduction in family size for the general population, women displaced by armed conflict and who live in marginalised areas plan less and have more pregnancies and larger families. For example, marginalised women on average have 5.3 live births as compared with the national average of 3.4 live births. There is very little knowledge of FP, especially emergency contraception, and demand for FP among IDPs appears to be variable with some wanting more children and others less. Women also lack access to contraceptives either because they are not available or are perceived to be too expensive.

Sexually transmitted infections including HIV/AIDS

STIs and HIV/AIDS are areas of concern for many of the organisations working in Colombia. Despite the lack of official statistics, there is evidence of a high occurrence of male-to-female and mother-to-child transmission of syphilis. Health service providers have found it difficult to treat men from indigenous communities and therefore women are hospitalised to prevent re-infection and mother-to-child transmission.

Ninety seven percent of marginalised women interviewed by Profamilia in 2001 reported knowledge of AIDS yet many did not know how it is transmitted or where to go

to get tested for the virus.³ Although STIs are as common among the displaced as other conditions such as malnutrition, respiratory illnesses, diarrhoea and parasitic diseases, many women are unaware of their symptoms. The Revolutionary Armed Forces of Colombia (FARC) has been reported to test people for HIV and severely discriminate against those who are HIV/AIDS-positive, this includes killing them.

Gender-based violence

GBV is a serious problem in Colombia. In a 2001 Profamilia survey, half the female respondents reported physical attacks, 50% of which were perpetrated by their partners.³ One in every five displaced women reported having been a victim of sexual violence and 24% reported having been raped.

Domestic violence is also a major issue. In 2000, Profamilia found that 65% of women had experienced verbal violence in the home and 41% had suffered physical violence. Education levels did not seem to influence the extent of GBV. Only 22% of all female victims of GBV reported the violence.⁴



Photograph by Claire Morris

In September 2001, research was undertaken on the types and extent of violence by armed forces. Findings

include direct killing of women as a form of punishment; killing men and women so children are without a family; forced recruitment of boys and girls for domestic servitude; sexual exploitation and forced abortions.⁵

Adolescents

Displaced adolescents have the highest pregnancy rate in the country and often face serious problems in their sexual and reproductive lives. Psychosocial issues are major contributing factors. Thirty percent of displaced girls are already mothers or pregnant with their first child. The girls say they want babies to fulfil their need for personal security, recognition, love and safety. However, displaced teenage males are rarely interested in supporting the children.

Prior to displacement, most adolescents attended schools, had jobs and worked around the home. Displaced adolescents frequently lack access to education, employment and recreation, and are unfamiliar with their new urban environment. The few who attend school are discriminated against by administrators and teachers and are ridiculed or neglected by their non-displaced peers. With the loss of their home communities, family and socio-cultural norms, many adolescents are insecure, have little to occupy them, and are vulnerable to conscription by paramilitaries, to recruitment by drug dealers and to sexual exploitation. GBV, including rape, exploitation and prostitution has increased the risk of IDP adolescents for unwanted pregnancies, unsafe abortions and STIs.

The future

If adequate health services for IDPs are to be developed a significant increase in financial and technical support is required at a local level including commitment among humanitarian organisations to support the *MISP*. In particular, referral to hospitals for IDP women with obstetric emergencies needs to be substantially improved.

Raising human rights awareness should create an environment in which IDPs feel safe to officially register themselves and to take advantage of the

services designed for them. The encouraging news is that United Nations (UN) agencies are intending to double the resources committed to Colombia to implement the *Humanitarian action plan*.

Update

During 2002, the situation for IDPs worsened further. Targeted by armed groups, the numbers of IDPs surged dramatically throughout the year. On average, 772 people were displaced every day in 2002 compared to an average of 472 per day in 2001. In addition, a new campaign of terror in which rural villages are besieged by armed groups and people are cut off from access to their survival needs and humanitarian assistance has been recognised by the United Nations System (UNS).⁶

The report of the UN Special Rapporteur on Violence Against Women was released in early March 2002. The report documents the effect of the internal conflict in Colombia on the human rights of women, including the widespread, systematic and overlooked GBV perpetrated by armed groups with impunity.⁹

In November 2002, the UNS Thematic Group on Internal Displacement in Colombia (TGID)¹⁰ presented a collaborative strategic planning framework entitled the *Humanitarian action plan (HAP) 2003 for Colombia*. Encouragingly, specific plans of action within the health, education and family welfare sector include:

- strengthening, through technical co-operation and training, the local and regional capacity for timely and efficient response, with a special emphasis on vaccine-preventable disease, sexual and reproductive health (SRH), mental health, emerging diseases, nutritional

³ Profamilia. Survey: Salud sexual y reproductiva en zonas marginadas – situación de las mujeres desplazadas (Sexual and reproductive health in marginal areas – the state of displaced women). Colombia. 2001.

⁴ Profamilia. National demographic health survey. Salud sexual y reproductiva en Colombia (Sexual and reproductive health in Colombia). Colombia. 2000.

Photograph: A group of young people in the internally displaced persons camp, Puibdóí Chocó.

⁵ Working Group on Armed Conflict. Interviews with representatives and reports in preparation for the UN Special Rapporteur on human rights and violence. 2001.

⁶ United Nations System Thematic Group on Internal Displacement. Humanitarian action plan 2002–2003. Colombia.



Photograph by Claire Morris

improvement and upgrading of information on the health situation

- improved access to SRH services for displaced populations, particularly adolescents, is one of the three major objectives in the UNFPA RH sub-programme for 2003–2007. Activities will include training and institutional capacity building of organisations working with IDPs to enable them to raise awareness among IDPs of their RH rights and implement integrated SRH services with particular emphasis on adolescents.¹¹

Photograph: Internally displaced persons camp in Barranquilla.

⁹ Commission on Human Rights. Integration of the human rights of women and the gender perspective: violence against women. 11 March 2002.

¹⁰ The Thematic Group on Internal Displacement consists of representatives of 12 United Nations System agencies present in Colombia: UNHCR, OCHA, FAO, UNFPA, UNDCP, IOM, UNHCHR, PAHO-WHO, UNIDO, UNDP, UNICEF and UNIFEM.

¹¹ Executive Board of the UNDP and of the UNFPA Country Program for Colombia. October 2002.

Democratic Republic of Congo

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Internal displacement in the Democratic Republic of Congo

Sites visited: Kalima health zone, Maniema province, and the Goma health zone, Kinshasa

Date of visit: July 2002

Assessment team: Sara Casey, the Reproductive Health Response in Conflict Consortium; Beldinah Nyanga and Jeannot Wabulakombe, Merlin

Why are the internally displaced persons there?

The Democratic Republic of Congo (DRC) is located in the heart of central Africa. Following three decades of corrupt leadership that impoverished DRC, two outbreaks of war have further devastated the country. The four and a half years of war have taken more lives than any other since World War II and it is the deadliest documented conflict in African history.¹

A Rwanda and Uganda backed rebel army overthrew Mobutu Sese Seko in 1997, and installed rebel leader Laurent Kabila as president. War erupted again in 1998 when Kabila turned against his former foreign supporters, and Rwanda and Uganda supported a new rebellion against the government which degenerated into a region-wide conflict involving troops from seven countries and several different rebel groups. Despite the presence of United Nations (UN) troops in some areas following a 1999 cease-fire, sporadic fighting between different rebel factions, militia movements and the foreign armies continued in eastern DRC as the country was looted of its vast natural resources. Although most of the foreign armies had withdrawn their forces by October 2002 and the Congolese parties signed a power-sharing agreement in December 2002, intermittent fighting continues in eastern DRC. At present, the country remains divided between rebel-controlled territory in the east and government-held territory in the west, with communication and travel between the two highly restricted.



Photograph by Sara Casey

Over 2.5 million Congolese are internally displaced (although some sources estimate the number may be as high as four million), while another 355,000 have fled the country as refugees or asylum seekers.² Approximately 90% of internally displaced persons (IDPs) are in the east and 75% live in rebel-controlled areas.² In addition to the displaced Congolese, DRC also hosts approximately 335,000 refugees from seven neighbouring countries.³

Which agencies are assisting the internally displaced persons?

Although humanitarian aid may be safely implemented in many parts of the country, some areas of DRC remain inaccessible due to insecurity. The US Committee for Refugees estimated that at least one million IDPs receive no humanitarian aid due to their inaccessibility.² Several UN agencies and international non government organisations (NGOs) – including Merlin, the International Rescue Committee (IRC) and Médecins Sans Frontières (MSF) – operate in eastern DRC along with local NGOs and church groups.

General conditions

The humanitarian crisis in DRC is amongst the most severe in the world. Fighting has driven people into the

forests, decimated the healthcare system and destroyed much of the country's infrastructure. One UN official reported that armed groups are targeting civilian populations.⁴ In areas where there is currently no fighting, the inability to trade goods on roads and via rivers blocked by the various military forces has left people as economically destitute as those in the heart of the violence. Many people have no access to even basic services, including education and health. Hopes that the peace agreements would bring stability to the country have been dashed as fighting and displacement increases.

General health conditions and services

A mortality survey by the IRC attributed an estimated 3.3 million deaths to the war, most of them due to malnutrition and disease.⁵ The public health system has been destroyed by years of neglect and conflict, and the different fighting forces in the east have made a habit of looting health facilities during attacks on towns and villages. Health facilities are run on a cost-recovery system in which people are expected to pay for consultations and medicines. In some cases, patients have remained as virtual prisoners at health centres long after their treatment is complete until their families have managed to find the money to pay their fees.

Health facilities suffer from a lack of supplies and trained medical personnel. The few personnel who remain have not received their salary in years, and many lack motivation or refuse to treat patients until payment is made. At one hospital visited, the principal doctor had been suspended for corruption and "lewd behaviour," while the acting head doctor had recently been accused of raping an adolescent patient.⁶

DRC's health indicators are among the worst in the world. The infant mortality rate is estimated at 128 per 1,000 live births compared to 81 for Uganda and 100 for Rwanda.⁷ In five of the seven locations surveyed in eastern DRC in 2001, the IRC found an under-5 mortality rate of over 10 per 1,000 per month which appears to

have been the rate for years.⁸ They noted that "a continuous under-five mortality rate of 10 per 1,000 per month means that 60% of children die before their fifth birthday."⁸ Major causes of morbidity and mortality include malaria, acute respiratory illnesses, and malnutrition.

Reproductive health conditions and services

Eastern DRC should be considered a chronic emergency, yet the international response does not correspond to the severity of the situation. Not even the minimum standards for reproductive health (RH) are being met. Few NGOs are working in any of the four technical areas of RH: safe motherhood, family planning (FP), HIV/AIDS/sexually transmitted infections (STIs), and gender-based violence (GBV), and none offer comprehensive RH programmes.⁹ Some of this lack of attention could be due to the persistent attitude that RH services are not included in basic emergency interventions. Even in the more stable government-controlled zone, many people lack access to basic RH services.

Safe motherhood and emergency obstetric care

DRC has among the highest maternal mortality indicators in the world (1,837 deaths per 100,000 live births). In some parts of eastern DRC, the situation is even more dire; there the maternal mortality rate has been estimated to reach 3,000 per 100,000 live births.⁸ Malaria and malaria-induced anaemia are significant causes of maternal morbidity. In addition, poor nutrition contributes to poor maternal health. The high rates are predictable given the high fertility rate, low contraceptive prevalence, the short period of time between pregnancies, lack of access to emergency obstetric care (EmOC) and the high numbers of unsafe induced abortions, especially among young women. Women tend to deliver at home with untrained traditional birth attendants (TBA), a large number of whom use unhygienic practices in delivering babies. In addition, many women wait too long before seeking help with

¹ Conflict in Democratic Republic of Congo deadliest since World War II, says the International Rescue Committee. <http://www.theirc.org/mortality/> 8 April 2003.

² United States Committee for Refugees. Congo-Kinshasa Country Report 2002. <http://www.refugees.org/world/countryrpt/africa/congokinshasa.htm> 2002.

³ UN Office for the Co-ordination of Humanitarian Affairs (UN OCHA). Consolidated inter-agency appeal for the Democratic Republic of Congo 2003. These numbers include some 187,000 from Angola, 76,000 from Sudan, 20,000 from Burundi, 23,000 from Uganda, 3,500 from Central African Republic, 3,000 from Congo-Brazzaville, and 2,400 from Rwanda. <http://www.reliefweb.int/appeals/2003/files/drc03.pdf> 19 November 2002.

Photograph: Kakaleka health facility, Maniema Province.

⁴ Reuters. Rapes, killings continue in Congo despite pact-UN. 21 February 2003. <http://www.alertnet.org/thenews/newsdesk/L21105226>

⁵ Roberts, Les et al. Mortality in the Democratic Republic of Congo: results from a nationwide survey. International Rescue Committee. 2003.

⁶ Personal communication with NGO staff in eastern Democratic Republic of Congo.

⁷ Save the Children. State of the world's mothers. 2002.

⁸ Robert, Les et al. Mortality in the Democratic Republic of Congo. 2001.

⁹ The International Rescue Committee is implementing a comprehensive reproductive health programme including the four technical areas at a camp for Angolan refugees on the southern border of the Democratic Republic of Congo.



Photograph by Janet Meyers

a problem delivery, one of the major contributors to maternal death and disability. Several women recounted that a TBA may abandon a woman if she needs assistance beyond her abilities.

Merlin recently began implementing a safe motherhood initiative to improve services for pregnant women in the Goma health zone and three zones in Maniema province. Community education has raised awareness of ante-natal care (ANC) in these health zones. Since the programme began, Merlin has seen an increase in ANC attendance and in deliveries at health centres. Staff members have been trained to identify problem pregnancies and refer them to the hospital for delivery before they become emergency cases. In addition, the IRC supplies health facilities in three health zones in South Kivu and Kisangani with materials to support ANC and safe delivery.

The referral hospitals in both Goma and Kalima offer comprehensive EmOC, although the quality of that care is questionable due to the lack of resources and skilled personnel. Many health centres are a long distance from the hospital, and no transportation is available for women in need. Often the woman must travel by bicycle or on

a stretcher carried by family members over poor roads. Due to insecurity caused by the conflict, travel at night is dangerous and rarely possible.

Family planning

FP is not well integrated into the Congolese health system and only three percent of Congolese women use a modern method of contraception.¹⁰ Despite high rates of unsafe abortion, few public health centres have contraceptives available. In those facilities that do offer FP, stocks often run out leaving women unable to depend on a steady supply of their chosen contraceptive. The main pharmacy supply NGO in Goma, ASRAMES, did not carry contraceptives until recently and even now it only supplies condoms. Contraceptives can be found in some pharmacies, but they are too expensive for most women, yet in the open market, where prices are lower the quality is questionable; some products have expired, others are in a poor condition, and expiry dates may have been changed.

An additional impediment to women's use of FP is their low status in Congolese society. Men manage the family and make all related decisions. It is difficult for women to discuss the use of contraception with their husbands yet married women need a husband's signature to receive contraceptives (and to work or travel), and are reportedly refused them without one. By law, single adult women have the right to contraceptives without a signature, yet they are often refused service without one. Men must be targeted, therefore, with information if women are to have the option of using FP.

In many cases, health staff reported that women were not interested in FP; however the women themselves told a different story. Each of the four groups of women interviewed in Kalima zone asked for contraceptives, and reported that men are the barriers to their use of FP. Couples tend to have between eight and 12 (and sometimes up to 15) children each.¹¹ If a woman has only four or five children, her husband may take a second

wife because he thinks this is not enough. Women told us that health workers must educate their husbands on the benefits of FP before they will be allowed to use it. In all of the locations visited the common practice of unsafe induced abortions was discussed, corroborating the need for increased FP.

Sexually transmitted infections including HIV/AIDS

Good quality data on HIV infection in DRC is difficult to find. DRC presents near ideal conditions for STI and HIV transmission: widespread population movement, low social status of women, significant military presence and the use of rape as a weapon of war. The Ministry of Health estimates an HIV prevalence of five percent in the country although surveys of blood donors in the eastern region show an HIV prevalence of around 20%.¹² The military presence in eastern DRC contributes greatly to the higher prevalence found there and service statistics showed a significant increase in STI cases during a period of increased military activity in the Kalima zone. According to MSF-Holland, more than 350 women who had been raped were treated for STIs in Shabunda between October 2001 and March 2002.¹³ Despite these contributing factors, little education about STIs or HIV/AIDS is being conducted and condoms are rarely available in the east.

Few health facilities have condoms, and none conducted information, education and communication activities on AIDS. Although the women we spoke to said they had heard of AIDS, they knew very little about how it is transmitted or prevented. The extent of their knowledge generally was that they had been told to stay with one man to avoid AIDS. In Goma, we were told that many people do not believe AIDS exists.

According to the National AIDS Control Programme, 80% of health facilities that transfuse blood do not test donated blood for HIV; however, most NGO-supported hospitals now perform testing on all blood for transfusions, which they had not done previously.

MSF-Holland implements the only voluntary counselling and HIV testing programme in eastern DRC, in Bukavu.

Gender-based violence

GBV is reported by local and international humanitarian and human rights organisations to be widespread. Rape has been used as a weapon of war by all of the different fighting forces and according to one UN official working in the eastern Congo: "*Thousands of women [are] raped every day, by everybody.*"¹⁴ An inter-agency delegation collecting information on sexual violence in Shabunda district in South Kivu province in May 2001 found that some 2,000 women were raped, and held for sex for periods ranging from two weeks to two years.¹⁵ Women have reported incidents of gang rape, involving two to 15 men at a time; being penetrated with objects such as wooden sticks; and being shot in the genital area.¹⁶ The majority of reported rape cases are of women under the age of 25, suggesting that young women are systematically targeted for rape and abduction.¹⁵ Women in the Kalima health zone corroborated this finding. In addition, the culture of impunity and violence is such that rapes by civilians are increasing as well.¹⁴

Gang rapes by military forces, which have been shown to have higher STI and HIV rates than civilian populations, place women at great risk of infection. The Médecin Chef de Zone at Shabunda general hospital estimated that 80% of women treated at the hospital had STIs.¹⁵

Few facilities have protocols for treating rape survivors and the fear of stigma has prevented some women from seeking medical attention. However, long periods of abduction sometimes prevent women from keeping their secret. Often a husband will send his wife away after she has been raped, although some men acknowledge that the woman was forced and was not to blame. In some cases, the husband will take a second wife and the rape survivor is relegated to a lower status in the household. Survivors are victimised not only by the rape experience, but also by their family's subsequent rejection of them.

¹⁰ International Planned Parenthood Federation. Country profiles: Democratic Republic of Congo. http://ippfnet.ippf.org/pub/IPPF_Regions/IPPF_CountryProfile.asp?ISOCODE=CD, Accessed 3 March 2003.

¹¹ Numbers were reported by the women in four focus groups in Kalima health zone.

¹² Ministère de la Santé. 2001. Plan intégré de lutte contre le VIH/SIDA: appui au sous-secteur santé (Comprehensive plan of combatting HIV/AIDS: supporting the HIV/AIDS health sub sector). 2002–2004.

¹³ MSF-Holland. On-going sexual violence in Shabunda territory, South Kivu, Democratic Republic of Congo. 2002.

¹⁴ Human Rights Watch and Astill, James. The land where rape is an everyday horror. Guardian Unlimited. 18 May 2002.

¹⁵ International Rescue Committee. Gender-based violence assessment report. 2001.

¹⁶ Human Rights Watch 2002. The War within the war: Sexual violence against women and girls in Eastern Congo. International Rescue Committee. 2001. MSF-Holland. 2002.

Emergency contraception is generally not available and women and girls whose rapes result in pregnancy may often find themselves traumatised and alone; many may then resort to unsafe abortions placing them at further risk.

The scale of the violence against women has pushed some churches, human rights organisations, women's groups and other NGOs to assist survivors.¹⁶ MSF-Holland staff provide free medical care to rape survivors in Shabunda, and work with a local women's group to inform women of the free services available and encourage them to seek help. The IRC recently began implementing a broad-based support programme for victims of sexual violence and torture in North and South Kivu provinces. The programme focuses on improving survivor access to medical, legal and psychosocial services by supporting local community-based groups and NGOs working in this area. It also focuses on conducting education campaigns to encourage the reintegration of these survivors.¹⁵

Adolescents

No evidence of youth-oriented RH services in eastern DRC was apparent, with the exception of some HIV education targeting young people. The adolescent fertility rate for DRC is among the highest in the world with 230 births per 1,000 women aged 15 to 19.¹⁷ Many young women attempt to induce abortion or resort to unsafe abortions, often resulting in death or disability.

Contraceptives are not widely available, and are even less accessible to adolescents. The National Reproductive Health Programme requires young women to come with someone "responsible", such as a parent or fiancé, in order to receive contraceptives. In addition, the reportedly wide-spread belief among health workers that a woman who has never been pregnant should not use hormonal contraceptives further limits a young woman's choice.

Early marriage for girls is common, and is as young as

12 years in rural areas, while boys tend to marry between the ages of 18 and 25. The strong preference for boys denies girls an education and condemns them to early marriages and frequent childbearing. According to women in Kalima health zone, most young people are sexually active before marriage, against their parents' wishes.

Few adolescents recognise the risk that HIV poses for them, seeing it as a disease that affects adults or prostitutes, despite the fact that infection rates are rising most rapidly among young people in Africa. Several local NGOs in Goma are targeting young people with AIDS prevention education while the IRC has implemented a pilot peer educator project to increase awareness of HIV among young people in Katana and Kabare health zones in South Kivu. In addition, they have trained health workers in HIV/AIDS counselling for young people.

The future

The RH situation in DRC is extremely poor. Basic services are not available, despite a clear need for countrywide comprehensive services. Greater resources should be allocated to health in general, and to RH in particular. *The Minimum initial service package* should be implemented by all health agencies, with comprehensive RH services made available in those areas where security allows. The involvement of men is essential, especially for FP and GBV programmes.

East Timor

Internal displacement in East Timor

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¹⁷ UNICEF. Age specific fertility rate (15–19 years). <http://www.childinfo.org/eddb/fertility/dbadol.htm> 2002-2005.

Internal displacement in East Timor

Sites visited: the districts of Alieu, Dili and Manatuto

Date of visit: September 2002

Assessment team: Janet Meyers, the Reproductive Health Response in Conflict Consortium and Dr Joao Martines, School of Public Health, Dili, East Timor

Why are the internally displaced persons there?

It is estimated that over 200,000 East Timorese people, one third of the population, may have died either directly or indirectly from the conflict that lasted from 1975 to 1999.¹ Immediately after the referendum for independence in September 1999, there was intense fighting in East Timor between the East Timorese and militias backed by the Indonesian government, forcing the United Nations (UN) to withdraw its mission. This led to an almost total collapse of the infrastructure, creating a community in crisis with as many as 500,000 people fleeing into East Timor's hilly interior. The UN returned as the Intermediate Force in East Timor (INTERFET) on 27 September after evacuating two weeks earlier.

By October 1999, approximately 250,000 people were forcibly displaced and at the end of 2000,² an estimated 110,000 displaced East Timorese remained in the Indonesian territory of West Timor. With 70% of private homes and public buildings destroyed during the war, many East Timorese remain internally displaced, often living in *ad hoc* arrangements with family or friends.³

Which agencies are assisting the internally displaced persons?

A range of local and international agencies⁴ are working with the Ministry of Health (MOH), in the areas of sexually transmitted infections (STIs)/HIV/AIDS, gender-based violence (GBV), adolescent reproductive health (RH) and safe motherhood.

General conditions

In 1999, East Timor was ranked 152 out of the 162 countries in the human development index, the lowest

figure in Asia. The average life expectancy is 57 years and more than two in five East Timorese are living below the national poverty line of 0.55 US\$ per capita per day.⁵

After the vote in favour of independence on 30 August 1999, the East Timorese were faced with the task of rebuilding much of their country in the wake of destruction, significant loss of life, rape, assault, displacement of the population, the total collapse of the economy and the deterioration, and strategic undermining of most of their cultural heritage and institutional memory. The United Nations Transitional Assistance in East Timor (UNTAET) was established with a mandate for governmental authority unprecedented in its breadth. They had responsibility for security, law and order, establishing an effective administration, developing civil and social services, ensuring the provision of humanitarian aid, supporting capacity building for self-government and helping to establish the conditions for sustainable development.⁶

General health conditions and services

In 2000, a trust fund for East Timor was established under the World Bank consisting of two projects. The first was designed to address the immediate basic health needs and health system through the restoration of access to a basic package of services. The second was aimed at rehabilitating and developing a cost-effective and financially sustainable health system with an integrated and sustainable health policy framework to prepare the health system to meet future needs.⁷

Prior to independence, attendance at Indonesian run clinics was low, particularly among teenage girls and women, due to a lack of trust in the Indonesian government's health services as well as due to a lack of supplies. People were therefore heavily reliant on Catholic and Protestant Church clinics where medicines were less expensive but often staffed with non-professionals. They also relied on traditional medical practitioners, many of whom were women.

Currently, East Timor has one national hospital, three district hospitals, 10 community health centres with in-patient capacity, 53 community health centres (out-patient only), 86 health posts and 135 mobile clinics. In addition, several non government organisations (NGOs) are focussing their efforts on general health service provision.

Data on various diseases is collected monthly. However, little RH data is regularly collected although there are plans to revise the information gathering system. Leading causes of morbidity reported by health facilities include respiratory infections, suspected malaria cases, acute febrile illness and diarrhoea.⁸

Reproductive health conditions and services

RH services are limited in most of East Timor with significant discrepancies between rural and urban areas. Few facilities are able to respond to obstetric complications or reproductive tract infections and family planning (FP) supplies are inconsistently available. Gender bias in access to overall healthcare and the tendency for women to feel shame or fear to disclose intimate health issues exacerbate the poor RH situation.

Safe motherhood and emergency obstetric care

The maternal mortality ratio is estimated at 860 per 100,000 live births. Twice as many women in East Timor die as a result of childbirth compared with surrounding countries in South East Asia.⁹ One of the reasons for this high rate is due to the low utilisation of skilled assistance for ante-natal care, delivery and post-natal care services. Sixty percent of women give birth at home unattended by health professionals or trained traditional midwives. The infant mortality rate is also high at 135 per 1,000 live births.

At the Dili hospital, one of two hospitals capable of providing comprehensive emergency obstetric care (EmOC), many cases of pre-eclampsia and eclampsia have been observed. However, the main problems for



Photograph by UNOCHA

pregnant women identified through clinical records are severe anaemia, iron deficiency, ankylostomes, and malaria. The lack of qualified staff, essential drugs and supplies, health education and adequate transport for midwives along with poor data collection and records all contribute to poor safe motherhood and EmOC services. There is no referral system in place to ensure early identification and transfer of emergency obstetric cases.

In an effort to address the needs for improved safe motherhood practices, the MOH, the United Nations Population Fund (UNFPA), the World Health Organisation (WHO) and the United Nations Children's Fund (UNICEF) instituted intensive training for midwives and nurses on clean safe delivery following the WHO standards of midwifery practice.

Family planning

Most families have between six and seven children. Condoms, oral contraceptives, intrauterine devices and injectables are available at a few clinics but the supplies are inconsistent and utilisation is poor. Lack of information about contraceptives, religious beliefs, lack of knowledge about FP on the part of the service providers and poor contraceptive logistics management

¹ Clionadh O'Keefe. Women in East Timor: a report on women's health, education, economic empowerment and decision making. Ireland Aid. 2001.

² Office of the Promotion of Equality (OPE). Women in East Timor: a report on women's health, education, economic empowerment and decision-making. 2002.

³ United States Committee for Refugees. World refugee survey. Country report. 2002.

⁴ World Health Organisation, Family Health International, United Nations Development Program, United Nations Population Fund, United Nations Children's Fund, United Nations High Commissioner for Refugees, Caritas, Café Timor, Health Net International, PRADET, Fokupers, International Rescue Committee and ETWAVE.

⁵ East Timor national development plan. May 2002.

⁶ UNDP. East Timor human development report, 2002.

⁷ East Timor health policy framework. June 2002.

⁸ Weekly epidemiological bulletin (WEB).

⁹ World Health Organisation. Media release. 2002.

Photograph: Settlement for internally displaced persons in Dili.

all contribute to this low rate. In addition, the history of abuses of contraceptives by Indonesia, including covert injections of contraceptives and sterilisation procedures of women who were in hospital for other reasons has caused widespread distrust of health services. The contraceptive prevalence rate for modern methods has fallen from 20% during the last years of the Indonesian administration to a current estimate of 5.6%. The Catholic Church recently issued a statement to all health providers and UN agencies involved in FP and sexually transmitted infections (STIs)/HIV/AIDS prevention stating that the distribution of condoms and emergency contraception pills is unacceptable.

The UNFPA has supplies of contraceptives but has been unable to distribute them widely. However, at the request of the MOH, a draft FP policy has been developed. Stakeholder meetings, which involve the Catholic Church, have discussed the FP policy and as a result a national FP programme will follow. Organisations such as Caritas widely promote natural FP while Café Timor clinics provide educational material on modern and natural methods but do not offer contraceptive supplies.

Sexually transmitted infections including HIV/AIDS

A significant number of women are infected with STIs, especially gonorrhoea. This is attributed to the high level of sexual violence perpetrated by Indonesian soldiers. In 1995, there were 27 STIs per 10,000 population, double Indonesia's rate. A lack of testing facilities for STIs/HIV makes it difficult to calculate the exact number of cases and at present no statistics on STIs are being collected by the MOH. In addition, lack of client confidentiality in testing for STIs is common and exposes people to stigma which impacts negatively on those who might otherwise seek treatment.

The incidence of HIV/AIDS in East Timor is not known, but a draft national HIV/AIDS strategic plan has been put in place. Voluntary counselling and testing services are

in the process of being set up at Dili Hospital and are planned for other sites.

Gender-based violence

Anecdotal reports from human rights organisations suggest that during the Indonesian occupation and siege, East Timorese women and girls were subject to violations of RH rights, rape, sexual harassment, enforced slavery, and forced or coerced prostitution servicing Indonesian military troops. In addition to discrete forms of violence that escalated during Indonesian occupation, traditional East Timorese attitudes and practices related to GBV have been informed by Indonesian legal and social systems that favour male domination in public and private spheres. Following independence, however, burgeoning and pre-existing women's organisations convened their first congress, from which they produced a comprehensive platform of action calling for the reduction of spousal abuse, polygamy, marital rape, incest, violence against women and girls in schools, bride price and other inheritance inequities. During the same period, the International Rescue Committee (IRC) initiated a broad-based capacity-building programme the objectives of which included providing on-going co-ordination and support to local NGOs undertaking GBV related activities. The United Nations High Commissioner for Refugees has also facilitated training for police cadets and the United Nations-administration (CIVPOL) instituted a data collection system that disaggregated reports of GBV. In December 2000, over 260 cases of domestic violence and sexual assault were reported to the Dili police unit.

The Reproductive Health Response in Conflict Consortium (RHRC Consortium) GBV Research Officer profiled East Timor in the GBV global report.¹⁰ She subsequently collaborated with the IRC's GBV programme and its implementing partners to conduct a field test of a GBV prevalence survey. Upon completion of the field-test in 2002, the IRC GBV programme linked with the UNFPA to undertake a national survey on GBV. This survey will

inform a three-year project by UNFPA to confront and reduce GBV throughout East Timor. This project will work with East Timor's Office of the Promotion of Equality (OPE), as well as with local women's NGOs, to promote policy change, expand community education efforts, and improve direct services for survivors. In addition, UNHCR has plans to start providing workshops on sexual- and gender-based violence through NGO partners in targeted areas with many returnees.

Adolescents

Information and services for adolescents are rare. However, a small number of peer educators conduct HIV/AIDS information campaigns around the country. Post war syndrome is affecting many adolescents and there is a need for personal counselling and guidance along with skills training and education. Many of the people consulted had ideas of how to involve adolescents although there was no discussion with young people themselves.



Photograph by Danielle Miller

Photograph: Timorese family in Dili.

The future

The East Timor health policy framework, draft HIV/AIDS strategic plan and draft family planning policy provide much guidance in the area of RH and are evidence of attention to the issue. Government strategies are also being formulated to improve access to healthcare and to win the confidence of the East Timorese people. In addition, partnerships with private and church related clinics will help strengthen the health system to reach more people and gain trust within communities. At the same time, the Trust Fund for East Timor is working to address the immediate and future health needs of the country. The GBV research undertaken by the RHRC Consortium, the IRC and the UNFPA will be used to inform policies and programmes that address violence against women and girls.

Although there are many efforts underway to specifically address the population's RH needs, the country's needs are great. On-going support and attention from the international community is essential to ensure that progress is made and results are achieved if the RH status of the East Timorese people is to be improved.

¹⁰ If not now, when? Addressing gender based violence in refugee, internally displaced and post-conflict settings. Reproductive Health for Refugees Consortium 2002.

Pakistan & Afghanistan

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Afghan refugees in Pakistan with an overview of post-conflict Afghanistan

Pakistan

Sites visited: the North West Frontier, Baluchistan and Punjab provinces

Date of visits: August 2002 and July 2003.

Assessment team: Dr Ouahiba Afzal, the Women's Commission for Refugee Women and Children

Why are the refugees there?

Approximately 1.5 million¹ Afghan refugees remain within Pakistan's borders. They are primarily ethnic Pashtuns who have fled armed conflict, inter-ethnic rivalries, severe drought, food shortages and economic destitution since 1978. In addition, almost 200,000 refugees fled Afghanistan in the weeks preceding and following retaliatory attacks by the United States on the Taliban authorities in the aftermath of 11 September 2001.²

The Pakistan government officially closed its borders with Afghanistan in November 2000 and refused to re-open them despite international pressure. Throughout 2001, when the number of Afghan refugees in Pakistan was estimated to peak at three million – and even more so following the events of 11 September – refugees endured extreme hardship to find their way across Pakistan's borders. The majority of those refugees sought refuge among relatives and friends in urban areas or were forced to settle in designated camps such as the Jalozai camp in Peshawar. Residents of Jalozai were later transferred to new camps in the North West Frontier, Punjab and Balochistan provinces.²

Which agencies are assisting the refugees?

The United Nations High Commissioner for Refugees (UNHCR) and the Pakistan Commissionerate for Afghan Refugees co-ordinate refugee assistance, security and protection within refugee camps. Attention in recent years has focussed on the return and reintegration of these refugees, resulting in a decline in funding and support for those remaining in Pakistan. However,

numerous international and local organisations continue to provide support, albeit at reduced levels, to implement primary healthcare services. These services include reproductive health (RH) care.

General conditions

Support for Afghan refugee programmes in Pakistan began waning in the mid-1990s. Food aid was cut in 1995 and international assistance dwindled throughout the late 1990s as humanitarian assistance providers shifted their attention to facilitate the repatriation and reintegration of Afghan refugees. The UNHCR reported that 1.5 million refugees were repatriated from Pakistan to Afghanistan in 2002.¹

Primary healthcare services, including RH, are provided through basic health units (BHUs), community labour rooms (CLRs) for basic emergency obstetric care (EmOC), and referral hospitals. Selected indicators of mortality for Pakistan reveal a life expectancy of 61 years and a maternal mortality rate of 300 deaths per 100,000 live births. The total fertility rate is 5.0 and contraceptive prevalence for modern methods of family planning (FP) is 20%. The prevalence of HIV in Pakistan is estimated at 0.1% and 67% of infections are the result of heterosexual transmission.³



Photograph by Meriwether Beatty

Photograph: Young Afghan refugees in Peshawar.

¹ United Nations High Commissioner for Refugees. UNHCR emergency updates: Afghanistan humanitarian update. Number 67. January 2003.

² United States Committee for Refugees. World refugee survey. 2002.

³ UNAIDS/WHO. Global Fund to Fight HIV/AIDS proposal. March 2003.

Reproductive health conditions and services

Two recent studies reflect the precarious RH status of Afghan refugees in Pakistan despite the number of local and international agencies operating in the camps. Forty one percent of deaths among women of reproductive age were due to maternal causes and 60% of their infants were either stillborn or died shortly after birth.⁴ In addition, 48% of women have an unmet need for FP.⁵

Until the late 1990s, the focus of RH services remained limited to maternal and child health (MCH) programmes integrated with primary healthcare (PHC) services. More recently, limited child spacing and sexually transmitted infections (STIs) programmes have been initiated. Most agencies working with refugees who arrived in 2001 in the new camps provide traditional components of relief assistance and limited PHC to control communicable and infectious diseases. Some explained that they do not intend to expand MCH care to broader RH services because of funding constraints. While some basic RH care is available, substantial gaps remain.

Technical assistance for non government organisations (NGOs) remains a priority despite the designated RH officers at UNHCR provincial offices in Quetta and Peshawar who co-ordinate, supervise and monitor implementing partner projects.

Of the 18 implementing partners in refugee camps in the Baluchistan and North West Frontier provinces, only six have a RH co-ordinator. The other partners have medical co-ordinators, but RH is not a particular focus of their programmes. Other non-UNHCR partner NGOs do provide RH care for refugees.

Safe motherhood and emergency obstetric care

At the BHU level, pregnant women are generally provided with ante-natal and post-natal care. Lady Health Visitors (LHVs) monitor pregnant women through three to four ante-natal visits as per World Health Organisation standards. During ante-natal care, pregnant women

usually undergo some basic laboratory tests, including blood grouping and haemoglobin tests. However, blood grouping and syphilis testing is not always carried out for all pregnant women. Most agencies only conduct these tests for women with high-risk pregnancies.

In the third trimester of pregnancy, most pregnant women or their traditional birth attendants receive clean home delivery kits. In 1998, the United Nations Population Fund provided kits directly to UNHCR which distributed them to the International Rescue Committee (IRC), Save the Children USA, Médecins Sans Frontières and other partners. In December 2001, UNHCR and the Pakistan Project Directorate Health received an additional 118 RH kits for new camps and repatriation centres. During 2003, all UNHCR partners that work in both old and new camps and provide health services to the refugee population are being provided with funds to prepare locally procured and assembled clean delivery kits for distribution to pregnant women.

LHVs provide ante-natal and post-natal care during home visits. Most working inside camps have complete midwife delivery kits provided by UNFPA Islamabad. In those camps where access to a community labour room is not possible, the LHVs frequently conduct normal deliveries at home.

Although emergency obstetric care (EmOC) referral systems have been established, refugee women are often unable to use them due to a lack of transport or inability to pay the fees. The switch to a system of charges is based on both short-term funding problems and a longer-term desire to make the services financially sustainable. Both the UNHCR and its implementing partners have agreed to reduce fees for EmOC to make services affordable to Afghan women.

Some CLRs established to provide basic EmOC are not functioning in this capacity because they are inadequately equipped or lack a trained female medical officer to

⁴ Linda Bartlett et al. Maternal mortality among Afghan refugees in Pakistan, 1999–2000. *The Lancet*. Vol. 359: 23 February 2002.

⁵ Basia Tomczyk et al. Unmet need for family planning among Afghan refugee women – Pakistan 2000. Unpublished paper. March 2001.

ensure 24-hour services. Referral hospital staff complain that women arrive at the obstetric out-patient department in very critical condition, indicating that health education on pregnancy-related complications for refugee women and health workers may be inadequate. Alternatively, BHU/CLR may staff need further training to stabilise patients before referring them to the hospital for comprehensive obstetric care.

The American Refugee Committee and the IRC have recently initiated projects to establish and improve EmOC services in Pakistan.

Family planning

A multi-agency⁶ study was undertaken between 1999 and 2000 among Afghan refugees in Pakistan to improve family planning (FP) continuation. Findings showed that of the two most commonly used modern methods of FP, continuation was significantly higher for injectables than pills. Younger women also had higher continuation rates than older women. Researchers concluded that the quality of FP counselling, particularly with regard to pills, should be improved.⁷ JSI Research and Training Institute also conducted an assessment on contraceptive logistics supply and a workshop for health workers and procurement officers on contraceptive logistics management.

FP services are available although staff require refresher training in modern contraception technology, communication and counselling skills. Only a few LHVs and medical officers had knowledge of emergency contraception.

The most available modern methods are oral pills and injectable contraception with only a few BHUs providing intrauterine devices. Refugee women reportedly prefer injectable contraception because it is easy and confidential to use. Overall, the number of current users is very low and the discontinuation rate very high.

All CLRs have some post-abortion care services but little attention is given to post-abortion counselling for FP. BHU frontline staff and community health workers, particularly males, are rarely involved in promoting child spacing among the male population.

Sexually transmitted infections including HIV/AIDS

Most staff have not received refresher training and lack proper equipment and supervision to adhere to universal precautions to prevent the spread of HIV/AIDS and other infections through blood and bodily fluids. Many of the outlets visited do not perform proper decontamination of instruments and medical waste disposal. Although condoms were available at all of the BHUs and urban clinics visited the supplies are not always free and safer sex behaviour is not promoted. It is not clear how partner treatment is conducted.

Most agencies state they are following syndromic management of STIs. Some are also conducting partner notification and treatment, as well as free condom distribution. However, there are no separate registers for STIs and protocols and guidelines for syndromic approach and counselling services are not readily available.

Gender-based violence

The Reproductive Health Response in Conflict Consortium gender-based violence (GBV) Research Officer documented high levels of GBV and a dearth of programmes to address it during her site visit to Pakistan in April 2001. NGOs, human rights organisations and the UN Special Rapporteur have all reported incidences of GBV, including domestic violence, along with a rise in case fatalities, sex trafficking, sexual assault, forced early marriages, child sexual abuse, prostitution, abduction and rape of women – all without consequence for perpetrators.⁸

Under severe socio-cultural, security, political and judicial constraints, several local NGOs⁹ have developed

successful projects that could provide a model for organisations addressing GBV among Afghan refugees. To date, the lack of international commitment and donor support has been a primary barrier to GBV prevention and management programmes for Afghan refugees in Pakistan.⁷

However, in December 2002, UNHCR launched an initiative aimed at reducing the levels of GBV in the camps. It organised a working group made up of the implementing partners, collaborating agencies and advocacy NGOs to plan GBV services. Local Afghan NGOs working in the camps and the provincial capitals of Quetta and Peshawar also joined the group, which is fuelled by both goodwill and a sense of urgency. The Women's Commission for Refugee Women and Children (Women's Commission) is co-ordinating with UNHCR to revive the prevention and response system currently in place.

Adolescents

Most BHUs only provide MCH care; unmarried young girls who face RH problems do not receive youth-friendly services. Moreover, they are unlikely to seek services fearing stigmatisation and service provider bias.

Although little is known about adolescents living in refugee camps in Pakistan, adolescent refugees in urban areas of Pakistan are particularly neglected and exploited without the protection and care afforded through United Nations-administered camps. Among the problems adolescents endure are harmful child labour to support survival needs, sexual violence, sex trafficking and early marriage exposing pre-pubescent girls to physical injuries and high-risk pregnancies.¹⁰

The health risks of Afghan adolescents in urban areas of Pakistan are both fuelled and compounded by a lack of access to shelter, food, education and health services. The Afghan NGO Shuhada, once funded through a Women's Commission small grant, provides social,

economic and health services including RH to Afghans in Afghanistan and Pakistan. Shuhada staff report that the needs far exceed their capacity to provide services for adolescents in Pakistan, especially child workers.¹⁰

Male involvement

For the most part, men and young boys appear to have access only to curative care; health promotion campaigns or disease prevention services aimed at them are very limited. Men rarely seek medical help for RH problems such as sexual disorders and STIs, or to request condoms. Although there are male BHU staff only clinical out-patient services are provided for men. There are no RH counselling or education services provided for men on FP or safer sex.

The future

Afghanistan, Pakistan and UNHCR signed an agreement in March 2003 to establish a formal process to resolve the 23-year-old Afghan refugee situation.¹¹ Continued civil strife along with the devastation of the basic infrastructure and inadequate living conditions, however, are obstacles that must be addressed before all refugees are able to return home.¹² Although there are major efforts to improve conditions in Afghanistan, humanitarian aid workers must continue to address the needs, including the RH needs of Afghan refugees in the camps and urban areas of Pakistan. One concrete step would be the revival of the RH working group to co-ordinate improvements in the quantity and quality of RH services available to Afghans in Pakistan.

⁶ Sach, Savera, Sahil and Rozen. Local non government organisations in Islamabad serving the Pakistani community.

⁷ Jeanne Ward. If not now, when? Addressing gender-based violence in refugee, internally displaced and post-conflict settings. Reproductive Health for Refugees Consortium. April 2002.

⁸ Heilbrunn Center for Population and Family Health, Columbia University; International Rescue Committee; JSI Research and Training Institute; Kuwait Joint Refugee Committee; Project Directorate health; Save the Children – US, UNFPA, UNHCR, Union Aid for Afghan Refugees. Frontier Primary Health Care.

⁹ Poonam Mazhar. Findings on reproductive health of refugees and displaced populations proceedings. Reproductive Health for Refugees Consortium conference. December 2000.

¹⁰ Jane Lowicki. Fending for themselves: Afghan refugee children and adolescents working in urban Pakistan. Women's Commission for Refugee Women and Children. May 2002.

¹¹ UNWIRE. 19 March 2003.

¹² UNHCR. Afghan regional leaders agree to end ethnic strife. UNHCR website. February 2003.

Post-conflict Afghanistan

Site visited: Kabul

Assessment date: March 2003

Assessment team: Therese McGinn, Heilbrunn
Department of Population and Family Health,
Columbia University

General conditions

Refugees both leaving and returning to Afghanistan come from a country where access to survival needs is an on-going struggle. The basic infrastructure and systems have been destroyed and the average life expectancy is only 43.¹³ In the former Taliban-controlled areas, Afghans, particularly women, endured some of the worst human rights abuses in the world.⁷ Women's rights remain seriously constrained, affecting their access to the extremely limited social and economic opportunities, and health services, available.¹⁴

Reproductive health conditions and services

The entire health system in Afghanistan has been devastated for more than two decades and key health and RH indicators are among the worst in the world, especially in rural areas. In a recent study, the maternal mortality rate (MMR) was estimated at 1,600 deaths per 100,000 live births, with significant differences between urban and rural areas.¹⁵ For example, in the remote area of Badakshan, the MMR was reported at 6,500 per 100,000, a rate that exceeds any previously recorded in the world. Another 2002 study in the Herat province in western Afghanistan by Physicians for Human Rights estimated the maternal mortality rate at 593 maternal deaths per 100,000 live births, using the indirect 'sisterhood method'.¹⁶ The overwhelming majority of deaths, primarily caused by haemorrhage and obstructed labour, were due to a lack of access to health services (70%) and deemed preventable (87%). In addition, only



Photograph by Ami Vitale

seven percent of women had the benefit of a skilled health worker at delivery.¹⁷ The total fertility rate is 6.8 and the use of modern contraceptives is four percent.¹³

Patriarchal cultural traditions support gender discrimination and other forms of GBV in Afghanistan. While data on GBV in the country is limited, human rights groups have reported abduction, rape and forced early marriages carried out by the Taliban and other armed groups. Under the Taliban, women who survived sexual violence were saddled with the unrealistic burden of proof for non-complicity and faced accusations of adultery with subsequent forced marriage to perpetrators. In extreme cases they were murdered. Reports from NGOs and investigators also indicate a high prevalence of domestic violence, as well as sex trafficking.⁷

Afghanistan's commitment to women's health

Afghanistan has been at war since 1979, initially in a decade-long struggle between the Soviet Union and local resistance movements, and then after the Soviet withdrawal with a civil war between various factions. This eventually resulted in a victory for the Taliban, who governed most of the country between 1996 and November 2001.

Photograph: Marie Stopes International centre in Kabul.

As the world came to realise, Taliban policies regarding women were especially oppressive. The post-Taliban interim government is committed to rectifying these wrongs and to fully including women in the country's redevelopment. Afghanistan's national development plan calls for progress in all critical sectors and highlights women's health, and specifically maternal death, as an area of intense need.

The pledge to reduce maternal deaths was translated into a safe motherhood strategy for Afghanistan, drafted by the Ministry of Health and its partners. Based on global evidence, it has three components:

- improvement in the coverage, utilisation and quality of EmOC
- improvement in the coverage of skilled attendance at birth
- ensuring effective ante-natal care for all women.

The three strategic components will be implemented in a way that ensures links with FP services so that women have access to the full range of care with which they can control their reproductive lives. It is clear that development in many other sectors will contribute to, and indeed will be required for, the realisation of the strategy, including improvements in education, higher education, rural reconstruction, infrastructure development, governance and security.

Women are, finally, recognised as integral partners in Afghanistan's national development. Progress on the safe motherhood initiative will serve as a marker of continued commitment to this goal by the government and its partners in development.

A number of local and international agencies are now working to increase access to RH services yet it will take many years of on-going support to overcome the numerous barriers to good quality services.

Noteworthy initiatives

Marie Stopes International opened its first RH centre in Kabul in August 2002. Located in the busy Kart-i-Parwan district, it serves an immediate population of around one million. Services include integrated primary health and RH care, with a focus on MCH care. Counselling and outreach education are important components of the programme.

Marie Stopes International has also opened three mini-centres in association with UN Habitat in their sponsored women's community centres in Kabul. These centres provide counselling, education and MCH services, and refer women to Marie Stopes International's main centre in Kabul for specialised services and treatment. In addition, mobile services are run to villages on the outskirts of Kabul serving vulnerable populations, including returnees from Pakistan.

A social marketing programme has also been launched after consultation with community leaders and traders. The programme currently provides condoms but is investigating the provision of other products including paediatric supplies. Marie Stopes International, in line with government policy, has always planned to open centres outside of Kabul and recently opened one in Kapisa Province. The organisation is also investigating the possibility of opening centres in the Bamyan, Badakshan and Nuristan provinces.



Photograph by Julie Porksen

Photograph: Afghan women in the desert.

¹³ UNFPA. State of world population. 2002.

¹⁴ International Centre for Human Rights and Democratic Development. Women's rights in Afghanistan: report of rights and democracy's mission to Afghanistan. September 2002.

¹⁵ <http://www.unicef.org/noteworthy/afghanistan/motherhood>. Accessed 18 March 2003.

¹⁶ Amowitz, Lynn L; Chen Reis; Vincent Iacopino. Maternal mortality in Herat province, Afghanistan. JAMA. Vol 288. No. 10:1284-1291. 11 September 2002.

¹⁷ Relief Web. Afghanistan is among worst places on the globe for women's health say UNICEF and CDC. UNICEF. 6 November 2002.

The Maidan Shahr clinic in Wardakh, near Kabul, is a Ministry of Health (MOH) facility managed by the International Medical Corps. In late 2002, the staff started providing basic EmOC on a 24-hour basis. At the time of the visit they had seen over 200 women and undertaken approximately 130 deliveries, half of which, they estimated, were complicated. Their referral sites are Malalai and Rabia Balkhi Hospitals in Kabul, on a paved road about one hour away by ambulance.

The clinic staff now provide all basic EmOC signal functions except vacuum extraction. However, the staff are trained and experienced in the procedure so when the equipment arrives that service too will be delivered.

To upgrade the clinic to a comprehensive EmOC facility, the MOH is constructing a surgical wing in which caesarean sections and blood transfusion services will be added to the services already available. When that is completed, women in the area can receive all forms of emergency care there instead of making the time-consuming and expensive trip to Kabul.

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Internal displacement in Sri Lanka

Sites visited: uncleared areas (under the control of the Liberation Tigers of Tamil Eelam) in the Mannar and Vavuniya districts, and the Kilinochchi district

Date of visit: December 2002

Assessment team: Sara Casey, the Reproductive Health Response in Conflict Consortium; S Suriyamurthy; T G Anandarajah (Vavuniya); Annie Mahendrapala (Mannar); K S Kumarasamy (Vavuniya and Kilinochchi) and M I A Razzak (Mannar and Kilinochchi), – all from Population Services Lanka

Why are the internally displaced persons there?

Following independence from the United Kingdom in 1948, Sri Lanka's Tamil population faced increasing marginalisation at the hands of the majority Sinhalese population. Anti-Tamil riots in 1983 led to an increasing cycle of violence when the Tamil separatist Liberation Tigers of Tamil Eelam (LTTE) launched a civil war against the Sri Lankan government for an autonomous Tamil state in the north and east of the country. The country became divided between uncleared areas, under LTTE control, in the north and east, and cleared areas, under government control, in the south (although the government was nominally still responsible for providing services in the uncleared areas). Since 1983, the war has claimed over 64,000 lives,¹ and at the height of the conflict more than one million people were displaced.

In February 2002, the government and the LTTE signed a Memorandum of Understanding (MOU) for a long-term ceasefire. Travel restrictions were eased, allowing civilians from the north and east to travel without obtaining a special pass although the main road leading north to Jaffna only opened to public traffic in mid-2002 (after 12 years). This greatly improved transportation and access to the uncleared areas, and allowed many internally displaced persons (IDPs) to visit their homes for the first time in years. More than 230,000 IDPs

spontaneously returned to the north and east in 2002, but an estimated 800,000 remain scattered throughout the country.² Despite the ceasefire, there are continued outbreaks of violence causing on-going displacement.

Which agencies are assisting the internally displaced persons?

Throughout the war, the Sri Lankan government took responsibility for the IDPs, and in December 2001 created the Ministry for Rehabilitation, Resettlement and Refugees (MRRR) to focus on durable solutions for the IDP population. A number of local and international non government organisations (NGOs) provide services to the displaced populations, including Marie Stopes International's local partner, Population Services Lanka (PSL); the International Committee of the Red Cross (ICRC); Médecins Sans Frontières (MSF) and FORUT. The United Nations High Commissioner for Refugees, working closely with the MRRR, has been the focal point agency for the IDPs. As the country shifts from conflict to post-conflict, however, better co-ordination among the different governmental, NGO and international agencies will be needed.

General conditions

Although some IDPs are housed in government-run welfare centres, many live with friends or relatives or on their own, receiving no assistance. Conditions in the welfare centres are dismal, with overcrowding and frequent food shortages. The areas to which people are returning are completely devastated, lacking clean water, sanitation facilities and healthcare. Many buildings, including houses and health facilities, were completely or partially destroyed whilst roads and other parts of the infrastructure have deteriorated. In addition, the Defence Secretary estimates that there are 700,000 landmines, many in heavily-populated and fertile areas.³



Photograph by Sara Casey

General health conditions and services

Prior to the war, the north and east had among the best health indicators in Sri Lanka. However, current data suggests that health indicators in these districts have fallen behind those of the rest of the country.⁴ The uncleared areas suffer from a particularly acute shortage of services, and little has improved since the signing of the MOU. Many health facilities were completely or partially destroyed, and those that do exist are unable to serve the increasing numbers of IDPs returning home after up to 20 years of displacement. Although people are happy at being able to finally return to their homes, this feeling may dissipate if services and the infrastructure are not improved.

A shortage of qualified medical personnel hinders the provision of health services with nearly one-third of the medical staff positions in the north and east vacant.⁴ Many health personnel fled the fighting, few are willing to accept appointments in conflict areas, and the facilities to support them, including housing and offices, are often unavailable. The need for field level personnel, such as public health midwives (PHM), is particularly acute. For example, six PHMs are responsible for Kilinochchi district; each one covers 10,000 people, even though the Ministry of Health (MOH) recommends one midwife for

every 2,500 people. Volunteer community health promoters (CHPs) trained by NGOs are unofficially filling some of the gaps, providing basic first aid in mini-clinics and conducting home visits.

The government and some NGOs extend health services to the uncleared areas with mobile clinics. However, due to the poor road conditions and the lack of resources these efforts are only marginally successful. The LTTE has assigned several of their "doctors"⁵ to provide basic primary healthcare in locations the government is not yet able to reach. Of those interviewed, none had received training in reproductive health (RH). In some cases, the LTTE provides the personnel while the government provides the medicines and supplies; in others, the LTTE provides both personnel and supplies. Although the Sri Lankan government and the LTTE have been fighting a prolonged war, it appears that MOH and LTTE staff in the health sector collaborate relatively well on the ground.

Reproductive health conditions and services

RH services are unavailable in most of the uncleared areas. Few NGOs and no LTTE providers include them within healthcare provision. As more people return to their homes, the lack of services that people have become accustomed to will become more important. Although the government is making some effort to extend ante-natal care and family planning (FP) to the uncleared areas via mobile clinics, the poor conditions of the roads and the lack of resources limit the success of these efforts. In many cases, women must travel long distances to access safe delivery and FP services or do without. Very little attention is paid to sexually transmitted infections (STIs) and knowledge about AIDS is very low. Despite the reported high prevalence of gender-based violence (GBV), including domestic violence, few formal services are available for survivors.

¹ Human Rights Watch. Sri Lanka: human rights and the peace process. <http://hrw.org/backgrounder/asia/srilanka/srilanka.pdf> July 2002.

² Global internally displaced persons project. Returning Sri Lankans need help. <http://www.reliefweb.int/w/rwb.nsf/6686f45896f15dbc852567ae00530132/3b4c0a75965225c8c1256cc600450372?OpenDocument> Geneva. 7 February 2003.

³ International campaign to ban landmines (ICBL). Landmine monitor report 2002: Sri Lanka. http://www.icbl.org/lm/2002/sri_lanka.html August 2002.

Photograph: Mobile maternal and child health clinic in LTTE centre.

⁴ WHO. Health system and health needs of the north-east Sri Lanka. August 2002.

⁵ The LTTE trained so-called "doctors" to serve their army. These "doctors" have received no formal medical training; the training they have received tended to concentrate on war surgery and other areas necessary to maintain a healthy military, such as infectious disease treatment.

Safe motherhood and emergency obstetric care

Women's knowledge and behaviour regarding safe motherhood is relatively good. Sri Lanka's maternal mortality rate of 60 deaths per 100,000 live births is among the lowest in the developing world.⁶ This is due to a strong government commitment to improving access to healthcare. However, maternal mortality in the north and east is estimated to be 81–100.⁴ Few public health midwives, who used to visit women in their homes, are posted in the uncleared areas and half of the positions remain vacant.⁴ Women make an effort to attend monthly ante-natal care where it is available but in much of the uncleared areas it is only available via unreliable mobile clinics that come once a month. Women who attend receive tetanus toxoid vaccinations, nutritional counselling, fortified food, iron supplementation, malaria prophylaxis and vitamins. Several clinics stated that they occasionally run out of some supplies although this has improved since roads were re-opened and restrictions relaxed. Volunteer CHPs visit women in their homes to encourage them to attend ante-natal appointments and to bring young children for immunisations.

Most women prefer to have their babies delivered in a hospital or health centre, and make an effort to travel to a health facility before their due date. Poor road conditions and the long distances mean that some



Photograph by Sara Casey

Photograph: Vavuniya internally displaced persons camp.

women end up delivering by the side of the road. Those in remote areas have few options, especially during the rainy season when some roads are impassable. Comprehensive emergency obstetric care (EmOC) is available in the base hospitals in Vavuniya and Mannar districts (although there is no obstetrician stationed at Mannar hospital), and in two MSF-supported hospitals in the Mullaitivu district.

Family planning

Knowledge of FP is high. Sri Lanka's contraceptive prevalence rate is 66%; 22% of which is attributed to traditional methods.⁶ Although Depo-Provera is the most popular temporary modern method, voluntary surgical sterilisation, known as LRT (left, right tubal ligation) is widely-used. For women that choose LRT, the government reimburses lost wages and travel costs of 500 rupees (US\$5). The LTTE imposes restrictions on when sterilisation can be performed on women who live in the uncleared areas – the woman must be at least 35 years old and have a minimum of five children.

Although women claimed they wanted, and had access to, FP, the number of children many couples have is higher than the number they said they would like to have. The reason or reasons for this are unclear. Some women reported that the LTTE prohibited the use of FP (both temporary and permanent methods) and would punish women who used them during the conflict because they wanted to increase the Tamil population. Although the LTTE now allows the use of temporary methods, some women may be prevented from seeking contraceptives due to a lack of clarity about the LTTE position on their use. However, the LTTE cadre questioned during the assessment (all were involved in health services) were supportive of the government's and NGOs' efforts to expand RH services, including FP, to areas under their control, indicating that they understand the value of FP or are at least willing to allow its provision.

⁶ UNFPA. State of world population. 2002.

Contraceptives are available in the base hospitals and PSL centres in Mannar and Vavuniya, and in the MSF-supported Madhu hospital as well as in the temporary primary healthcare clinic in Kilinochchi town (Depo-Provera only). In the uncleared areas, FP is available at the monthly mobile ante-natal clinics provided by the government. Given the poor road conditions and the lack of resources for preventive health services, the mobile clinics are unreliable and do not cover all of the uncleared areas. Also, if they fail to arrive, women must do without, wait another month and risk the lapse of their protection, or, if possible, travel long distances to either Mannar or Vavuniya over poor roads to get their supplies.

Sexually transmitted infections including HIV/AIDS

Knowledge of AIDS is limited. Most women said they had heard of AIDS, but knew very little about it. Some said that they are supposed to remain faithful to their husbands to avoid AIDS. According to UNAIDS, HIV prevalence in the adult population is 0.1%;⁷ however, some known risk factors for HIV transmission are present in Sri Lanka: population movement (including an expected influx of refugees returning from higher-prevalence countries like India), a high concentration of military forces, the use of sexual violence, and poverty. Knowledge of other STIs was also low. During the visit it was reported that STIs are not a problem in the uncleared areas because the LTTE is quite strict in regards to sexual behaviour. Few health facilities in these areas could diagnose STIs, referring patients to facilities in cleared areas for diagnosis and treatment. In addition, HIV testing is not available in any part of the north and east (in cleared or uncleared areas), although hospitals do screen blood for transfusions for HIV.

⁷ UNAIDS. Epidemiological fact sheet on HIV/AIDS and sexually transmitted infections update. 2002.

Gender-based violence

Although written reports document the use of sexual violence in the Sri Lankan conflict, accounts of GBV were rare among the women interviewed. Women reported that the LTTE was extremely strict, and would simply execute someone accused of rape; as a result, rape was not a problem in the uncleared areas. According to one group, however, the Sri Lankan army raped many Tamil women in the areas under their control.⁸ One woman reported that soldiers had tied up her husband and then raped her in front of him before throwing both of them into prison. Others reported women being forced to have sex with security forces in order to see imprisoned children or husbands. Soldiers would also reportedly imprison women on false pretexts if they refused their sexual advances. No formal services are available for survivors of GBV, although some churches provide *ad hoc* counselling to those seeking assistance.

Domestic violence, however, was widely reported as a problem. Women said that men could be violent with their wives when they drank alcohol. In most cases, the women would keep quiet about the violence although some in a predominantly Christian area mentioned that they would speak to their local priest who would try to help the couple resolve their problems.

Adolescents

FP is not freely provided to adolescents who, according to social mores, are not supposed to be sexually active. However, some RH and sex education is given in school. Health providers in uncleared areas claimed there was no need to give adolescents FP information because the LTTE's fiercely puritanical approach prohibited sexual activity between teenagers. According to them, much more adolescent sex happens in the cleared areas. PSL counsellors do meet with adolescents to discuss sexual and RH, including STIs and HIV/AIDS. Some donors are funding RH projects which include adolescents as a specific component although this remains an underserved

⁸ Amnesty International. Sri Lanka: rape in custody. ASA 37/001/2002. <http://www.web.amnesty.org/ai.nsf/index/asa370012002> 28 January 2002.

area. In addition, despite the LTTE's moral code, several health facilities mentioned that they do see some adolescent girls who are pregnant.

In Sri Lanka the age of marriage is generally high at between 23 and 28 years. One group of 15 to 29 year old unmarried women in an uncleared area of Mannar district explained that one of their biggest concerns is the dowry system. Before the war, dowries were not a problem, but now paying the dowry is very difficult, forcing many young women to delay marriage even more. This could lead more young couples to engage in sexual activity before marriage. However, due to the taboo against sex outside of marriage, it is unlikely that they would have access to FP to prevent pregnancy or STIs.

The future

Health services are sorely lacking in the north and east of Sri Lanka, particularly in the uncleared areas. As the pace of IDP return accelerates, both the government and the LTTE will be held accountable for the lack of services. Many people told us there had been little change in nearly a year of peace following the signing of the MOU. Currently, women have very good health seeking behaviours and make good use of safe motherhood and FP services. However, these positive behaviours may be discouraged if these services are not available in the areas to which communities are returning. In addition, the incidence of domestic violence could increase as frustration mounts over lack of services and employment in the uncleared areas as more IDPs return home.

Zambia

Refugees in Zambia

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Refugees in Zambia

Sites visited: refugee camps in Nangweshi, and Mayukwayukwa, Western province and Kala and Mwange, Northern province

Date of visits: September 2001, April 2002 and February 2003

Assessment team: Sandra Krause and Julia Matthews, the Women's Commission for Refugee Women and Children and Janet Meyers, the Reproductive Health Response in Conflict Consortium

Why are the refugees there?

Zambia is host to approximately 250,000 refugees.¹ The vast majority, more than 190,000, are Angolans, while the remainder come primarily from the Democratic Republic of Congo (DRC) as well as other African countries such as Rwanda, Burundi and Somalia. To accommodate the rapid influx of refugees in the past few years, new camps have opened and/or expanded.

The achievement of peace in Angola has allowed the repatriation of some refugees, but people fleeing the fighting in DRC continue to cross into Zambia. The United Nations High Commissioner for Refugees (UNHCR) is planning to repatriate approximately 60,000 Angolan refugees between May 2003 and the start of 2004. Early results from surveys show that the refugees want to make sure their return would be well-timed for the planting season, that children could continue their schooling and above all that the conflict has truly ended.

Which agencies are assisting the refugees?

United Nations agencies and numerous local and international non government organisations (NGOs)² in the country support health services for refugees in Zambia. UNHCR is the main co-ordinating body and international NGOs working with refugees meet on a regular basis to share information. The UNHCR and the United Nations Population Fund (UNFPA) also work closely together and the UNFPA's work in Zambia

supports national development objectives in reproductive health (RH).

General conditions

Despite the on-going turmoil experienced by its neighbours to the north and west, Zambia itself enjoys relative peace. Over the past thirty years the country has provided a safe haven for refugees during which time there has been little conflict between the host and refugee populations. However, the Zambian economy has suffered over the last decade and tensions have begun to surface where they did not exist before. In an effort to deal with its economic problems, the country has recently moved from a paternalistic governing style with free social services and price controls to a free-market approach. It has also been struck by famine, as have many other southern African countries, putting a quarter of the population at risk of hunger and disease and exacerbating RH problems such as HIV/AIDS.³

Under Zambian law, refugees have equal rights as the country's citizens. In the past, Zambian citizens had free access to healthcare, but now fees are charged; the UNHCR is responsible for the health fees incurred by refugees. The Zambian government, with help from the UNHCR, supports referral services for refugees to local district hospitals and provides some health supplies including contraceptives to the refugee population through the Ministry of Health.

General health conditions and services

The government is the largest provider of health services in Zambia. However, almost one third of the population use church-supported health services and a small percentage of Zambians access private services. The majority of these health services emphasise curative and out-patient care to the detriment of preventive services such as maternal and child health (MCH) services and health education. A large portion of the population frequents traditional healers in addition to using conventional care.

Access to services declined from 1985 to 1995. An insufficient number of facilities as well as the large distance and poor terrain between facilities and communities have contributed to this decline. The introduction of healthcare charges – which apply to everyone except children under five, pregnant women and the elderly – seems to be discouraging poor families (approximately 60% of the population) from using public services. This situation is made worse by the low quality of the services available and the high cost of medicine. Compounding these problems is the devastating impact that HIV/AIDS is having on the country. With a prevalence rate of 21.5%, many people who would be contributing to the country's development are dying, leaving behind an estimated 570,000 orphans.⁴ The rapid decline in Zambia's life expectancy is attributed to the AIDS pandemic.

The government is supporting a number of initiatives that indirectly benefit refugees which include a programme geared to increase the equity and quality of healthcare in the country; a strategy to prevent and manage HIV/AIDS, and a policy aimed at making women full and equal partners at all levels of national development. In addition, the Zambia Initiative is a new, local integration project aimed at providing agriculture and income generation projects along with social services to both the refugees in Nangweshi camp and the local community.⁵

Reproductive health conditions and services

The RH of refugees is being taken seriously in Zambia. The UNHCR hosted two RH workshops focusing on HIV/AIDS in 2001 and another focusing specifically on gender-based violence (GBV) in 2002 attended by field staff working with refugee populations all over the country. However, while these were important steps towards addressing RH within all camps and ensuring that it is a priority of all implementing partners, it is not clear that these efforts will be continued due to UNHCR budget constraints. In addition, several organisations



Photograph by Julia Matthews

have hired RH or HIV/AIDS co-ordinators who are essential to facilitate the work of the various implementing partners in the camps and reducing inefficiencies in agency efforts.

A newly formed National AIDS Council is working to address HIV/AIDS in the country, including the refugee community. GBV is becoming a higher priority issue with prevention and response initiatives being undertaken in conjunction with refugee committees in a number of camps. In addition, reports highlighting sexual exploitation in West Africa in 2001 and the subsequent development of codes of conduct by the UNHCR and the international community has increased awareness in Zambia. The UNHCR has reviewed its code with its staff and visited each camp to bring attention to this issue.

¹ UNHCR. Zambia annual statistical report. 2002.

² World Vision, Hodi, Aktion Afrika Hilfe, Zambian Red Cross Society, UNFPA, YMCA, Lutheran World Federation African Humanitarian Action, Christian Outreach for Relief and Development, CARE and Africare.

³ Relief Web: Africa: Update on the food crisis threatening over 30 million people in Southern and East Africa. 25 February 2003.

⁴ UNAIDS, Zambia: Epidemiological fact sheet on HIV/AIDS and sexually transmitted infections 2002 update. 2002.

⁵ Conversation with the UNHCR Zambia Deputy Representative. 12 February 2003.

Photograph: Maternal and child health clinic.

Safe motherhood and emergency obstetric care

Most refugee women give birth at health facilities with the assistance of clinic staff, traditional birth attendants (TBAs) and/or female family members. Safe motherhood services are often better for the refugees than for the local population and refugees typically receive satisfactory ante-natal care. Physicians at referral sites for refugees claim that they are seeing the appropriate number of emergency obstetric care cases based on the number of pregnant women of reproductive age expected to have complications in the camp, whereas the local population is referring far fewer women than would be expected. Although not without problems, it is clear refugee women have better access to emergency services in this stable setting, helped by the attention of NGOs to the issue and access to transportation through humanitarian assistance. The only exception to this are the refugees dispersed in the urban/peri-urban areas who, like the local population, have difficulty with transport.

The prevalence of unsafe abortion is unclear, and although a variety of sources – district hospital, refugees, NGO staff – note that traditional methods such as herbs are used to abort. As one physician working at the referral hospital for Nangweshi camp explained, *“Yes, it’s very effective, the women miscarry or she dies.”* This physician believes what he was seeing is only the *“tip of the iceberg.”* The YMCA indicates that many cases of incomplete abortions have been reported from the urban/peri-urban population. In most camps, reported maternal deaths were rare (refugees citing only one in the last year) whereas neo-natal deaths were more common (two/three in the months prior to the 2001 assessment visit). In the urban/peri-urban area, refugees believed that a contributing factor to maternal and infant mortality was early discharge from health facilities leading to women suffering complications at home where they lack any medical assistance. Since the time of the first assessment, more training for TBAs has taken place, services have been strengthened and some of the remaining transportation issues have been resolved.



Photograph by Sandra Krause

Family planning

Refugees tend to be reluctant to use family planning (FP) methods. Angolans, for example, have endured 30 years of war and some feel the need to produce the next generation after the many losses they have suffered. Other barriers to use include:

- husbands not wanting their wives to use FP
- religious and community beliefs that women should have as many children as God gives them
- the notion that FP methods are only suitable for women who already have children
- lack of community-based distribution programmes and
- women’s difficulty in persuading their partners to use condoms.

Photograph: Woman refugee in Nangweshi.

The most commonly used methods in camps are condoms, pills and injectables, though traditional methods and abstinence are also used. The Planned Parenthood Association of Zambia, the UNFPA and the MOH provide some supplies to camp health facilities but logistical problems still exist. Community health workers in most camps play an active role to educate refugees about their FP options, but there is a lack of community-based distribution of FP supplies. In nearly all camps emergency contraception (EC) is an unknown concept to refugees and health staff. Although some clinics carry oral contraceptives to enable them to provide EC and one carried a dedicated EC product in the past, lack of awareness in general by staff and refugees made it clear that women are not getting access to this essential method of pregnancy prevention.

Sexually transmitted infections including HIV/AIDS

Generally there is a good level of awareness concerning the prevention of sexually transmitted infections (STIs) and HIV/AIDS including methods and locations for treatment. Many camps have HIV/AIDS committees or task forces in which refugees and NGO partners participate. There is, however, a great deal of fear surrounding the disease. Premarital sex, polygamy and sex for survival are common in camps and alcoholism is a factor in this. Although there are numerous suspected HIV/AIDS cases, there are few diagnosed patients and a persistent scepticism about the existence of the disease remains.

There are a number of other concerns related to STIs as well. Refugees in some camps seek treatment for sterility, a condition most likely due to untreated STIs, and Angolan refugees reported that male circumcision is typically performed on young boys in the community by indigenous providers, possibly indicating unhygienic practices. Furthermore, many patients diagnosed with an STI do not comply with the recommendation of partner notification and go to a pharmacy instead to

self-treat, posing further danger to the individual’s and partner’s health.

The availability of male condoms is inconsistent in many of the camps. Female condoms have been introduced in some settings but supplies are almost non-existent and awareness of this alternative is still low. Voluntary counselling and testing (VCT) is available in only a few camps as well as in some district hospitals and two centres in Lusaka; the degree of counselling provided with testing is unclear. The VCT services are not well used, perhaps due to fear or denial, or because the community does not see the value of testing without treatment options available for HIV-positive diagnoses.

Gender-based violence

GBV is a topic most people are reluctant to discuss. However, most NGOs, UNHCR representatives and refugees acknowledge that it occurs in the camps. Domestic violence is the most frequently reported type of abuse, which is often exacerbated by alcohol and drug use/abuse. Another less common form of GBV is teachers violating young schoolgirls.

In one camp, Médecins Sans Frontières is attempting to respond to the complaints of female refugees by increasing the number of female maternity staff – currently only four of the fourteen health providers are females. Women do not feel comfortable seeing male providers for violence-related incidents and the lack of female midwives limits the GBV services provided in the maternity clinic.

Most health facilities lack any type of protocol to manage the consequences of rape. The fact that women and girls are having sex for survival and material goods is acknowledged by refugees and implementing partners in most camps. Rape incidents are sometimes resolved by the victims’ families forcing the perpetrator to marry the victim or exacting financial payment from the perpetrator

as compensation. Victim Support Units (VSU) are in place at camp police stations and some refugees are aware of their services; however, it is not clear that the VSU staff are appropriately trained to serve victims of violence. In some camps, refugees do not report rape incidents for fear of retaliation by the perpetrator. CARE has managed GBV projects in Nangweshi and Mwange camps focusing on training and development for a multi-sectoral response which involves the police, clinical providers and community services. Hodi, the only local NGO working with refugees in the country, is continuing CARE's project in Mwange camp and has also initiated a GBV project in conjunction with Christian Outreach for Relief and Development (CORD) in Mayukwayukwa camp.

Adolescents

RH services for adolescents are limited and *ad hoc* at best. Early marriage is common for girls; many marry as early as 13, while most men marry between the ages of 20 and 25. Adolescents are a sexually active population and are particularly vulnerable given the lack of readily available condoms and comprehensive services targeting their needs. Although there is awareness among refugees that adolescents are sexually active, there is still reluctance to allow young people to have access to the services and supplies critical to protect themselves from unwanted pregnancies and STIs/HIV/AIDS. For example, in one camp the HIV/AIDS committee said that a person would have to be at least 16 to obtain a condom.

In other camps, it is common for adolescents to have to go to the MCH clinic to obtain supplies although many are reluctant to do so for fear of seeing an elder they know. To deal with this, NGOs have established peer-education groups to cover issues such as early

child-bearing, unsafe sex, unsafe abortion, unwanted pregnancy and STIs/HIV/AIDS. For example, CORD built a youth-friendly centre in the Nangweshi camp to serve as a community centre for adolescents to engage in activities and obtain more information about RH topics.

The future

Communication is one area in which RH for refugees programming could be strengthened. Ensuring good quality RH involves exploring new and challenging technical areas. Collaboration among partners is also crucial to utilising scarce resources efficiently and achieving improvements in the availability of RH for refugees. Efforts should be made to ensure that the different camps share the expertise they have acquired.

Although there is still a great deal of work to be done, there are many knowledgeable, skilled and enthusiastic people who are passionate about their work to improve the lives of refugees in Zambia. These workers on the "frontline" must be given the support necessary to carry out their programmes. The political will to move forward the RH for refugees agenda must also be encouraged.

Concrete future actions to improve RH include establishing a Lusaka-based RH working group making information, education and communication materials in all RH technical areas available in each camp, and ensuring a RH co-ordinator to lead a working group in each camp.

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Reproductive Health Response in Conflict Consortium initiatives

The Reproductive Health Response in Conflict Consortium (RHRC Consortium) is undertaking initiatives in the following areas:

- advocacy
- emergency obstetric care (EmOC)
- gender-based violence (GBV)
- monitoring and evaluation (M&E)
- small grants and
- training and capacity building.

Advocacy

The publication of the Women's Commission for Refugee Women and Children (Women's Commission) seminal report *Refugee women and reproductive healthcare: reassessing priorities* heralded a period of intense global advocacy and awareness raising activities around reproductive health (RH) for conflict-affected populations.

Members of the RHRC Consortium have developed a carefully targeted, multi-faceted advocacy plan aimed at policy makers in the United Nations (UN), inter-governmental organisations, governments, non government organisations (NGOs), donors, academics and researchers, the media and the general public in the North and South. Advocacy activities aim to increase awareness of the need for RH care services for displaced populations and to build capacity to provide those services. The programme of activities includes:

- the development and dissemination of fact sheets, media messages, assessment reports and field-friendly tools
- the publication of articles in a range of international publications
- the organisation of meetings, conferences and events to provide technical expertise and policy advice to donors, policy-makers, international and local NGOs.

Through successful advocacy, alliances and collaboration between key partners much has been achieved. There is increased commitment and a diversified funding base for appropriate and sustainable RH services. The RHRC has

worked closely with host country governments and local and international organisations to increase technical and administrative capacities to provide improved and expanded services. In addition, input to policy documents and humanitarian standards have yielded significant results. For example, the *Minimum initial service package* of RH activities has been established as a standard of care in the Sphere *humanitarian charter and minimum standards in disaster response*.

Increased advocacy, leadership and commitment have been particularly notable over the past several years in the areas of EmOC, GBV, HIV/AIDS and adolescent RH care. A targeted research agenda has also been established which documents the needs of conflict-affected populations and supports evidence-based programming.

Despite advances made in the field of RH for refugees there remain substantial obstacles to overcome. Continued advocacy is required at all levels to ensure that advances made are not lost, that the provision of quality RH services continues to increase and to counter the direct assault on the rights of displaced communities worldwide.

The RHRC Consortium will persist in highlighting the importance of RH for displaced populations to various governmental bodies. In Europe, for example, Marie Stopes International will continue to work specifically with the institutions of the European Union and Member States to ensure that language relating to the RH and rights of displaced communities is reflected in policy. US-based RHRC Consortium members will work with government and international bodies to provide technical expertise and policy advice as well as advocate for expanded support for provision of RH services in the emergency and post-conflict phases.

Emergency obstetric care

Every year, 515,000¹ women die from complications of pregnancy and childbirth in developing countries. Fifteen million² more suffer long-term chronic illness and disability as a result of care they did not receive in pregnancy and childbirth. These risks are magnified for women displaced by conflict where the majority give birth in temporary shelters in countries where health systems are shattered or struggling.

Maternal deaths are caused by three major delays:

- a delay in the decision to seek care
 - a delay in transportation to an appropriate health facility
 - a delay in receiving appropriate care at the facility.
- As with all women, 15% of conflict-affected pregnant women will experience complications of pregnancy and childbirth.

In January 2001, the RHRC Consortium initiated a three-year project to avert maternal death and disability among war-affected populations administered by the Women's Commission.³ At its heart are 11 pilot programmes that will serve as models of best practice in the provision of life-saving EmOC in high-risk settings.

The project involves site-specific needs assessments and project design in addition to on-going M&E. Needs assessments have revealed a chronic lack of attention to EmOC for conflict-affected populations, with a lack of co-ordination among key service providers. The basic infrastructure of health centres and hospitals require upgrading and three evidence-based interventions are lacking in many settings:

- the use of the drug magnesium sulfate to control convulsions in the treatment of pre-eclampsia and eclampsia
- the use of intramuscular injection of oxytocic drugs during the second stage of labour to prevent postpartum bleeding

- the use of manual vacuum aspiration to remove retained products following complications from miscarriage or unsafe abortion.

With support from the RHRC EmOC Technical Advisor, international and local NGOs, UN agencies and others are undertaking projects that include:

- working with governments, NGOs, policy makers, donors and others to improve refugee women's access to EmOC
- upgrading, rehabilitating and constructing health centres and hospitals
- ensuring that health centres and hospitals have appropriate equipment, supplies and essential drugs
- establishing and implementing protocols and guidelines for the provision of good quality EmOC services
- increasing the number of skilled staff motivated to provide good quality EmOC by providing on-going training, monitoring of projects and supportive supervision.

Gender-based violence

Knowledge and recommended practice to address GBV in conflict and post-conflict settings has grown exponentially in the past decade, and there are now programmes in many field sites seeking to prevent GBV and provide appropriate, compassionate care to survivors. Nevertheless, GBV remains one of the most challenging issues in humanitarian settings.

Even as GBV awareness, resources, and programmes evolved throughout the latter half of the 1990's, there was no comprehensive compilation of GBV field tools, nor any clear or recommended methods for evaluating programme quality or effectiveness. It was difficult for organisations to identify and use appropriate materials, tools, and technical expertise to support development of quality GBV programmes.

¹ UNFPA. State of world population. 1999.

² UNICEF. Progress on maternal mortality. 1996.

³ This project is funded by and receives technical support from the Heilbrunn Center for Population and Family Health – Averting Maternal Death and Disability (AMDD) Program at the Mailman School of Public Health at Columbia University.

The RHRC Consortium has established two projects to address GBV programme development and support the need for inter-agency and multi-sectoral prevention and response in humanitarian settings around the world:

- the Gender-based Violence Initiative implemented jointly by the Women's Commission and the International Rescue Committee
- the Gender-based Violence Global Technical Support Project, implemented by JSI Research & Training Institute.

These two projects have developed a range of published materials and provided technical assistance (TA) to strengthen prevention and response to GBV in field sites.

Global review and analysis of gender-based violence programmes, successes, and challenges

The report entitled *If not now, when? Addressing gender-based violence in refugee, internally displaced, and post-conflict settings* was published in 2002. It provides a descriptive overview of some of the major types of GBV, existing programmes and an analysis of gaps in programming that exist in humanitarian settings around the world. The report is composed of 12 country profiles from Africa, Asia, Europe, and Latin America. Each profile describes the displaced population; the nature and extent of GBV; the programmes addressing GBV and offers recommendations to strengthen programming in field sites.

In 2003, *Gender-based violence: emerging issues in programs serving displaced populations* was published. This report is a compendium of key issues, themes, and lessons learnt during GBV technical support missions to humanitarian settings world-wide. The report describes the key challenges that organisations face at policymaking and field implementation levels. Each chapter analyses an issue and offers recommendations for action to resolve the challenges. The report also includes summaries of seven GBV programmes visited by the RHRC Consortium's GBV Global Technical Support

Project in 2001–2002, serving as a microcosm of the status of GBV programmes serving displaced populations.

Technical support for gender-based violence programmes in the field

A web-based bibliography was established on the RHRC website in 2001. With over 600 annotated entries, many with links for downloading publications, it provides information on training materials and other resources available on the internet. The bibliography receives an average of 1,500 visitors per month.

The Gender-based violence tools manual for assessment and program design, monitoring, and evaluation, was published in 2003 to address the lack of GBV resources. The manual is designed to facilitate GBV data collection as well as programme design and M&E. Assessment tools range from a situational analysis guide, to focus group guidelines and other participatory appraisal techniques. The programme design tools provide an introduction to the causal pathway framework, as well as recommendations for staff recruitment and hiring. The M&E tools include sample GBV indicators, an incident report form, and guidelines for collecting and reviewing incident and outcome data.

Also included in the assessment tools is a standardised prevalence questionnaire designed for population-based data collection in conflict-affected settings. The RHRC Consortium plans to conduct surveys during 2003–2004 to allow for continued refinement of the research process. These studies will also yield scientific data that can serve to highlight the major GBV issues in the countries under investigation, and can begin to provide a core set of data that will improve international and local understanding of the nature and scope of GBV among conflict-affected populations.

The Global GBV Technical Advisor provides a range of training, planning, and TA to enhance concrete action from interagency teams, including the displaced

community, to address GBV. Follow up support is an important component of this TA. Outcomes and long term results are monitored to enable continuous review and the development of TA services and tools. Training and planning methods, including workshop guidelines, will be published in late 2003 and will available as training tools for use by humanitarian actors world-wide.

Monitoring and evaluation program

M&E is the process through which we gain information about the activities and achievements of programmes in order to make decisions to improve them. In the best RH programmes, M&E is a core part of the activities because good managers are always looking for ways to improve their services. So why is M&E so often neglected in RH programmes? In humanitarian settings, there are many reasons. The needs of direct services can seem more urgent to staff, and M&E is often viewed as a job for specialists. Also, short project cycles and the rapid staff turnover common in humanitarian programmes may make it seem that there is no 'right time' to set up an M&E system.

In spite of these challenges, the RHRC Consortium's M&E program administered by Columbia University has demonstrated that data collection and use can be done well in conflict settings, and that this data can be used to improve RH programmes. The premise of the programme, established in 2000, is that the provision of good quality RH services with a strong focus on data collection and use, along with professional peer support will foster greater utilisation of services and contribute to improved RH status of the populations served. Furthermore, the programme holds that systematic dissemination of field experiences and results will contribute to improved RH services and status among other refugee populations.

The M&E program is a network of 10 RH field projects run by RHRC Consortium member agencies and partners. Activities include technical support to the field staff for M&E initiatives such as baseline and end-of-project

surveys; improving information systems and qualitative studies; regular all-project workshops to increase the staff's RH knowledge and computer skills; and assistance to field staff to share their project findings through presentations at professional conferences and publishing articles in professional journals.

Since the programme began there have been substantial successes. The field projects have regularly functioning monitoring systems and have also collected adequate baseline and end-of-project data to evaluate their effects. Several projects have measured quality of care that has helped to improve the quality of the services provided. Staff have also presented their findings at international conferences, such as the Global Health Council annual meeting, and published articles in professional journals, making project findings available to a broad international audience. The programme has also collected the full range of protocols and instruments developed by the projects into an M&E Tool kit, pertinent to other field projects. This is available at www.rhrc.org

The M&E program ends in December 2003, but the M&E experiences gained by the staff and the improvements in the health systems and services will remain.

Small grants program: launching reproductive health activities

The RHRC Consortium administers the Small Grants Program through one of its member organisations, JSI Research & Training Institute. The purpose of this programme is to support and encourage local NGOs to institutionalise RH for refugee services, thereby increasing the access of refugees and displaced persons to quality RH care services.

This programme reaches a geographically diverse group of organisations and communities in Africa, Asia, Latin America, and Europe. Technically diverse, the programmes span the breadth of RH issues and often combine several services into one programme. To date,

the programmes' donors have been the Andrew W. Mellon Foundation, the Bill and Melinda Gates Foundation, and the U.S. Department of State's Bureau for Population Refugees and Migration.

Grants are generally awarded for a period of six months to two years and are available for local and international NGO projects. Organisations applying for grants are encouraged to apply for TA from the RHRC Consortium to facilitate project implementation, especially to assess needs and evaluate results. Since 1995, nearly 30 small grants totalling almost one million dollars have been disbursed.

The programme has been highly successful, expanding refugee and internally displaced persons (IDPs) access to RH services around the globe. Since local NGOs often do not have access to information through such sources as the internet or an international headquarters, the RHRC Consortium has played a valuable role in connecting these organisations to worldwide resources. Yet despite the programme's success to date, there is still great potential for improving the quality and amount of RH services available to refugees and IDPs. The key to the future is capacity building – that is, more funding and TA focused on helping local organisations to gain the skills they need to provide sustainable services.

Training and capacity building

The RHRC Consortium has used a variety of approaches to keep field staff up-to-date with the latest and best thinking on providing quality RH services in conflict settings thereby building local, regional and international capacity and leadership. Approaches include the development and distribution of new modular training materials, in-country workshops, and TA for public health and emergencies courses within academic and NGO agencies. Training is undertaken by representatives of the RHRC Consortium agencies and technical advisors, often in conjunction with local experts and UN agencies. In addition, many RHRC Consortium members partner with

local organisations to implement programmes. These partnerships may include some component of capacity building or TA to strengthen the service delivery for refugees. CARE has developed a new resource *Building partnerships for health in conflict affected settings* to explore the complex issues of inter-organisational partnering and the tools that can be used to help select appropriate partners and maintain healthy inter-organisational relationships.

On behalf of the RHRC Consortium, CARE has developed two training manuals to raise awareness of the need for quality RH programmes and to increase staff capacity to provide these programmes.

Moving from emergency response to comprehensive reproductive health programs: a modular training series provides a practical resource for health staff who wish to plan, implement, monitor and evaluate RH programmes among refugee and displaced populations. The training material includes participatory exercises, slides for presentations, and resource materials. The material is specifically designed to help field-based participants assess their own setting and prepare action plans to address specific elements of RH within their own context.

Raising awareness for reproductive health in complex emergencies: a training manual provides an overview for participants new to this field. The materials include specific instructions, slides for presentations, participatory exercises, and key background resources.

Both training manuals are accompanied by CD Roms that contain electronic versions of the manuals as well as all of the presentation slides. The CD also contains electronic versions of all of the necessary resource materials needed for the training programmes.

Following ten years of collaboration, the RHRC Consortium will continue to develop innovative projects to ensure that communities affected by conflict have access to quality RH information and services.

Acronyms

AIDS	Acquired Immune Deficiency Syndrome	JSI	JSI Research and Training Institute
ARC	American Refugee Committee	LHV	Lady health visitors
BHU	Basic health unit	LRT	Left, right tubal ligation
CHP	Community health promoter	LTTE	Liberation Tigers of Tamil Eelam
CLR	Community labour room	M&E	Monitoring and evaluation
DRC	Democratic Republic of Congo [formerly Zaire]	MCH	Maternal and child health
EC	Emergency contraception	MINARS	Ministry for Social Assistance and Reinsertion (Angola)
EmOC	Emergency obstetric care	MINFAMU	Ministry of Family and Protection of Women (Angola)
FAO	Food and Agriculture Organisation of the United Nations	MISP	Minimum initial service package
FARC	Revolutionary Armed Forces in Colombia	MMR	Maternal mortality ratio
FP	Family planning	MOH	Ministry of Health
GBV	Gender-based violence	MOU	Memorandum of Understanding
HAP	Humanitarian Action Plan	MRRR	Ministry for Rehabilitation and Resettlement of Refugees (Sri Lanka)
HDPFH	Heilbrunn Department of Population and Family Health – Columbia University	MSF	Médecins Sans Frontières
HIV	Human Immunodeficiency Virus	NGO	Non government organisation
IAWG	Inter-agency Working Group	PAHO-WHO	Pan American Health Organisation-World Health Organisation
ICRC	International Committee for the Red Cross	PHC	Primary healthcare
IDP	Internally displaced person	PMTCT	Prevention of mother-to-child transmission
IEC	Information, education and communication	PHM	Public health midwives
INTERFET	Immediate Force in East Timor (UN)	PSL	Population Services Lanka
IOM	International Organisation for Migration (UN)	RH	Reproductive health
IRC	International Rescue Committee	RHR	Reproductive health for refugees
IUD	Intrauterine device	RHRC Consortium	Reproductive Health Response in Conflict Consortium

SM	Safe motherhood	USAID	United States Agency for International Development
SRH	Sexual and reproductive health	VCT	Voluntary counselling and testing
STI	Sexually transmitted infection	VSU	Victim support unit
TA	Technical assistance	Women's Commission	Women's Commission for Refugee Women and Children
TBA	Traditional birth attendant	WHO	World Health Organisation
TGID	Thematic Group on Internal Displacement (UN)		
UN	United Nations		
UNAIDS	Joint United Nations Program on HIV/AIDS		
UNDCP	United Nations International Drug Control Program		
UNDP	United Nations Development Program		
UNIFEM	United Nations Development Fund for Women		
UNFPA	United Nations Population Fund		
UNHCHR	United Nations High Commissioner for Human Rights		
UNHCR	United Nations High Commissioner for Refugees		
UNICEF	United National Children's Fund		
UNIDO	United Nations Industrial Development Organisation		
UNITA	National Union for the Total Independence of Angola		
UNOCHA	United Nations Office for the Co-ordination of Humanitarian Assistance		
UNS	United Nations System		
UNTAET	United Nations Transitional Assistance in East Timor		

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