

Reproductive Health for Refugees RHR Consortium



Women's Commission for
Refugee Women and
Children
NEW YORK

CONFERENCE 2000: FINDINGS ON REPRODUCTIVE HEALTH OF REFUGEES AND DISPLACED POPULATIONS

PROCEEDINGS

**WASHINGTON, D.C.
DECEMBER 5-6, 2000**

CONFERENCE CO-HOSTS:



The Global Health Council

The RHR Consortium aims to increase access to a broad range of high quality, voluntary reproductive health services for refugees and the displaced around the world. For additional information, please visit www.rhrc.org.

Acknowledgments

The Reproductive Health for Refugees Consortium, and its co-hosts Global Health Council and InterAction, wish to thank all of the 250 conference attendees representing local and international nongovernmental organizations, research organizations, governments, donors and others for their participation in Conference 2000: Findings on Reproductive Health of Refugees and Displaced Populations. In particular, we would like to thank the conference presenters who worked hard to collect the data and share their information at Conference 2000. We would also like to thank the conference moderators whose expertise on the panel topics was vital to the success of the conference.

To all of the volunteers who generously donated their time before and during the conference, very grateful thanks are extended. The RHR Consortium also thanks Columbia University School of Public Health interns Sara Casey, Mona Selim and Mariana Zantop for their exceptional contributions in organizing this conference.

The research presented at Conference 2000 could not have been done without the support of a multitude of donors. We would particularly like to thank the following donors whose generous support made this conference possible: Ford Foundation, William and Flora Hewlett Foundation, Andrew W. Mellon Foundation, and David and Lucile Packard Foundation.

FORWARD

The Reproductive Health for Refugees Consortium and its co-hosts, InterAction and the Global Health Council, are pleased to present these proceedings of Conference 2000: Findings on the Reproductive Health of Refugees and Displaced Populations, the first international meeting reporting on this topic.

Concern for the reproductive health of forced migrants has been growing in the last several years, especially following the 1994 International Conference on Population and Development. National, international, intergovernmental and nongovernmental agencies have worked together to develop guidelines for practice. It is imperative that valid data are used to ensure that refugees and displaced persons have access to good quality services. The papers reported at this conference are one step in the process of using data to that end. In furthering that aim, we encourage all who care to support the reproductive rights of forced migrants to use these proceedings for advocacy or as the basis for further research.

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Conference 2000 Highlights

The Reproductive Health for Refugees Consortium's *Research Conference 2000: Findings on Reproductive Health of Refugees and Displaced Populations* was convened as a forum for service providers, researchers, policy makers and donors to share program findings garnered over the last several years. These data must now be used to improve ongoing programs and initiate new ones. Increasing coverage of comprehensive reproductive health services is critical. Agencies questioning the need for reproductive health services can consult the findings presented concerning the heightened risk of refugees^{*} for sexually transmitted diseases (STDs), including HIV, and sexual and gender-based violence, their poor pregnancy outcomes, and their expressed desire for reproductive health services. Projects should be carefully planned, adapting interventions that have proven to work elsewhere. When new interventions are tested, planners must ensure that there is a strong evidence-based likelihood of success. The following three needs are especially crucial to the ability of a war-impacted society to rebuild and flourish:

- address the reproductive health needs of adolescents specifically;
- stop HIV transmission; and
- embark on a multi-sectoral offensive against sexual and gender-based violence.

It is imperative that the ideas and information presented at *Conference 2000* be applied as participants and others plan programs, design studies, make funding decisions and provide services.

In 1993, the Women's Commission for Refugee Women and Children found few or no reproductive health services offered in eight refugee sites it visited. Reproductive health for refugees was a low priority for most organizations; and the assessment team found little interest or awareness among non governmental organizations (NGOs) or donors. Many relief agency staff assumed that refugees did not want reproductive health services, or that these services would be culturally inappropriate. Data were lacking on refugees' stated needs and priorities, the medical and public health impact of providing reproductive health services, and on how these services could be appropriately offered to refugees and displaced people.

The intervening years have brought a substantial change in the attention given to reproductive health in refugee settings. Propelled by the Program of Action of the 1994 International Conference on Population and Development in Cairo and the Platform for Action of the 1995 Fourth World Conference on Women in Beijing, by

* In this article, the term refugee is used for disaster-affected populations, which may include internally displaced persons, refugees or returned refugees.

growing recognition of the human rights and health relevance of reproductive health services, and by UN and NGO agencies' willingness to work together toward a common end, many more groups are now active in the reproductive health service, research and policy areas than in 1993.

Efforts to develop quality programs have been hampered by the lack of published reports specific to war-affected and displaced populations. While it is important to utilize the findings and lessons learned from the development field, an analysis of data from a specific literature review offers some conclusions about the effects of displacement on a person's reproductive health -- understanding these effects is essential to the initiation of effective interventions. Most of the data used in these analyses were derived from stable camp populations.

- The data indicate that fertility, family planning and safe motherhood issues are more influenced by factors similar to those in settled populations than by the fact of displacement. For example, refugee demand for family planning is affected by personal knowledge, attitudes, practices and the availability of services.
- Similarly, poor pregnancy outcomes are common in refugee settings, but not necessarily more common than in settled populations of similar socioeconomic and cultural backgrounds. In fact, refugees in camps may have an advantage, since emergency obstetric services are likely to be more accessible than in their homeland.
- While data suggest little effect of displacement on reproduction, evidence does indicate that displacement increases the transmission of STDs, including HIV. It is important to recognize that transmission moves from a higher prevalence population to one with lower prevalence -- not necessarily from the refugees to the local residents.
- The incidence of rape during conflict is well documented. The literature demonstrates that for women, exposure to armed men -- soldiers, militias, border guards, etc -- is a major risk factor for rape.
- Other forms of gender-based violence, such as coercion of sex for food and domestic violence, are common among the war-affected; but one is unable to say whether they are more common than among the settled due to a lack of substantive data in either settled or displaced settings. One can surmise that sexual and gender-based violence is at least as, and probably more, common among war-affected people as a result of social and economic disruption.

An understanding of the effects of displacement, along with an awareness of reproductive rights, demands delivery of good quality reproductive health services for refugees and other displaced persons. This is not an argument for the prioritizing of resources to meet reproductive health needs over the delivery of other basic health services. Rather, we are obliged to build on what we know and to adapt programs to respond to all of the demonstrated needs of war-affected persons.

Seven years after the Women's Commission assessment, we ask "Have things improved?" One study revealed that most US-based international NGOs supporting or providing services in the health sector in refugee settings include some component of reproductive health. This finding is corroborated by a Johns Hopkins University/Centers for Disease Control and Prevention study which found at least three methods of family planning available in 51 of 52 refugee camps surveyed in the post-emergency phase. However, it is critical to note that this does not reflect the situation in all camps or in new and chronic emergency settings.

Conference 2000 played a vital role in presenting new data from programs in the field that we can now use to improve and/or initiate quality reproductive health interventions. Some 250 people from 27 countries attended, an indication in itself of the extraordinary interest and desire for information in this evolving field. We heard from colleagues presenting the results of their work in approximately 40 settings around the world. Participants shared new ideas and renewed their commitment to provide good quality reproductive health services to refugees and other displaced populations.

Sharing ideas and information is, however, just a first step in improving services. Now, it is essential that we take this new knowledge and apply it in the real world. For example, we no longer need worry that talking about reproductive health is culturally inappropriate. Several studies showed that if, rather than assuming we know what refugees need, we ask them, they will discuss their interests and concerns regarding reproductive health. Other findings show that refugees are fully capable and highly interested in participating in the design, monitoring and evaluation of reproductive health programs in their communities. Service providers should be trained in counseling to help individuals make informed decisions with regards to safe motherhood, family planning, STDs/HIV/AIDS, and sexual and gender-based violence. Effective community outreach and participation has proven to be vital to the success of programs from the inception of an intervention.

From the presentations, we also see that reproductive health is for everyone, not just for women or married couples, but for men, women and adolescents. Men should be involved in education and decision-making. A need for adolescent-specific programming has been clearly identified. The transition from child to sexual adult is the defining characteristic of adolescents; however, adolescents represent a traditionally ignored population that is at high risk of reproductive health problems due to a lack of knowledge. They also represent the future leaders of their communities. If they are uninformed and unhealthy, the future will be bleak. Programmers concerned about the sensitivity of providing information and services to young people can reference presentations on the reproductive health status of adolescents and successful community-accepted approaches for reaching these groups.

The findings demonstrate that appropriate interventions can improve the reproductive health status of refugees. Good quality services must be provided and integrated with primary health care. We must collect reliable data. As several studies noted, we need to standardize definitions and procedures in order to do this. Finally, we must reiterate the need to use the data to improve programs, as well as to document and publish findings so others have access to valid information.

The information presented at the conference has important implications for reproductive health policies and programs:

- Adolescent-specific programming is crucial to enabling war-affected societies to rebuild for the future.
- War-affected populations are disproportionately at risk for STDs, including HIV, and for sexual and gender-based violence. More attention must be focused on these issues.
- To reduce women's risk of death from unsafe abortion, programs must provide comprehensive post-abortion care, as well as family planning to prevent unwanted pregnancy.
- Collection of data, including demographic information, for decision-making must be included in project plans.
- Projects must be planned carefully, using evidence to make decisions and select interventions that have demonstrated success.
- Multi-year funding for programs is essential for sustainability, given that war-affected populations often remain displaced for years at a time.
- Collaborative, inter-agency efforts, including coordination with host governments, yield far-reaching results.
- Internally displaced persons lack an internationally recognized status, which adds to their neglect and the dearth of services available to them. Programs must be extended to these populations.

Conference 2000 represents an important milestone in the reproductive health for refugees movement as an occasion for practitioners to share applied research, program findings and data to improve reproductive health programs serving populations in crisis. The interest in and success of *Conference 2000* illustrate the importance for continued research and dialogue to support improved reproductive health among war-affected populations around the world.

RHR Consortium
**CONFERENCE 2000: FINDINGS ON REPRODUCTIVE HEALTH
OF REFUGEES AND DISPLACED POPULATIONS**

Washington, D.C.

December 5-6, 2000

TUESDAY, DECEMBER 5

8:00 Registration/Continental Breakfast

9:30 Opening Plenary Session
Ballroom

Moderator: Sandra Krause, Women's Commission for Refugee Women and Children

Presentations:

Carolyn Makinson *Historical perspective of refugee reproductive health*
Aziza Khalidi *Example from the Palestinian refugees in Lebanon*
Therese McGinn *Reproductive health of war-affected populations: What do we know?*

10:45 Coffee Break

11:15 – 12:30 Panel

Reproductive Health for Refugees – Multi-Site Perspectives

Ballroom

Moderator: Margaret Pollack, Bureau of Population, Refugees and Migration,
US Department of State

Presentations:

Carolyn Mansfield *The complex impact of conflict on women's health*
Daniel Pierotti *The RH-Kit: A useful tool to implement reproductive health services during
an emergency*
Michelle Hynes *Reproductive health indicators of displaced persons in post-emergency
phase camps of humanitarian emergencies*

12:30 Lunch – on your own

2:00 – 3:15 Concurrent Sessions

Panel 1 : Improving Refugee Women's Health During Pregnancy and Delivery

Sky Room

Moderator: Deborah Maine, Heilbrunn Center for Population and Family Health,
Columbia University

Presentations:

- | | |
|---------------------|---|
| Linda Bartlett | <i>The burden of mortality due to reproductive health-related causes among Afghan refugees in Pakistan</i> |
| Jeannie Chamberlain | <i>Returning to Kosovo, CARE's lessons learned from implementing a region-wide reproductive health training project</i> |
| Ahlam Abd Elmgeed | <i>CARE International in Sudan, "Basic health assistance for war displaced" (BHAWD) impact assessment, July 2000</i> |

Panel 2 : Using Participatory Data Collection Methods to Plan Reproductive Health Programs

Ballroom

Moderator: Beverly Tucker, Family Health International

Presentations:

- | | |
|-------------------|---|
| Zeinab Abdi Ahmed | <i>SGBV as viewed by refugees in Kenya: Learning about sensitive RH issues and developing responses using participatory assessment techniques</i> |
| Tracey Lee | <i>NORPLANT® for Karen refugees on the Thai-Burmese border</i> |
| Aftab Tariq Ihsan | <i>Participatory rapid appraisal (PRA) of the reproductive health needs of Afghan refugees in Pakistan</i> |

3:15 Coffee Break

3:45 – 5:00 Concurrent Sessions

Panel 1 : Sexual and Gender-Based Violence – Size and Scope of the Problem

Ballroom

Moderator: Beth Vann, UNHCR, Consultant

Presentations:

- | | |
|-------------------------------|---|
| Haifa Jammal
Aziza Khalidi | <i>Domestic violence among selected Palestinian refugee communities in Lebanon: An exploratory study and ideas for further action</i> |
| Sam Posner | <i>Factors associated with self-reported forced sex among Azerbaijani women</i> |
| Josephat
Nyarubakula | <i>Unsafe Haven: Report on the findings of the baseline sexual violence survey among Burundian refugees</i> |

Panel 2 : Challenges in Implementing Reproductive Health Programs in Complex Emergencies

Sky Room

Moderator: Maurice Middleberg, CARE

Presentations:

Claire Hoffman	<i>Community participatory family planning and reproductive health with internally displaced communities, Sri Lanka</i>
A. Sam-Abbenyi	<i>HIV/STD prevention among the returnee and resettled population of Gitarama, Rwanda, 1996-2000</i>
Carolyn Baer Neena Philip	<i>Knowledge, attitudes and practices of reproductive health, Kajo Keji County, Southern Sudan</i>

5:30 Reception to Honor Julia Taft, Assistant Secretary of State, Bureau of Refugees, Population and Migration

Washington Room

Moderator: Mary Diaz, Women's Commission for Refugee Women and Children

Speakers:

Nils Daulaire	<i>Refugee reproductive health and the Global Health Council</i>
Margaret Pollock	<i>Acceptance on behalf of Julia Taft</i>
Lorelei Goodyear	<i>Acknowledgement of Daniel Pierotti</i>

WEDNESDAY, DECEMBER 6

8:00 Continental Breakfast

9:30 – 10:45 Concurrent Sessions

Panel 1 : Family Planning – An Ongoing Challenge

Parkview Room

Moderator: Steve Hawkins, USAID

Presentations:

Rosemary Barber-Madden	<i>Demographic profile and the reproductive health of internally displaced persons in Angola</i>
Se Youry	<i>Research on reproductive health: Lessons learned in Khao Phlu refugee camp, Thailand</i>
Poonam Mazhar	<i>A family planning continuation study among Afghan refugees in Pakistan</i>

Panel 2 : Improving Service Delivery Systems in Post-Conflict Settings

Ballroom

Moderator: Ron Waldman, Heilbrunn Center for Population and Family Health,
Columbia University

Presentations:

Susan Igras	<i>Revitalizing health services in northwestern Somalia: CARE's experience</i>
Doris Bartel	<i>Responding to Kosovo's reproductive health crisis</i>
Jesse Rattan	<i>Participatory assessment of women's issues in East Timor, May 2000</i>
Melissa Sharer	

10:45 Coffee Break

11:15 – 12:30 Concurrent Sessions

Panel 1 : HIV/STDs – What Do We Know and What Can We Do?

Ballroom

Moderator: Brad Woodruff, Centers for Disease Control and Prevention

Presentations:

Meriwether Beatty	<i>Reproductive health KAP survey amongst refugees in Guinea: Findings concerning STIs & AIDS</i>
Luke Mullany	<i>HIV/AIDS awareness among Burmese migrant factory workers along the Thai/Burma border, Tak Province, July 2000</i>
Nipaporn Intong	<i>Increased condom practice in the refugee population, Nu Po camp in Thailand</i>

Panel 2 : Expanding Our Base – New Audiences, New Services, New Channels

Parkview Room

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

Presentations:

Nadia Ali El Toum	<i>A qualitative assessment of reproductive health among the displaced communities of Khartoum, Sudan</i>
Fariyal Fikree	<i>Enhancing the use of emergency contraception: A baseline survey in Kakuma refugee camp, Kenya</i>
Suzanne Fustukian	<i>Spreading the word: Health on air in the Somali-speaking Horn of Africa</i>

12:30 Lunch – on your own

2:00 – 3:15 Concurrent Sessions

Panel 1 : Adolescents – Who Are They and How Do We Serve Them?

Ballroom

Moderator: Pamela Delargy, UNFPA

Presentations:

Allison A. Pillsbury *Addressing war-affected adolescents' reproductive health needs*

Margaret Mukabana *Reproductive health KAP survey of refugee adolescents in the Kigoma region of Tanzania*

Matthew Tiedemann *The “Health of adolescent refugees project” (HARP): A peer education project in Egypt, Uganda and Zambia*

Panel 2 : Using Data to Improve Reproductive Health Programs

Parkview Room

Moderator: Suzanne Fustukian, London School of Hygiene and Tropical Medicine

Presentations:

Amarasiri de Silva *Are IDPs at increased risk of reproductive ill health? Measuring RH risk in a displaced setting using a reproductive health risk index (RHRI)*

Henia Dakkak *Improving reproductive health services among Roma women refugees in Macedonia through program monitoring*

Beth Vann *How-To Guide: Monitoring and evaluation of sexual and gender-based violence programs*

3:15 Coffee Break

3:45 Closing Plenary Session

Ballroom

Moderator: Kathleen Newland, Women’s Commission for Refugee Women and Children

Presentations:

Susan Purdin *Where do we go from here?*

Nadia Ali El Toum *Personal perspective on taking the conference into the future*

Julia Taft *Remarks*

5:00 Conference ends

Opening Plenary Session

Moderator: Sandra Krause, Women's Commission for Refugee Women and Children

Presentations:

Carolyn Makinson *Historical perspective of refugee reproductive health*

Aziza Khalidi *Example from the Palestinian refugees in Lebanon*

Therese McGinn *Reproductive health of war-affected populations: What do we know?*

Historical perspective of refugee reproductive health

Presenter Carolyn Makinson

Remember how it was in 1993 when the Women's Commission for Refugee Women and Children visited eight refugee sites, and documented that almost nothing was provided in terms of reproductive health services. They found little interest among NGOs or donors, with many assuming that refugees did not want reproductive health services, or that these services would be culturally inappropriate. Data were lacking on refugees' stated needs and priorities, the medical and public health importance of providing reproductive health services to refugees, and on how these services could best be adapted to refugee and displaced settings. Fortunately, Serge Male of UNHCR and Daniel Pierotti of UNFPA were interested, and managed to prod their agencies rather quickly to produce the *Inter-agency Field Manual: Reproductive Health in Refugee Situations*. I can hardly believe that now a conference is occurring on reproductive health with this number of key people and agencies. I just returned from a field trip to Pakistan and Afghanistan where I saw the changes with my own eyes. Those camps are one example of a change of heart taking place with regard to provision of services for refugees. We cannot limit our assistance to the bare minimum needed to keep people alive. Forced displacement is a tragedy for those involved. But it doesn't have to be just a tragedy; it can also be an opportunity to introduce new ideas, new information and new services. It is to be hoped that refugees will eventually take home with them these new ideas and a determination to demand better health and education programs for themselves and their children.

Example from the Palestinian refugees in Lebanon

Presenter Aziza Khalidi

Reproductive health among the Palestinian refugees in Lebanon, as in any other refugee situation, revolves around the centrality of return to the homeland. A socio-demographic profile of the Palestinian refugee population was then presented based primarily on Fafo survey 1999. Issues regarding the provision of reproductive health services include a lack of knowledge about the services, a lack of a comprehensive assessment of such services, and the minimal participation of men in reproductive health programs. Recommendations include: (1) establishing a coordinating body for health services in general and reproductive health in particular; (2) analyzing available information from recent surveys and ongoing programs; (3) expanding reproductive health programs to include services pertaining to domestic relations--health education, counseling (such services would form the umbrella for the social aspect of family planning); (4) ensuring comprehensiveness of reproductive health services through integration with primary care as a strategy to achieve health for all.

Reproductive health of war-affected populations: What do we know?

Presenter Therese McGinn

A review of available published and unpublished reports demonstrates if and how reproductive health status is affected by refugee or displaced status. Data suggest that refugees' status with respect to fertility, family planning and safe motherhood is largely determined by factors similar to those in settled populations: socio-demographic factors and access to services, rather than refugee status *per se*, appear to influence fertility desires and health behavior with respect to these reproductive health concerns. The data indicate that war-affected populations are disproportionately at risk for STDs as displacement promotes transmission between high and low prevalence groups and exposure to the military further promotes transmission. The data suggest that conditions of refugee life are particularly conducive to sexual violence both in the early stages of complex emergencies when rape is used by armies as a weapon of war and in the stable phase when violence perpetrated by partners or acquaintances may become more prevalent. Understanding the ways in which refugees' reproductive health problems are similar to and different from those of settled populations can help policymakers and programmers adapt existing service models to refugees' specific needs.

Reproductive Health for Refugees – Multi-Site Perspectives

Moderator: Margaret Pollack, Bureau of Population, Refugees and Migration,
US Department of State

Presentations:

Carolyn Mansfield *The complex impact of conflict on women's health*

Daniel Pierotti *The RH-Kit: A useful tool to implement reproductive health services during an emergency*

Michelle Hynes *Reproductive health indicators of displaced persons in post-emergency phase camps of humanitarian emergencies*

The complex impact of conflict on women's health	
Abstract revision date: January 15, 2001	
Authors	Manuel Carballo, International Centre for Migration and Health (ICMH) Carolyn Mansfield, International Centre for Migration and Health (ICMH)
Presenter	Carolyn Mansfield
Background	This presentation draws on 3 separate studies conducted by ICMH that assessed a) the impact of siege on the health of pregnant women in Sarajevo, b) the health and social status of displaced people in Bosnia and c) sexual violence in refugee camps.
Purpose of study or program	The purpose of the 3 studies was to describe ways in which conflict and displacement impacts on reproductive health.
Data collection methods	The 3 studies utilized varied methodologies. The survey of pregnancy outcomes involved detailed analysis of health records of women attending the Kosovo Clinic and Maternity Hospital in Sarajevo from 1992-1995. The survey of the health of displaced people in Bosnia involved a population-based, nationally representative sample of over 5000 family units in Bosnia-Herzegovina. The survey on sexual violence involved extensive literature review, field interviews with NGO staff in Tanzania, Cambodia and Bosnia, and focus group discussions with refugee women in Cambodia and Tanzania.
Study or program findings	<p>Pregnancy Outcomes Among Displaced and Non-Displaced Women in Bosnia and Herzegovina</p> <ul style="list-style-type: none"> • Available ob/gyn hospital beds reduced from pre-war 450 to 50; available operating rooms from 4 to 1; estimated 60 senior staff members lost. • Immediate reduction in the number of live births from pre-war average of 10,000 per year to 2,000 per year during the war. • Abortion requests rose, averaging more than 2 abortions for each pregnancy taken to term. • Perinatal mortality rate rose from 15.3 per 1000 live births before the war to 38.6 after the war. • Low birthweight (<2500 g) rate rose from 5.3 to 12.8. • Frequency of congenital abnormalities involving anencephalus or hydrocephalus rose from 0.37% to 3.0% (until Feb. 1994) <p>Health & Social Status of Displaced People in Bosnia-Herzegovina (Sarajevo, Tuzla, Zenica, Mostar)</p> <ul style="list-style-type: none"> • Only 17% of displaced women sought or were able to access gynaecological care. • Among displaced women, 11% aged 16 to 49 said that they personally knew of a woman who had been sexually tortured/abused/raped during the war; they reported that 34% of the victims became pregnant as a result. Of the women who were reported to be pregnant, 31% were known to have interrupted their pregnancies and 9% were known to have taken them to term. 92% of the sexual violence survivors were reported to have serious psychological impairment. • 3% of non-displaced women knew of someone who had been sexually tortured/abused/raped. <p>Sexual Violence in Refugee Settings</p> <ul style="list-style-type: none"> • A longstanding historical "tradition" of rape during conflict has been neglected and the concept of safe havens has been exaggerated. • Women face sexual violence during flight/transit and in refugee camp settings. Women may be at increased risk of politically motivated sexual violence during the acute phase of conflicts, but face sexual exploitation for goods or services once they reach refugee camps. • Variations in national legislation and local attitudes towards rape and its sequelae are a problem. These influence post-rape access to services and care in refugee settings. • While many aid agencies provide staff with reproductive health training, there is limited training on sexual violence prevention and treatment. Coordinated efforts are also still weak. • In Cambodia and Tanzania, interviewees indicated a reluctance to report rape due to concerns about confidentiality and a lack of confidence in the legal system. Resorting to traditional mechanisms of dispute resolution offered few solutions to women. • Interviewees indicated that the most frequent perpetrators of rape were likely to be people in positions of authority in the camps, followed by other refugees, friends, family and local people.
Conclusions and program implications	These surveys indicate that the reproductive health of women in conflict situations has been neglected. A large proportion of humanitarian relief agencies still do not have the necessary technical guidelines available to field workers to maximize interventions in this domain, making it a priority area. Comprehensive reproductive health strategies are required that involve prevention, protection and timely action to promote women's safety and health.
For further information	Dr. Manuel Carballo, Coordinator, International Centre for Migration and Health 11 Route du Nant D'Avril, Geneva, Switzerland, CH 1214 Email: icmh@iom.int

The RH-Kit: A useful tool to implement reproductive health services during an emergency	
Abstract revision date: December 5-6, 2000	
Authors	D. Pierotti, C. Saunders, T. Myint, T. Delvaux, W. Doedens; UNFPA
Presenter	Daniel Pierotti
Background	<p>In June 1995, the first symposium on "Reproductive health in refugee situations" was organized jointly by UNFPA and UNHCR and attended by more than 20 UN agencies and NGOs. An output of the symposium was the creation of an InterAgency Working Group (IAWG) as well as a "Minimum Initial Service Package" (MISP), a new concept which incorporates RH activities required during an emergency.</p> <p>UNFPA hired 2 consultants (a midwife and a gynecologist, former Médecins Sans Frontières staff members) to design the RH-Kit; decisions were approved by the IAWG. The result was a RH-Kit composed of 13 sub-kits that would allow for the delivery of comprehensive RH services in an emergency. In May 1998, UNFPA assembled the RH-Kit and made it available to UN and NGO partners.</p>
Purpose of study or program	The RH-Kit would play an important role in facilitating the work of an RH coordinator and the implementation of the MISP in emergency situations.
Data collection methods	Statistics on RH-Kit orders were compiled from requisitions made between May 1998 and October 2000 (29 months).
Study or program findings	<p>During this period, RH-Kits were ordered on 73 occasions for use in a total of 34 countries. Multiple requests came from Afghanistan (6 occasions); East and West Timor (6); Angola, Eritrea, Kosovo and Uganda (4 each); Congo/Brazzaville, Nicaragua, Rwanda and Sierra Leone (3 each); and twice from 7 additional countries. 74% of the orders come from UNFPA country offices, 26% from other UN agencies (UNHCR and Unicef) and from international NGOs (e.g., ARC, IRC, RI).</p> <p>Kits ordered by UNFPA are distributed to implementing partners. The sub-kits most frequently requested are the 2 designed for assisting with deliveries: midwife sub-kit N° 6 (856 times) and clean delivery sub-kit N° 2 (874 times). The STD sub-kit N° 5 has also been in high demand (820 times). Other popular sub-kits include the oral and injectable contraception sub-kit N° 4, the condom sub-kit N° 1 and sub-kit N° 8 for management of the complications of abortion. The cost of a complete RH-Kit (excluding transport) has decreased from US \$10,870 in June 1998 to US\$9,940 in October 2000.</p> <p>In 5 projects, training related to the use of the sub-kits was organized for doctors, nurses, community health workers or traditional birth attendants. Training included safe delivery, STD care, condom use, post-rape management, contraceptive use and management of complications of abortion.</p> <p>At the end of the first year of use, questionnaires were sent to 18 users to review the kit and how it was being utilized. The results and recommendations were presented in February 2000 to the 5th IAWG meeting, which suggested the formation of a sub-working group to revise the kit. The sub-working group met in Geneva in July 2000. As a result, a second edition of the RH-Kit is due to be finalized prior to the end of 2000 and this will contain, among other improvements, additional promotion and training documents, both in hard copy and as a CD-ROM.</p>
Conclusions and program implications	The RH-Kit is an excellent example of a successful and innovative initiative, completed only through the collective effort of numerous motivated UN and NGO partners.
For further information	<p>Dr Daniel Pierotti, UNFPA Geneva Principal Officer, Crisis Relief, GEC Building, 9 Chemin des Anémones, 1219 Geneva, Switzerland</p> <p>Telephone 41-22 917 8314</p> <p>Fax 41-22 917 8049</p> <p>Email unfpaero@undp.org</p>

Reproductive health indicators of displaced persons in post-emergency phase camps of humanitarian emergencies	
Abstract revision date: December 5-6, 2000	
Authors	Michelle Hynes, Division of Reproductive Health, Centers for Disease Control and Prevention, Atlanta, GA. Mani Sheik, Center for Refugee and Disaster Studies, Johns Hopkins School of Public Health, Baltimore, MD. Hoyt Wilson, Division of Reproductive Health, Centers for Disease Control and Prevention, Atlanta, GA. Paul Spiegel, International Emergency and Refugee Health Branch, Centers for Disease Control, Atlanta, GA.
Presenter	Michelle Hynes
Background	Although the international community has recently emphasized reproductive health (RH) services for displaced populations, there is a paucity of epidemiological data on RH outcomes among these populations during the post-emergency phase of humanitarian emergencies.
Purpose of study or program	To determine the most important factors which affect RH outcomes of displaced populations in 52 post-emergency camps in seven countries; to compare RH outcomes of displaced populations in camps to outcomes of their host country and country of origin.
Data collection methods	A retrospective survey covering a 3-month period in each camp was conducted from November 1998 through March 2000 among displaced populations in 52 post-emergency phase camps in Azerbaijan, Ethiopia, Myanmar, Nepal, Tanzania, Thailand, and Uganda. For rate comparison, camp data was aggregated into 11 displaced population groups according to country of origin. Main outcome measures were crude birth rate (CBR), neonatal mortality rate (NNMR), maternal mortality ratio (MMR), incidence of complications of unsafe and spontaneous abortion (ICUSA), and percentage of low birth weight babies (LBW). Rates and ratios were compared to host country and country of origin rates.
Study or program findings	RH outcome measures among displaced groups living in camps were better than those found in host countries and countries of origin. Nine of the 11 displaced groups (82%) had significantly lower NNMRs; 6 of 8 groups (75%) had significantly lower MMRs; and 7 of 9 groups (56%) had significantly lower LBW percentages than both host countries and countries of origin. In addition, 8 of 11 groups (73%) had significantly lower CBRs than those of the host country and country of origin. Multivariate analysis showed that NNMR was positively associated with a per capita increase in the number of traditional birth attendants ($p < 0.01$), and percentage of LBWs was positively associated with a per capita increase in the number of local health staff ($p = 0.04$). No significant associations were found for MMR and ICUSA. CBRs were negatively associated with longer established camps ($p = 0.02$)
Conclusions and program implications	Displaced populations in post-emergency phase camps may have better RH outcomes than populations in their respective host countries and countries of origin. Higher per capita health care staffing was associated with poorer outcomes in some of the RH measures, most likely due to more complete and accurate surveillance. CBRs decreased with the length of existence of the camps.
For further information	Paul Spiegel MD, MPH, Centers for Disease Control and Prevention, International Emergency and Refugee Health Branch, Mailstop F-48, 4770 Buford Highway NE, Atlanta, GA 30341 USA Telephone 770-488-3136 Fax 770-488-7829 E-mail pos4@cdc.gov

Improving Refugee Women's Health During Pregnancy and Delivery

Moderator: Deborah Maine, Heilbrunn Center for Population and Family Health,
Columbia University

Presentations:

- | | |
|---------------------|---|
| Linda Bartlett | <i>The burden of mortality due to reproductive health-related causes among Afghan refugees in Pakistan</i> |
| Jeannie Chamberlain | <i>Returning to Kosovo, CARE's lessons learned from implementing a region-wide reproductive health training project</i> |
| Ahlam Abd Elmgeed | <i>CARE International in Sudan, "Basic health assistance for war displaced" (BHAWD) impact assessment, July 2000</i> |

The burden of mortality due to reproductive health-related causes among Afghan refugees in Pakistan Abstract revision date: January 15, 2001	
Authors	L. Bartlett, Division of Reproductive Health, Centers for Disease Control and Prevention Tila Khan, International Rescue Committee (IRC), Hangu, Pakistan Munawar Sultana, International Rescue Committee (IRC), Hangu, Pakistan D. Jamieson, Division of HIV/AIDS Prevention, Centers for Disease Control and Prevention Reproductive Health for Refugees Steering Committee
Presenter	Linda Bartlett
Background	Documentation of the public health importance of reproductive health (RH) related mortality among refugees is needed to guide resource allocation, plan health care services and develop policy. However, RH surveillance is rarely conducted in refugee camps and RH has only recently been recognized as a major contributor to morbidity and mortality in these settings. This study reports RH-related mortality among Afghan refugees in Pakistan.
Purpose of study or program	To determine the burden of RH-related mortality among refugees measured as the proportional mortality due to RH-related causes, assess patterns in cause of death, and identify barriers to health care access.
Data collection methods	RH-related deaths were defined as deaths in women due to complications of pregnancy, puerperium or post-partum, gynecological infections; and deaths of neonates (# 28 days of age). All deaths during January 20, 1999 to August 31, 2000 among males and females of all ages were actively identified in a census of all families living (population=134,406) in 12 villages served by IRC in Hangu, Pakistan. IRC staff recorded the identity, age and gender of the deceased. Deaths among women of reproductive age were further investigated using verbal autopsy interviews of family members to identify the cause of death, if it was RH-related and if there were avoidable factors that contributed to deaths.
Study or program findings	Overall, 1195 deaths occurred during the study period. 17% more deaths were identified by the census than had been reported through routine sources in 1999. Preliminary analyses indicate that RH-related causes were the leading cause of death at 22% (95% CI = 19.8–24.6%), including 28 maternal and 234 neonatal deaths. We found that 79% of maternal deaths had barriers to health care access, while only 58% of non-maternal deaths in women of reproductive age had identifiable barriers.
Conclusions and program implications	As a result of this study, IRC plans to develop interventions to address barriers to health care access such as increasing the number and training of birth attendants; and improving access to emergency transportation and emergency obstetric services. Furthermore, we anticipate these data will inform resource allocation among other refugee populations globally and indicate areas for further research and policy development.
For further information	Linda Bartlett, Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, 4770 Buford Highway NE, MS-K-23, Atlanta, GA 30341 Telephone (770) 488-5187 Fax (770) 488-5628 Email ltb7@cdc.gov

Returning to Kosovo, CARE's lessons learned from implementing a region-wide reproductive health training project	
Abstract revision date: January 15, 2001	
Author	Jeannie Chamberlain, formerly CARE Kosovo's Reproductive Health Training Project (RHTP) Manager
Presenter	Jeannie Chamberlain
Background	In September 1999, when CARE Kosovo's Reproductive Health Training Project (RHTP) started, the majority of ethnic Kosovar Albanians had returned to Kosovo from neighboring countries where they had fled ethnic violence and conflict in Kosovo. Upon return, they found a collapsed health care system and health professionals who lacked information on current RH knowledge, skills and practices.
Purpose of study or program	To improve the RH status of Kosovar women and infants by increasing the RH knowledge of health care providers throughout Kosovo.
Data collection methods	CARE International, Relief International (RI) and International Rescue Committee (IRC) joined together to implement a standardized RHTP throughout Kosovo for health care providers. <ul style="list-style-type: none"> • As lead agency, CARE organized and implemented a two-week Training of Trainers (TOT) course for National and International Trainers from CARE, IRC and RI. They were trained in participatory methodologies, training techniques and course content. • The RHR manual, <i>A Five-Day Training Program for Health Personnel, RH Programming in Refugee Settings</i>, was adapted as the standard training curriculum by CARE, IRC and RI. • The curriculum was translated into Albanian and revised by CARE to meet the special cultural needs of the Kosovar returnees. • A <i>One-Day RH Awareness</i> course was used to sensitize department heads and program planners to the critical need for RH services.
Study or program findings	CARE's RHTP ran from September 1999 through June 2000. <ul style="list-style-type: none"> • During a six-month training period over 800 health professionals were trained. In total over 1600 health care providers were trained throughout Kosovo by the combined effort of CARE, IRC and RI. • CARE's course participants represented 38 health facilities and 14 municipalities surrounding Pristina and Mitrovica. • Health care providers were trained in Safe Motherhood, Family Planning, STDs including HIV/AIDS, and Sexual and Gender-Based Violence. • RH knowledge improved by 30% as a result of the training (comparing pre- and post- tested scores). • In follow-up visits, health care providers reported spending more time with clients and providing them with more RH information and guidance than before the training. • Participatory methodologies, new to the Kosovar context, proved to be powerful teaching and learning tools for participants and trainers. • During project implementation, trainees and trainers identified additional RH clinical training needs at the health facility level.
Conclusions and program implications	<ul style="list-style-type: none"> • Prior to the RHTP, there were no comprehensive RH education programs or services in Kosovo. CARE's lead in the RHTP laid the groundwork for a coordinated, inter-agency RH effort in Kosovo. • Throughout the program, an active communication network developed among donors, the National Institute for Public Health, UNFPA, WHO and other NGOs involved in RH training in Kosovo allowed for sharing information and discussion of pertinent RH issues. • Based on the success of the RHTP, WHO and UNFPA are promoting the use of a joint agency approach in RH training programs in Kosovo. • Inter-agency collaboration and standardization of the RH training program proved successful for training a large number of health professionals across Kosovo.
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CARE International in Sudan, <i>Basic health assistance for war displaced (BHAWD) impact assessment, July 2000</i> Abstract revision date: December 5-6, 2000	
Authors	Ian Willis, Project Manager, CARE International, Sudan Ahlam Abd Elmgeed, Monitoring and Evaluation Officer, CARE International, Sudan
Presenter	Ahlam Abd Elmgeed
Background	BHAWD is a partnership project comprising health, water, sanitation and flood mitigation components. The project coordinates health services among implementing NGOs. CARE works with 25 clinics in 8 partner organizations.
Purpose of study or program	The 2000 Impact Assessment (IA) is a tool that the project introduced to better orient project activities towards achieving goals. The IA looked into behavioral changes and discussed utilization and dissemination of information.
Data collection methods	Both quantitative tools (questionnaires) and qualitative tools (Participatory Learning and Action) were used. The quantitative assessment targeted women of child bearing age with children. Material consulted in the preparation of the assessment was the BHAWD phase 1 baseline survey in August 1998 and phase 2 logical framework, monitoring plan and indicators. For the 2000 IA, 41 clusters were selected randomly using cluster sampling methodology. The assessment was carried out by teams of project staff and some partner NGOs.
Study or program findings	<p>Ante-natal care (ANC). In 1998, 70% of women interviewed had at least 1 ANC visit. The 2000 IA figure was 88.4%. The project is currently looking into the detection of pregnancy complications and referrals.</p> <p>Tetanus Toxoid (TT). In 1998, 45.7% of women in their last pregnancy received 1 shot; the 2000 IA found that 79% had.</p> <p>Who helped with delivery? The 1998 baseline found that 43.3% were helped by untrained personnel and 56.8% by trained providers. In 2000, the percentage of deliveries attended by midwives and trained TBAs was 58%, and 37.2% of the deliveries were aided by an untrained provider.</p> <p>Vitamin A after birth. The 1998 baseline survey found that only 26.5% of respondents were given Vit A after birth; this rose to 51.4% in 2000. More progress is needed.</p> <p>Post-natal care (PNC) in 24 hours. The 2000 IA revealed that 75.2% of new mothers were visited during the first 24 hours after delivery.</p> <p>Exclusive breastfeeding. The 2000 IA revealed that 85.9% did not breastfeed their children exclusively.</p> <p>Modern methods of family planning. In the 2000 IA, 20.4% used no method for spacing, 7.8% used the rhythm method, 25.1% mentioned abstinence, 37.9% mentioned breastfeeding and 8.8% used the pill. Condoms were not mentioned at all.</p>
Conclusions and program implications	<ul style="list-style-type: none"> • We do not know our target population well enough. • We must place more emphasis on child spacing. • We need more activity for Vitamin A and TT coverage. • Can the project have an impact on exclusive breastfeeding if the message has not been working for the last 6 years? • The project needs to focus on information gathering, pregnancies, deliveries and outcomes. • All our partners in the project must learn to use and analyze information in order to fine tune their project activities.
For further information	Ian Willis, Project Manager, CARE International, Sudan Email willisi@care.org

Using Participatory Data Collection Methods to Plan Reproductive Health Programs

Moderator: Beverly Tucker, Family Health International

Presentations:

- | | |
|----------------------|---|
| Zeinab Abdi
Ahmed | <i>SGBV as viewed by refugees in Kenya: Learning about sensitive RH issues and developing responses using participatory assessment techniques</i> |
| Tracey Lee | <i>NORPLANT[®] for Karen refugees on the Thai-Burmese border</i> |
| Aftab Tariq Ihsan | <i>Participatory rapid appraisal (PRA) of the reproductive health needs of Afghan refugees in Pakistan</i> |

SGBV as viewed by refugees in Kenya: Learning about sensitive RH issues and developing responses using participatory assessment techniques

Abstract revision date: December 5-6, 2000

Authors	Susan M. Igras, CARE-USA Health Unit Zeinab Abdi Ahmed, CARE-Kenya Refugee Assistance Program
Presenter	Zeinab Abdi Ahmed
Background	Sexual and gender-based violence (SGBV) in the Dadaab refugee camps in northern Kenya has been an issue since refugees began arriving from Somalia. In response, an inter-agency SGBV program has existed in Dadaab since the early 1990s. A 1999 survey indicated that 28% of women in the camps had been sexually aggressed since becoming refugees. The program was viewed as needing to respond better.
Purpose of study or program	CARE's RH for Refugees Initiative staff facilitated a multi-agency assessment of SGBV in late 1998 that focused on substantive discussions with refugee groups, using participatory exercises to focus discussions.
Data collection methods	The 1995 UNHCR publication, <i>Sexual Violence Against Refugees: Guidelines on Prevention and Response</i> , guided the development of question guides for use at the community level to explore the problem and its causes, and to solicit solutions to reduce violence. Concurrently, a systems analysis of the actual SGBV reporting, treatment and support systems was conducted.
Study or program findings	Refugees provided their definitions of violence and its consequences. They identified areas where they felt vulnerable to assault within the camps. They spoke of individual and community coping mechanisms to prevent violence and support survivors of violence. When asked about solutions, ideas emerged: forming vigilance groups to patrol the camps at night, cleaning up bushes inside camps that could hide perpetrators, asking UNHCR and the police to establish 'safe corridors' for firewood collection, and expanding economic opportunities for women so they would not need to collect firewood or enter into coercive sexual relationships. The systems review indicated that greater sensitivity was needed for rape survivors as they maneuvered numerous and at times uncoordinated services.
Conclusions and program implications	Suggestions from the assessment resulted in improvements in the SGBV program, including better inter-agency coordination of reporting, treatment and support services, and refugee outreach activities to recognize trauma, support survivors of violence, and prevent violence from occurring in the first place. CARE, Médecins sans Frontières/Belgium and the National Council of Churches of Kenya plan to expand the program further to address new forms of violence (intimate partner violence and coercion) and to experiment with women's drop-in centers to bring services closer to the refugee communities and expand RH and social services to women in the camps. The use of participatory assessment techniques provides an appropriate way to get input on sensitive issues and plays a critical role in identifying issues and better supporting survivors and communities faced with violence. Concurrent systems analysis can validate these issues and help define what solutions are feasible given available resources.
For further information	Zeinab Abdi Ahmed, Vulnerable Women & Children's Supervisor, Refugee Assistance Project, Dadaab, CARE Kenya, PO Box 43864, Nairobi, Kenya. Telephone 254-131-2060 Fax 254-131-3242 Email zeddie@ddb.care.or.ke

NORPLANT® for Karen refugees on the Thai-Burmese border	
Abstract revision date: December 5-6, 2000	
Authors	T. Lee, N. Lay Hter, D. D. Cho, Eh Paw, R. McGready, F. Nosten; Shoklo Malaria Research Unit
Presenter	Tracey Lee
Background	The use of long-term, reversible contraceptives is infrequently reported in displaced populations. In 1996, Norplant®, a sub-dermal implant with contraceptive duration of five years, was offered free of charge within a family planning program. The program served a stable population of 30,000 Karen displaced persons in Maela camp on the western border of Thailand. Norplant has been used in Thailand since 1987 but is unavailable in Burma. The proportion of women who chose the method was 6%.
Purpose of study or program	To describe use of Norplant®, a long-term contraceptive, by a refugee population.
Data collection methods	Between January 1997 and March 1999, 105 consenting Norplant® users were followed every three months in order to establish rates of continuation and side effects. At least six months after insertion, women were questioned regarding reasons for choosing the method and plans for removal in the event of returning to Burma. A further 33 known Norplant® users who did not participate in the routine follow-up and who consented to interview were included for comparison.
Study or program findings	70% (n = 74) of women were able to be followed. The remainder either went to work, moved or were lost to follow-up (n = 31). One third (n = 24) of women requested to have the implants removed. The most commonly cited reasons for requesting removal were pain or infection at the insertion site or desire for pregnancy. 17% (4/24) of removal requests were attributed to bleeding irregularities. Headache and dizziness were the most frequently reported side effects. The median (range) number of weeks before removal was 35 (1-135).
Conclusions and program implications	The study reports Norplant® usage by refugees in stable circumstances, a novel report. While requiring extensive training for providers and client counseling, it expanded contraceptive choice for this displaced population.
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Participatory rapid appraisal (PRA) of the reproductive health needs of Afghan refugees in Pakistan	
Abstract revision date: December 5-6, 2000	
Author	Ariel Ahart, Save the Children Consultant
Presenter	Aftab Tariq Ihsan, Save the Children Federation, Pakistan
Background	Save the Children/United States (SC/US) provides assistance to 105,000 Afghan refugees in the Haripur District of Pakistan through meeting basic health needs: child health care, tuberculosis and malaria control programs, basic curative services and reproductive health programs including safe motherhood and family planning.
Purpose of study or program	In April 1997, SC/US initiated a study on the RH needs of Afghan refugees. The main purposes of the study were to: 1) field test the RHR Consortium's needs assessment guide and 2) ascertain the community's knowledge, beliefs and practices related to critical RH areas.
Data collection methods	SC/US used the Participatory Rapid Appraisal (PRA) technique to gather information through a multidisciplinary team. A total of 1,370 Afghan Refugees participated (920 women, 450 men). PRA tools included: direct observation, secondary sources, pair-wise ranking, causal flow, lifeline analysis and livelihood analysis diagrams. The team secured community support before embarking on the survey and cross-checked results with refugees before writing the final report.
Study or program findings	<ul style="list-style-type: none"> • Married Afghan women typically reported 8 to 11 pregnancies over the course of their reproductive lives. • Refugees expressed the desire to space their children in order to protect the mother's health and/or because they could not afford additional children. • Knowledge about STDs and HIV/AIDS was extremely poor. Men who had sex with multiple partners and/or traveled outside the camp were at greatest risk of contracting and transmitting STDs and HIV. • A number of health problems identified amongst women pointed to a high incidence of RTIs and genital prolapse. • The incidence of domestic violence appears to be high. Husbands were identified as the primary perpetrators. However, the role of other family members deserves further attention. • Early marriage is common and increases the risk of domestic violence. • Major weaknesses were identified in the referral system. • Girls and boys had limited knowledge about puberty, their bodies, and reproductive health.
Conclusions and program implications	Through PRA, it is possible to openly discuss RH topics within a conservative Islamic community. A number of program implications were identified: the need to make contraceptives more readily available; greater education on critical areas of RH as well as RTIs, STDs and HIV/AIDS; increased access to emergency obstetric services; education and outreach to primary RH decision makers; and additional training of staff. The issue of domestic violence emerged as one of the most sensitive and most difficult topics to address, one which must acknowledge the cycle of violence and the role of different family members.
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Sexual and Gender-Based Violence – Size and Scope of the Problem

Moderator: Beth Vann, UNHCR Consultant

Presentations:

Haifa Jammal Aziza Khalidi	<i>Domestic violence among selected Palestinian refugee communities in Lebanon: An exploratory study and ideas for further action</i>
Sam Posner	<i>Factors associated with self-reported forced sex among Azerbaijani women</i>
Josephat Nyarubakula	<i>Unsafe Haven: Report on the findings of the baseline sexual violence survey among Burundian refugees</i>

Domestic violence among selected Palestinian refugee communities in Lebanon: An exploratory study and ideas for further action Abstract revision date: December 5-6, 2000	
Authors	Association Najdeh staff and Aziza Khalidi, Association Najdeh consultant
Presenters	Haifa Jammal and Aziza Khalidi
Background	Domestic violence (DV) is a social issue from a human rights perspective as well as a public health perspective at a global level. There are indications of a problem among Palestinian refugees in Lebanon, but concrete qualitative and quantitative evidence about its magnitude and dimensions is limited.
Purpose of study or program	The study objectives were: (1) to assess the prevalence of domestic violence among families of children attending Najdeh kindergartens (KGs) in several Palestinian camps in Lebanon during the school year 1998-1999; (2) to examine relationships among domestic violence indicators; (3) to explore relationships between beating of wives by their husbands and a set of socioeconomic and demographic correlates; (4) and to derive ideas for avenues for action within current realities.
Data collection methods	DV data were generated from interviews conducted by trained KG teachers with 452 Palestinian refugee mothers of children attending KGs in Palestinian camps in Lebanon during February and March of 1999. Socioeconomic and demographic data were obtained from KG records.
Study or program findings	<p>Findings showed that 29.6% of women were subjected at least once during their marriage to beating by the husband. 67.9% of children were subjected at least once to beating, almost entirely by parents. 44.7% of women reported being shouted at at least once during their marriage. 12.2% of women reported being insulted at least once during their marriage, primarily from husbands.</p> <p>When women reported an excellent relationship with their husbands, 11.9 percent of them reported being beaten by their husbands.</p> <p>Correlation was high among indicators of domestic violence with varying types and perpetrators. Multivariate logistical regression analysis was conducted to assess the relationship between socioeconomic and demographic correlates and beating of wives by their husbands. Findings indicated that the odds of ever being beaten by their husbands were 32 times higher for women who reported their relationship as bad compared to those who reported an excellent relationship. Being in families earning a median income and having a husband between 46 and 67 years of age were shown to decrease the odds of being beaten. When women reported having chronic illness, the odds of being beaten by their husbands increased significantly threefold.</p>
Conclusions and program implications	The study shows that domestic violence among the study population of refugees is a problem of significant magnitude that requires action coupled with further research. This study recommends interventions along three avenues: (1) developing a surveillance program, (2) conflict management skills development program, and (3) direct counseling program.
For further information	Haifa Jammal, Vice Executive Director, Association Najdeh, PO Box 113-6099, Hamra Beirut 1103-2100, Lebanon Telephone (961) 1-302 079 or (961) 1-703 357 Fax (961) 1-703 358 Email association@najdeh.org.lb

Factors associated with self-reported forced sex among Azerbaijani women	
Abstract revision date: December 5-6, 2000	
Authors	J Kerimova, Relief International SF Posner, YT Brown, J Schmidt, S Hillis, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion S Meikle, National Institutes of Health J Lewis, Centers for Disease Control and Prevention, National Center for Infectious Diseases A Duerr, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion
Presenter	Sam Posner
Background	Previous reports have indicated that refugee and internally displaced (R/IDP) women are at high risk for experiencing violence, including forced sex. Few research studies have been conducted to systematically collect data on the prevalence and incidence of forced sex among R/IDP women.
Purpose of study or program	This report presents data on the prevalence of women who reported experiencing forced sex and the age at which it last occurred.
Data collection methods	A total of 701 women from 1 urban and 3 rural reproductive health clinics participated in a study on women's health. Both refugee and local women participated in the study. The relationship between self-reported forced sex and reproductive history, demographics and adverse living conditions were examined.
Study or program findings	Nearly a quarter (24.1%) of the women reported that they had been forced to have sex at some point in their life. Women were at higher risk for forced sex if they were refugee/IDP (OR 1.72, 95% CI 1.04-2.86), wanted their last pregnancy (OR 3.03, 95% CI 1.73-5.33), used withdrawal as their primary form of birth control (OR 2.37, 95% CI 1.32-4.25), thought their husband had other partners (OR 2.57, 95% CI 1.30-5.08) and were married longer (OR 1.06, 95% CI 1.02-1.10).
Conclusions and program implications	This study is one of the first studies to document the prevalence of forced sex among refugee women in a refugee setting. While previous reports have documented similar rates of forced sex, fewer have identified factors associated with experiencing forced sex.
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Unsafe Haven: Report on the findings of a baseline sexual violence survey among Burundian refugees	
Abstract revision date: December 5-6, 2000	
Author	Laurel K. Fain, International Rescue Committee Consultant
Presenter	Josephat Nyarubakula, Field Researcher, International Rescue Committee, Tanzania
Background	Outbreaks of conflict in Burundi during the last decade have caused hundreds of thousands of deaths and the displacement of over 1,000,000 people since 1993. In late 1999, a new camp, Karago, was prepared for the expected continued influx.
Purpose of study or program	In February 2000, a baseline survey of sexual violence was conducted among the population of 41,399 refugees residing in the newly created Karago refugee camp. The aim of the survey was to interview a representative sample of all women over the age of twelve years about their experiences with and concerns about sexual violence and sexual harassment.
Data collection methods	A standardized questionnaire was administered by trained interviewers selected from among community health workers and community services workers from Karago camp. 10% of households on the food ration registration list for Karago were randomly selected to be contacted by interviewers. However, this method of random selection proved problematic, and respondent households were instead selected by their addresses within the camp. Respondents were randomly identified from among the adult women in each selected household. Responses were analyzed utilizing the EpiInfo data management program.
Study or program findings	Survivors of rape made up 8.2% of the women surveyed. Respondents who indicated that they had experienced sexual harassment made up 11.1% of the population surveyed. The overwhelmingly physical nature of the sexual harassment experienced by the refugee women is notable. Marriages for the purpose of protection or as a result of abduction and/or rape make up 25% of marriages that occurred since relocation. 29% of the incidents of rape reported during this survey occurred either within the refugee camp environment (20%), or after crossing the Tanzanian border as refugees traveled to Karago camp (9%). Risk groups were identified through statistical analysis. A woman who has experienced sexual harassment was found to have a much greater chance of experiencing rape, as were women under the age of 35. Similarly, women under 25 are more likely to have experienced sexual harassment. A lower risk of experiencing rape was associated with having a husband during flight and with having been a refugee previously.
Conclusions and program implications	At least 63% of the incidents of rape experienced by women in Karago camp can be seen as closely related to the current instability in Burundi, either directly by soldiers invading their homes or indirectly through their flight or their status as refugees. This study has found refugee camps to be dangerous places for refugee women, places where their risk of sexual violence is quite high.
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Challenges in Implementing Reproductive Health Programs in Complex Emergencies

Moderator: Maurice Middleberg, CARE

Presentations:

Claire Hoffman *Community participatory family planning and reproductive health with internally displaced communities, Sri Lanka*

A. Sam-Abbenyi *HIV/STD prevention among the returnee and resettled population of Gitarama, Rwanda, 1996-2000*

Carolyn Baer
Neena Philip *Knowledge, attitudes and practices of reproductive health, Kajo Keji County, Southern Sudan*

Community participatory family planning and reproductive health with internally displaced communities, Sri Lanka	
Abstract revision date: December 5-6, 2000	
Authors	Claire Hoffman, International Planned Parenthood Federation (IPPF), London Family Planning Association of Sri Lanka
Presenter	Claire Hoffman
Background	Sri Lanka has faced an unprecedented problem of internally displaced persons created in the wake of escalated ethnic strife plaguing the country for the last 15 years. There are a reported 400,000 internally displaced families living in centres located mostly in border areas of conflict zones. Whilst bare essentials such as food, clothing and shelter have been provided, health care has been grossly neglected.
Purpose of study or program	The Family Planning Association (FPA) of Sri Lanka – an affiliate of IPPF – designed a project with the overall goal of raising the health conditions of displaced communities to be at par with the national average.
Study or program findings	<p>Increased CPR among married couples The project saw a significant increase in the Contraceptive Prevalence Rate (CPR). The baseline survey showed that 40.06% of 11,271 eligible couples were practising a method of FP; of this modern methods accounted for only 33%. At the end of the project (January 2000), FP practice levels ranged from 40.6% to 69%, of which modern methods accounted for 57.5%. In some of the camp clusters, the rate had doubled.</p> <p>Increased community awareness and involvement in providing FP and RH services By the end of the project, community camp leaders were well informed about the FP and RH needs for the total well-being of the community. They had been fully involved in addressing the FP and RH needs and had provided leadership to health volunteers and CBDs. Overall, community participation throughout the project was at a high level.</p> <p>RH information and counseling to adolescents As part of an extension to the initial project, young people's needs were addressed. Some 66 young people were trained as peer educators, each of whom educated at least 20 other youths and have continued their support role. Counselling services for young people at the camp level were introduced with 52 suitable individuals trained to work as part-time counsellors.</p>
Conclusions and program implications	<p>A number of key lessons were learned during the implementation of this project, some of which were not necessarily explicit in the initial design of the project.</p> <p>Community involvement A key element to the success of the project was the involvement of beneficiaries at all stages of project implementation.</p> <p>Adolescent reproductive health needs must be addressed Addressing the needs of, and involving, young people was an element that was initially missing from the project. The clear conclusion was that young people's RH needs should be an <u>integral</u> element in every RH programme.</p> <p>Empowering women Although the primary objective was to promote FP and RH, the project also played an important role in empowering women. More than 50% of health volunteers were women, and the project has directly and indirectly assisted reproductive rights among women.</p> <p>Success in seemingly impossible situations Initially the Sri Lanka FPA had been cautioned by health and public officials that FP promotion among the primarily Muslim displaced population was an "impossible" task. Nevertheless, after some initial opposition, contraceptive acceptance was significant – largely due to community involvement, participation and leadership in the project.</p>
For further information	Claire Hoffman, Advocacy Officer, IPPF, Regent's College, Inner Circle, Regent's Park, London NW1 4NS UK Telephone +44 (0) 20 7487 7856 Fax +44 (0) 20 7287 7865 Email choffman@ippf.org

HIV/STD prevention among the returnee and resettled population of Gitarama, Rwanda, 1996-2000	
Abstract revision date: December 5-6, 2000	
Authors	A. Sam-Abbenyi, U. Korus, P. Crussard, T. Ndibeshye, CARE Rwanda
Presenter	A. Sam-Abbenyi
Background	CARE Rwanda implemented an HIV/STD prevention project in 3 phases using peer educators/health animators (HA) in Gitarama, Rwanda. Beginning in 7 communes in 1996, the project progressively covered all 17 communes in Gitarama Region by 1999-2000. In the aftermath of genocide in 1994, the project was designed to help the Ministry of Health (MOH) revitalize HA networks after refugees returned to Gitarama after the war. Promiscuous life in refugee camps in eastern Congo, lack of information and education on HIV/STDs and inadequate STD services contributed to greatly increased prevalence of HIV/STDs in Rwanda. The MOH wanted to concentrate health animator efforts in this domain.
Purpose of study or program	<ul style="list-style-type: none"> To measure changes in returnees' knowledge, attitudes and practices (KAP) of HIV/STDs in all 3 phases of the project. To ensure a smooth phase-over of the health animator network from CARE to the Gitarama Health Region (GHR) and build the capacity of the GHR to oversee community-level education and condom distribution for HIV/STD prevention.
Data collection methods	Between 1996 and 2000, 4 KAP studies were conducted using two-stage cluster samples. During the same period 3 qualitative studies were undertaken using focus group discussions and in-depth interviews of key informants.
Study or program findings	Revitalized health animator activities resulted in improved knowledge and use of STD services: over 95% of both sexes cited 2 or more STDs. Female youth under 20 years had lower levels of knowledge than males. Condom use increased: ever-use of condoms was reported by 16.9% of women in 1999 versus 9.3% in 1996. Women's use of condoms during last intercourse rose from 4.4% to 9.3%. Men's ever-use of condoms rose from 10.8% to 20% and use of condoms during last intercourse increased from 7% to 9.4% in 1999. Condoms were not used because of trust in partners (that they were not infected), belief that spouses/partners were faithful, or condoms were not available. Only 200 HAs (18.2%) sold condoms, accounting for 7.5% of total condoms sold/distributed. HA's did not sell for reasons of religion or comfort level. Patient consultations in health facilities for STDs increased six-fold from 0.9% in 1998 to 5.4% in 1999.
Conclusions and program implications	The challenge to maintain community outreach networks is twofold: the GHR requires a budget line for HA activities and the annual HA drop-out rate of 20% is high. HA's are volunteers and need to be organized in resource-generating associations. Future HA selection criteria may need to include a desire to provide contraceptive/condom messages and services. There is a need to focus more on youth to prevent HIV transmission.
For further information	A. Sam-Abbenyi, MD, MSc, Reproductive Sector Coordinator, CARE Rwanda, Box 550, Kigali, Rwanda Telephone 250-72402, 72907 Fax 250-76012 Email abbenyi@rwanda1.com

Knowledge, attitudes and practices of reproductive health, Kajo Keji County, Southern Sudan	
Abstract revision date: December 5-6, 2000	
Authors	Neena Philip, Intern/Consultant, American Refugee Committee, Southern Sudan
Presenters	Carolyn Baer, American Refugee Committee, and Neena Philip
Background	Kajo Keji County is one of the southernmost counties in Sudan with approximately 120,000 people, more than 43,000 of whom are internally displaced persons. Since 1994, ARC has been providing primary health care (PHC) services; reproductive health services were introduced in 1998.
Purpose of study or program	<ul style="list-style-type: none"> To obtain information that would assist in efforts to ensure that PHC (including reproductive health and water/sanitation) program activities in the county are appropriate and effective in meeting the priority needs of the community (county). To obtain information from which program effectiveness can be assessed; and To provide ARC, SUHA (indigenous health NGO), SRRRA authorities and the County Health Department staff experience in development, implementation and analysis of a comprehensive survey.
Data collection methods	<p>Sample population: men and women 15-45 years old. Sample size: 1,211 men and 1,786 women in 1,130 households</p> <p>Survey Area: Kajo Keji County, southern Sudan</p> <p>Study Design: Interviews were conducted for 3 weeks in July 2000 using a 40 cluster sampling design consisting of 45 females and 30 males per cluster.</p> <p>Survey instrument: 3 instruments were used: a women's survey, a men's survey and a household survey translated into Dinka, Bari and English</p> <p>Interviewers: 102 interviewers (21 female) who were involved in the PHC system and who received a 4-day training.</p>
Study or program findings	<p>Safe motherhood (parous women)</p> <ul style="list-style-type: none"> 82% had seen a trained health care worker during their most recent pregnancy. 56% were able to list 2 complications during delivery that would require assistance from a health worker. 53% had a trained attendant at their last delivery. <p>STD/HIV/AIDS (all respondents)</p> <ul style="list-style-type: none"> 78% were able to cite 3 (of 4) modes of HIV transmission. 36% were aware that condoms can prevent HIV transmission. Condom use among those who are aware is 43%. 65% believe that STDs cannot be asymptomatic. <p>Family planning/child spacing</p> <ul style="list-style-type: none"> Among males, 52% are familiar with 2 or more methods of family planning. 40% of respondents currently use a child-spacing method (46% abstinence, 25% condoms). 70% stated 2 years or more is the best amount of time between births. <p>Sexual and gender-based violence</p> <ul style="list-style-type: none"> 63% of all respondents stated that females are forced to have sex against their will. 69% of all respondents stated that men have a right to beat their partners. 17% of the women stated that they had been hit or beaten by their boyfriend or husband within the previous month.
Conclusions and program implications	<ul style="list-style-type: none"> Continue efforts to increase knowledge of reproductive health issues. Build effective campaigns based on current levels of knowledge to encourage practices which lead to improved RH (use of condoms, child spacing, reduction in violence). Continue to monitor population's knowledge, attitudes and practices in order to assure effective programming.
For further information	<p>David and Paulette Hassell, Co-Country Directors, Carolyn Baer, RH Coordinator, ARC International Southern Sudan/Uganda Programs, PO Box 7868, Kampala, Uganda</p> <p>Fax 256-41-533737 Email arc@swiftuganda.com</p> <p>Neena Philip Email neenaphilip@hotmail.com</p>

Family Planning – An Ongoing Challenge

Moderator: Steve Hawkins, USAID

Presentations:

Rosemary Barber-Madden *Demographic profile and the reproductive health of internally displaced persons in Angola*

Se Youry *Research on reproductive health: Lessons learned in Khao Phlu refugee camp, Thailand*

Poonam Mazhar *A family planning continuation study among Afghan refugees in Pakistan*

Demographic profile and the reproductive health of internally displaced persons in Angola	
Abstract revision date: December 5-6, 2000	
Authors	Rosemary Barber-Madden, Jose TL Ribeiro, Ana Leitão, João Bosco Feres, UNFPA Angola
Presenter	Rosemary Barber-Madden
Background	In 2000, the Angolan government registered a total of 4 million IDPs (or 1/3 of the estimated national population) from the war. In 1999, the provincial governments of Huila and Benguela requested technical assistance from UNFPA to explore the needs of the growing number of IDPs in camps and peri-urban areas surrounding local cities.
Purpose of study or program	This study examined the conditions of family life and of reproductive health among persons living in IDP camps and in peri-urban areas of major cities in Huila and Benguela Provinces. The study was undertaken in conjunction with the health, education, social communications and planning sectors in order to develop a program of intervention at the community/camp level.
Data collection methods	The study was conducted in 2 phases: a survey in the early phase and focus groups and in-depth interviews in the second. The survey questionnaire consisted of 70 questions regarding: homeland of origin, fertility, assistance to pregnant women, knowledge of family planning, infant and child mortality, knowledge of STDs, use of male and female condoms, unwanted pregnancy and abortion, sexual and physical violence, prostitution. The focus groups and in-depth interviews pursued these same issues. This paper presents a summary of the survey data. For the survey, a sample of 710 women, men and youth was drawn using stratification by geographic zones in IDP camps and peri-urban areas where IDPs were re-integrated into the communities of the 2 provinces.
Study or program findings	The majority of IDPs in the survey were from rural areas of the same province, many having been displaced more than once. The average number of children per woman was 8.6, with 3.8 children having died. 15.4% of the women were pregnant at the time, with 2/3 reporting having received some prenatal care. The infant mortality rate was 236 per 1000 live births, with an under-5 mortality rate of 395 per 1000 live births. The fertility and mortality rates are significantly higher than the national average. 60.7% of men and 38.7% of women had heard about STDs, with 80.3% of men and 60% of women having heard of AIDS. Condom use was limited, with 8.7% of men and 3.6% of women reporting having used a condom during the last sexual contact. However, it must be noted that condom availability (male and female) is very limited in the provinces.
Conclusions and program implications	Together with the provincial authorities, UNFPA proposed an emergency reproductive health package. With funds from the Dutch government and OCHA, these services were introduced in IDP camps and peri-urban areas of Huila, Benguela, Malange and Huambo provinces in 2000: <ul style="list-style-type: none"> • upgrading maternity services by providing equipment (including RH kits/MISP), materials, contraceptives, medications and training for integrated RH care, essential obstetrical care, STD diagnosis and treatment • providing female- and male-directed RH education by health promoters supervised by provincial mobile RH teams in 9 camps • special radio programmes broadcast in national languages and Portuguese at listening posts in selected camps and peri-urban areas • <i>okulyelisa</i> (intimate hygiene kit) at health services points and in IDP camps (containing material for menstruation, soap, male and female condoms)
For further information	Rosemary Barber-Madden, UNFPA Representative/ Angola, Mailing address: 137 West Central Park North, Apt 7E, New York, NY 10026 USA Telephone 212- 531-4985; Email rbarber_madden@hotmail.com Dra. Ana Leitão, National Project Advisor and Dr. João Bosco Feres, Chief Technical Advisor, UNFPA, Rua Major Kanhangulo, 197, CP 910 Luanda, Angola Telephone 244-2-393531; Email raul.feio@netangola.com , joabos@hotmail.com

Research on reproductive health: Lessons learned in Khao Phlu refugee camp, Thailand	
Abstract revision date: January 15, 2001	
Authors	Virginia Morrison, Lowell Community Health Center, Lowell, MA, Se Youry, Clinical Coordinator, American Refugee Committee, Sangklaburi, Thailand
Presenter	Se Youry
Background	Research done in 1998 attempted to document the need for and barriers to contraceptive services in Khao Phlu. This camp existed from 1997-1999, housing approximately 12,000 people. Reproductive health services were provided by the American Refugee Committee under the auspices of the United Nations High Commission for Refugees. Populations in Khao Phlu came from border areas of Cambodia and had little access to government health services for 25 years.
Purpose of study or program	This was one of the first efforts to document the implementation of the Reproductive Health for Refugees Consortium recommendations. This presentation will cover methodological and practical findings learned during research and data collection.
Data collection methods	Quantitative data included serial interviews with women living in the camp as well as midwives working at the maternal child health center. Qualitative data were collected through three focus groups with Khmer men and two focus groups with traditional birth attendants. Records from the log books at the maternal child health center provided demographic data and number of women obtaining contraception through ARC services.
Study or program findings	<ol style="list-style-type: none"> 1. Findings indicated a greater need and demand for contraception since arriving at the camp among all participants. Barriers to contraception included fear of side effects, being labeled as promiscuous, embarrassment and difficulty traveling to the health center. 2. Interviews and focus groups gave extensive information on contraceptive services. As a possible result, more women came for contraceptives during and after data collection, a trend not observed in a nearby camp. 3. The maternal child health center changed its family planning schedule from twice a week to everyday services to meet this need. Additional rape crisis protocol was put in place as a result of women who mentioned they had been victims of rape.
Conclusions and program implications	<ol style="list-style-type: none"> 1. Identify areas of local concern by assessing the population before formulating research questions. 2. Security is difficult to guarantee and may present limitations on access to the camp. Collaboration with camp and expatriate staff is essential. This can avoid delays in permission from the host authority to access the camp and builds on an established relationship with camp residents. 3. Camps are highly mobile, making it difficult to enumerate populations or guarantee random sampling. This can be ameliorated with division of the camp into different sections or obtaining information on native country origins of participants. 4. More research is needed in the beginning of refugee crises when women are at highest risk for rape and unwanted pregnancy. The research protocol should assure services for women at highest risk, sensitize staff to concerns of SGBV and train staff in detection, counseling and treatment of those affected.
For further information	Dr. Se Youry, American Refugee Committee, P.O. Box 6 Sangklaburi, Kanchanaburi 71240, Thailand Telephone and Fax 6634 595-177 Email arcsang@loxinfo.co.th

A family planning continuation study among Afghan refugees in Pakistan	
Abstract revision date: December 5-6, 2000	
Authors	This work is a joint effort of staff of Frontier Primary Health Care; Heilbrunn Center for Population and Family Health, Columbia University; International Rescue Committee, Hangu; JSI Research & Training Institute; Kuwait Joint Refugee Committee; Project Directorate Health; Save the Children/US, Haripur; UNHCR/UNFPA Reproductive Health Unit, Peshawar; Union Aid for Afghan Refugees
Presenter	Poonam Mazhar, UNHCR/UNFPA, Pakistan
Background	<p>UNHCR and its partners provide health services to 1.2 million Afghan refugees residing in 170 officially recognized refugee villages in the North West Frontier Province (NWFP), Balochistan and Punjab provinces of Pakistan. Some 78% of the current refugee population reside in the NWFP.</p> <p>One aspect of UNHCR's Reproductive Health Project, initiated in January 1999, was to improve its own and its partners' capacity to collect, analyze and use program data to improve services. Collaborative workshops among 7 local agencies and 2 US-based RHR Consortium member agencies led to a decision to carry out a joint study to improve family planning continuation.</p>
Purpose of study or program	The intent of the joint study was to learn the 3-, 6- and 12-month family planning continuation rates; to gain an understanding of the program and community factors affecting continuation and discontinuation; to apply that awareness to programs to better serve couples; and, in the process, for staff of the 9 agencies involved to improve their data collection and management skills.
Data collection methods	<p>The study has 4 components.</p> <p>BHU record review: Data on age, parity, method, and duration of use, where possible, were compiled on all 1,550 women accepting a family planning method from January to June 1999 at the 46 project BHUs offering family planning services.</p> <p>Review of agencies' policies and management systems: Self-administered open- and closed-ended questionnaires were completed by each of the 7 local participating agencies, covering agency-level information on policies and management systems relevant to the organizations' family planning services.</p> <p>BHU survey: Self-administered open- and closed-ended questionnaires were completed by all 54 BHUs managed by the partners, covering information on policies and management systems relevant to their family planning services.</p> <p>Follow-up survey of acceptors: A simple random sample of 716 women drawn from the 1,550 who accepted a family planning method at one of 46 project BHUs from January to June 1999 were visited and interviewed in October-November 2000.</p>
Study or program findings	<p>Preliminary analysis of the BHU record review, which appears to be confirmed by the follow-up survey, suggests that continuation is considerably higher for injectables than for pills, the 2 most common methods, and higher among younger women than older. Program and community factors associated with continuation and discontinuation are currently being analyzed.</p> <p>Agency and BHU policies and management systems are adapting to family planning, a relatively new service, as they are to other reproductive health services, also recently introduced. Continued support from UNHCR is important to maintain momentum.</p>
Conclusions and program implications	Improved counseling to users of all methods, particularly the pill, appears needed. Additional program shifts and community awareness-raising will be called for to respond to additional study findings.
For further information	<p>Dr. Poonam Mazhar, UNHCR/UNFPA, I Gulmohr Lane, Peshawar, Pakistan Telephone 92 91-842375/ 76; 842998 Fax 92 91-842101 Email pakpe@unhcr.ch</p> <p>Dr. Emel Khan, Frontier Primary Health Care, PO Box 52, GPO, Mardan, Pakistan Telephone 92 931-63837 Fax 92 931-61403 Email fphe@brain.net.pk</p>

Improving Service Delivery Systems in Post-Conflict Settings

Moderator: Ron Waldman, Heilbrunn Center for Population and Family Health,
Columbia University

Presentations:

Susan Igras *Revitalizing health services in northwestern Somalia: CARE's experience*

Doris Bartel *Responding to Kosovo's reproductive health crisis*

Melissa Sharer *Participatory assessment of women's issues in East Timor,*
Jesse Rattan *May 2000*

Revitalizing health services in northwestern Somalia: CARE's experience	
Abstract revision date: December 5-6, 2000	
Author	Wairimu Gakuo, Senior Program Officer, CARE International, Somalia
Presenter	Susan Igras, CARE, Atlanta
Background	The health system in the North West Zone/Somalia is struggling to re-establish itself as a public sector institution after years of civil war. The current health services, particularly preventive services, are underutilized by communities due to social and economic factors.
Purpose of study or program	The 2-year CARE Somalia Safe Motherhood pilot project has been designed to build on the 4 key interventions that can have the greatest impact on maternal mortality: family planning, antenatal care, clean delivery and essential obstetric care. The project will strengthen the links between the interventions, and between communities and MCH centers (3 rural and 3 urban) serving an estimated population of 30,000 women of reproductive age in North Western Somalia, to improve the demand for, access to and quality of safe motherhood services. Support is being provided to community health educators and TBAs to create demand for and help restore confidence in the health care system. In this way, the project will address the key problems of limited access, demand and appropriate use of safe motherhood services in clinic and home settings.
Data collection methods	A baseline KAP survey was conducted in October 1999; additional information is being collected as the project progresses.
Study or program findings	<p>The October 1999 baseline KAP survey confirmed the poor status in the provision of and access to safe motherhood services in the target area of Somaliland. Though UN statistics had set the maternal mortality ratio at 1,600/100,000 live births and the infant mortality rate at 125/100,000 live births, the baseline survey found these figures to be 826/100,000 and 103/100,000 respectively.</p> <p>Use of modern contraceptive methods was 1% while the total fertility rate stood at 7.9. The baseline established the need to target rural areas more than urban areas as the situation in these areas indicates lower access to services and knowledge of safe motherhood practices. The challenge is to increase acceptance of child spacing methods in an environment that is resistant due to religious and cultural beliefs.</p> <p>Training of health staff is a priority for the project. Centralized training has proven to be a difficult strategy to implement due to high (financial) expectations by trainees. On-job training is being used and has proven to be more effective in improving the skills of health staff in the target MCH centers.</p> <p>A referral (coupon) system was established by the project, and emergency cases are being referred to the main referral hospital. However, villages that are far from the centers have no access to this facility.</p>
Conclusions and program implications	The Safe Motherhood Project continues to face many challenges, the least of which are the religious and cultural biases of the target communities. Creative mechanisms to meet the challenges are being continuously explored and it is anticipated that the IEC campaigns, support to MCH mini-projects and increased skills of health staff through on-job training will enable the project to meet its objective of increased access and use of safe motherhood services.
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Responding to Kosovo's reproductive health crisis	
Abstract revision date: December 5-6, 2000	
Author	Doris Bartel, International Medical Corps
Presenter	Doris Bartel
Background	Refugees who returned to Kosovo following the conflict faced significant barriers to reproductive health (RH) services, in part due to the lack of health professionals trained in appropriate clinical skills. Fewer than 150 gynecologists provided RH services to Kosovo's 1.8 million people. Kosovo has one of the highest infant and maternal mortality rates in Europe.
Purpose of study or program	The goals of the program were to increase community-based health promotion and demand for reproductive health care services, to improve access to quality reproductive health care for women, and to increase the knowledge and clinical skills of health care providers in primary care settings.
Data collection methods	The program followed a three-part approach to health sector reform. The first was direct reproductive health service provision via mobile clinics to women in underserved areas. The second was on-the-job reproductive health clinical skills training of the staff who work in primary care clinics. The third was health promotion and outreach to communities without access to health information. Data collection included basic demographic data from the clinic clients and qualitative data on rural women's reasons for coming for care.
Study or program findings	<p>Outreach to the community was undertaken through the formation of women's groups in each village which met regularly with lay health educators to discuss health concerns. RH services were introduced via mobile clinics with small teams of trained general practitioner doctors, nurses and midwives in October 1999. The number of women utilizing the new services grew to over 1200 visits per month within one year.</p> <p>Women reported that they came for RH services because they were convenient to home, free, and were provided by empathetic female service providers who emphasized client-centered care.</p> <p>A survey of medical staff working at the primary care setting revealed that over 70% were eager to learn new clinical skills as provided by the mobile team models. On-the-job clinical skills training is currently underway.</p>
Conclusions and program implications	Health education and outreach was successfully implemented in rural Kosovo via women's groups. RH services provided in traditional primary care settings by nontraditional staff were found to be acceptable to recently returned Kosovar refugee women. After observing this model via mobile teams, a majority of the primary care staff stated they wanted similar on-the-job RH skills training. The success of the program was enhanced by a community-based approach to health sector reform.
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Participatory assessment of women's issues in East Timor, May 2000			
Abstract revision date: January 15, 2001			
Authors	Melissa Sharer, Milena Vilanova, Jesse Rattan; IRC East Timor		
Presenters	Melissa Sharer Jesse Rattan		
Background	Announcement of the referendum results on August 30, 1999, when 78% of the population voted for independence, sparked an explosion of violence in East Timor. Ensuing massacres by paramilitary militias, destruction and chaos forced approximately 250,000 people to flee the country. The health infrastructure was nearly totally destroyed, including a loss of drugs, equipment and supplies specific to reproductive health. There is evidence that women were subjected to many types of sexual and gender-based violence, both over the past 25 years and most recently during the emergency phase following the referendum.		
Purpose of study or program	IRC's program has worked to address both immediate emergency needs through Minimum Initial Service Package (MISP) provision and emergency condom distribution, and longer-term needs through a participatory assessment of sexual and gender-based violence (SGBV) and facilitation of collective action by international and national reproductive health stakeholders.		
Data collection methods	The reproductive health assessment. The participatory assessment for SGBV utilized quasi-focus group settings. Fifteen trainers were trained to deliver participatory workshops to 456 self-selected women (between the estimated ages of 14-70) in 9 towns/villages and in 6 out of 13 districts in East Timor.		
Study or program findings	The reproductive health assessment found inadequate numbers of physicians, destroyed and looted clinics, a history of coercive family planning, anecdotal evidence of sexual and gender-based violence and heightened risk of HIV transmission from expatriate humanitarian and military groups. The participatory SGBV assessment discovered common themes from the group discussions. 1. Category One: Problems related to women's rights, gender issues and violence against women in East Timor. The issues the women discussed fell into 5 themes. These included <i>physical abuse, cultural factors, psychological abuse, economic factors</i> and <i>special issues related to young women</i> . 2. Category Two: Solutions related to the community-identified problems related to women's rights, gender issues and violence against women in East Timor. The issues the women discussed fell into 2 themes: <i>individual solutions (e.g. communication skills in partnership)</i> and <i>community and organizational solutions (e.g. small business start-up)</i> . 3. Category Three: The immediacy related to this critical, transitional time in the history of East Timor. East Timorese women believe that now is a crucial time to advocate for change. Women felt they deserved the opportunity to let their voices be heard during the rebuilding of East Timor. The program found: <ul style="list-style-type: none"> ▪ challenges in transition from the emergency to rehabilitation phase, specifically defining the NGO role vis-à-vis the emerging health authority within a UN transitional authority; ▪ a need for strong RH leadership with adequate human and technical resources in a post-conflict situation; ▪ the political nature of HIV interventions, specifically condom distribution; ▪ the inherent need for family planning despite a history of coercive national program focused on population control. 		
Conclusions and program implications	<ul style="list-style-type: none"> ▪ Local participation is crucial from the beginning. ▪ Advocacy is an important component to communicate women's voices and needs which are often neglected in post-conflict situations. ▪ An expert lead agency or group needs to present reproductive health as a relevant component of the humanitarian response during and after emergencies. ▪ Condom distribution can be politically sensitive. ▪ NGOs can play a key role in post-conflict reconstruction by working at the community level, but also in the building of national level systems and structures. 		
For further information	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> Melissa Sharer 215 North Park Avenue Geneseo, IL 61254 USA 309-441-5430 melissa_sharer@hotmail.com </td> <td style="width: 50%; vertical-align: top;"> IRC-East Timor 90 Mitchell Street Darwin, Australia NT 0800 irceasttimor@octa4.net.au </td> </tr> </table>	Melissa Sharer 215 North Park Avenue Geneseo, IL 61254 USA 309-441-5430 melissa_sharer@hotmail.com	IRC-East Timor 90 Mitchell Street Darwin, Australia NT 0800 irceasttimor@octa4.net.au
Melissa Sharer 215 North Park Avenue Geneseo, IL 61254 USA 309-441-5430 melissa_sharer@hotmail.com	IRC-East Timor 90 Mitchell Street Darwin, Australia NT 0800 irceasttimor@octa4.net.au		

HIV/STDs – What Do We Know and What Can We Do?

Moderator: Brad Woodruff, Centers for Disease Control and Prevention

Presentations:

Meriwether Beatty *Reproductive health KAP survey amongst refugees in Guinea: Findings concerning STIs & AIDS*

Luke Mullany *HIV/AIDS awareness among Burmese migrant factory workers along the Thai/Burma border, Tak Province, July 2000*

Nipaporn Intong *Increased condom practice in the refugee population, Nu Po camp in Thailand*

Reproductive health KAP survey amongst refugees in Guinea: Findings concerning STIs and AIDS	
Abstract revision date: December 5-6, 2000	
Authors	Anna v. Roenne, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) Sarah Kollie, Reproductive Health Group
Presenter	Meriwether Beatty, JSI Research and Training Institute
Background	The Reproductive Health Group (RHG) is a refugee NGO providing RH services for Sierra Leonean and Liberian refugees in Guinea since 1995.
Purpose of study or program	RHG conducted a survey amongst a representative sample of Sierra Leonean and Liberian refugees living in camps in Guinea's Forest Region to explore their knowledge, attitudes and practices in relation to family planning, STIs and AIDS and antenatal and delivery services. This paper presents the findings in relation to STIs and AIDS.
Data collection methods	A cluster sample of refugees of reproductive age (15-49 years) was interviewed in their homes, using a 14-page questionnaire developed on the basis of validated questionnaires. 895 valid observations resulted, and univariate and bivariate statistical analyses were performed.
Study or program findings	<p>Most respondents had heard about these reproductive health problems (STIs: 91%, AIDS: 88%). They knew that faithfulness (93% for STIs, 96% for AIDS) and condom use (92% for STIs, 93% for AIDS), as well as the use of clean needles for injections (94%) are effective ways of preventing transmission. At the same time, various misconceptions were prevalent, including a belief in HIV transmission through mosquito bites (54%) or public toilets (44%), as well as concerns that touching (26%) or sharing food (30%) with people with AIDS might cause infection.</p> <p>Health facilitators, i.e. refugee women trained and supervised by RHG, were named as the most important source of information about STIs/AIDS (56%) and their users were significantly better informed about these health problems than respondents using other sources of information.</p> <p>26.7% of refugees stated that they had suffered genital discharge and/or genital ulcers during the past 12 months. The majority (78%) had sought advice at a health facility, yet even more (82%) had bought medication at private pharmacies, highlighting the chronic lack of STI drugs at health facilities.</p> <p>Gender patterns emerged in relation to reported changes in sexual behaviour during STI episodes or in response to the AIDS threat. Although women are equally well informed about STIs, better informed about AIDS and see themselves at greater risk to 'catch AIDS,' they are less likely than men to report changes in their sexual behaviour. It is hypothesized that women's lack of control over their sexuality prevents them from acting upon their knowledge.</p>
Conclusions and program implications	Program implications include focused IEC messages to combat misconceptions about STIs and AIDS, highlighting the alarming STI prevalence and the chronic lack of the necessary drugs as well as the need to develop gender-specific interventions that allow women to protect themselves from STIs/AIDS.
For further information	Sarah Kollie, RHG, c/o UNHCR, Monrovia, Liberia Anna v. Roenne gtz-guinea@gn.gtz.de

HIV/AIDS awareness among Burmese migrant factory workers along the Thai/Burma border, Tak Province, July 2000 Abstract revision date: December 5-6, 2000	
Authors	Cynthia Maung, Director, Mae Tao Clinic, Mae Sot, Thailand Luke Mullany, Johns Hopkins School of Public Health Aung Tun, Health Program Director, National Health and Education Committee (NHEC) Po Thaw Dah, Burma Medical Association (BMA)
Presenter	Luke Mullany
Background	Over 1 million Burmese migrant workers currently live along the Thai/Burma border having fled oppression in Burma. Thousands find work in factories, shops, farms, construction projects and restaurants, where they are vulnerable to exploitation through low wages and harsh working conditions. Their legal, social and economic situation prevents access to basic social services, including health care and education, and has led to high-risk sexual and social behavior.
Purpose of study or program	Little information has been systematically gathered on either the prevalence of HIV virus infection or the level of knowledge within this sub-population concerning risk factors, prevention and/or transmission of HIV. The Burma Medical Association (BMA) and National Health and Education Council (NHEC) designed an HIV/AIDS education pilot project outside the Mae Sot municipal area (Tak Province, Thailand) in collaboration with Thai Public Health officials.
Data collection methods	A survey was carried out in 8 factories to provide an outline of general and specific HIV/AIDS knowledge levels among migrant workers and to assist in the design and implementation of the peer-education training curriculum. Workers were questioned about their knowledge of prevention, transmission and risk factors of HIV infection. The sampling of interviewees may not have been completely random as factory owners excluded the HIV/AIDS working group from the selection process.
Study or program findings	Responses were grouped into prevention, transmission and risk categories, and the percentage answered correctly in each category was recorded for all participants. Men consistently scored higher than women in each category, with significant gender differences in the prevention and transmission questions. Only 26.5% of respondents knew that they needed to have their blood tested to learn their HIV status. 15% of females reported ever seeing a condom and only 41% of the women understood that contraceptive pills do not prevent infection. Men were eight times more likely than women to report using a condom at least once (12.7% vs 1.7%, $p < .00001$).
Conclusions and program implications	Caution must be used when interpreting these results because of the sensitivity of the questions and the relative unfamiliarity of the interviewees in being questioned by their peers. However, the results remain important as virtually zero access has been extended to persons trying to document health status or education in migrant worker factories. The survey reveals a significant lack of knowledge about HIV and suggests the need for an extensive broad-based educational curriculum, with messages specifically tailored to the sexes. Varying levels of knowledge indicate areas that need to be stressed during the training of peer-educators.
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Increased condom practice in the refugee population, Nu Po camp in Thailand	
Abstract revision date: December 5-6, 2000	
Author	Nipaporn Intong, American Refugee Committee, Thailand
Presenter	Nipaporn Intong
Background	Nu Po camp is a Karen refugee camp on the Thai-Burma border with about 8,200 refugees. The refugees are those who fled to Thailand from the Burmese army offense in their villages in 1997. The reproductive age group (15-45 years) comprises 46% of the population. Condom practice among this group is a priority given the HIV/AIDS situation in Thailand, Burma and the refugee camps. The attitudes of the refugees toward condom use, the denial of HIV/AIDS infection in the camp and the opposition of the camp committee on condom education were program challenges. To overcome these challenges, a variety of theoretical perspectives in health education were drawn upon to guide the program's condom promotion activities.
Purpose of study or program	The purposes of this program were to increase condom practice and to change attitudes among refugees in the camp in preventing HIV/AIDS transmission.
Data collection methods	Information was gathered to plan and conduct condom promotion activities. Personal interviews, survey, focus group, program document review and community observations were conducted during the pre-assessment. A surveillance system was developed to record/collect condom distribution by area, gender and marital status. New and old users were also recorded. Data were used to monitor and evaluate program implementation.
Study or program findings	The results of the pre-assessment showed that refugees would accept condoms as a choice of contraceptive method. Condoms were more acceptable when distributed to married couples and for family planning purposes. Talking about condoms to prevent HIV/AIDS infection caused a negative reaction and was embarrassing because of the conservative culture. Many women believed strongly that their husbands were faithful and honest; they did not realize that some of the men were practicing high-risk behaviors such as drug and alcohol abuse and experimental sex. Some refugees did not understand that condoms could protect them from HIV/AIDS/STDs, besides preventing unwanted births. Some understood the health benefits, but denied using condoms because of the associated stigma. The survey found only 33 out of 1,214 couples (7.7%) who used condoms. The refugees felt comfortable talking about and asking for condoms from the community health educator (CHE) in their sections. The use of condoms increased from 0 to 39 people in the year 1999, according to family planning service records. In addition, refugees who stopped using pills and DepoProvera started using condoms.
Conclusions and program implications	Seven activities were undertaken: (1) staff training, (2) community condom distribution, (3) group discussion about condom practice, (4) community health education and promotion, (5) community health meetings to raise awareness of condom practice, (6) family planning counseling and (7) epidemiological surveillance. Post-implementation results showed some changes. Approximately 398 refugees (10.6%) were using condoms and more than 7,000 condoms had been distributed from February 1999 to August 2000. The percentage of persons using condoms increased by about 10% from the beginning of the implementation. Refugees now are more familiar with condoms and openly talk about them. Any refugee who needs condoms can easily get them from community health education workers providing culturally sensitive services in every section of the camp.
For further information	Ms. Nipaporn Intong, American Refugee Committee, P.O. Box 7, Umphang Tak 63170 Thailand Telephone and Fax 6655 561-177 Email arcumpha@loxinfo.co.th

Expanding Our Base – New Audiences, New Services, New Channels

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

Presentations:

- Nadia Ali El Toum *A qualitative assessment of reproductive health among the displaced communities of Khartoum, Sudan*
- Fariyal Fikree *Enhancing the use of emergency contraception: A baseline survey in Kakuma refugee camp, Kenya*
- Suzanne Fustukian *Spreading the word: Health on air in the Somali-speaking Horn of Africa*

A qualitative assessment of reproductive health among the displaced communities of Khartoum, Sudan	
Abstract revision date: December 5-6, 2000	
Authors	Laurel K. Fain, Nadia Ali El Toum, International Rescue Committee, Khartoum, Sudan
Presenter	Nadia Ali El Toum
Background	An estimated 2.2 million displaced people reside in camps, squatter and settlement areas around Khartoum, Sudan. Little attention has been given to reproductive health issues, despite an apparent need for services. Maternal mortality for the entire country is estimated to be 365/100,000 live births, but for displaced populations is 865/100,000 live births; infant mortality is 78/1,000; and the fertility rate is 5.4 children per woman. 82% of women in Sudan are estimated to have undergone female genital cutting.
Purpose of study or program	The purpose of this qualitative study conducted in El Salam displaced camp was to gain information about the reproductive health status of the Khartoum displaced population in order to design reproductive health outreach programs applicable to the needs of these communities.
Data collection methods	This assessment included a series of focus groups with men and women living in El Salam displaced camp to assess their knowledge, attitudes and practices about reproductive health issues. Nineteen focus groups were designed to allow for representation from all areas and tribes within El Salam camp. Participants were selected randomly, and men and women were assigned to separate groups of six to ten people each.
Study or program findings	<p>Focus group participants expressed knowledge of certain health issues, reflecting successes of current health education projects in the camp. Financial and transportation issues were identified as barriers to accessing quality care.</p> <p>Most women in the camp give birth at home, with or without the help of traditional birth attendants. Little knowledge or use of modern contraceptive methods was indicated. Participants demonstrated some knowledge of HIV and AIDS, and reported that people in El Salam camp are afraid of getting AIDS. Little awareness of modes of transmission and treatment for sexually transmitted diseases was expressed by focus group participants. High-risk sex activities were described as common in El Salam camp. The majority of participants had never heard of condoms.</p> <p>Domestic violence is reported to be the norm among families in El Salam camp. According to focus group participants, the suna form of circumcision, or removal of the clitoris, is the form of circumcision most commonly practiced by camp residents.</p>
Conclusions and program implications	These findings provide an example of the health situation that can develop when issues of reproductive health are not immediately addressed within an emergency situation. The authors hope this information will be useful to the design and implementation of reproductive health services programs among displaced populations, for which a need is clearly present.
For further information	Nadia Ali El Toum, Health Education Coordinator, International Rescue Committee Sudan, PO Box 8269, Khartoum, Sudan Email Nadiaali60@hotmail.com

Enhancing the use of emergency contraception: A baseline survey in Kakuma refugee camp, Kenya	
Abstract revision date: December 5-6, 2000	
Authors	Esther Muia, Reproductive Health Program Associate, Population Council, Nairobi, Kenya Fariyal F. Fikree, Program Associate, Population Council, New York Joyce Olenja, Consultant, Population Council
Presenter	Fariyal Fikree
Background	Kakuma Refugee Camp, located in Turkana District of northern Kenya, has a population of 79,316 refugees of whom 40% are women.
Purpose of study or program	To contribute to the improved quality of reproductive health services for refugees through an operations research project regarding emergency contraception in the context of expanding family planning access.
Data collection methods	A baseline survey applying qualitative and quantitative techniques was conducted to assess knowledge, attitude and practice regarding emergency contraception in late 1999. A total of 927 women of reproductive age residing in the refugee camps and 16 health care providers were interviewed. This was complemented by focus group discussions among opinion leaders, adolescents (male and female) and representatives from the women's support groups.
Study or program findings	<p>Sixteen health care providers, the majority of whom were Kenyans (56.3%) or Sudanese (31.3%), were interviewed. Though 12 were female, only one doctor, a Kenyan male with 10 years experience, serviced the refugee population.</p> <p>Family planning services currently offered included contraceptive pills and condoms. Information and/or supplies were provided, on average, to 2 clients per month for emergency contraceptives and only at the camp hospital. There was no consistency regarding the emergency contraceptive regimen offered. Furthermore, there were no educational materials on emergency contraceptives or standard service delivery guidelines available in the camp hospital.</p> <p>Most of the women respondents interviewed were either refugees from Sudan (50.5%) or Somalia (32.0%). Nearly 56% were unaware that anything could be done to prevent a potential pregnancy following unprotected sex. The most frequently reported option (25.7%) was to go to the hospital. Nearly 15% of women claimed to have ever heard of emergency contraception, nearly half of whom had heard about emergency contraceptives recently.</p> <p>The majority of the focus group participants had not heard about emergency contraceptives despite their availability at the camp hospital. However, the community elders strongly advocated dissemination of emergency contraceptives through their active participation and support. The avenues for dissemination of information recommended included health facilities, youth and women support groups, drama and puppetry sessions, among others.</p>
Conclusions and program implications	Findings from this study reflect the lack of knowledge regarding emergency contraception both among health care providers and the refugee population and its restricted availability at the camp hospital. Our results therefore suggest training regarding protocol regimens, counseling, provision of IEC materials at health facilities and dissemination of information via youth and women support groups be considered.
For further information	Dr Esther Muia, Reproductive Health Program Associate, Population Council, Multichoice Towers, Upper Hill, PO Box 17643, Nairobi, Kenya Email emuia@popcouncil.or.ke

Spreading the word: Health on air in the Somali-speaking Horn of Africa	
Abstract revision date: January 15, 2001	
Authors	Suzanne Fustukian, Research Fellow, Health Policy Unit, Department of Public Health and Policy, London School of Hygiene and Tropical Medicine
Presenter	Suzanne Fustukian
Background	<p>Health Unlimited, a British-based non governmental organisation initiated the 'Well Women Media Project' (WWMP) in the Somali-speaking Horn of Africa in November 1997. The project represents an ambitious programme aimed at increasing awareness, discussion and acceptance of safe and informed sexual and reproductive health outcomes in a context of instability and poorly developed regional infrastructure and communication systems.</p> <p>Gender roles, as elsewhere, are highly differentiated in Somali society. Following the conflict in the late 1980s and 1990s in Somaliland, a change in gender roles has been noted, with women "increasingly emerging as the major breadwinners and as heads of households."¹ However, "traditionally the man has overall responsibility for the family and its finances; it is the woman's job to look after the children and the livestock and do the housework."² It is in the context of such gender relations, in which male family members remain dominant, that the project context must be understood.</p> <p>¹ Abdillahi, Mohamed Sheik. (1997). <i>Somaliland NGOs: challenges and opportunities</i>. London, CIIR. ² Evaluation fieldwork focus group discussion (1999)</p>
Purpose of study or program	Radio is used as a means of communicating health information aimed at promoting positive change in health and social behaviour.
Data collection methods	An evaluation was undertaken by the presenter. Qualitative research methodology was used to gather information regarding the relevance and cultural appropriateness of the radio programme to the audience and their families. This included discussion with well-informed stakeholders, established and informed audience groups, focus groups and natural groups in several urban and rural sites.
Study or program findings	<p>Two inter-related issues will be the focus of the presentation:</p> <ul style="list-style-type: none"> • the socio-cultural issues raised by research on female genital mutilation (FGM) in the context of Somaliland; • the significant contribution of radio in highly decentralised 'post'-conflict countries. <p>The project objectives targeted women's reproductive health, with a particular focus on FGM. The strategy used, however, was to broadcast a radio programme to a wide, undifferentiated radio audience. It is important, therefore, to consider the gendered response to the issues raised in the programme, for example, to what extent women and men had different responses to the information. Although gender analysis was not directly attempted by the evaluation team, some observations emerged from the discussions with the stakeholders and discussion groups. These will be presented under the following headings: marital relations, virginity and marriage, and women's status.</p>
For further information	<p>Suzanne Fustukian, Research Fellow, Health Policy Unit, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, UK</p> <p>Telephone 00 44 020 7927 2275 Fax 00 44 020 7637 5391 Email suzanne.fustukian@lshtm.ac.uk</p>

Adolescents – Who Are They and How Do We Serve Them?

Moderator: Pamela Delargy, UNFPA

Presentations:

Allison A. Pillsbury *Addressing war-affected adolescents' reproductive health needs*

Margaret Mukabana *Reproductive health KAP survey of refugee adolescents in the Kigoma region of Tanzania*

Matthew Tiedemann *The “Health of adolescent refugees project” (HARP): A peer education project in Egypt, Uganda and Zambia*

Addressing war-affected adolescents' reproductive health needs	
Abstract revision date: December 5-6, 2000	
Authors	Jane D. Lowicki, Allison Anderson Pillsbury, Women's Commission for Refugee Women and Children
Presenter	Allison Anderson Pillsbury
Background	Adolescents have distinct experiences in armed conflict, distinct needs and distinct capacities for recovering. However, information about war-affected adolescents' needs and programming to meet those needs, including in the realm of reproductive health, has been insufficient.
Purpose of study or program	To raise awareness among decision-makers and practitioners about the reproductive health rights and needs of war-affected adolescents; spur and strengthen further action-oriented research and field programming; and generate funding to create new programs for adolescents.
Data collection methods	The Women's Commission conducted an adolescent-specific policy and program review across five sectors: health and reproductive health, education, livelihood, psychosocial and protection. Staff interviewed and collected documentation from dozens of representatives from donor governments, intergovernmental organizations, nongovernmental organizations and academic institutions about their past, current and future work with adolescents affected by armed conflict. In doing so, the Women's Commission identified gaps and barriers to meeting the needs of war-affected adolescents, along with achievements.
Study or program findings	As they enter their reproductive years, adolescents affected by armed conflict are generally not targeted in the provision of reproductive health information and services despite facing many distinct risks. Adolescent girls are primary targets for sexual violence perpetrated as a weapon of war, including rape, sexual assault and sexual slavery. Some of the health consequences of sexual violence and exploitation are STDs, including HIV/AIDS; unwanted pregnancy, often leading to potentially dangerous childbirth or unsafe abortion; and physical and mental trauma, leading to excess morbidity and mortality. Adolescents, particularly girls, are also less likely to have access to formal school settings, where reproductive health information may be available and where their health condition may be more easily monitored. Often with few alternatives, girls are particularly at risk of sexual exploitation and prostitution. Furthermore, boys and men are rarely targeted in efforts to promote and ensure the prevention of sexual violence and exploitation, or in efforts to promote their reproductive health and that of women and girls.
Conclusions and program implications	While the specific reproductive health needs of adolescents are gaining increased attention, on the whole few reproductive health programs are designed to meet the needs of adolescents, and more are urgently needed. Adolescent programming must be approached holistically, including cross-sectorally. Better age- and gender-specific data collection is needed to help programmers better identify and address adolescent reproductive health care needs. Furthermore, involving adolescents themselves in identifying their needs and participating in creating solutions to their problems greatly contributes to appropriate programming on their behalf. Finally, programming must be culturally appropriate and should ensure the training and sensitization of those working with adolescents.
For further information	Allison Anderson Pillsbury, Project Manager, Children and Adolescents Project, Women's Commission for Refugee Women and Children, 122 East 42nd Street, 12th floor, New York, NY 10168-1289, USA Telephone 212-551-3107 Fax 212-551-3180 Email allison@theIRC.org

Reproductive health KAP survey of refugee adolescents in the Kigoma region of Tanzania	
Abstract revision date: December 5-6, 2000	
Authors	Margaret T. Mukabana, Consultant, International Federation of Red Cross and Red Crescent Societies Michelle M. Thompson, Consultant, Women's Commission for Refugee Women and Children
Presenter	Margaret T. Mukabana
Background	For the past 30 years, Tanzania has hosted refugees escaping ethnic and political violence from throughout the Great Lakes Region. UNHCR reported that at the end of 1999 there were approximately 410,000 refugees in 11 Tanzanian refugee camps, including an estimated 290,000 from Burundi and 100,000 from Congo-Kinshasa.
Purpose of study or program	The objectives of the KAP survey were to assess the level of knowledge and attitudes of refugee adolescents about sexual and reproductive health (SRH) issues and the magnitude of SRH problems, in order to help design appropriate adolescent-specific interventions.
Data collection methods	During February and March 2000, a cross-sectional KAP survey was conducted amongst 1,572 adolescents, aged 10 to 19 years, from 3 selected refugee camps (Lugufu, Mtendeli and Karago) in the Kigoma region of Western Tanzania. 100 interviewers were recruited from the cadre of community health workers and health information team members. In each camp, 25% of the villages were randomly selected, 7% of the households were chosen, then one boy and one girl were interviewed per household. The questionnaire had been translated into Kiswahili and Kirundi, and interviews were conducted in these languages.
Study or program findings	<p>The mean age of survey respondents was 15.6 years and 58.9% were male. 43.4% of the adolescents were Congolese and lived in Lugufu camp; refugees from Burundi lived in Mtendeli (33.3%) and Karago (23.3%). For all ages, more boys than girls currently attend school. 18.1% of the females said they are married versus none of the males. 16.7% of the adolescents reported that they are sexually active; amongst non-married adolescents, more males (18.5%) than females (13.8%) are sexually active.</p> <p>12% of adolescents said they have heard of family planning (FP) - females were more aware (17.4%) than males (8.1%), and a greater proportion of sexually active respondents have heard of FP (35.0%) than those not sexually active (5.9%). Of the 41 adolescents who were pregnant at the time of the interview, 21.9% said they wanted to get pregnant, 36.6% would have preferred to get pregnant later and 41.5% did not want to get pregnant at all. 76.7% of the survey respondents have heard of AIDS (males 72.2%, females 83.2%) and 21.5% have known someone who has died from the disease. Amongst those who were aware of AIDS, only 26.3% had discussed the disease with anyone. 66.7% of males believed that condoms can prevent AIDS versus 71.8% of females. 57.3% of sexually active adolescents said they could get a condom if they needed one as compared to 29.8% of those not sexually active.</p>
Conclusions and program implications	Knowledge about family planning was quite low. Education efforts should be targeted equally to male and female adolescents, and to both sexually active and non sexually-active adolescents. Awareness of AIDS was fairly high, yet there is a need to discuss the disease openly in order to dispel myths and to provide counseling for adolescents who have lost family members or friends. Additionally, it is important that the adolescents know where they can access condoms and other contraceptives. The development and implementation of adolescent reproductive health programs in the refugee camps of Tanzania will be a challenge. However the process will be greatly enhanced if a multi-sectoral approach is utilized, including the direct participation of the adolescents themselves.
For further information	Michelle M. Thompson, WCRWC Consultant, Department of Epidemiology, University of Washington, School of Public Health and Community Medicine, Box 357236, Seattle, WA 98195 USA Fax 206-543-8525 Email mmt@u.washington.edu

The “Health of adolescent refugees project” (HARP): A peer education project in Egypt, Uganda and Zambia Abstract revision date: December 5-6, 2000	
Authors	Cynthia Waszak, Matthew Tiedemann, Family Health International
Presenter	Matthew Tiedemann
Background	<p>Family Health International (FHI) collaborated with the World Association of Girl Guides and Girl Scouts (WAGGS) to conduct the Health of Adolescent Refugees Project (HARP), a UNFPA-supported reproductive health education and clinical services project for adolescent girls living as refugees in Egypt, Uganda and Zambia. HARP was implemented through the Girl Guide Associations in the 3 countries, with the collaboration of local partners, including UNHCR, the Ministries of Health and other NGOs from 1997 to 2000.</p> <p>Up to 300 refugee girl guides in each country completed a curriculum developed by FHI and WAGGS to earn a reproductive health merit badge and certificates for peer education activities. The curriculum covered physical and psychological well-being and emphasized utilization of clinical services to protect one's health.</p> <p>FHI trained clinical service providers in the refugee communities to provide adolescent-sensitive information to the participating guide units. HARP activities facilitated linkages between the girl guides and local health clinics.</p>
Purpose of study or program	HARP was a pilot project designed to improve the health of female adolescent refugees through peer education emphasizing reproductive health, and through linking the adolescents to local health providers.
Data collection methods	Process data were collected throughout the project. FHI conducted a baseline qualitative assessment prior to the intervention and an end-of-project assessment. Interviews were conducted with leaders and Girl Guides from most project Guide units.
Study or program findings	<ul style="list-style-type: none"> • Increased comprehension and awareness of health issues among the adolescents, though the level of knowledge varied among groups and across topics. • While the concept of self-esteem was difficult to convey, many participants were proud of their new knowledge and were eager to convey it to their peers. • Involving community leaders and parents is critical; the project generated demand for including additional girls and programming for boys. • There was evidence of increased utilization of health services by adolescents in the target communities. <p>Additional outcomes not directly related to the original objectives include:</p> <ul style="list-style-type: none"> • HARP created a safe space and provided productive activities for refugee adolescents. • HARP increased guide leaders' RH knowledge and community status. • The project raised community awareness of RH topics and services.
Conclusions and program implications	HARP demonstrated that the model was feasible and sustainable, as the 3 national Girl Guide Associations have continued the project beyond the pilot phase. The project has been adapted for non-refugee boys and girls in India. Further adaptations for other countries are under consideration.
For further information	Matthew Tiedemann, Senior Program Officer, Field Operations, Family Health International, PO Box 13950, Research Triangle Park, NC 27709 USA Telephone 919-544-7040 x 210 Fax 919-544-7261 Email Mtiedemann@fhi.org

Using Data to Improve Reproductive Health Programs

Moderator: Suzanne Fustukian, London School of Hygiene and Tropical Medicine

Presentations:

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|--------------------|--|
| Amarasiri de Silva | <i>Are IDPs at increased risk of reproductive ill health? Measuring RH risk in a displaced setting using a reproductive health risk index (RHRI)</i> |
| Henia Dakkak | <i>Improving reproductive health services among Roma women refugees in Macedonia through program monitoring</i> |
| Beth Vann | <i>How-To Guide: Monitoring and evaluation of sexual and gender-based violence programs</i> |

Are IDPs at increased risk of reproductive ill health? Measuring RH risk in a displaced setting using a reproductive health risk index (RHRI)	
Abstract revision date: January 15, 2001	
Author	Amarasiri de Silva, Department of Sociology, University of Peradeniya, Sri Lanka
Presenter	Amarasiri de Silva
Background	Data on reproductive health (RH) among IDPs has been problematic particularly in the developing world. Implementers of RH programmes in such situations face difficulties in identifying at-risk persons and groups to whom to direct interventions.
Purpose of study or program	This paper aims at developing a behavioural Reproductive Health Risk Index (RHRI), which helps to identify women and groups who are potentially at risk for RH problems, and to delineate factors that influence reproductive ill health in community settings of the IDPs.
Data collection methods	Data for the study were obtained from a larger study of the RH situation among the IDPs in Sri Lanka. The data were collected in 2 phases; first in a formative phase where variables related to RH behaviours were identified using narratives, random walk observations, case histories, listing, pile sorting and ranking. The data were analysed to see patterns and relationships of variables. Later, a survey instrument was developed on the basis of qualitative data for the second phase of the research. The findings reported in this study are drawn from the sample survey of 834 families in 6 districts of Sri Lanka where the IDPs are located.
Study or program findings	<p>The survey identified 122 items in 4 behavioural domains that are important in order to measure the RH risk in IDP populations of Sri Lanka. Reliability analysis of items in the four domains indicated that each variable domain has an alpha of .82, .85, .69 and .73 respectively. The RHRI scale was used to create a categorical variable comprising three levels of LOW RISK, AVERAGE RISK and HIGH RISK. The LOW RISK group, which comprises the scale below one standard deviation (SD) of the mean, is 35.1% of the sample. The AVERAGE RISK group, which comprises +/- 1 SD of the mean is 30.7%, while the HIGH RISK group comprising those who were above +1 SD of the mean is 23.3%.</p> <p>In order to check the reliability of the scale, some correlations were performed between RHRI scale and RHRI outcomes. It shows that 66.2% of reported abortions and 83% of infant deaths occurred in the High and Average Risk groups in the RHRI scale. When analyzed against variables that have a potential impact on RH of the IDPs, it showed that living-together arrangements (not legally married), poor SES, not having formal education or fewer years of schooling, young age at marriage (especially below 16 yrs), having an older husband (especially older by 5 years) and proposed/arranged marriages are some of the factors that have increased the potential RH risk among IDP women in Sri Lanka.</p>
Conclusions and program implications	The RHRI scale can be used to identify potential risk groups for RH in IDP settings. The scale has the potential for developing a simple mechanism for rapid assessment of RH status of women in IDP settings, which can help RH service programme organisation and delivery of reproductive health services in a much more focused and efficient manner.
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Improving reproductive health services among Roma women refugees in Macedonia through program monitoring Abstract revision date: December 5-6, 2000	
Authors	Henia Dakkak, Visiting Scholar, Columbia University, New York City Nermine Zitkovic, Ahmed Dakkak, International Medical Corps, Macedonia
Presenter	Henia Dakkak
Background	The influx of Roma refugees into Macedonia coincided with movement of Kosovar refugees in 1999. At the end of NATO operations, Albanian refugees returned to Kosovo, leaving a number of Roma refugees in camps. Feeling threatened in Kosovo, more Roma refugees fled into Macedonia. International Medical Corps (IMC) was a designated health provider for refugees in Macedonia.
Purpose of study or program	Analysis of morbidity statistics in camps showed an increase in gynecological diseases among Roma refugee women. Health providers also documented an increase in referrals for hospital deliveries. This indicated a need to integrate RH services into the PHC delivery system in camps. Integration made it possible for health care providers to better understand the refugee population and to collect data necessary for a baseline survey while providing quality health care services.
Data collection methods	Initially, health providers in camps spent a majority of their time developing relationships and gaining the trust of female refugees. IMC developed a questionnaire designed to collect detailed obstetric and gynecological histories. All female refugees were encouraged to come for an exam and to complete the questionnaire as part of their medical record. There was 100% compliance due to good relationships developed between refugees and providers. Data collected included history on: general health, obstetrics, gynecological problems, family planning and breastfeeding.
Study or program findings	<ul style="list-style-type: none"> • The Roma population consisted of 550 women of reproductive age, which represented 24% of the total refugee population. • 40% of the women had delivered at home in Kosovo with lay attendants, despite the official Yugoslav statistics showing 100% facility delivery. Roma in the Macedonia camps were more likely to deliver in facilities. • Refugee women reported complex histories of induced abortion. • There was high interest in family planning methods among women 25-49. • Women aged 25-49 had high incidence of gynecological problems. • Women were married and became sexually active early in life. • "Law in Yugoslavia does not permit marriage at a young age – that means all young people who get married do not register with the government." • Early marriages led to: early start of sexual activity, high rate of home deliveries in Yugoslavia since unregistered couples could not seek medical assistance in government hospitals, a tendency to change sexual partners as they get older.
Conclusions and program implications	<p>The RH program developed included safe motherhood classes, family planning counseling and care, treatment of STDs, condom distribution and an education campaign.</p> <p>The study helped in registering pregnant women among Roma refugees. Monitoring indicators established early in the program showed increased utilization of family planning methods and a decrease in morbidity/mortality statistics compared to baseline information.</p> <p>In stable refugee settings, medical records may be used to document previous health history, which is useful as a research tool for measuring the impact of health services.</p>
For further information	Henia Dakkak, Women's Commission for Refugee Women and Children, 122 East 42nd Street, 12th floor, New York, NY 10168-1289 USA Fax 212-551-3180 Email hdakkak@theIRC.org

How-To Guide: Monitoring and evaluation of sexual and gender-based violence programs	
Abstract revision date: January 15, 2001	
Author	Beth Vann, UNHCR consultant
Presenter	Beth Vann
Background	In 1998, UNHCR was awarded a \$1.65 million grant from the United Nations Foundation – funds provided by Ted Turner – to strengthen sexual and gender violence (SGV) programming in refugee situations. In Tanzania, a multi-sectoral prevention and response programme is being implemented in 11 refugee communities with 480,000 refugees from Burundi and the Democratic Republic of Congo. The programme involves 8 NGOs, UNHCR staff in all sectors, Tanzanian authorities and the 11 refugee communities.
Purpose of study or program	UNHCR deployed a consultant (the author) in early 2000 to assess program monitoring and facilitate development of systems for multi-sectoral monitoring and evaluation of the program.
Data collection methods	The first step was to gather information on the specific SGV issues in this setting, program objectives and activities, data collection and analysis systems, reporting/referral systems, and mechanisms for program development, monitoring, and evaluation. Methods used to gather this information included camp visits, stakeholder interviews, group discussions and record reviews. UNHCR, NGOs, refugees and host government authorities were involved in these discussions and reviews.
Study or program findings	<p>There is a broad array of activities underway for prevention and response to SGV in all 11 camps. In general, activities have been response-driven with less attention to the analysis of data to guide prevention and target program strategies. There was no consistent system for compiling data to analyze problems and plan program activities. Each NGO and UNHCR field office classified and counted incidents of SGV differently. Intended outcomes of program activities in each sector and program-wide were not clearly defined or measured.</p> <p>In general, it was impossible to review reports and gather a clear picture of SGV in the camps in Tanzania – prevalence rate, types, contributing or causative/risk factors, survivor and perpetrator details, and outcomes.</p> <p>Participatory meetings and workshops were conducted with actors in all sectors to facilitate resolution of these problems. With the emphasis on participatory design and active engagement of all actors, program monitoring and evaluation mechanisms were developed. Implementation of the new systems began in April 2000.</p>
Conclusions and program implications	<p>The Tanzania experience is not a unique one. Similar observations concerning the challenges of data collection and analysis and program monitoring and evaluation have been made in SGV programs in other countries.</p> <p>This <i>How To Guide</i> was developed to offer the Tanzania experience as an example for other programs worldwide. Hopefully, this will trigger dialogue and further steps in developing standard definitions and prevalence calculations, designing program strategies and evaluating outcomes and impact of multi-sectoral SGV programs in refugee settings.</p>
For further information	<p>Beth Vann Bethv007@aol.com</p> <p>Kate Burns, UNHCR, CP 2500, 1211 Geneva, Switzerland</p> <p>Telephone 41 22 739 8003</p> <p>Fax 41 22 739 7371</p> <p>Email burns@unhcr.ch</p>

Closing Plenary Session

Moderator: Kathleen Newland, Women's Commission for Refugee Women and Children

Presentations:

Susan Purdin *Where do we go from here?*
 Nadia Ali El Toum *Personal perspective on taking the conference into the future*
 Julia Taft *Remarks*

Where do we go from here?	
Presenter	Susan Purdin
<p>When we began yesterday morning we talked about how all this started just a few short years ago with the realization that millions of refugees, who have the same wants and needs as any of us, were not allowed access to even basic reproductive health services. What has happened since has been nothing short of revolutionary – no one dares to argue that refugees don't need reproductive health services. In fact, we now see that the majority of health programs have at least some reproductive health services. But what is there is still not enough and it's not always good enough.</p> <p>We've learned many lessons since the 1993 study and we've learned even more in this conference. The presentations covered many aspects of many topics and we have an obligation to put effective ideas into practice.</p> <p>Some of the key points that I've identified from listening to people at this conference are:</p> <ul style="list-style-type: none"> ● If we will just ask people, and listen to them, and work with them (rather than pretending we know what they need), programs will yield better results. ● Appropriate interventions can improve reproductive health status. We need to start with good quality services, then promote utilization. ● We need to continue to collect reliable data – using standard definitions and sound methodology. We need to share our findings about what works and what doesn't work. We need to base programming decisions on evidence of success. ● Collaborative efforts yield far-reaching results. ● Multi-year funding is essential to sustain beneficial outcomes. 	

Personal perspective on taking the conference into the future	
Presenter	Nadia Ali El Toum
<p>Yesterday when I entered this hall I found more than 300 people, from different countries, of different colours, different ages, males and females, all with one goal which is reproductive health. I said to myself "don't worry about refugees and IDPs, women and children in our countries; there is the RHR Consortium take care of them." On behalf of all participants, I would like to thank the RHR Consortium and Women Commission for giving us this great chance to participate in this conference where a large number of research results have been presented and discussed. I would like also to draw more attention to helping refugees and IDPs, women and children: they are suffering, they are crying, seeking help and assistance. Please please help them, and do reproductive health!</p>	

Remarks	
Presenter	Julia Taft
<p>It's a wonderful and very special privilege to be honored by the RHR Consortium. We've come a long way since the founding of the RHRC in 1995. Activities supporting refugee women and children have become more the norm of our collective efforts to protect the rights and lives of those most vulnerable. Thanks to much of your work--you representing the organizations who are the backbone of our assistance efforts--the reproductive health needs of refugees and displaced persons are no longer considered secondary to their other needs for shelter, water and sanitation. But we all know that we still have a long way to go. We know far too many displaced women are still too often at risk of sexual violence and that the HIV/AIDS pandemic's continued devastating spread places displaced persons at great risk. And we know that many of those traditional "relief cowboys" still don't like to talk about delivery logistics for establishing safe settings for women who have been raped. So we know what challenges remain. The good thing is, we know how to meet them. We know that we need more hard research and more data to help us better design our programs. We know that we need greater attention to preventing the spread of AIDS among displaced persons. We need to provide displaced adolescents with adequate reproductive health information and services so that this far too valuable generation can have some manner of control over their lives. These are the reasons PRM are particularly proud to support the work of UNHCR, UNFPA, individual NGOs and consortia in meeting these critical needs of refugees around the world. I'm thrilled that my work and that of my staff is being honored here. And I'm thrilled to see so many of you continue your unwavering commitment to meeting those needs as well.</p>	

Abstracts of Poster Presentations

Presenter	Title of Presentation
Sara Casey	RHR Consortium survey of refugee and IDP reproductive health services
Elizabeth Coker Jill Brennick	Findings from a pilot study to develop a comprehensive research agenda in the area of fertility and reproductive health among asylum seekers and refugees in Cairo, Egypt
Henia Dakkak	Using quantitative and qualitative research techniques to design a sustainable RH project for the Roma population in Shito-Rizari, Macedonia
Henia Dakkak	Current overview of reproductive health assistance in Albania for coordination and planning services through questionnaire survey
Degni Filio	Childbearing and birth control experiences among Somali refugee women in Finland: A social and cultural challenge
Ani Gurciyan	Providing minimum reproductive health services to refugee populations: Evaluation of the Minimum Initial Service Package (MISP)
Tracey Lee	A comprehensive family planning and sexually transmitted disease service for Karen refugees
Aimee Lehmann	Expanding reproductive health services in refugee settings: Post-abortion care in two Kenyan refugee camps
Jacinta K. Muteshi	Sexual and gender-based violence in the Dadaab refugee camps: The challenges of FGC
Sam Posner	Differences between refugee/internally displaced and local Azerbaijani women: A comparison of demographics, behavioral factors and reproductive history
Kavita Singh	Child mortality estimation techniques in refugee and host populations

RHR Consortium survey of refugee and IDP reproductive health services	
Abstract revision date: January 15, 2001	
Authors	Sara Casey, Rachel K. Jones, Sandra Krause Women's Commission for Refugee Women and Children
Presenter	Sara Casey
Background	The Women's Commission for Refugee Women and Children, on behalf of the Reproductive Health for Refugees Consortium, conducted a survey of U.S.-based international NGOs and schools of public health to determine which ones are directly providing or indirectly supporting reproductive health services to refugees and/or IDPs.
Purpose of study or program	The purpose for gathering this information was to target reproductive health for refugees advocacy initiatives, and to find ways to foster greater cooperation and collaboration in reproductive health service delivery to refugees and IDPs worldwide.
Data collection methods	In August 2000, the survey was sent to 165 NGOs and schools of public health culled from members of InterAction and the Association of Schools of Public Health. 70 NGOs and 11 schools of public health participated in the survey representing a 48% response rate. We included in this list many NGOs and schools whose mandate included health or reproductive health, but whose mission may not have involved work with refugees or IDPs, a likely contributor to the low response rate.
Study or program findings	<p>The percentage of respondents who provide or support specific reproductive health services for refugees follows: family planning (26%), HIV/STD (22%), safe motherhood (19%), emergency obstetrics (12%), SGBV (9%), services to youth (8%), and MISP (4%). The primary roles of respondents in supporting or providing reproductive health services to refugees or IDPs follow: training (31%), technical assistance (22%), direct service provision (19%), advocacy (12%), research (10%), and policy development (6%). The geographical distribution of sites where the respondent organizations provide or support reproductive health services shows a heavy concentration in Africa (52 projects in 18 countries), with a high presence in Eastern Europe and the former Soviet Union (30 projects in 10 countries), followed by Asia (22 projects in 6 countries), Central and Latin America (8 projects in 3 countries), and the Middle East, primarily work with Palestinians (6 projects in 4 countries).</p> <p>42% of those currently supporting reproductive health services to refugees and IDPs do not yet have a copy of the <i>Inter-agency Field Manual for Reproductive Health in Refugee Situations</i>. 54% of respondents expressed interest in participating in further discussions.</p>
Conclusions and program implications	<ul style="list-style-type: none"> • Agencies need to provide a more comprehensive package of RH services to avoid a much greater emphasis on some areas (e.g., family planning) and much less on others (e.g., services to youth). • Need for more information on RHR among headquarters program staff. • Inter-Agency Field Manual should be distributed more widely to headquarters and field offices. • Increased membership in IAWG could help to foster better communication and collaboration regarding RHR issues and services (e.g., Field Manual distribution and its actual use).
For further information	Rachel K. Jones, Women's Commission for Refugee Women and Children, 122 East 42nd Street, New York, NY 10168 USA Telephone 212-551-3112 Fax 212-551-3180 Email rachel@theIRC.org

<p>Findings from a pilot study to develop a comprehensive research agenda in the area of fertility and reproductive health among asylum seekers and refugees in Cairo, Egypt</p> <p>Abstract revision date: January 15, 2001</p>	
Authors	Elizabeth M. Coker, Ph.D., The American University in Cairo Jill Brennick, MPH, Forced Migration and Health Program, Columbia University
Presenters	Elizabeth M. Coker and Jill Brennick
Background	As of May 2000 there were 2,688 registered Sudanese refugees in Cairo. However, many thousands more have either been denied refugee status, or are "sitting out" a waiting period which can be as long as one year. Consequently, thousands of individuals and families struggle to survive on little or no formal assistance, employed in the informal sector. In short, these individuals and families exist "in limbo" socially, economically and culturally.
Purpose of study or program	The purpose of this pilot study was to develop a research agenda to study patterns of familial adaptation, negotiation of gender roles and reproductive health issues among asylum seekers and refugees in Cairo. A central theoretical focus is that childbearing and other fertility-related issues must be understood in light of their cultural meaning for the family and society in question.
Data collection methods	The data for the present project were collected in Cairo, Egypt during June and July 2000. The study yielded qualitative and quantitative data from the following sources: in-depth interviews with Sudanese men and women; interviews with midwives and other professionals providing healthcare to refugees; focus group discussions with pregnant Sudanese asylum seekers; and home visits with families in the Cairo area. Home visits were made to mothers of new babies and Sudanese families.
Study or program findings	<p>A striking finding of the present study was the stated desire to limit family size, an attitude that is unique to the refugee context. Therefore, reproductive decision-making is an important area of familial adjustment for this population. Prior to migration to Cairo, the most commonly practiced forms of birth control were breastfeeding and abstinence. Now, many Sudanese women are considering modern methods of birth control for the first time, as traditional birth-control practices have broken down. Breastfeeding habits are also changing. Employment options are limited, and, as women are able to find work more easily than men are, some women are decreasing the duration of breastfeeding so they can return to work. In order to provide for their families, women are starting to switch over to formula soon after birth so that they can return to work.</p> <p>(The use of the terms "modern" and "traditional" in reference to types of birth control is consistent with the Reproductive Health for Refugees Consortium assessment tool. In this case traditional may include, but is not limited to, breastfeeding, calendar method and coitus interruptus. Modern may include oral contraceptives, injections, IUDs and condoms.)</p>
Conclusions and program implications	The results of this study contribute to the body of literature concerning gender and family roles under conditions of forced migration, as well as the growing body of literature on urban refugee reproductive health. Finally, through this research we have gained insight into the specific needs of the growing refugee population in Cairo.
For further information	<p>Elizabeth M. Coker, Ph.D., The American University in Cairo, Department of Sociology, Anthropology, Psychology and Egyptology Tel: (20) 2 797-6154 Email: emcoker@aucegypt.edu</p> <p>Jill Brennick, MPH, Forced Migration and Health Program, Columbia University Research Fellow, School of Humanities and Social Sciences, The American University of Cairo E-mail: jb922@columbia.edu</p>

Using quantitative and qualitative research techniques to design a sustainable RH project for the Roma population in Shito-Rizari, Macedonia <small>Abstract revision date: January 30, 2001</small>	
Authors	Juileta Calvo, International Rescue Committee, Macedonia Henia Dakkak, Columbia University, New York
Presenter	Henia Dakkak
Background	Shito-Rizari is a neglected neighborhood in Skopje, Macedonia. The population of Shito-Rizari consists of around 40,000 people, mostly of Roma ethnic background and newly resettled Roma refugees from Kosovo. There is little reproductive health data available in Macedonia, especially for the Roma population which has historically been neglected. There is no data regarding their knowledge, attitudes and behavior (KAPB) related to reproductive health. In the past, most health programs in Macedonia that targeted the Roma population have failed either due to mistrust by the Roma population towards authority or to insensitivity to their culture and beliefs.
Purpose of study or program	The purpose of the study was to gather baseline information about KAPB of the Roma population regarding reproductive health issues. The study also aimed to show how utilizing sensitive approaches in data collection and early involvement of the Roma community in the design of data collection methodology would guarantee success in getting vital information about knowledge, attitudes and behaviors regarding reproductive health.
Data collection methods	Household KAPB survey questionnaire of 600 Roma women of reproductive age (15-49 years) from the host and refugee community of Shito-Rizari. Focus Group Discussions Facility and health providers checklist In-depth interviews of 200 Roma women above the age of 35 for cervical cancer screening.
Study or program findings	10% of women interviewed were pregnant at the time of the data collection. 75% of respondents had heard about or knew the meaning of family planning. 52% reported having used a family planning method at some point. 42% are using some family planning method. 32% of the respondents who are using any method of family planning are using natural methods (coitus interruptus). 10% of the respondents are using modern contraceptive methods. Pills are the most commonly used, with IUDs and condoms used equally among the respondents to a lesser extent. The study showed that there is a lack of modern contraceptive usage among the Roma population and very high illiteracy that should be taken into consideration in designing programs to improve access to modern contraceptives.
Conclusions and program implications	Combining more than one research methodology is very helpful in getting in-depth information about the target population. Utilizing sensitive data collection strategies is important in achieving research results which will play a significant role for future program design, monitoring and evaluation. The importance of involving and utilizing local capacity in the research design and implementation is vital for community acceptance and entry. Creating a consortium-like effort in the field of reproductive health in Macedonia helped in identifying gaps that could be addressed by civil society and ones that could be addressed by the government. This research was part of the effort and initiative created by some of the member organizations of the Reproductive Health for Refugees Consortium in Macedonia during the Kosovo refugee crisis and in the post-crisis return period.
For further information	IRC- Health Unit (Mary Otieno or Richard Brennan) 122 East 42nd St. New York, NY USA Phone: 212-551-3000 Fax: 212-551-3185 E-mail: maryo@theIRC.org or rbrennan@theIRC.org

Current overview of reproductive health assistance in Albania for coordination and planning services through questionnaire survey	
Abstract revision date: December 5-6, 2000	
Authors	Henia Dakkak, Columbia University Sameh Yousef, International Rescue Committee, Albania Arian Pano, International Rescue Committee, Albania Alexander Sallabanda, International Rescue Committee, Albania
Presenter	Henia Dakkak
Background	During the spring of 1999, Albania hosted more than half a million Kosovar refugees, most of whom returned to Kosovo after the NATO intervention. The influx of refugees had exacerbated the already bad situation that had existed since the civil war and unrest in 1997. There is a large number of IDPs in Albania due to mass population movement from rural to urban areas because of the civil unrest.
Purpose of study or program	To map what services in RH assistance programs exist in Albania. There is fragmented information especially after the Kosovo crisis. There was a big influx of international NGOs into Albania during the refugee crisis, some of whom had left and some still remained in the country. There is a lack of information about local NGOs working in reproductive health. The aim of the overview is to gather information about agencies working in reproductive health, in order to build a platform for coordination and future planning.
Data collection methods	Survey questionnaire was used consisting of 29 questions that were distributed to 90 organizations (local, international and UN). The questionnaire was reviewed and coordinated with the UNFPA head of mission in Albania.
Study or program findings	There is a lack of coordination of reproductive health activities in the country, due to lack of coordination with the Ministry of Health. There is a concentration of activities in Tirana and some other major cities, with a severe lack in rural and remote areas. Reproductive health is still understood only as family planning programs by many agencies. There is a lack of emergency obstetric programs by local and international organizations. Safe motherhood is still understood as maternal and child health, with emphasis on child health. Post-natal care is non-existent. Almost all agencies agreed that there is a big need for coordination of reproductive health activities.
Conclusions and program implications	The survey questionnaire was a helpful tool to document the present situation of reproductive health assistance programs in Albania. It was helpful to gather this baseline information after the refugee crisis in order to get a real picture of the situation in the field. The information helped in creating a consensus among agencies about the need for coordination for quality service delivery. Funding for reproductive health is going to be a major issue for a lot of organizations in order to continue working in Albania.
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Childbearing and birth control experiences among Somali refugee women in Finland: A social and cultural challenge	
Abstract revision date: January 15, 2001	
Author	Degni Filio, Åbo Akademi University, Finland
Presenter	Degni Filio
Background	According to the Finnish National Population Register Center's figures of January 1, 1999, there are 6000 Somalis in the country, of whom 45% are children under the age of 16 and the proportion of men and women are equal (Statistics, Finland 1999). In their resettlement in Finland, the women's genital organ mutilation, which may affect the sexual and reproductive health of the majority of them is the central question of discussion; to that were added their social status and number of children (6-7 children per woman). While the women's issues preoccupied the Finnish political and health care policy makers, conflicts resulting from the Somalis' tradition and religion versus the Finnish liberal culture of women's birth control by the use of contraception worried the men and religious leaders as gate-keepers of their cultural, tradition norms and religious beliefs within their community.
Purpose of study or program	The aim of this research was to study the childbearing and birth control experiences among the refugee Somali women in Finland. I also wanted to improve the understanding of the readers regarding the Somalis' social, cultural and religious meanings of childbearing and birth control in their country of origin and the reasons for changes in Finland.
Data collection methods	All the participants arrived in Finland between 1990 and 1998. They were living in the cities of Helsinki, Espoo, Turku and Tampere, where the interviews were conducted between March 1997 and June 1998. Two Somali interpreters were recruited to assist me to collect information. One hundred and seventy nine (179) persons participated. The female participants were selected according to their age (18-44 years old), single and married. The male participants were also selected based on the same criteria and were contacted by the male assistant. All interviews varied in length from two to six hours, depending on the respondents' time and willingness to talk about the research problems. Revelations of new beliefs and experiences characterized the data collection that was then analyzed using the Grounded Theory technique. The family planning medical professionals (34 persons) gynecologists, obstetricians, midwives and nurses involved with Somali women were interviewed. All the participants were assured of the confidentiality of any information they gave. The investigation with the medical professionals received approval from the Ethical Research Community of each municipality medical center.
Study or program findings	<ul style="list-style-type: none"> • Childbirth can be described as a universal phenomenon, surrounded by social and cultural characteristics (Jordan, 1980; Chalmers and Meyer, 1994). Giving birth in a foreign country implies experiencing a life event with little or no access to your own, well-known traditions and environmental social supports. It can, therefore, be assumed that it is a real challenge for the foreign mother and father (Sachs, 1983, 1986). • The Somalis' parenthood experiences were influenced by unfamiliar social and cultural conditions of the host country and those related to the country of origin. In this study, I investigated the Somalis' childbearing and women's birth control experiences, because no studies have been undertaken about immigrant or refugee women's health, childbirth or family planning in Finland, compared to the other Scandinavian countries (Anderson, 1985; Sachs, 1986, 1983; Jeppesen, 1993). The Finnish health care system cannot be described as an active multicultural meeting-point as extensive research has not been done about ethnic minorities and women's health and reproductive health that includes birth control through the use of contraception. • This cross-cultural research is held within the field of medical sociology where the theoretical understandings of the Somali women's childbearing and birth control in Finland falls within the frame of relevant social theory. Another theoretical basis was the anthropological contribution that covers the cultural aspects on childbearing and birth control experiences in this research.
Conclusions and program implications	This study showed that a process of adaptation in which changes in the family structure are taking place as Somalis acquire new skills and new attitudes as a consequence of their exposure to a new and dominant culture. Somalis -- men and women -- are started to establish control over their lives by studying and acquiring a degree or profession to establish new social status and position in the household. These expectations have had an impact as the women attempt a reinterpretation of their traditional role of childbearing in Finland, though some explained that they could not regularly attend Finnish language courses because they were frequently pregnant. The striking findings were Somalis' new interpretation of gender relationships and childbearing experiences in Finland. The largest proportion of contraceptive users were the married women (with 4 to 7 children) with the consent of the husbands.
For further information	Degni Filio, Ph.D. candidate, Population and Reproductive Health, Department of Social Sciences Åbo Akademi University, Piispankatu 15, 20500 Åbo/ Turku, Finland Tel +358 2 2153291 Fax +358 2 2154802 E-mail: fdegni@abo.fi

Providing minimum reproductive health services to refugee populations: Evaluation of the Minimum Initial Service Package (MISP)	
Abstract revision date: January 15, 2001	
Authors	Ani Gurciyan, Mary Otieno
Presenter	Ani Gurciyan
Background	<p>The Minimum Initial Service Package (MISP) was designed by the Inter-Agency Working Group on Refugee Reproductive Health spearheaded by the United Nations High Commissioner for Refugees (UNHCR) and the United Nations Population Fund (UNFPA) to respond to the reproductive health needs of populations in the early phase of a refugee situation. The MISP is not just kits of equipment and supplies; it is a set of activities that must be implemented in a coordinated manner by appropriately trained staff. The objectives of the MISP are to:</p> <ul style="list-style-type: none"> • Identify organizations and individuals to facilitate the coordination and implementation of the MISP • Prevent and manage the consequences of sexual violence • Reduce HIV transmission by: <ul style="list-style-type: none"> ○ Enforcing respect for universal precautions against HIV/AIDS and ○ Guaranteeing the availability of free condoms • Prevent excess neonatal and maternal morbidity and mortality by: <ul style="list-style-type: none"> ○ Providing clean delivery kits for use by mothers or birth attendants to promote clean home deliveries ○ Providing midwife delivery kits (UNICEF or equivalent) to facilitate clean and safe deliveries at the health facility ○ Establishing a referral system to facilitate appropriate management of obstetric emergencies • Plan for the provision of comprehensive reproductive health services, integrated into Primary Health Care (PHC), as soon as possible
Purpose of study or program	To evaluate the implementation of the MISP as part of the International Rescue Committee's (IRC) reproductive health program in Kenema District, Sierra Leone. The MISP includes 12 subkits, which can be ordered separately from the United Nations Population Fund (UNFPA). These subkits contain pre-packaged materials and supplies to suit the needs of the targeted population. IRC Sierra Leone procured subkits 0 to 5 related to: training and administration, condom use, clean delivery (individual), post-rape, oral and injectable contraception, sexually transmitted diseases, and delivery at health facility, in order to implement the MISP activities.
Data collection methods	Interviews with key informants: Reproductive Health Coordinator, administrators and community-based outreach workers.
Study or program findings	The work that IRC is doing in traditional birth attendant (TBA) training, family planning and sexual and gender-based violence was found to be working to address urgent and overwhelming needs. However, the lack of primary health care (PHC) services at the community level constrains the implementation of the MISP. The negative consequences of providing the MISP kits in rural communities where there are no primary health care services available should be carefully considered.
Conclusions and program implications	Although funds for comprehensive services are severely lacking, the program must expand, integrate with primary health care and collaborate more with other organizations and the Ministry of Health to meet the needs. The program is being revised accordingly.
For further information	Mary Otieno, Reproductive Health Program Officer, International Rescue Committee, 122 East 42 nd St., New York, NY 10168-1289 USA, Tel: 212-551-3000, Fax: 212-551-3185 Email: maryo@theIRC.org

A comprehensive family planning and sexually transmitted disease service for Karen refugees	
Abstract revision date: December 5-6, 2000	
Authors	T. Lee, D.D. Cho, N. Lay Hter, R. McGready, and F. Nosten; Shoklo Malaria Research Unit
Presenter	Tracey Lee
Background	While international agencies advocate integration of reproductive health (RH) services into refugee assistance programmes, in practice, specific RH services that address family planning (FP) and sexual health needs are infrequently provided.
Purpose of study or program	In this paper we describe the initiation of an FP and sexually transmitted disease (STD) service in an essentially naive population of Karen, long-term displaced persons, on the western border of Thailand.
Data collection methods	<p>From inception of the service in May 1996 to August 1998, 1509 'clients' voluntarily sought FP services at clinics adjoining established maternal and child health clinics. Following education regarding FP options, interviews, counseling and physical examination, clients chose a method of contraception. Follow-up remained voluntary and all services were provided free of charge. Counseling and treatment for sexually transmitted diseases (STDs) were provided on the same basis.</p> <p>Contraceptive method mix included: natural family planning; condom; monophasic oral contraceptive (30mcg Ethinylloestradiol); Depot medroxyprogesterone acetate (150mg, three monthly injection); NORPLANT[®]; Intra Uterine Device (IUD, Multiload - 250[®]); vasectomy and tubal ligation via mini-laparotomy.</p>
Study or program findings	<p>The cohort comprised 1495 women and 14 men. Median age of clients was 26 (range, 14 - 46); 10% were adolescents and 14% thirty-five or older. Nulliparous women comprised a small proportion of those seeking services (2%). Parous women proportioned as follows: 1 child, 22.4%, 2-3 children, 39.6%, 4 or more children, 36%.</p> <p>Women sought to space their births by a median of 4 (1-10) years. Depo-provera was the most frequently requested contraceptive and Norplant[®] was more popular than IUDs for long-term contraception. 229 women stated they had finished their family, though almost 20% of these (n = 43) were afraid of undergoing sterilisation; 40% (n = 108) requested sterilisation and the remainder chose an alternative contraceptive method. Approximately 8% of women were using modern methods of contraception at the initial consultation. Within the first twenty-eight months of the programme, the contraceptive prevalence rate rose to almost 21%.</p> <p>Three-quarters of consultations were for contraceptive supply. Other reasons for utilising the service were to seek contraceptive advice or treatment for a range of medical conditions. Sexually transmitted diseases were infrequently noted in this community.</p>
Conclusions and program implications	FP & STD services offered to this Karen population as a component of an established RH program, were well accepted and supported. Apart from contraceptive supply, the clinic served as a center for education, counselling and women's health.
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Expanding reproductive health services in refugee settings: Post-abortion care in two Kenyan refugee camps	
Abstract revision date: December 5-6, 2000	
Author	A. Lehmann, K. Otsea, Ipas
Presenter	Aimée Lehmann
Background	Complications from unsafe abortion are well documented as one of the major contributors to maternal morbidity and mortality worldwide. Through displacement and resettlement, refugee women may be at higher risk of unwanted pregnancy and unsafe abortion given the disruption of cultural and social networks, increased risk of sexual violence, lack of health care structure and limited or nonexistent provision of contraceptive supplies. Recent recommendations for abortion care have been included in refugee literature, based on the 1994 ICPD program of action that states: "In circumstances where abortion is not against the law, such abortion should be safe. In all cases women should have access to quality services for the management of complications arising from abortion. Post-abortion counseling, education and family planning services should be offered promptly which will also help to avoid repeat abortions."
Purpose of study or program	The purpose of the program was to establish integrated post-abortion care (PAC) into existing refugee reproductive health services, based on the available health care providers and infrastructure of the two camps. PAC implementation focused on training doctors and mid-level providers in Manual Vacuum Aspiration (MVA), counseling skills and management of complications. MVA was promoted as a non-surgical, low-technology resource for these settings, and training was designed to link clients to other reproductive health information and services.
Data collection methods	Based on the recommendations for incorporation of PAC services into refugee reproductive health services, Ipas trained twenty-two health care providers in two refugee camps in Kenya in the treatment of post-abortion complications, family planning provision and linkages to other reproductive health services.
Study or program findings	MVA was proven an appropriate post-abortion care technology for these refugee settings. Providers were able to increase on-site reproductive health services to the refugee women, and provide links to other services, including contraception. Training and implementation of services was done in collaboration with local government and non governmental organizations and was supported by providers, clients and administrators. Specific challenges to implementing PAC services in refugee settings were also noted, especially issues of high medical staff turnover, the need for on-the-job training (OJT) to maintain sustained services, and a lack of client information and education around available reproductive health services.
Conclusions and program implications	Post-abortion care can be provided on-site in refugee settings along with other existing reproductive health services using appropriate technology and focusing on mid-level health care providers. A specialized training approach should be considered to address issues of staff turnover. Community education on PAC and RH services should be included in such interventions.
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Sexual and gender-based violence in the Dadaab refugee camps: The challenges of FGC Abstract revision date: January 15, 2001	
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Presenter	Jacinta Muteshi
Background	Recognizing Female Genital Mutilation (FGC) as a human rights issue and harmful traditional practice with short- and long-term psychological and physical health effects upon girls and women, a multi-country project and concurrent operations research study was developed. Baseline research findings from the Dadaab refugee camps in Kenya are presented, of communities where CARE and the National Council of Churches of Kenya (NCCCK) have begun to expand prior NCCCK activities on FGC.
Purpose of study or program	Using an experimental research design, the effectiveness of an education program using behavior change communication approaches in one camp will be compared to an education program coupled with community-level advocacy activities in a second camp. Education and advocacy interventions are designed to improve awareness of, create debate and support actions to combat the harmful effects of FGC, eventually leading to abandonment of the practice.
Data collection methods	Two rounds of qualitative research occurred: the first focused on knowledge, beliefs, attitudes, and values associated with FGC; the second focused on how people defined human rights, rights to health, rights of women and children. CARE designed an Operations research study and a randomly sampled survey of 1298 Dadaab refugee men and women was conducted, establishing a quantitative baseline.
Study or program findings	<ul style="list-style-type: none"> • FGC of the Pharaonic type is universal among women in the Dadaab refugee communities, with mothers making key decisions to circumcise. • Islam was intricately linked with many reasons to practice FGC, yet religious leaders were divided on the stand of religion regarding FGC. • Many positive beliefs and values were associated with FGC in religious, social, cultural/traditional and psychosexual domains. • Knowledge of men, women and adolescents of diverse negative health and social consequences of FGC was limited, but with males (71%) having more knowledge than females (57%) and adolescents having very little knowledge. • Only two people in all first-round groups mentioned FGC as a gender or human rights issue. Second-round group discussions showed general agreement on what constituted human rights, with women's rights being accessed through the husband, and parents assuring their children's rights. Rights were seen by all as defined in Islam. • Some thought change in the practice could happen. Most spoke of changing to the less invasive Sunna circumcision; none spoke of abandonment. Suggested strategies for change included women informing other women on the negative effects of the practice and Sheikhs providing guidance on the stand of Islam.
Conclusions and program implications	The underlying principle of FGC abandonment strategies is that change has to come from within the community. Outreach activities need to provoke debate and discussion while providing information and new ideas (e.g., rights related to health) to inform debates and decisions. Reinforcing positive, unharmed reasons and values associated with circumcision are important.
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Differences between refugee/internally displaced and local Azerbaijani women: A comparison of demographics, behavioral factors and reproductive history	
Abstract revision date: December 5-6, 2000	
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Background	In most refugee crises international aid organizations prioritize efforts to provide for health care and other services to refugees. Previous reports suggest that the host populations often have less access to health care and development programs than the refugees they are hosting.
Purpose of study or program	The purpose of the present study was to compare local and internally displaced (IDP) women living in Azerbaijan with respect to economic, demographic characteristics and reproductive health outcomes. Nearly one million people were displaced for the past 6 years because of the conflict with Armenia.
Data collection methods	A total of 701 local and IDP women who attended one of four reproductive health clinics participated in this study. Bivariate analysis was conducted to identify disparities between the local and IDP women. The internally displaced women lived in newly built settlements or other existing buildings rather than controlled access camps.
Study or program findings	There were few differences among IDP and local women on behavioral and demographic factors. The IDP women reported significantly worse economic indicators including employment status, income, home ownership and not having enough money for food ($p < 0.01$ for all comparisons). The two groups of women reported similar reproductive histories. The local women were: 1) more likely to report using Ministry of Health hospitals for abortion services, 2) self report lower abdominal pain in the last year, and 3) be diagnosed with PID at the study visit using a modified version of Hager's criteria ($p < 0.05$ for all comparisons). IDP women were more likely to be diagnosed with bacterial vaginosis and trichomoniasis ($p < 0.01$ for both comparisons).
Conclusions and program implications	The data collected in this study suggest that IDP women in this chronic setting are economically disadvantaged, have less access to Ministry of Health services and are at higher risk for most sexually transmitted diseases (STDs). This study demonstrates the need for ongoing efforts to provide access to reproductive health care for both local and IDP women. Furthermore, intervention programs to reduce risk for STDs among these women are urgently needed.
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Child mortality estimation techniques in refugee and host populations	
Abstract revision date: December 5-6, 2000	
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Presenter	Kavita Singh
Background	Because children comprise a large proportion of refugee populations and because they suffer high mortality, it is imperative that their health needs be addressed. Current methods of under-five mortality calculation have tended to rely upon hospital and burial records and population counts, though they are acknowledged to be unreliable. I propose the use of three indirect techniques – The Brass Indirect Method, The Time Since First Birth Technique and The Preceding Birth Technique. These techniques do not suffer from selection bias, which is found in hospital and burial data, and they render independent population counts unnecessary. They can be used in conjunction with some simple migration data to obtain estimates pertaining to women living in particular residential arrangements and to women stratified by their migration status.
Purpose of study or program	Precise under-five mortality rates could give donors and relief workers an idea of how to best allocate resources and plan health intervention programs.
Data collection methods	Data for this paper comes from The Demography of Forced Migration Project, a study aiming to understand how migration affects fertility, mortality and violence in refugee and host populations. Fieldwork for the project was conducted in Arua District, Uganda and Yei River District, Sudan between September 1, 1999 and March 4, 2000. A multi-stage sampling frame was employed to administer questionnaires to men and women in six study populations: 1) Ugandans living in the absence of refugees, 2) Ugandans living in the presence of settled refugees, 3) Ugandans living in the presence of self-settled refugees, 4) Sudanese refugees living in a settlement, 5) Sudanese refugees who are self-settled, and 6) Sudanese living in Sudan. A total of 3,354 interviews were conducted.
Study or program findings	Findings for this paper are still being analyzed. However, preliminary results suggest that refugees and nationals in Uganda have had similar mortality in the past five years, while Sudanese children in Sudan suffer higher mortality. The data is currently being stratified so that mortality rates can be calculated for women by particular migration and residential status.
Conclusions and program implications	This paper has the potential to improve upon current methods of mortality estimation in displaced populations. The paper will also yield data on how migration affects mortality and how residential arrangement impacts mortality in refugee and host populations. Data on these issues is virtually non-existent so this paper hopes to make a significant scientific contribution.
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