

Sexual and Reproductive Health  
of Displaced Populations

# **Refugees and Internally Displaced Persons (IDPs)**

## **Chad and Uganda**





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# FOREWORD

## UPHOLDING SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN EMERGENCY SITUATIONS

The history of humanity is made up of contrasts and ambiguities that are dictated by the objective circumstances of people. Political or tribal conflict situations generate both international reprobation and a resolve to meet the basic needs of the people. Having been, in a recent and remote past, the most hit of all five continents by waves of people displacement, Europe was able to set up consistent institutional relief mechanisms through the establishment of the High Commission for Refugees in 1943 and the adoption of the Convention on Refugees in 1951. Such strategies laid emphasis on basic issues such as provision of safe drinking water, food, sanitation and tents.

The world is still experiencing waves of refugees or internally displaced people (IDPs), with their accompanying frustrations of all sorts inflicted to these peoples. The bulk of these people are mostly made up of children and women who are often subjected to sexual violence.

These situations should be related to a number of factors including political and tribal conflicts as well as natural disasters such as tsunamis (290,000 dead or missing).

According to statistics published by the UNHCR, over 20 million people are internally displaced in the world. The African continent is the most hit, with over 4 million refugees and internally displaced people. Emergency relief is a recurrent reality in the continent despite the significant drop in refugee numbers across the world.

At present, many humanitarian crises still loom on the horizon with the political crises in the Democratic Republic of Congo (DRC), Côte d'Ivoire, Somalia, Sudan, Guinea Conakry, Chad, Uganda, Central African Republic (CAR), Burundi, etc. going unabated.

The IPPF – Africa Region (IPPFAR) is however adamant on one fact: notwithstanding the political crises and waves of people displacement that occur in Liberia, Sierra Leone, the DRC, Rwanda, Congo Brazzaville – though some time back now –, Togo, Chad, Côte d'Ivoire, Burundi, etc., our member associations have continuously provided sexual and reproductive health (SRH) services, because we rely on locally-raised resources, and because we made it a calling to ensure access to services for people, without discrimination based on ethnical, political or racial belonging, despite all the hardship involved with resource mobilization.

Our member associations need to be adequately equipped to ensure provision of HIV/AIDS care and support for gender-based violence to refugees and IDPs. It should be noted that our member associations in Guinea, Uganda, the Gambia and Burundi were previously exposed to useful experience in implementing projects for these groups of people.

It is building on this that the IPPFAR commissioned a study on SRH, which came up with recommendations and guidelines to better focus the SRH solutions implemented by our member associations and their partner communities operating on internally displaced or refugee settings.

Two case studies were conducted among IDPs living in emergency settings in the Gulu district, Uganda, and among refugees living in emergency situation in Chad, in September, 2004 and February 2005 respectively. Uganda hosts about 1.4 million IDPs who live in the Northern and North-Eastern parts of the country in the Gulu, Kitgum, Pader, Katakwi and, more recently, Lira and Apach districts.

In the Gulu district where the study was conducted, there are 419,258 IDPs representing 90% of the total population in the district. The 55 IDP camps that were set up host between 2,000 and 67,000 people (including in Pabbo, the largest camp in the district). The Unyama camp host about 20,000 IDPs

IDPs live in squalid camping conditions which include overcrowding, poor environmental and sanitation conditions, lack of drinking water and poor accommodation. Access to health services is limited in view of insecurity.

An estimated 232,125 Sudanese refugees have settled in camps in the Eastern part of Chad (UNHCR, 2005). Refugee exodus towards the Eastern part of Chad began in January, 2004. Sudanese refugees are distributed in eleven camps with a total of 213,314 of them (91.9%) living in camps under the protection of the UNHCR. About 18,811 refugees (8.1%) have spontaneously settled along the border between Chad and Sudan, while an increasing number of refugees have been leaving home families to join refugee camps.

As part of its mandate, IPPFAR ensures that the SRH needs of any group of populations are met. This is a human right issue, and we bet that this study is a fulfilment of our commitment to push the SRH agenda forward, including for refugees and IDPs. This work would not have been achieved without the cooperation of the UNHCR, UNFPA Chad and Uganda, refugee populations, IDPs, NGOs implementing health components of projects with the support of Médecins Sans Frontière Luxembourg and IMCI. The UNFPA has established a major tool for sexual and reproductive health interventions: the Minimim Service Package in Emergency Situation, which remains a reference tool for the Inter-Agency Working Group.

It is hoped that these guidelines for meeting the multidimensional SRH needs of people on the ground will be useful for all major relief stakeholders, including the major beneficiaries, IPPFAR member associations and the Inter-Agency Working Group, which already, has done a great job. This is just an initial step which will enable us to open up more prospects, building on the best practices instilled by our member associations in Chad, Uganda, Kenya, Tanzania, Rwanda, Burundi, the DRC, Guinea Conakry and Côte d'Ivoire.

**Tewodros Melesse  
Regional Director, IPPF – Africa Region**



# Contents

Acknowledgements	vi
Abbreviations and Acronyms	ix
Executive Summary	x
<b>Section 1: Introduction</b>	<b>1</b>
1.1    Background	1
1.2    Terms of Reference	2
1.3    Objectives	2
<b>Section 2: Methodology</b>	<b>3</b>
2.1    Study Settings	3
2.2    Study Design	4
2.3    Study Populations	4
2.4    Data Collection Procedures	5
<b>Section 3: Findings</b>	<b>6</b>
3.1 <b>Case Study 1:</b> Sexual and Reproductive Health in Emergency Refugee Settings – CHAD	6
3.2    Conclusions	10
3.3    Recommendations	13



3.4	<b>Case Study 2:</b> Sexual and Reproductive Health in Post emergency Internally Displaced Persons Settings – UGANDA	16
3.5	Conclusions	20
3.6	Recommendations	22
<b>Section 4: Comparative Analysis of Sexual and Reproductive Health</b>		<b>26</b>
1.1	Comparative Analysis of Sexual and Reproductive Health in Emergency and Post Emergency Refugee Settings	
<b>Section 5: A bridged Recommendations/Guidelines for General and Sexual and Reproductive Health for Displaced Populations</b>		<b>29</b>
5.1	Recommendations/Guidelines for General Health Services Response in Displaced Population Settings	29
5.2	Recommendations/Guidelines for Sexual and Reproductive Health Response in Refugee Emergency Situations	31
5.3	Recommendations/Guidelines for Sexual and Reproductive Health Response in Refugee Post Emergency Situations	33
Bibliography		37
Appendices		38
Appendix 1	List of Key Informants	38
Appendix 2	Map of Uganda showing Refugee and IDP affected Districts	39



## ACKNOWLEDGEMENTS

IPPF is grateful to several persons who facilitated the implementation of the study with the facilitation of Professor Garimoi from Makerere University who has helped us to have a better understanding of Refugees SRH needs IPPF AR Staff Odete Cossa, Ada Pouye, Dr Wilfred Ochan, Dr Cheikh Oudreago. Several staff of UN agencies – UNHCR, WFP, UNICEF and WHO and many international NGOs staff gave us various types of assistance ranging from logistical, transport and accommodation during the fieldwork in Chad Ndjamena, Abeche, Guerida and Iriba. IPPFAR heartfelt thanks and appreciation for the kindness and warm assistance you accorded us. Particular thanks to Mrs Ana UNHCR Tchad representative , Dr Lizette UNHCR/Abeche health coordinator, Chad; Nguelle Executive Director of ASTABEF Chad, and Dr Vincent Orinda and Dr Geoffrey Acaye of UNICEF Country Office, Kampala Uganda.

IPPF is equally thankful to Dr Paul Onek District Medical Officer (DMO) Gulu, Sr Tamale Luguma and Dr Felix Kaducu of Gulu district for the help rendered to the research team during the fieldwork in Gulu - Uganda. To my Research Assistants Jacqueline Kevin Akello and Stephen Acelllam in Gulu thank you for your dedication and hard work.

Finally IPPF Africa Region heartfelt thanks to both the Internally Displaced Persons (IDPs) in Gulu – Uganda, and several refugee leaders and communities in Abeche Chad who accorded us very warm reception and co-operation during the period of the field studies. To you this work is dedicated.

# ABBREVIATIONS AND ACRONYMS

<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>ANC</b>	Antenatal Care
<b>ARI</b>	Acute Respiratory Infections
<b>ART</b>	Anti Retroviral Therapy
<b>ASTEF</b>	Association Tchadienne Pou le Bien-etre Familial
<b>CBO</b>	Community Based Organisation
<b>CEOCC</b>	Comprehensive Essential Obstetrical Care
<b>DMO</b>	District Medical Officer
<b>EOC</b>	Emergency Obstetric Care
<b>FGD</b>	Focus Group Discussion
<b>FGM</b>	Female Genital Mutilation
<b>FLHF</b>	First Line Health Facility
<b>GBV</b>	Gender Based Violence
<b>HC</b>	Health Centre
<b>HIV</b>	Human Immunodeficiency Virus
<b>IEC</b>	Information Education and Communication
<b>IMC</b>	International Medical Corps
<b>IDP</b>	Internally Displaced Persons
<b>IOM</b>	International Organisation of Migration
<b>IPPFAR</b>	International Planned Parenthood Federation for Africa Region
<b>KII</b>	Key Informant Interview
<b>MUIPH</b>	Makerere University Institute of Public Health
<b>NGOs</b>	Non Governmental Organisations
<b>OPD</b>	Out Patient Department
<b>RH</b>	Reproductive Health
<b>RTI</b>	Respiratory Tract Infection
<b>RTA</b>	Road Traffic Accident
<b>STDs</b>	Sexually Transmitted Diseases
<b>STI</b>	Sexually Transmitted Infection
<b>SRH</b>	Sexual and Reproductive Health
<b>TBAs</b>	Traditional Birth Attendant
<b>UNFPA</b>	United Nations Fund for Population Activities
<b>UNDP</b>	United Nation Development Programme
<b>UNICEF</b>	United Nations Children's Fund
<b>UNHCR</b>	United Nations High Commissioner for Refugees
<b>WFP</b>	World Food Programme

# EXECUTIVE SUMMARY

## Background

The International Planned Parenthood for African Region (IPPFAR) commissioned a study to explore sexual and reproductive health (SRH) and develop recommendations /guideline to guide effective SRH response by humanitarian aid agencies working in displaced population settings. IPPFAR is a non-governmental organization whose strategic focus is to provide SRH services to vulnerable and marginalized populations.

Two case studies were conducted with internally displaced persons (IDPs) in post emergency setting in Gulu district Uganda and with refugee populations living in emergency situation in Chad during September 2004 and February 2005 respectively.

## Objective

The main objective of the study was to assess and define SRH service package, delivery modes, advocacy strategies and rights issues and policy options for effectively responding to the sexual and reproductive health needs of displaced populations. The study also sought to identify opportunities for integrating SRH and HIV/AIDS interventions as part of emergency humanitarian aid response for displaced populations.

## Methods

Data were collected in both emergency and stable settings of displaced persons i.e refugees or internally displaced persons. Qualitative research methods were primarily used in data collection. The various qualitative research techniques used included key informant interviews, focus group discussions, observations and record reviews.

## Key Findings

### A: Sexual and Reproductive Health Needs and Services in EMERGENCY SETTINGS

#### Safe motherhood

- Sexual and Reproductive Health services are not fully mainstreamed in the emergency package of health services interventions. However some elements of safe motherhood interventions such as natal and postnatal services are provided in camp health facilities. Hence minimum initial service package (MISP) is not fully implemented in this emergency situation.
- Although post natal service is provided, attendance is low in the health facilities. This is explained partly by the 40 days seclusion – cultural practice where mothers are not supposed to leave the house-*tukul*.
- Both women and men focus groups expressed the need for emergency medical care-ambulance – permanence in the camp, and need for adequate availability of medication and equipment. Laboratory diagnostic services are lacking in most facilities, and the health facilities do not provide 24-hour service, due in part to insecurity and inadequacy of trained personnel e.g midwives.
- There is lack of trained staff - midwife to attend to delivery. The TBAs who work in health facilities are trained. The need for strengthening capacity of TBAs – through further training was expressed.
- A number of newly established health facilities still do not have delivery room, and are not yet equipped. They also lack laboratory facility.
- Teen-age pregnancies were reported to be common. Likewise premature deliveries were reported to be common. The causes of premature delivery are however not known but attributed to excessive work done by women during pregnancy.

## Family Planning

- Family planning services have been introduced in the camp settings. Camp health facilities have started stocking the various contraceptive methods (oral pills, injectables- depo provera etc). Sensitization on family planning has been initiated. However demand for family planning is low. However the women folks, more than men, expressed desire for accessing family planning service. Both populations (men and women) consider FP as important, although men advocate for/prefer natural FP method abstinence, and don't like to use condoms.



- The community is awareness about some family planning methods such as injectable (depo provera) condoms, oral pills. However the level of awareness is not for certain known across population groups in the community.

## Sexually Transmitted Infections/HIV/AIDs

- Several key informants have reported that the refugee community members don't freely talk about STDs. The level of awareness about the STIs/STDs is thus limited.
- STD treatment and partner follow up is being carried out in the various health facilities. However host hospitals have inadequate drugs for STI treatment.

- The communities perceive that HIV/AIDS exist in Chad, not in the camp. Information about HIV/AIDS is being disseminated.
- Sensitisation - awareness creation about STDs/HIV/AIDS was initiated early in December 2004 in the displacement phase. Staff members have been trained in the management of STDs.
- Information, education and communication (IEC) materials are limited in health facilities and more so within refugee camp settings.
- The main modes of delivery of IEC health messages are through professional/qualified and community health workers (CHW). Other methods of delivery of IEC messages e.g drama and role-plays are being gradually introduced. IEC materials development is underway.

## Gender Based Violence

- Female genital mutilation (FGM), with attendant complications of vesico vaginal fistulae (VVF), is reported to be common. FGM is commonly performed during the month of February. Other cases of gender based violence reported include rape, and forced marriages. Rape cases have been reported to occur when women go to collect firewood in the community outside camps as well as in camp settings.
- A predisposition to gender based violence (forced marriage) reported is the fact that the cost of marriage is high expensive.

## Adolescent Sexual and Reproductive Health

- Reproductive health services for adolescent are not provided in exclusive places/locations, but in the framework of the general health services rendered to the entire refugee population.



### **Package of Sexual and Reproductive Health Services**

- Safe motherhood – ANC, natal as well as postnatal services are rendered in various camp health facilities.
- STI treatment is provided using the syndromic approach. HIV/AIDS care – treatment of opportunistic treatment is provided in host hospitals; it's being introduced in camp first line health facilities.
- Family planning services – contraceptives are being introduced in camp facilities.
- Gender based violence interventions including – awareness creation is being introduced.
- Most health facilities are of temporary structures. There is lack of laboratory facilities in most camp health facility.

### **Modalities of SRH Services Delivery**

- In the emergency refugee setting, the general health service delivery is being undertaken in static service points-facilities in semi permanent structures. International NGOs including MSF and IMC provide health services in the camps.

- Referrals for major medical, obstetric and surgical interventions take place in host health facilities - hospitals. Ambulance is accessible from the Regional referral hospital. Ambulance is free of charge for the refugee populations.
- Due to insecurity, transport services to health facilities do not operate at night.

### **Information Education and Communication (IEC) Strategies in IDP settings**

- Sensitisation on various health problems is undertaken by various cadres of health workers – both qualified and community based. Community leaders sensitise the masses on various health and socio-economic issues.
- Limited print media e.g posters/pamphlets obtained from Ministry of Health (MOH) of Chad are available in health units.

### **Reproductive Health Rights**

- There is apparent lack of awareness about sexual and RH rights. The observance of law and order and law enforcement is weak. Most cases sexual rights abuse are concealed.
- Education facilities - primary schools are being established in the camp settings.
- Income generating activities (IGAs) for refugees are being introduced.

### **Challenges of Health Service Provision in Emergency Settings**

- The numbers of trained personnel working are few. Moreover those working have high turn over rates. It's a big challenge to obtain qualified personnel from the region-which is remote and has few trained staff. Hence there is need to strengthen capacity of local health facilities.
- There is often high workload in the health facilities during the emergency phase of displacement. The

average number of OPD curative consultations ranges between 100-250 attendees daily. The majority of ailments treated are psychosomatic. High workload is compounded by rapid turn over of staff.

- Insecurity due to cross borders bombings has been reported. This makes movements unsafe and access to services for emergency obstetrical care (EOC) impossible during at night.
- The health facility physical infrastructure is temporary. This has implications on quality of services provided e.g privacy – auditory and visual.

## B: Sexual and Reproductive Health in POST EMERGENCY SETTINGS

### Safe motherhood

- In Gulu district an estimated 30% of pregnant women were reported to have delivered under skilled attendants in health facility during the year 2003/2004. Hence most mothers (pregnant women) deliver within the camps under TBA care. Emergency transport services are not available at night due to insecurity.
- Generally ANC attendance is high over 80% of women attend ANC at least once during a pregnancy. Postnatal attendance is however generally low. This is partly because most mothers' do not consider it as important.
- In general most health facilities in the district have permanent physical structures but are poorly equipped.

### Family Planning

- Family planning services are rendered by a variety of service providers including community-based distributors, peers groups leaders; and in bars, lodges and shops and health facilities.
- The informal sites (e.g bars, lodges etc) that distribute family planning methods are viewed as enhancing

accessibility of FP services to the community especially for the youths.

### Sexually Transmitted Infections HIV/AIDS

- Sero prevalence of HIV/AIDS is 11.5% in Gulu district based on Lacor HIV sero-prevalence sentinel site (DMO Gulu 2004).
- The population has expressed need for voluntary counseling and testing services. To date VCT is limited in the IDP camp settings.
- STDs/HIV/AIDS services are integrated in the overall sexual and reproductive health service delivery.

### Gender Based Violence

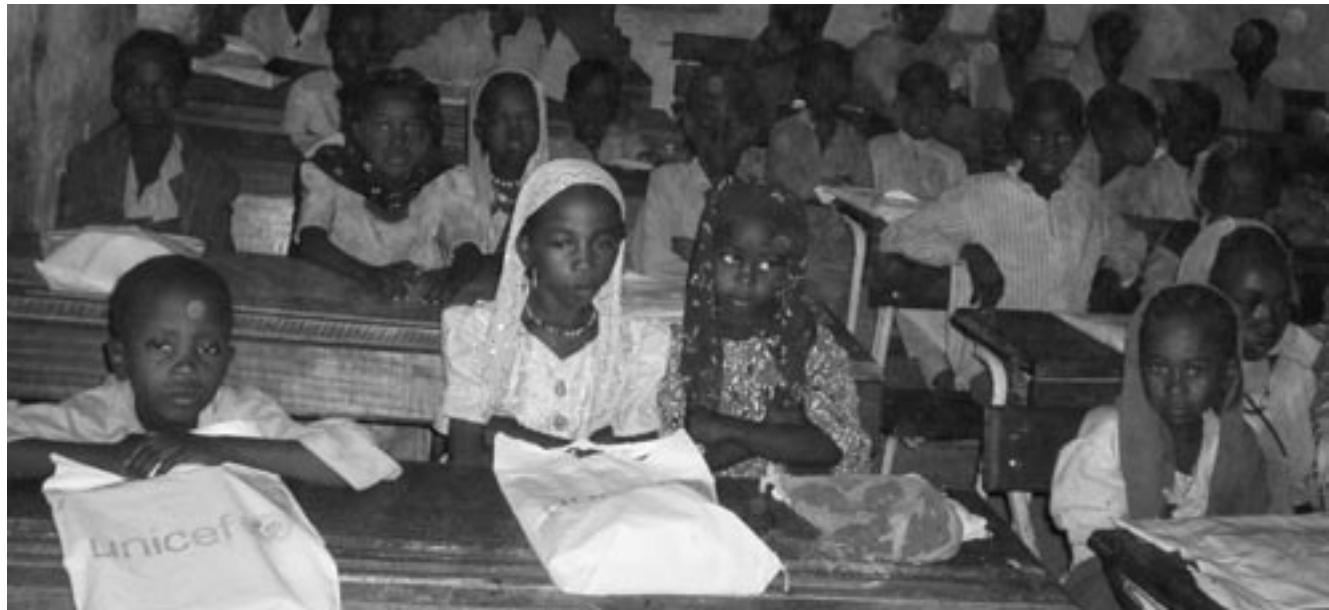
- Cases of rape, defilement are reported to be frequent in the camps. Perpetrators include fellow IDPs, armed personnel – rebels and government soldiers.
- The health facilities lack trained personnel able to provide effective care to gender based violence victims in the areas of psycho social and counseling services.
- There is low level of awareness of sexual reproductive health rights issues amongst displaced populations. This may be attributable to the extreme powerlessness the community has been subjected to.

### Adolescent Sexual and Reproductive Health

- Reproductive health services for adolescent services are not provided in exclusive places but in the context of general health services rendered. Main adolescent health needs include access to family planning service, treatment of STIs; information on sexuality and reproductive health and curative services for medical conditions e.g STDs etc.

### Package of Sexual and Reproductive Services

The package of services offered in camp first line health facilities – e.g Unyama, an Emergency Health Unit,



ranged from curative OPD consultation to preventive services.

SRH services provided includes; Safe motherhood – ANC, natal as well as post natal services; STI treatment using syndromic approach. HIV/AIDS care includes treatment of opportunistic infection, referrals for treatment in hospital for testing and anti retroviral therapy (ART). Adolescent health services include – family planning, condom, treatment of STIs. Family planning services – contraceptives provided include condoms, depo provera and oral pills. Access to contraceptives is difficult to IDP especially when they have to pay for the interventions/services.

#### **Modalities of SRH Services Delivery**

- The modality of service provision in the stable IDP setting is mainly static service facilities points in permanent physical structures. Outreach immunization services are also existent. The various reproductive health services provided are integrated.
- Government – district local health service run most IDP first line health facilities. The facilities range from HC level 2 to HC grade 4. Emergency Health Facilities exist.

- Emergency transport facilities - Ambulance service is accessible from the DMOs office or the Regional referral hospital by the communities, free of charge. However due to insecurity, health facilities do not operate at night in the camps.

#### **Information Education and Communication (IEC) Strategies in IDP settings**

- Both qualified health workers – based at the facilities and community health workers (CHWs) undertake sensitisation on various health issues.
- Various media i.e posters, pamphlets are available and in use. Radio programme and Drama groups are also being used, the former frequently, to disseminate information.

#### **Reproductive Health Rights**

- There is apparent lack of awareness about sexual and RH rights. The observance of law and order is poor especially by the military. Law enforcement is equally very weak. Parents fear reporting cases of sexual rights abuse e.g defilement. Early marriage of teenage girls

is common due to fear of abduction of young girls by rebels.

- IDPs live in abject poverty. There are limited sources of income generation - few IGAs projects for the internally displaced persons. The UNDP Human development report identifies the people in northern region as having the lowest human development index (HDI) in the country.
- Education facilities, mainly for primary schools, exist in the camps. There is generally lack of sport and recreational activities in the camp settings.

#### Challenges to Health Service Provision in Conflict Settings

- Insecurity is a major problem in the camp settings. Thus movement of persons from the camp is prohibited during the early mornings, evening, and at night. This implies no emergency referrals at night.
- There is generally high workload in the IDP health facilities. This is attributable to high demand for curative care and lack of qualified personnel working in IDP camp facilities. The ratio of population to trained staff-nurses is high.
- The enforcement of laws to punish those who sexually abuse women and children is weak. There is fear in the general population who doesn't report perpetrators- especially government soldiers.

#### Conclusions: Sexual and Reproductive Health in Emergency Settings - CHAD

##### Safe motherhood

- Most births take within the camps with few, less than 1 in ten of deliveries taking place in the camp health facilities. Some elements of safe motherhood services-interventions – ANC, natal and postnatal care activities take place in camp health facilities. However not all facilities provide delivery services.
- Although postnatal services are undertaken, attendance is low. A major constraint accounting for low post natal care attendance is the 40 days

seclusion – cultural practice that inhibit mothers from leaving the house.

- SRH services are not mainstreamed in health services interventions during emergency phase of displacement.
- There is a lack of emergency transport ambulance services- permanence in the camp. However other private means of transport are used at night. Availability of medicine/drugs and laboratory facilities is limited in the camp health facilities.
- Trained professional staff is few. However TBAs are trained and work alongside the professional staff in the health facilities.

##### Family Planning

- Family planning services have been initiated in most camp settings. However demand for family planning service is low. Camp health facilities have started stocking contraceptives.
- There is some awareness about a number of family planning methods injectables, condoms, pills. The communities especially the women folks demand for family planning service. Men however advocate for natural methods (abstinence), are reluctant to use conventional family planning methods e.g condoms. Men perceive condoms use as encouraging extramarital sexual intercourse.

##### Sexually Transmitted Infections/HIV/AIDS

- STD treatment and partner follows up are being carried out. The host referral facility i.e (Abeche hospital) however lacks essential drugs for STI management.
- There is apparent low level of awareness about STDs including HIV/AIDS. The community perception is that HIV/AIDs is prevalent 'exists' mainly in Chad, not in the refugee camps.
- The community (mostly men) perceives abstinence as best methods/approach towards STDs/HIV/AIDs prevention.

- IEC materials are limited in the camp health facilities. The materials are not available in hosts/ IDP communities. Development of IEC materials is underway.
- Mode of delivery of health messages use is mainly through community sensitisation by professionally trained (nurse midwives) and community health workers (CHWs). Other methods e.g drama and role-plays are being gradually introduced.

### **Gender Based Violence**

- The common forms of gender based violence reported are FGM, rape, and domestic violence. Rape commonly occurs both within the camp and when women go outside camps to collect firewood.
- FGM is perceived as common and a problem leading to complication fistula formation and other social problems. FGM is undertaken as a period perennial event – peak period is the month of February. High cost of marriage is reported as a factor promoting gender based violence – forced marriages.

### **Adolescent Sexual and Reproductive Health**

- Adolescent reproductive health services are not provided in exclusive places but within the general health services delivery framework – for the entire displaced - refugee population.
- Adolescents commonly seek services for – treatment of medical conditions, STIs, family planning-condom, and information on sexuality and reproductive health.

### **Package of Sexual and Reproductive Services**

- Various reproductive health services offered are provided in an integrated manner. Comprehensive SRH services provided include safe motherhood – ANC, natal and postnatal services. Camp health facilities provide basic essential obstetric care (BEOC) while host health facilities are used for the delivery of CEOC. STI treatment is based on syndromic

approach. Referrals for treatment in hospital for testing and treatment are undertaken. Adolescent health services are not offered in exclusive sites, includes – family planning-condom, treatment of STIs. Family planning services are being introduced in camp facilities.

### **Modalities of Sexual and Reproductive Services Delivery**

- The various reproductive health services provided are integrated. They are rendered in static service points-facilities, most being temporary with a few permanent physical structures. The main providers of services are international NGOs and host government health institutions.
- Transport - Ambulance services transport is available free of charge. Due to insecurity, access to health facilities in the camps is limited at night.

### **Information Education and Communication (IEC) and Advocacy Strategies in Refugee Settings**

- The approaches for awareness creation being used in refugee camps include sensitization by professional and CHWs. Posters are being used mainly within the health facilities.
- The various implementing agencies/NGOs - UNHCR/NGOs aim to mainstream SRH as an integral component of health interventions during emergency phase of response.

### **Reproductive Health Rights**

- There is limited awareness about sexual and RH rights within the refugee community. Community sensitization is limited regarding sexual and reproductive rights.
- Education facilities – primary schools exist/being introduced in the camps. Income generating activities opportunities for the displaced are still limited.



### Challenges of Health Service Provision in Refugee Emergency Settings

- There is high workload during emergency phase of encampment. This due to few qualified staff. This is compounded by high turn over of staff high in the setting. Qualified personnel from the region are few trained staff. The existent health facilities in the region also have few qualified staff. Hence there is need to strengthen capacity of local health facilities.
- Service delivery during emergency phase is constrained by access to referral facilities. Distance to referral hospital in the case of refugees in Eastern Chad – Abeche is long. This has implications for rehabilitation of rural hospitals to function as referral facility.
- Security is a problem in the region. Conflicts across borders and between refugee and host exist, hampers movements at night and late in the evenings to health facilities in general and emergency medical care/interventions in particular.

- ANC attendance is high. However postnatal attendance is generally low. This is partly because most mothers' do not consider it very important.
- Although most health facilities have permanent physical infrastructure, the facilities are poorly equipped with reproductive health interventions – facilities for management of SRH problems as well as deliveries.

### Family Planning

- Contraceptive Prevalence Rate (CPR) is generally low in the district amongst the IDPs. Low CPRs may be attributed to community desire to procreate to replace the "family members" who have died in the conflict.
- Family Planning services are provided in the various camp settings. Options for accessing FP methods-services vary, and include static health facility, community-based distributors and other channels of distribution such as through bars and lodges.

### Conclusions: Sexual and Reproductive Health in Post Emergency IDP Settings - UGANDA

#### Safe motherhood

- Most pregnant mothers deliver at home (within camps) under TBA care. Few births 3 in 10 take place in health facility under trained-skilled attendants. There is general shortage of qualified personnel in the health facilities. Transport facilities for referrals i.e ambulance services are limited in the settings, particularly at night due to insecurity.

#### Sexually Transmitted Infections/HIV/AIDS

- The prevalence of HIV/AIDS is high in the district of Gulu i.e 11.5% amongst pregnant mothers attending ANC in Lacor Hospital. STDs are reported to be common.
- Lack of awareness knowledge on various STIs including HIV/AIDS is reported. The level of awareness is affected by the "care free" attitudes of the IDPs who are stressed by hard conditions of

living hence engage in risky sexual behaviour for purposes of survival.

- Services for STDs exist in the camp facilities and are integrated. Syndromic approach is used for treatment of STDs. Drugs shortages are often reported in IDP health facilities. HIV/AIDS specific services e.g voluntary counseling and testing services do not exist in camp health facilities except in governmental regional referral hospital and Lacor faith based hospitals.

### **Gender Based Violence**

- Gender Based Violence cases e.g rape, defilement and domestic violence are reported as common in the camps. The main perpetrators include fellow IDPs, soldiers – government soldiers and rebels.
- The level of awareness about sexual and reproductive health rights amongst the displaced populations is low. The low level of awareness may be attributed to their vulnerability- marginalisation.
- Mechanisms of reporting/documentation and law enforcement to prosecute perpetrators of GBV are very weak in IDP camp settings.
- The provision of care and support – medical, psychosocial and community based peer support systems are weak and hardly existent. Trained medical personnel to provide effective psychosocial and counseling services are few.

### **Adolescent Sexual and Reproductive Health**

- Adolescent reproductive health services are provided in the framework of general health services to the entire displaced population.
- Commonly services sought by adolescents reported include – treatment of medical conditions, STIs and family planning-condom etc.

### **Package of Sexual and Reproductive Services**

- Comprehensive SRH services are provided and include the basic element of safe motherhood – ANC to delivery services as well as post natal services; STI treatment using syndromic approach; health

promotion - Health talks etc. STD/HIV/AIDS care includes treatment of opportunistic infection; follow up of home base care, referrals for treatment in hospital for testing and treatment. Adolescent health services include – family planning-condom, treatment of STIs. Family planning services – contraceptives provided include condoms. Access to contraceptives is difficult to IDP especially when they have to pay for the services. The various reproductive health services are provided are integrated.

### **Modalities of Sexual and Reproductive Services Delivery**

- The main modality of service provision in the IDP setting of northern Uganda, are static service points-facilities in permanent structures. The main provider is government with few NGOs. The government – district local health service, primarily runs the IDP first line health facilities. The facilities range from HC level 2 to HC grade 4. Referrals are made to secondary and tertiary hospitals but limited at night due to insecurity.
- Few temporary health services points referred to as Emergency Health Facilities exist. The emergency health units were established in places-camps where no health facilities previously existed. The package of services provided in the emergency health unit range from curative OPD consultation to preventive services.
- The DMOs office or the government referral hospitals provide transport - ambulance services. Ambulance service is free of charge. Due to insecurity, health facilities do not operate at night in the camps.
- The various reproductive health services provided are integrated.

### **Information Education and Communication (IEC) and Advocacy Strategies in IDP Settings**

- Several approaches for awareness creation and advocacy for SRH are being used in IDP camp settings. The methods commonly used include community sensitisation by professional and community based

health care workers. Various media namely posters, radio programmes, drama and peer groups are used to educate the populace.

### **Reproductive Health Rights**

- There is general lack of awareness about sexual and RH rights in IDP camp settings. Community sensitization is inadequate regarding sexual and reproductive rights. The observance and enforcement of law and order is poor. Most parents and guardians of children fear reporting cases of sexual rights abuse – defilement, rape committed especially by the army.
- Early marriage of young girls is common in the IDP camps. This is due mainly because of fear of abduction and defilement of young girls by rebels.
- Education facilities – schools exist in the camps. Most of these schools (primary) facilities are temporary. Thus quality of education is low.
- There is abject poverty amongst the displaced persons. IGAs opportunities for the displaced are scarce.

### **Challenges to Health Service Provision in Conflict Settings**

- The chronic ongoing war constrains delivery of health and social services to the IDP populations in the region-district. Thus financial, geographic and temporal accessibility to health services is poor.
- There is high workload in the IDP health facilities. The high workload is attributable to high demand for health care, compounded by high ratio of population to trained medical staff serving the population. This has important implications on the quality of services rendered.
- Sexual and RH rights abuse is prevalent amongst IDPs. Enforcement of laws and measures and to punish culprits is very weak.

### **Recommendations: Sexual and Reproductive Health in Refugee Emergency Settings**

#### **Safe motherhood**

The vast majority of mothers deliver within camps with only few births occurring in health facility. Hence

- Identify skill care providers within the community and train them – health professionals, TBAs in the settings.
- Mainstream SRH services in emergency setting. Initiate minimum initial service package (MISP) during emergency phase of intervention.
- Equip health facilities, with trained staff, adequate supply and materials for appropriate interventions.
- Ensure that transport facilities – ambulance for referrals of mothers who require major obstetrical interventions – surgical interventions i.e for Comprehensive Emergency Obstetric Care (CEOCC) is accessible.
- Sensitise the community, mothers and couples on safe motherhood issues – natal, pre natal and post natal care. Target men and community and opinion leaders for sensitization. Ensure that women know where to obtain assistance for delivery. Sensitise community on the 40 days seclusion – cultural practice where mothers are not supposed to leave the house.

#### **Family Planning**

Family planning offers dual advantages of preventing untimely and unwanted pregnancies and reducing risks of exposure against STD/HIV/AIDS, thus in emergency setting;

- Sensitise communities especially the men folks about family planning services. Assess community attitudes and perceptions towards family planning service.
- Initiated family planning service – condom use from the initial phase of displacement and encampment. Ensure regular/consistent availability of and access to FP planning methods - (condoms) and other FP methods at all times.
- Promote access to family planning distribution through channels such as community-based distributors, bars and lodges and health facilities. Promote access to and use to emergency post coital contraception in cases of rape or unprotected sex etc.



- Train staff to be competent in provision of family planning services-interventions.

#### **Sexually Transmitted Infections/HIV/AIDS**

Conditions of poverty, powerlessness and social instability predispose to the spread of STDs/HIV/AIDS. Hence

- Sensitise communities on risks of the various STI/HIV/AIDS in unstable settings. Target different levels of community – and target person to persons, family and community through mass sensitization.
- Use various media for communications including posters, drama groups etc. Ensure availability of IEC materials in health facilities. Avail/develop health education materials that are user friendly to the community.
- Provide information about HIV/AIDS in schools and within communities. Target youths, men and women folks for health education.
- Ensure consistent availability of drugs for STDs treatment and opportunistic infections against HIV/AIDS.
- Train personnel working in the facilities in STD management to ensure effective and quality treatment/management of STDs.
- Ensure health facilities provide user friendly STD services i.e private and confidential. Arrange health facilities to ensure women and youths are comfortable to use the services.
- Ensure availability of guidelines for case management of STDs-case definitions and management protocol of STDs.
- Provide effective STD treatment and partner follow up. Integrate services of the displaced with that of host populations to ensure the two populations access drugs and to lower prevalence of cross community infections.
- Institute voluntary counseling and testing (VCT) services. Support displaced persons to access anti retroviral drugs (ART) in established host or refugee health facilities.
- Ensure health facilities adhere to universal methods –precautions against HIV/AIDS prevention and control.

## Gender Based Violence

Gender based violence is often a problem but not well measured, therefore;

- Establish reporting and documentation of sexual and gender based violence in the camps settings. Sensitise community members, their leaders and service providers about GBV and establish mechanisms of reporting.
- Strengthen law enforcement and legal prosecution of perpetrators. Equip/train service providers, police and community leaders to take a lead in protection of community members in the prevention and sensitization about GBV.
- Trained health workers to provide effective – medical, psychosocial response/care.
- Support participation of IDPs especially women groups to establish networks to promote awareness, design and implement programmes to address sexual and gender based violence.
- Undertake campaigns – sensitisation against GBV. Support and equip community health workers, TBAs and community opinion leaders get involved and take a lead.

## Adolescent Health

- Provide adequate access to information about sexuality and reproduction. Involve adolescents-peers in passing messages - educating fellow adolescents/programmes.
- Ensure user friendly SRH services (i.e characterized by free or low cost, private and confidential, same sex providers, flexible time of facility openings etc). Adolescents and teenagers SRH services should include family planning and STI management.

## Package of Sexual and Reproductive Service

In emergency conflict settings, effective SRH services should provide;

- Provide MISP package to address SRH needs. Integrate reproductive health services in the context of primary health care (PHC).
- Ensure health services and logistical support/facilities e.g transport facilities are accessible also to local host populations to promote harmonious co-existence.

## Modalities of Delivery of Sexual and Reproductive Health Services

The provision of SRH services should consider;

- Implement the minimal initial service package (MISP) right from emergency phase of displacement. Strengthen emergency health facilities to provide full range of sexual and reproductive health services. Establish static service points-facilities with permanent or temporary structures.
- Ensure availability of transport - ambulance services to facilitate delivery of comprehensive essential obstetric care.
- Integrate health services provided by NGOs and government – district local health service.

## Information Education and Communication (IEC) and Advocacy Strategy

- Provide information about SRH.
- Use effective channels of communication including peer groups sensitisation/involvement, drama groups, and posters for sensitisation. Cultural sensitivity is essential.
- Develop culture specific and sensitive IEC materials. IEC materials be developed in the local languages as much as possible.

## Reproductive Health Rights

- Promote awareness about sexual and RH rights. Sensitized/educate and encourage parents be to report cases of sexual rights abuse - defilement. Enforce laws – measures to punish perpetrators of sexual and gender base violence.

- Support girl child education – stay at school. Discourage early marriage.
- Promote IGAs for the displaced populations in order to reduce poverty. Target women groups' especially single or female headed households.

## **Recommendations for Sexual and Reproductive Health in Post Emergency Refugee Settings**

### **Safe motherhood**

- Since most mothers deliver at home and only few births 1 in 3 take occur in health facility. Sensitise the community, mothers and couples on safe motherhood issues – natal, pre natal and post natal care. Target men and community and opinion leaders for sensitization. Train care providers and TBAs in the settings.
- Ensure that existent health facilities are staffed and adequately equipped to carry out deliveries.
- Ensure that transport facilities – ambulance for referrals of mothers who require major obstetrical interventions – surgical interventions i.e for Comprehensive Emergency Obstetric Care (CEO) is accessible.

### **Family Planning**

Given the low (CPR) in the district and amongst the IDPs, and the dual advantages of contraceptives – condoms – protection against unwanted pregnancy and STD/HIV/AIDS acquisition.

- Sensitise the community about correct use and the advantages of family planning.
- Diversify channels for accessing family planning services - to reach communities such as community-based distributors, bars and lodges and health facilities.
- Ensure regular or consistent availability of and access to FP planning methods - (condoms) and other FP methods at all times.

### **Sexually Transmitted Infections/HIV/AIDS**

Given the high prevalence of STDs/HIV/AIDS in the district and amongst the displaced populations;

- Continue – intensify awareness creation on various STI/HIV/AIDS. Use strategies-activities to reach different levels of community – and target person to persons, family and mass community/population sensitization. Use of various media including print posters/pamphlets, drama groups, and audio visual media are recommended.
- Health facilities should be designed-organised to ensure STD services are user friendly, private and confidential.
- Health facilities - services should be arranged to ensure women and youths are comfortable to use the services.
- Ensure consistent availability of drugs for STDs treatment and opportunistic infections against HIV/AIDS.
- Train personnel working in the facilities in STD management to ensure effective and quality treatment/management of STDs.
- Ensure availability of guidelines for case management of STDs-case definitions and management protocol of STDs.
- Institute voluntary counseling and testing (VCT) services. Support IDPs to access Anti retroviral drugs (ART) available in the district.
- Institute comprehensive care for people with HIV/AIDS. Educate individuals and families on HIV/AIDs prevention and care. Support social support systems for HIV/AIDS care and welfare services.

### **Gender Based Violence**

- Establish effective reporting and documentation of sexual and gender based violence in the camps settings. Sensitize communities, their leaders and service providers about the issue and establishing mechanisms of reporting.



STI treatment including HIV/AIDS care includes treatment of opportunistic infection; referral services for treatment in hospital. Adolescent health services include – family planning-condom, treatment of STIs. Family planning services – contraceptives provided include condoms.

- Integrated reproductive health services.
- Accessible health services and logistical support/facilities e.g transport facilities to local host populations who may not be displaced – host populations to ensure harmonious and peaceful co-existence.

### Modalities of Delivery of Sexual and Reproductive Health Services

- Use static service points-facilities with permanent or temporary structures. Encourage provision of integrated health services facilities belonging to public and or non-government institutions.
- Ensure availability of transport - ambulance services to facilitate delivery of comprehensive essential obstetric care.
- Strengthen health facilities to provide full range of sexual and reproductive health services. Implement the minimal initial service package (MISP) right from emergency phase of displacement.

### Adolescent Health

- Provide adequate access to information about sexuality and reproduction.
- Ensure friendly SRH services (i.e characterized by free or low cost, private and confidential, same sex providers, flexible time of facility openings etc). Adolescents and teenagers SRH services should include family planning and STI management.

### Package of Sexual and Reproductive Service

In post emergency conflict settings, provide;

- Comprehensive SRH services that include; Safe motherhood – prenatal, natal and post natal services.

### Information Education and Communication (IEC) and Advocacy Strategy

- Use various means of communication channels to create awareness including by using community leaders, peer groups educators, drama groups, radio programme as well as print media posters and pamphlets.
- Develop culture specific and sensitive IEC materials i.e IEC materials be developed in the local languages whenever possible.

### **Reproductive Health Rights**

- Promote awareness about sexual and RH rights. Sensitized/educate and encourage parents be to report cases of sexual rights abuse - defilement. Enforce laws – measures to punish perpetrators of sexual and gender base violence.
- Support girl child education – stay at school. Discourage early marriage.
- Promote IGAs for the displaced populations in order to reduce poverty. Target entire communities' especially vulnerable women groups e.g single or female headed households.



# 1.0 INTRODUCTION

## 1.1 Background

Displaced populations comprising – Refugees and Internal Displaced Persons (IDPs) represent under served populations with huge unmet sexual and reproductive health (SRH) needs particularly during the emergency phase of displacement. Although displaced populations often receive emergency humanitarian aid, SRH and HIV/AIDS interventions is often not part of the emergency health response package. This is despite their vulnerability to SRH and HIV/AIDS in such setting.

The provision of SRH and HIV/AIDS services including (information, education and communication [IEC]) present significant challenges to humanitarian agencies/ organizations working with the displaced populations. Part of the challenge is due to the fact that there is no well defined SRH and HIV/AIDS service package for such populations. They also live in temporary places and unstable settings, and the modality of service delivery is a challenge as well. The needs for SRH and HIV/AIDS interventions and how such interventions are delivered also vary during the emergency and stable post emergency situations.

To effectively reach the displaced populations with SRH and HIV/AIDS services present a unique opportunity since displaced population is already mobilized, less distracted by other activities and are also less occupied most times. The opportunity in reaching displaced population also presents a strategic choice in that the knowledge, skills and behavior they acquire while in displacement may be taken to benefit them and their children when they return to their homes.

The International Planned Parenthood for African Region (IPPFAR) commissioned a study whose aim was to define package of SRH and HIV/AIDS intervention for effective SRH an HIV/AIDS response in displaced settings and develop guidelines for SRH interventions. IPPFAR is a non-governmental organization whose strategic focus is to serve the vulnerable, marginalized, and hard to reach populations, with SRH information and services.

The study was conducted in two countries, Uganda and Chad. In Uganda the study focused on internally displaced populations who live in post emergency refugee situations in Gulu district. Today Uganda has an estimated 1.4 million IDPs found predominantly in the northern districts of Gulu, Pader, Kitgum and Lira, and eastern districts of Kumi, Soroti and Katakwi. Over 90% of the population of Gulu district live in 55 IDP camps. In Chad the study was carried out amongst Sudanese refugees living in emergency settings in the eastern province of Chad – i.e Abeche Gureda and Iliba. There are an estimated 234,343 refugees encamped in 11 camps in Eastern Chad. The main objective of the study was to explore and highlight sexual and reproductive health services and interventions for the displaced populations – refugees and IDPs in emergency and post emergency settings.

## 1.2 Terms of Reference (TOR)

The terms of reference for the consultancy were to;

1. Define what SRH and HIV/AIDS service package is needed by displaced population (internally displaced and refugees) in both fresh emergency and in a more stable displacement.
2. What service delivery mode/strategy would be suitable in such a setting to effectively reach the population in need (static clinic, satellite clinic, outreach services, CBD or other alternative service delivery mode?)
3. How can SRH and HIV/AIDS interventions be provided in a displaced settings (emergency, stable/ mature) as an integrated component incorporated in “humanitarian aid package”
4. What Communication for Behavior Development approach would be better used in SRH and HIV/AIDS in displaced settings to reach women, youth, men, camp leaders in such a setting? What is the role of (edu-sports, enter-educate, (video, theater, puppetry performance, etc.) community mobilization, health education talks?

5. How can SRH and reproductive rights of women and children (often the most vulnerable population in camp settings) be protected and promoted in displaced settings, yet - the very abusers and perpetrators of such abuses; (soldiers, camp leaders and elders within the camps), are the very people who should protect and promote such rights?

### **1.3 Objectives**

1. To define SRH and HIV/AIDS service package that respond to the expressed and normative SRH and HIV/AIDS needs of displaced populations.
2. To identify suitable and effective service delivery mode in reaching and providing SRH and HIV/AIDS information and service for displaced population (fresh emergency and stable/mature displacement).
3. To identify opportunities for integrating and incorporating SRH and HIV/AIDS interventions as part of emergency humanitarian aid for displaced populations.
4. Identify and recommend a suitable IEC/BCC or CBD approaches (edu-sport, enter-educate, peer education, video show, etc.) for creating awareness on SRH and HIV/AIDs to reach different groups in displaced settings.
5. Define advocacy strategy that may be used in securing legal and policy option to promote and protect the rights (sexual and reproductive rights) of the displaced population.

### **1.4 Phases of the Study**

The study was carried out in three phases. Desk review and analysis of sexual and reproductive health obtained in published and grey literature was undertaken in the first phase. The second phase comprised field based research. Field studies were carried out in two countries, namely Chad which currently hosts Sudanese refugees living in emergency situation, and in northern Uganda among Internally displaced persons (IDPs) living in chronic post emergency settings. Data was collected using mainly qualitative data collection techniques (comprising key informant interviews and focus/group, records reviews and observation). The third phase of the study entailed analysis, compilation of the final report, and dissemination - orientation of IPPFAR key staff on the proposed sexual and reproductive health recommendations [guideline] for populations living in displacement.

## 2.0 METHODOLOGY

### 2.1 Study Settings

#### 2.1.1 Chad

##### 2.1.1.1 Background

There are an estimated 232,125 Sudanese refugees encamped in eastern Chad (UNHCR 2005). The exodus of refugees into eastern Chad began in January 2004. The Sudanese refugees are accommodated in 11 camps. Most of the refugees (91.9%) 213,314 are living in camps under the protection of UNHCR. There are an estimated (8.1%) 18,811 refugees who are spontaneously settled along the Chadian/Sudanese borders. However, an increasing number of refugees are moving from host families to refugee camps.

**Table M1: Refugee Populations in Eastern Chad**

Location	Encamped Refugees	Self settled Refugee	Total
Bahai Oure-Cassoni	24,676	1650	26,326
Iriba	55,181	-	54,881
Iridimi	17,508	-	17,508
Touloum	21,243	-	21,243
Amnabak	16,130	-	13,130
Tine	300		3000
Gureda	27,643	4,511	32,154
Kounouningo	12,661	-	12,661
Mile	14,982	-	14,982
Adre	69,081	1650	70,731
Frachana			
Bredjing			
Tegune			
Goz Beida*	36,733	11,000	47,733
<b>TOTAL</b>	<b>213,314</b>	<b>18,811</b>	<b>232,125</b>

\* There are 6 Refugee camps in Goz Beida which include Goz amer; Djabal; Ade; Daguessa; Tissi and Murya.

### **2.1.1.1 Health Facility Settings**

In eastern Chad, both international NGOs and host government - ministry of health, regional and provincial health authorities provide health services for refugees. International NGOs including Medecins San Frontieres (MSF) and International Medical Corps (IMC) are responsible for health services provision for refugees.

### **2.1.2 Uganda**

#### **2.1.2.1 Background**

Since early 1990s Uganda has been host to both refugees and internally displaced persons. Uganda hosts an estimated 200, 000 refugees (map 1). Most of the refugees (>75%) live in the West Nile region districts of Adjumani, Arua, Moyo, and Yumbe.

There are an estimated 1.4 million IDPs living in northern and north eastern region Uganda, in the districts of Gulu, Kitgum, Pader, Katakwi and recently Lira and Apach (map 1).. The vast majority of IDPs live in the districts of Gulu, Pader, Kitgum, Apach and Lira in northern Uganda. The three districts of the Acholi Sub-region namely Gulu, Kitgum and Pader have had IDPs since about 1986. The IDPs live in squalid camp conditions, characterised by over congestion, poor environmental – sanitation, lack of water and poor shelter. Access to health services to the IDP in the camps is limited due to insecurity.

In Gulu district where the study was undertaken there are an estimated 419,258 IDPs comprising (90%) of the total population of the district as illustrated in table 2 below.

There are 55 IDP camps in the district. The IDP camps hosts between 2000 – with the largest camp Pabbo hosting an estimated 67, 000 inhabitants. Unyama camp hosts an estimated 20,000 IDPs.

#### **2.1.2.2 Health Facility Settings**

Gulu district has a total of 34 health facilities comprising 4 hospitals – 2 public and 2 private and the rest are first line health facilities – health centres. Three levels of health centres exist namely HC 2, HC3 and HC4. Two health facilities namely Pabbo Health centre grade 3 and Unyama Emergency health unit – HC level 2 were surveyed. On average each camp has a first line health facility. The health facilities surveyed belong to government. Health services for IDPs are provided mainly by – public/government - district local health service while faith based facilities and MSF provides services to support the efforts of the district local government.

### **2.2 Study Design**

This was a cross sectional study that employed mainly qualitative techniques of data collection.

### **2.3 Study Populations**

The study comprised two study populations - Refugees and IDPs in Chad and Uganda respectively. The two populations live in two different phases of emergency – the refugees live in emergency phase of displacement while the IDPs currently live in a chronic post emergency situation.

**Table M2: Population of Internally Displaced Persons in Uganda, 2003**

District	District Pop	IDP Pop	Percent (%) of Displaced Population
Gulu	468,408	419,258	89.5
Kitgum	286,122	281,372	98.3
Pader	293,679	229,115	78.0
Lira	757,763	79,097	10.4
Soroti	371,986	136,112	36.6
Katakwi	307,032	104,254	34.0
Kaberamiado	122,924	97,561	15.3
Kumi	388,015	59,207	15.3
<b>Total</b>	<b>2,995,928</b>	<b>1,405,976</b>	<b>46.9</b>

Source: Office of the Prime Minister (OPM) 2003; Key pop=population

## 2.4 Data Collection Procedures

### 2.4.1 Introduction

Data was collected in both emergency and stable settings for displaced persons i.e refugees or internally displaced persons (IDPs). Qualitative research methods were principally used in data collection. The various qualitative research techniques used are discussed in further details in section 2.4.2 below.



### 2.4.2 Data Collection Techniques

#### 2.4.2.1 Reviews of Documents

Review and analysis of secondary data was undertaken. Secondary data was collected from the organisations/institutions involved in the provision of care and support to the displaced populations – refugees and IDPs. These organisations included the UN agencies e.g UNHCR, UNICEF; Non governmental organisations (NGOs) MSF, IMC and community based organizations (CBOs), and National central government – MOH and sub-national (regional and district) health departments respectively.

Data sources included grey and published work i.e;

- (a) Programme/project reports, proposals and plans.
- (b) Policy documents and laws pertaining to refugees and internally displaced population.
- (c) Refugee and IDP service statistics including health and other social services.
- (d) Findings/reports of research/studies conducted in refugee and IDP settings.
- (e) Other publications e.g newspaper, newsletter articles focussing on both humanitarian assistance and SRH and HIV/AIDS issues.

#### 2.4.2.2 Key Informant Interviews (KII)

Interviews with key persons/representatives of relief organisations and national civic authorities were conducted. A total of 42 (i.e 21 and 20) Key informants were interviewed in Chad and Uganda respectively selected from the following organisations/institutions i.e;

- (a) UN agencies e.g UNHCR, UNICEF and IOM
- (b) Non governmental organisations (i.e international, regional and locally based NGOs e.g MSF, IMC,) as well as CBOs.

- (c) National government/civic authorities selected from national/central and sub-national i.e regional or district levels e.g MOH, district medical office (DMO).
- (d) Representatives of the displaced populations e.g settlement/camp commandants or leaders in refugee or IDP camps or settlements.

#### 2.4.2.3 Focus Groups Discussion (FGD) and Group Interviews

Focus Group Discussions (FGDs) were conducted with critical SRH programme beneficiaries. The targeted programme beneficiaries included women, men and youth and camp/settlement leaders. In each country study setting, 4 FGDs were conducted. Focus group discussion guide was developed to structure the discussions. The discussions were tape-recorded and lasted on average one hour.

#### 2.4.2.4 Observation

Inspection/observation of service health facilities such as first line health facilities (FLHF) used to provide health services to displaced persons - refugees or IDPs in the settlements/camps was undertaken. Inspection/observations were carried out in FLHF in emergency and stable settings. The aim was to compare the infrastructural set-up and evaluate the range of services rendered in these facilities during the emergency or stable situations. The inspection/observation of the physical infrastructure of the facilities gave insights into the adequacy or lack of both the physical infrastructure and the comprehensiveness of service delivered during emergency and post emergency phase settings.

## 3.0 FINDINGS

### 3.1 Case Study I: Sexual and Reproductive Health in Emergency Refugee Settings, Abéché, Eastern CHAD

#### 3.1.1 General Health Services

##### (a) Health Facility Settings

In Chad refugee both international NGOs and host government provide services. Medecins San Frontieres (MSF) and the International Medical Corps (IMC) provide services to complement the efforts of the host government.

**Table F1: Population and Staffing level in Refugee Health Facilities Eastern Chad**

<b>Staff Category/Refugee Population</b>	<b>Mile n</b>	<b>Amnabak n</b>
Pop of Refugees	14,980	16,183
Medical Doctor	-	1*
Midwife	1	1
Nurse	-	3*
Nursing assistant	3	3
Pharmacy assistant-Nurse	1	1
Nutritionist	-	2*
Total trained staff	5	6
Volunteers	4	0
Total	9	5

\* shared staff between the two health facilities

In general the ratio of refugee to trained staff in Mile and Amnabak refugee camps is 1: 2999 and 1: 2697 respectively.

## (b) Causes of Morbidity

The leading causes of morbidity amongst refugees in Tulum and Iridmi camps include;

- Acute respiratory tract infection
- Watery diarrhoea
- Polyathralgia
- Psychosomatic ailments<sup>1</sup>
- Gastritis
- Parasitosis
- Otitis
- Conjunctivitis

## (c) Coordination

The UNHCR works in close collaboration with local Chadian authorities, over 25 NGOs, the UN family and Red Cross/Red Crescent Movement. Efforts are underway to strengthen community services, education, and recreational activities for refugee children and teenagers. UNICEF and NGOs support educational activities in all the camps. An estimated (75%) 45,000 of the estimated 60,000 beneficiary children have enrolled in primary educational classes.

## (d) Capacity Building

Two individuals, refugees selected from Touloum refugee camps have been sent for a 6 months maternity care – midwifery training. The aim is to improve the capacity to carry out deliveries on a 24 hour basis in the health facility.

Traditional birth attendant (TBA) training courses have been conducted in the camps. The course takes 12 days for TBAs and 3 days for community health workers (CHWs). The TBAs and CHWs in the camps are paid 2000 CFA per day for their work.

## (e) Social Services Provision

To limit women traveling long distance outside camps to collect firewood, and hence likelihood of exposure to sexual violence, firewood is collected and brought to refugees within the camps. Some 5,000 improved stoves have been distributed in Oure Cassioni camp. In addition, sanitary materials have been procured and distributed to 60,000 women folks.

## (f) Security

Ensuring the security for staff and refugees is a primary consideration in the effective implementation of humanitarian assistance. This is undertaken collectively by the various UN agencies, NGOs and the host government personnel.

### 3.1.2 Sexual and Reproductive Health Findings

#### 3.1.2.1 Safe motherhood

Several needs of refugees living in emergency settings related to SRH as well as general health services provision – organization were identified;

- SRH services are not mainstreamed in the emergency package of health services interventions. Hence minimum initial service package during emergency (MISP) is not provided.
- Some elements safe motherhood interventions such as natal and post natal services are provided in the (all) camps facilities. Antenatal care (ANC) is conducted and awareness creation and preventive management - treatment of anaemia-with folic acid and ferrous is provided in camp health facilities.
- Although post natal service is provided, attendance is low in the health facilities. This is explained partly by the 40 days seclusion – cultural practice where mothers are not supposed to leave the house-tukul.
- In both women and men focus groups, the need for emergency medical care-ambulance – permanence in the camp, and need for adequate availability of medication were expressed. There is lack of laboratory diagnostic services, and the health facilities do not provide 24 hour service.
- There is lack of trained staff - midwife to attend to delivery. The pregnant women who attend ANC expressed need to be seen by trained staff such as midwives or medical doctor (MD). The need for strengthening capacity of TBAs – through more training and an increment in the number of ANC clinic days were expressed. TBAs are trained and competent. Skills need to be strengthened.

- The newly established health facilities still do not have delivery room, and are not equipped. Laboratory facility is lacking. Most clients/pregnant women prefer to deliver at home.
- Teen age pregnancy reported to be common. Likewise premature delivery is reported to be common. The causes of premature delivery is however not known but postulated to be due to excessive work done by women during pregnancy.

### **3.1.3.2 Family Planning**

- Family planning services have been introduced to the population in the camp settings. Camp health facilities have started stocking the various contraceptive methods (oral pills, injectables- depo provera etc). Sensitization on family planning has been initiated. Low demand for family planning intervention has however been noted.
- The women folks, more than men, expressed desire for accessing family planning service. In both men and women groups, there is agreement that women need to space pregnancy for at least 2 years. Both populations (men and women) consider FP as important. Men however advocate for/prefer natural FP method abstinence, and don't like to use condoms.
- There is awareness about family planning methods such as injectables-depo provera, condoms, oral pills. However the level of awareness is not known across population groups in the community.

### **3.1.3.3 Sexually transmitted Infections/HIV/AIDs**

- Several key informants have reported that the refugee community members don't freely talk about STDs. Awareness about the STDs is thus limited. Men are reluctant to use condoms.
- STD treatment and partner follow up is being carried out in the various health facilities. However host hospitals have inadequate drugs for STI treatment.
- The communities perceive that HIV/AIDs exist in Chad, not in the camp. Information about HIV/AIDS is being disseminated. Elderly men expressed the need to

sensitise young people to use condoms, while elderly men mentioned abstinence as best method.

- Sensitisation - awareness creation about STDs/HIV/ AIDS was initiated early in December 2004 in the displacement phase. Staff was sensitized - trained about the diseases in October 2004.
- Information, education and communication (IEC) materials are limited in health facilities and more so within refugee camp settings.
- The main modes of delivery of IEC health messages are through trained health workers and community health workers (CHW). Other methods of delivery of IEC messages include - drama and role-plays are being gradually introduced including audiovisual systems. The development IEC materials are being undertaken.



#### **3.1.3.4 Gender Based Violence**

- Female genital mutilation (FGM) is reported as a common problem, with complication such as vesico vaginal fistulae (VVF). FGM is commonly performed in February.
- Other gender based violence reported include rape, domestic violence and forced marriages. Rape cases have been reported to occur when women go to collect firewood in the community outside camps as well as in camp settings.
- A predisposition to gender based violence reported is the fact that marriage is considered as expensive. Excerpt, Men FGD "If you don't have money you can't marry. Cost of marriage is expensive, 25 camels 7 million CFA".

#### **3.1.3.5 Adolescent Sexual and Reproductive Health**

- Reproductive health services for adolescent are not provided in exclusive places/locations, but in the framework of the general health services rendered to the entire refugee population.

#### **3.1.3.6 Package of Sexual and Reproductive Health Services**

Not all packages of SRH services are provided in the emergency camp facilities, however;

- Safe motherhood – ANC, natal as well as postnatal services are rendered in various camp settings.
- STI treatment is provided using the syndromic approach. HIV/AIDS care – treatment of opportunistic treatment is provided in host hospitals; it's being introduced in camp first line health facilities.
- Family planning services – contraceptives are being introduced in camp facilities.
- Gender based violence interventions including – awareness creation is being introduced.
- There is lack of laboratory facilities in the camp health facility.

#### **3.1.3.7 Modalities of SRH Services Delivery**

- In the emergency refugee setting, the general health service delivery is being undertaken in static service points-facilities in semi permanent structures. International NGOs including MSF and IMC provide health services in the camps.
- Referrals for major medical, obstetric and surgical interventions take place in host health facilities - hospitals. Ambulance is accessible from the Regional referral hospital. Ambulance is free of charge for the refugee populations.
- Due to insecurity, health facilities do not operate at night in the camps. Hence TBAs attend to births while CHW treat simple cases of illness e.g malaria at night.

#### **3.1.3.8 Information Education and Communication (IEC) Strategies in IDP settings**

The IEC methods used to pass on information in camps include.

- Sensitisation by various cadres of health workers – both facility and community based. Community leaders take the initiative to educate the masses on various health and socio-economic activities.
- Print media e.g posters/pamphlets obtained from MOH of Chad, are available only in health units.

#### **3.1.3.9 Reproductive Health Rights**

- There is lack of awareness about sexual and RH rights. The observance of law and order and law enforcement is weak. Parents fear reporting cases of sexual rights abuse - defilement.
- Education facilities exist in the camps- primary schools are being established.
- IGAs for refugees are being introduced.

### **3.1.3.10 Challenges of Health Service Provision in Emergency Settings**

- Several challenges to sexual and reproductive health exist during the emergency phase of encampment. There is often high workload in the health facilities during the emergency phase of displacement. The average number of OPD curative consultations ranges between 100-250 daily. The majority of ailments treated are due to psychosomatic ailments. High workload is compounded by rapid turn over of staff.
- The numbers of trained personnel working are few. Moreover those working have high turn over rates. It's a big challenge to obtain qualified personnel from the region-which is remote and has few trained staff. Hence there is need to strengthen capacity of local health facilities.
- Establishment of services during emergency is constrained by the need to ensure referrals – services and facilities are accessible. In the case of refugees in Eastern Chad- there was long distance for referrals- Abeche. This has implications for rehabilitation of rural hospitals to function as referral facility.
- Insecurity. In the region, insecurity due to bombings from cross borders and between refugee and host has been reported. This makes movements unsafe at night and late in the evenings with important implications for poor emergency obstetrical care (EOC).
- The health facility infrastructure are temporary. This has implications on quality of services provided e.g privacy – auditory and visual.

## **3.2 Conclusions: Sexual and Reproductive Health Needs and Services for Refugees in Emergency Settings - CHAD**

### **3.2.1 Safe motherhood**

- Some elements of safe motherhood services have been established in the camp settings. ANC is conducted in all camp facilities and awareness creation-health education and treatment of anaemia-folic acid and

ferrous are provided. Few deliveries take place in some camp facilities. Not all facilities provide delivery services. Most births take at home - within the camps.

- SRH services are not mainstreamed in health services interventions during emergency phase of displacement.
- Although postnatal services are undertaken, attendance is low. A major constraint accounting for low post natal care attendance is the 40 days seclusion – cultural practice where mothers are not supposed to leave the house.
- There is a lack of emergency transport ambulance services- permanence in the camp. However other means – private means of transport are used at night. Availability of medicine/drugs and laboratory facilities are limited.
- Trained professional staff is few. However TBAs are trained and work alongside professional staff in the health facilities.

### **3.2.2 Family Planning**

- Family planning services have been initiated in most camp facilities. However demand for family planning service is low. Camp health facilities have started stocking contraceptives.
- The communities demand for family planning service- especially the women folks. Men however advocate for natural methods (abstinence), are reluctant to use conventional family planning methods e.g condoms.
- There is some awareness about a number of family planning methods including depo provera, condoms and the oral pills. Men don't like Condom and perceive condoms to encourage extramarital sex.

### **3.2.3 Sexually Transmitted Infections/HIV/AIDs**

- STD treatment and partner follows up are being carried out. The host referral facility i.e (Abeche hospital) however lacks essential drugs for STI management.



- There is apparent low level of awareness about STDs including HIV/AIDS. The community perception is that HIV/AIDs exist mainly in Chad, not in the IDP camps.
- The community (mostly men) perceives abstinence as best methods/approach towards STDs/HIV/AIDS prevention.
- IEC materials are limited in health in the camp facilities. The materials are not available in hosts/IDP communities. Development of health materials is underway.
- Mode of delivery of health messages use is through community sensitisation through professionally trained (nurse midwives) and community health

workers (CHWs). Other methods e.g drama and role-plays are being gradually introduced. Audiovisual systems are not being used.

### 3.2.4 Gender Based Violence

- The common forms of gender based violence reported include – FGM, rape, and domestic violence. Rape commonly occurs both within the camp and when women go outside camps to collect firewood.
- FGM is perceived as common and a problem - leading to complication fistula formation and other social problems. Domestic violence and other forms of sexual violence are also reported. Forced marriage exists. High cost of marriage 25 camels 7 million CFA is reported as a factor promoting gender based

violence. Refugees report that they have no money to marry.

- FGM is undertaken as a period perennial event – peak period is the month of February.

### **3.2.5 Adolescent Sexual and Reproductive Health**

- Adolescent reproductive health services are not provided in exclusive places but within the general health services delivery framework – for the entire displaced - refugee population.
- Adolescents commonly seek services for – treatment of medical conditions, STIs, family planning-condom, and information on sexuality and reproductive health etc.

### **3.2.6 Package of Sexual and Reproductive Services**

- Various reproductive health services offered are provided in an integrated manner. Comprehensive SRH services provided include safe motherhood – ANC, natal and postnatal services. Camp health facilities provide basic essential obstetric care (BEOC) while host health facilities are used for the delivery of CEOC. STI treatment is based on syndromic approach. Referrals for treatment in hospital for testing and treatment are undertaken. Adolescent health services are not offered in exclusive sites, includes – family planning-condom, treatment of STIs. Family planning services are being introduced in camp facilities.

### **3.2.7 Modalities of Sexual and Reproductive Services Delivery**

- The various reproductive health services provided are integrated. They are rendered in static service points-facilities, most being temporary with a few permanent physical structures. The main providers of services are international NGOs and host government health institutions.

- Transport - Ambulance services transport is available free of charge. Due to insecurity, access to health facilities in the camps is limited at night.
- The approaches for awareness creation being used in refugee camps include sensitization by professional and CHWs. Community health workers educate the masses. Posters are being used mainly within the health facilities.
- The various implementing agencies/NGOs - UNHCR/ NGOs aim to mainstream SRH as an integral component of health interventions during emergency phase of response.

### **3.2.9 Reproductive Health Rights**

- There is limited awareness about sexual and RH rights within the refugee community. Community sensitization is limited regarding sexual and reproductive rights.
- Education facilities – primary schools exist/being introduced in the camps.
- Income generating activities opportunities for the displaced are still limited.

### **3.2.10 Challenges of Health Service Provision in Refugee Emergency Settings**

- There is high workload during emergency phase of encampment. This due to few qualified staff. This is compounded by high turn over of staff high in the setting. Qualified personnel from the region are few trained staff. The existent health facilities in the region also have few qualified staff. Hence there is need to strengthen capacity of local health facilities.
- Service delivery during emergency phase is constrained by access to referral facilities. Distance to referral hospital in the case of refugees in Eastern Chad – Abeche is long. This has implications for rehabilitation of rural hospitals to function as referral facility.
- Security is a problem in the region. Conflicts across borders and between refugee and host exist, hampers

movements at night and late in the evenings to health facilities in general and emergency medical care/interventions in particular.

- Health facility physical infrastructure is temporary. This has implications on quality of services provided.

### **3.3 Recommendations: Sexual and Reproductive Health for Refugees in Emergency Settings – CHAD**

#### **3.3.1 Safe motherhood**

The vast majority of mothers deliver within camps with only few births occurring in health facility. Hence

- Identify skill care providers within the community and train them – health professionals, and TBAs in the settings.
- Mainstream SRH services in emergency setting. Initiate minimum initial service package (MISP) during the emergency phase of encampment.
- Equip health facilities, with adequate number of trained staff, supplies and materials for appropriate and effective health interventions.
- Ensure that transport facilities – ambulance for referrals of mothers who require major obstetrical interventions – surgical interventions i.e for Comprehensive Emergency Obstetric Care (CEOCC) is accessible.
- Sensitise community, mothers and couples on safe motherhood issues – natal, pre natal and post natal care. Target men and community and opinion leaders for sensitization. Ensure that women know where to obtain assistance for delivery.
- Establish ANC. Emphasize main benefits of ANC awareness creation-and treatment of anaemia-folic acid and ferrous are provided etc.
- Promote delivery under skilled attendants in health facility. Sensitise community on the 40 days seclusion – cultural practice where mothers are not supposed to leave the house.

- Ensure emergency medical care-ambulance – permanence in the camp and the availability of medicine/drugs. Equip health facilities – for appropriate laboratory diagnosis.

#### **3.3.2 Family Planning**

Family planning offers dual advantages of preventing untimely and unwanted pregnancies and reducing risks of exposure against STD/HIV/AIDS, thus in emergency setting;

- Sensitise communities about advantages of family planning services-interventions. Assess community attitudes and perceptions towards family planning service. Encourage and engage men to be involved in planning family planning services delivery.
- Initiated family planning services – condom use from the initial phase of displacement and encampment.
- Ensure regular/consistent availability of and access to FP planning services - methods - (condoms) and other FP methods at all times.
- Promote access to family planning distribution through channels such as community-based distributors, bars and lodges and health facilities.
- Promote access to and use of emergency post coital contraception in cases of rape or unprotected sexual engagement/involvement.
- Train staff to be competent in provision of family planning services-interventions.

#### **3.3.3 Sexually Transmitted Infections/HIV/AIDS**

Conditions of poverty, powerlessness and social instability predispose to the spread of STDS/HIV/AIDS in emergency and unstable situations. Hence

- Sensitise communities on risks of the various STI including HIV/AIDS in unstable settings. Target to reach different levels of community – and target

person to person, family and mass population sensitization.

- Use a variety media for communications including posters, drama groups etc. Avail IEC materials in health facilities and to communities. Introduce delivery of health messages through CHW, drama and role plays. Avail/develop health education materials that are user friendly to the community – in local languages/dialects whenever possible.
- Provide information about HIV/AIDS in schools and in the camps. Men are reported to be reluctant to use condoms. Specifically target men for health education as well as adolescents.
- Ensure consistent availability of drugs for STDs treatment and opportunistic infections against HIV/AIDS.
- Ensure health facilities provide user friendly STD services i.e private and confidential. Arrange health facilities to ensure women and youths and adolescents are comfortable to use the services.
- Train personnel working in the facilities in STD management to ensure effective and quality treatment/management of STDs.
- Ensure availability of guidelines and treatment algorithms for case management of STDs-case definitions and management protocol of STDs.
- Provide effective STD treatment, and partner follow up be carried out. Ensure availability of drugs. Integrate services of the displaced with that of host populations to ensure the two populations access drugs, minimize inequity and to lower prevalence of cross community infections.
- Institute voluntary counseling and testing (VCT) services. Support displaced persons to access anti retroviral drugs (ART) in established host or refugee health facilities.
- Ensure health facilities adhere to universal methods –precautions against HIV/AIDS prevention and control.

### **3.3.4 Gender Based Violence**

Gender based violence is often a problem but not well measured, therefore;

- Establish reporting and documentation of sexual and gender based violence in the camps settings.
- Sensitise community members, their leaders and service providers about the issue and establish mechanisms of reporting.
- Strengthen law enforcement and legal prosecution of perpetrators.
- Equip/train service providers, police and community leaders to take a lead in protection of community members in the prevention and sensitization about SGBV.
- Provide care and support – medical, psychosocial and community based per support systems need strengthening. Medical personnel should be trained to be able to provide effective – medical, psycho-social response/care.
- Support communities to provide social, psychosocial support through women community based peer support systems/networks.
- Increase participation of IDPs especially women groups, and establishment of networks in promoting awareness, design and implementation of programmes to address sexual and gender based violence.
- Undertake campaigns – sensitisation especially during peak period for FGM. The sensitization should address all forms of GBV including common ones. Community health workers, TBAs and community opinion leaders be involved.

### **3.3.5 Adolescent Health**

- Provide adequate access to information about sexuality and reproduction.

- Involve adolescents-peers in passing messages - educating fellow adolescents/programmes on various sexual and reproductive issues.
- Ensure user friendly SRH services (i.e characterized by free or low cost, private and confidential, same sex providers, flexible time of facility openings etc) for adolescents.
- Implement the minimal initial service package (MISP) as an integral part of health interventions right from emergency phase of displacement.

### 3.3.6 Package of Sexual and Reproductive Service

In emergency conflict settings, effective SRH services should ensure;

- Provision of MISP package to address SRH needs, and holistic and comprehensive RH services.
- Integration of reproductive health services in the context of primary health care (PHC) emphasizing prevention, curative and promotional activities.
- Reproductive health services and logistical support/ facilities e.g transport facilities are accessible to local host populations to promote harmonious and peaceful co-existence.

### 3.3.7 Modalities of Delivery of Sexual and Reproductive Health Services

The provision of SRH services should consider;

- Establishment of static service points-facilities with permanent or temporary structures. Encourage provision of integrated health services facilities belonging to public and or non-government institutions.
- Ensure availability of transport - ambulance services to facilitate delivery of comprehensive essential obstetric care.
- Provision of RH services in an integrated manner. Integrate health services provided by NGOs and government – district local health service.
- Strengthen emergency health facilities to provide full range of sexual and reproductive health services.

### 3.3.8 Information Education and Communication (IEC) and Advocacy Strategy

- Provide information about SRH services and about specific sexual and reproductive health problems such as Safe Motherhood, STDS/HIV/AIDS, Gender Based Violence etc.
- Use effective channels of communication including peer groups sensitisation/involvement, drama groups, posters for sensitisation. Ensure cultural sensitivity in packaging messages.
- Develop culture specific and sensitive IEC materials such as posters, pamphlets etc. As much as possible IEC materials be developed in the local languages and dialects.

### 3.3.9 Reproductive Health Rights

- Promote awareness about sexual and RH rights. Enforce laws and measures to punish perpetrators of sexual and gender base violence.
- Sensitized/educate and encourage parents be to report cases of sexual rights abuse - defilement.
- Support girl child education – stay at school. Discourage early marriage practices.
- Sensitise community on children's rights. Avail publications- literature on the subject in schools and public institutions. Target in and out of school adolescents-children for sensitization.
- Promote IGAs for the displaced populations in order to reduce poverty. Target women and or youth groups, and especially single or female headed households.

### **3.4 Case Study II: Sexual and Reproductive Health in Post Emergency IDP Settings, Gulu District, Northern UGANDA**

#### **3.4.1 General Health Services Findings**

##### **3.4.1.1 Health Facility Settings**

Gulu district has a total of 34 health facilities. There are 4 hospitals – 2 public and 2 private and the rest of the facilities are HC level 2, HC3 and HC4. The study was conducted in two health facilities namely Pabbo Health centre level 3 and Unyama Emergency health unit, HC level 2 respectively. On average there is a first line health facility in each camp. Health services for IDPs are provided mainly by the government, implemented by the district local health service. International NGOs e.g MSF renders some support to IDPs in a few camps.

**Table F2: Health Indicators Gulu District, 2001-2004**

<b>Indicator</b>	<b>Financial Year</b>		
	<b>2001/2002</b>	<b>2002/2003</b>	<b>2003/2004</b>
% Delivery in Health Facility	15.0	19.0	29.0
% HIV/AIDS Sero-prevalence	13.1	11.9	11.5
% Contraceptive Prevalence Rate	9.7	10.4	10.8
Ratio Doctor to Population	na	na	1:15,983
<b>Ratio Nurse/Midwife to Population</b>	<b>na</b>	<b>na</b>	<b>1:2,677</b>

Source: DMO Gulu 2003/4

Key na=not available

**Table F3: Population and Staffing Level in Pabbo and Unyama IDP Camp Health Facilities**

<b>Pop and Staff Category</b>	<b>Pabbo HC 3</b>	<b>Unyama HC 2</b>
Pop of IDPs	63,000	20,429
Qualified Staff	3	6
Clinical officer (CO)	2	1
Registered nurse	0	1
Enrolled midwife	1	3
Enrolled nurse	0	1
Nursing assistant*	8	2
Support staff	5	3
Support staff	1	3
Volunteers	4	0
<b>Total</b>	<b>16</b>	<b>11</b>

\* Nursing assistants are trained on the job (semi skilled) hence they are not considered as qualified staff.

The ratios of IDP population to qualified staff (CO and nurse midwife, excluding nursing assistants who are trained on the job) in Pabbo and Unyama camps are 21,000<sup>2</sup> and 3405 Unyama respectively.

### **3.4.2.2 Main Health Problems seen in Out Patient Department**

**Table F4: Causes of Morbidity, OPD Gulu District, 2003**

<b>Condition</b>	<b>Percentage (%)</b>
Malaria	32.6
Acute Respiratory Infection (ARI)	18.9
Helminthiasis	6.9
Skin conditions	5.1
Diarrhoeal diseases	5.0
Pneumonia	4.5
Trauma	3.8
Eye conditions	2.4
Sexually transmitted diseases	2.1
Otitis-Ear infections	1.8
<b>Others</b>	<b>16.9</b>

Source: DMO Gulu 2003

The three leading causes of morbidity are Malaria, ARI and Helminthiasis. Ho features as one of the ten leading cause of morbidity in the district.

**Table F5: Causes of Mortality in Population > 5 years of Age in Gulu District, 2003**

<b>Cause</b>	<b>Percentage (%)</b>
AIDS	17.8
Malaria	16.1
Tuberculosis (TB)	13.7
Pneumonia	9.6
Liver cirrhosis	5.6
Skin conditions	5.1
Trauma	4.8
Diarrhoeal diseases	5.5
Pneumonia	4.5
Anemia	3.5
Septicemia	3.2
Cardiovascular diseases	16.9

Source: DMO Gulu 2003

AIDS is the leading cause of mortality in Gulu district.

### **3.4.3 Sexual and Reproductive Health Findings**

#### **3.4.3.1 Safe motherhood**

- According to the DMOs of Gulu, during the fiscal year 2003/2004 an estimated 30% of pregnant women were reported to have delivered under skilled attendants in health facility. Hence most mothers-pregnant women deliver at home under TBA care. Emergency transport services for referrals is however not available at night due to insecurity.
- Generally ANC attendance is high over 80% in the district as of women attend ANC at least once during a pregnancy. Postnatal attendance is however generally low. This is partly because most mothers' do not consider it as important.
- While equipment for deliveries exists in most health facilities, they are either inadequate or old and in poor condition. The physical infrastructure of Unyama emergency facility, a permanent structure - donated on a temporary basis by the community is poor. Pabbo health facility has provision for delivery and maternity ward. In general most health facilities in the district permanent structures but are poorly equipped.

#### **3.4.3.2 Family Planning**

- Family planning services are provided by a variety of service providers. This includes community-based distributors, peers groups leaders; and in bars, lodges and shops and health facilities.
- The informal approaches to family planning service delivery (bars, lodges etc) are viewed as enhancing accessibility of FP services to the community especially for the youths.

#### **3.4.3.3 Sexually Transmitted Infections and HIV/AIDS**

- The sero prevalence of HIV/AIDS in Gulu district is 11.5% based on Lacor sentinel HIV sero-prevalence site (DMO Gulu 2004). A variety of STDs are reported common.
- There is lack of awareness on various STDs.

- The population has expressed need for voluntary counseling and testing services. Todate VCT is limited in the IDP settings.
- Space is often limited in the first line facilities hence privacy during services provision is a major concern.
- STDs/HIV/AIDS services are integrated in the overall sexual and reproductive health service delivery.

#### **3.4.3.4 Gender Based Violence**

- Cases of rape, defilement were reported to be frequent occurrence in the camps. Perpetrators include fellow IDPs, armed personnel – rebels and government soldiers.
- There is low level of awareness of sexual reproductive health rights issues amongst displaced populations. This may be attributed to the extreme hardship the community has been subjected to and the struggle to survive.
- The health facilities lack trained personnel able to provide effective response to gender based violence in the realms of psycho social and counseling services.

#### **3.4.3.5 Adolescent Sexual and Reproductive Health**

- Reproductive health services for adolescent services are not provided in exclusive places but in the context of general health services rendered. Adolescent health services include – family planning-condom, treatment of STIs. Like the rest of the displaced population, adolescents need information on sexuality and reproductive health and curative services for treatment of conditions e.g STDs etc.

#### **3.4.3.6 Package of Sexual and Reproductive Services**

The IDP camp first line health facilities are primarily run by the government – district local health service. The facilities range from HC level 2 to HC grade 4. Emergency Health Facilities have been established. The emergency health facilities were established in order to provide health services to IDP in geographic areas where no health facilities existed before.

In Unyama, an Emergency Health Unit, the package of services offered ranged from curative OPD consultation

to preventive services. The range of SRH services provided includes;

- Safe motherhood – ANC, natal as well as post natal services.
- STI treatment using syndromic approach. HIV/AIDS care includes treatment of opportunistic infection, referrals for treatment in hospital for testing and anti retroviral therapy (ART).
- Adolescent health services include – family planning-condom, treatment of STIs.
- Family planning services – contraceptives provided include condoms, depo provera and oral pills. Access to contraceptives is difficult to IDP especially when they have to pay for the interventions/services.

#### **3.4.3.7 Modalities of SRH Services Delivery**

- In the stable IDP setting, the modality of service provision being used is static service facilities points in permanent physical structures. The established public and non government health institutions are mostly permanent services points. Outreach immunization services are also existent. The various reproductive health services provided are integrated.
- The government – district local health service primarily runs the IDP first line health facilities. The facilities range from HC level 2 to HC grade 4. Other facilities are referred to as Emergency Health Facilities exist. The district health team initiated emergency health facilities in order to provide health services to IDP in areas where no health facilities existed beforehand.
- Emergency transport facilities - Ambulance service is accessible from the DMOs office or the Regional referral hospital by the communities. The ambulance service is free of charge to the IDP community members.
- Due to insecurity, health facilities do not operate at night in the camps. Hence emergency obstetric care and home base care of common illness e.g malaria, respiratory infections (RTI) are handled by TBAs and community based health workers respectively.

#### **3.4.3.8 Information Education and Communication (IEC) Strategies in IDP settings**

Several approaches for awareness creation in IDP camps are in existence.

- Sensitisation is undertaken by the various groups of trained health workers – based at the facilities and those based in the community - CHWs.
- Print media i.e posters, pamphlets are available and in use. However the community expressed need to have them written in local languages so that lay people may read them.
- Radio programme and Drama groups are being used to disseminate information with the former being used frequently.

#### **3.4.3.9 Reproductive Health Rights**

- There is lack of awareness about sexual and RH rights. The observance of law and order is poor especially by the military. Law enforcement is equally weak. Parents fear reporting cases of sexual rights abuse e.g defilement to civic authorities. Early marriage of teenage girls is common due to fear of abduction of the children by rebels.
- Education facilities, mainly for primary schools, exist in the camps.
- Owing to encampment the IDPs live in abject poverty. There are limited sources of income generation. There are few IGAs projects for the internally displaced persons. The UNDP Human development report identifies the people in northern region as having the lowest human development index HDI in the country.
- There is generally lack of sport activities in the camp settings.

#### **3.4.3.10 Challenges to Health Service Provision in Conflict Settings**

The following challenges have been identified in the provision of health services in IDP settings.

- Insecurity is a major concern. Thus movement of persons from the camp is prohibited during the early mornings, evening, and at night. This has important implication for referrals of emergency obstetric care (EOC). Thus, TBAs attended to delivery at night in the camps.



- There is generally high workload in the IDP health facilities. In Unyama emergency health unit the staff attends to between 180-200 consultations per day. In Pabbo's health unit the workload ranges between 100-250 consultations daily. This is against the background of lack of qualified personnel. The ratio of population to trained staff-nurses is high.
- The implementation of sexual and reproductive health rights- enforcement of laws to punish those who defile and sexually abuse women and children is weak. There is fear in the general population and they don't report perpetrators- especially government soldiers.

### **3.5 Conclusions: Sexual and Reproductive Health in Post Emergency IDP Settings - UGANDA**

#### **3.5.1 Safe motherhood**

- Most pregnant mothers deliver at home (within camps) under TBA care. Few births take place in

health facility under trained-skilled attendants. There is general shortage of qualified personnel in the health facilities. Transport facilities for referrals i.e ambulance services are limited in the settings, particularly at night due to insecurity.

- ANC attendance is high. However postnatal attendance is generally low. This is partly because most mothers' do not consider it very important.
- Equipment for reproductive health interventions - deliveries exists in most health facilities but is inadequate. Most health facilities have permanent physical infrastructure.

#### **3.5.2 Family Planning**

- Contraceptive Prevalence Rate (CPR) is generally low in the district amongst the IDPs. Low CPR due to the need for procreation to replace the "family members" who have died due the conflict.

- Family Planning services are provided in the various camp settings. Channels for accessing family planning methods-services vary. They include static health facilities, community-based distributors and other channels of distribution such as through bars and lodges.
- The provision of care and support – medical, psychosocial and community based peer support systems are weak and hardly existent. Trained medical personnel to provide effective response are few.

### 3.5.3 Sexually Transmitted Infections/HIV/AIDS

- The prevalence of HIV/AIDS is high in the district of Gulu i.e 11.5% amongst pregnant mothers attending ANC in Lacor Hospital. STDs are reported to be common.
- Lack of awareness knowledge on various STIs including HIV/AIDS is reported. The level of awareness is affected by the "care free" attitudes of the IDPs who are stressed by hard conditions of living hence engage in risky sexual behaviour for purposes of survival.
- Services for STDs exist in the camp facilities and are integrated. Syndromic approach is used for treatment of STDs. Drugs shortages are often reported in IDP health facility settings. HIV/AIDS specific services e.g voluntary counseling and testing services do not exist in camp health facilities but in the governmental regional referral hospital and Lacor faith based hospital.

### 3.5.4 Gender Based Violence

- Gender Based Violence cases e.g rape, defilement and domestic violence are reported as common occurrence in the camps. The main perpetrators include fellow IDPs, soldiers – government soldiers and rebels.
- The level of awareness about sexual and reproductive health rights amongst the displaced populations is low. The low level of awareness may be attributed to their vulnerability- marginalisation and preoccupation with basic survival issues.
- Mechanisms of reporting/documentation and law enforcement to prosecute perpetrators of GBV are weak in IDP camp settings.

### 3.5.5 Adolescent Sexual and Reproductive Health

- Adolescent reproductive health services are provided in the framework of general health services available to the entire displaced population.
- The common health services sought by adolescents reported include – treatment of medical conditions, STIs and family planning-condom etc.

### 3.5.6 Package of Sexual and Reproductive Services

- In general comprehensive SRH services are provided and include the basic element of safe motherhood – ANC to delivery services as well as post natal services; STI treatment using syndromic approach; health promotion - Health talks etc. STD/HIV/AIDS care includes treatment of opportunistic infection; follow up of home base care, referrals for treatment in hospital for testing and treatment. Adolescent health services include – family planning-condom, treatment of STIs. Family planning services – contraceptives provided include condoms. Access to contraceptives is difficult to IDP especially when they have to pay for the services. The various reproductive health services are provided are integrated.

### 3.5.7 Modalities of Sexual and Reproductive Services Delivery

- The main modality of service provision in the IDP setting of northern Uganda, are static service points-facilities in permanent structures. The main provider is government with few NGOs. The government – district local health service, primarily runs the IDP first line health facilities. The facilities range from HC level 2 to HC grade 4. Referrals are made to secondary and tertiary hospitals but limited at night due to insecurity.

- Few temporary health services points referred to as Emergency Health Facilities exist. The emergency health units were established in places-camps where no health facilities previously existed. They are set up in shelters/houses, which were either permanent building, or occasionally in temporary shelters. The package of services provided in the emergency health unit range from curative OPD consultation to preventive services.
- The DMOs office or the government referral hospitals provide transport - ambulance services. Ambulance service is free of charge to community members. Due to insecurity, health facilities do not operate at night in the camps. Hence home base care – vaccinators treat simple cases of illness e.g malaria and TBAs attend to delivery of mothers.
- The various reproductive health services provided are integrated.

### **3.5.8 Information Education and Communication (IEC) and Advocacy Strategies in IDP Settings**

- There are several approaches for awareness creation and advocacy for SRH are being used in IDP camp settings. The methods commonly used include community sensitisation by professional and community based health care workers. Various media namely posters, radio programmes, drama and peer groups are used to educate the populace.

### **3.5.9 Reproductive Health Rights**

- There is lack/limited awareness about sexual and RH rights in IDP camp settings. Community sensitization is inadequate regarding sexual and reproductive rights. The observance and enforcement of law and order is poor. Most parents and guardians of children fear reporting cases of sexual rights abuse – defilement, rape committed especially by the army.
- Early marriage of young girls is common in the IDP camps. This is due mainly because of fear of abduction and defilement of young girls by rebels.
- Education facilities – schools exist in the camps. Most of these schools (primary) facilities are temporary

- except where they were old structures existed prior to displacement. Thus quality of education is low.
- There is abject poverty amongst the displaced persons. IGAs opportunities for the displaced are very scarce.

### **3.5.10 Challenges to Health Service Provision in Conflict Settings**

- The chronic insecurity situation due to the ongoing war between the rebel Lord's Resistance Army (LRA) and government forces poses serious constraints to health and social services delivery to the IDP populations in the region-district. The insecurity poses financial, geographic and temporal constraints to accessing first line and referrals facilities.
- There is high workload in the IDP health facilities. The high workload is attributable to high demand for health care, compounded by high ratio of population to trained medical staff serving the population. This has important implications on the quality of services rendered.
- Sexual and RH rights abuse is prevalent amongst IDPs. Enforcement of laws and measures to punish culprits is very weak.

## **3.6 Recommendations: Sexual and Reproductive Health in Post Emergency IDP Settings, UGANDA**

### **3.6.1 Safe motherhood**

- Since most mothers deliver at home and only 1 in 3 births occur in health facility, identify skill care providers and train TBAs in the settings.
- Ensure that existent health facilities are staffed and adequately equipped to carry out deliveries.
- Ensure that transport facilities – ambulance services for referrals of mothers who require major obstetrical interventions – surgical interventions i.e for Comprehensive Emergency Obstetric Care (CEOCC) is accessible.
- Sensitise the community, mothers and couples on safe motherhood – natal, pre natal and post natal

care -interventions. Target men and community and opinion leaders for sensitization.

### 3.6.2 Family Planning

Given the low (CPR) in the district and the dual advantages of family planning – condoms use – protection against unwanted pregnancy and STD/HIV/AIDS acquisition.

- Sensitise the community about correct use and the advantages of family planning.
- Diversify channels for accessing family planning services for communities such as community-based distributors, bars and lodges and health facilities.
- Ensure regular or consistent availability of and access to FP planning methods - (condoms) and other FP methods at all times.

### 3.6.3 Sexually Transmitted Infections/HIV/AIDS

Since STDs/HIV/AIDS is a major cause of morbidity and mortality in the district.

- Intensify awareness creation on various STI/HIV/AIDS amongst the displaced populations. Use various strategies-activities to reach different levels of community – and target person to persons and family through mass community/population sensitization; various media e.g posters, drama groups etc.
- Designed/organize health facilities to ensure STD services are user friendly, private and confidential.
- Ensure health facilities - services are arranged to ensure women and youths are comfortable to use the services.
- Ensure consistent availability of drugs for STDs treatment and for treatment of opportunistic infections against HIV/AIDS.
- Train personnel working in the facilities in STD management to ensure effective and quality treatment/management of STDs.
- Ensure availability of guidelines for case management of STDs-case definitions and management protocol of STDs.

- Institute voluntary counseling and testing (VCT) services in camp health facilities. Support IDPs to access Anti retroviral drugs (ART) available in the district.
- Institute comprehensive care for people with HIV/ AIDS. Educate individuals and families on HIV/AIDs prevention and care. Provide social support systems for HIV/AIDS care and welfare services.

### 3.6.4 Gender Based Violence

Effective sexual and gender based violence response interventions should encompass;

- Establishment of a reporting and documentation of sexual and gender based violence in the camps settings.
- Sensitization of community, their leaders and service providers about the issue and establish mechanisms of reporting.
- Strengthening law enforcement and legal prosecution of perpetrators.
- Equipping/training service providers, police and community leaders to take a lead in protection of community members in the prevention and sensitization about GBV.
- Provision of care and support – medical, psychosocial and community based per support systems need strengthening. Medical personnel should be trained to be able to provide effective – medical, psycho-social response/care.
- Provision and strengthening of social, psychosocial and community based peer support systems.
- Increase participation of IDPs especially women groups and establish networks for promoting awareness and design and implementation of programmes to address sexual and gender based violence.

### 3.6.5 Adolescent Health

Effective sexual and reproductive health interventions/response for adolescents should entail;

- Provision of adequate access to information about sexuality and reproduction.



- Ensuring friendly SRH services (i.e characterized by free or low cost, private and confidential, same sex providers, flexible time of facility openings etc) are provided.
- Integrate various reproductive health services.
- Ensure accessibility of health services and logistical support/facilities e.g transport facilities to local host populations who may not be displaced – host populations in order to enhance harmonious and peaceful co-existence.

### **3.6.6 Package of Sexual and Reproductive Service**

In post emergency conflict settings, effective SRH services should;

- Provide comprehensive – full range of RH services that include; Safe motherhood – prenatal, natal and post natal services. STI treatment including HIV/AIDS care includes treatment of opportunistic infection; referral services for treatment in hospital. Adolescent health services include – family planning-condom, treatment of STIs. Family planning services – contraceptives provided include condoms.

### **3.6.7 Modalities of Delivery of Sexual and Reproductive Health Services**

The provision of SRH services should consider;

- Use static or outreach service points-facilities with permanent or temporary structures for various SRH interventions.
- Sexual and reproductive health services – interventions are provided in an integrated manner.

- Ensure availability of transport - ambulance services to facilitate delivery of comprehensive essential obstetric care.
- Integrate health services provided by NGOs and government – district local health service for displaced and non-displaced populations. Strengthen emergency health facilities to provide full range of sexual and reproductive health services. Implement the minimal initial service package (MISP) right from emergency phase of displacement.

### 3.6.8 Information Education and Communication (IEC) and Advocacy Strategy

- Promote awareness creation on SRH issues by involving community leaders to sensitise/educate the populace. Use a variety of channels of communication such as Peer group educators; Drama groups; Radio programme and Posters/pamphlets.
- Develop culture specific and sensitive IEC materials – e.g posters and pamphlets, whenever possible in the local languages.

### 3.6.9 Reproductive Health Rights

- Promote awareness about sexual and RH rights. Enforce laws and punitive measures against perpetrators of sexual and gender base violence.
- Sensitized/educate and encourage parents/guardians to report cases of sexual rights abuse - defilement.
- Support girl child education. Discourage early marriage.
- Sensitise community on children's rights. Avail publications- literature on the subject in schools. Sensitise in and out of school adolescents.
- Promote IGAs for the displaced populations in order to reduce high poverty levels. Target women groups' especially single or female headed households.

## 4.0 COMPARATIVE ANALYSIS

**Table F6:Sexual and Reproductive Health in Emergency and Post Emergency Settings**

	<b>UGANDA Post emergency Situation</b>	<b>CHAD Emergency Situation</b>
<b>Background</b>		
Population category	IDPs	Refugees
Total population estimates	1,600,000	230,000
Duration of displacement	18 year	1.5 year
Type of settlement	Camps	Camps
Main source of Food	WFP and Self	WFP
Main sources of assistance	Host Gov't & Relief Organisations	UNHCR&Relief Organisations
Environmental condition	Savannah	Semi-desert
<b>Sexual and Reproductive Health Safe motherhood Interventions</b>		
Antenatal Care	High attendance	Medium attendance
Natal care	29% under skilled care/facility	<1 in 10 in health
facility Post natal care seclusion) cultural	45-50% attendance	Very low (40 days)
<b>Family Planning</b>		
Contraceptive prevalence	10.8%	Very low(unknown)
Reasons for low acceptance	Procreation Polygamy Security for family	Procreation Polygamy Securityfor family
<b>STDS/HIV/AIDS</b>		
Prevalence	High 11.5% [HIV/SIDS]	Unknown
Risk Factors	Mobility Army & pop mixing Poverty STIs prevalent in IDP community	Mobility Army & pop mixing Poverty STIs prevalent in refugee community

	<b>UGANDA</b> <b>Post emergency Situation</b>	<b>CHAD</b> <b>Emergency Situation</b>
<b>Gender Based Violence</b>		
Prevalence Common GBV cases Factors Perpetrators	Reported, common Domestic violence, rape Stress on men Drinking Soldiers, fellow IDPs	Reported, common Domestic violence, rape Cultural-marriage related Collection firewood Hosts, fellow refugees
<b>Adolescent Sexual and Reproductive Health</b>		
Common problems/needs	STIs treatment, FP service  Adolescent friendly services	STIs treatment, FP service  Adolescent friendly services
<b>Reproductive Health Rights</b>		
Awareness/information Formal Education Opportunity Empowerment – IGA opportunity Advocacy	Low Limited Lacking Limited	Low Limited Lacking - being initiated Limited

	<b>UGANDA</b> <b>Post emergency Situation</b>	<b>CHAD</b> <b>Emergency Situation</b>
<b>General Health Service Provision</b>		
Physical Infrastructure Qualified personnel Drugs/Supplies Equipment	Most are permanent structures Few qualified Limited Lacking	Most are temporary structures Few qualified Available/limited Not yet available
<b>Accessibility to SRH Services</b>		
Geographic Temporal Financial Acceptability	Low due to insecurity Fair Low due to poverty UNHCR/ Generally high – low FP men	High Fair High services paid for by NGOs Generally high – low FP men
<b>IEC/Advocacy Strategies</b>		
Media -pamphlets/posters Community sensitisation Other media (drama, radio)	Used Used Used	Used - limited Used Limited

# 5.0 RECOMMENDATIONS

## Section 5:Recommendations/Guidelines for Sexual and Reproductive Health Response in Unstable Situations

### ABRIDGED VERSION

#### Contents

- 1.1 Recommendations/Guidelines for Key Principle for General Health Services in Displaced Population Settings
  - 5.1.1 Initial Assessment
  - 5.1.2 Health Service Intervention - Delivery
  - 5.1.3 Strengthening Capacity of Local Health System
  - 5.1.4 Coordination
- 1.2 Recommendations/Guidelines for Sexual and Reproductive Health in Emergency Situations
  - 5.2.1 Safe motherhood
  - 5.2.2 Family Planning
  - 5.2.3 Sexually Transmitted Infections and HIV/AIDS
  - 5.2.4 Gender Based Violence
  - 5.5.5 Adolescent Health
  - 5.5.6 Package of Sexual Reproductive Health Services
  - 5.5.7 Modalities for Sexual and Reproductive Health Service Delivery
  - 5.5.8 Information, Education Communication and Advocacy Strategy
  - 5.5.9 Sexual and Reproductive Health Rights
- 1.3 Recommendations/Guidelines for Sexual and Reproductive Health in Post Emergency Situations
  - 5.3.1 Safe motherhood
  - 5.3.2 Family Planning
  - 5.3.3 Sexually Transmitted Infections and HIV/AIDS
  - 5.3.4 Gender Based Violence
  - 5.5.5 Adolescent Health
  - 5.5.6 Package of Sexual and Reproductive Health Services

- 5.5.7 Modalities for Sexual and Reproductive Health Services Delivery
- 5.5.8 Information, Education Communication and Advocacy Strategy
- 5.5.9 Sexual and Reproductive Health Rights

### 5.1 Recommendations/Guidelines of Key Principles for the Establishment of General Health Services for Displaced Populations

The following set of four key activities namely initial assessment; health services interventions, support to local health institutions and coordination are recommended as guidelines (principles) for effective, sustainable and equitable health services interventions in displaced population (refugee and IDP) settings as further elaborated in sections 5.1.1 – 5.1.4 below.

#### 5.1.1. Initial Assessment

##### 5.1.1.1 Objective

The main objective of initial assessment is to collect data to identify needs, guide priority setting and decision for implementation of health interventions. Initial assessment serves as entry point for any particular health intervention. The base line data gather are used to monitor and evaluate the health and welfare conditions of the affected population.

##### 5.1.1.2 Recommended Tasks

- Undertake initial assessment to determine as accurately as possible general health needs and needs in specific areas e.g the sexual and reproductive health of displaced populations and establish priorities for health interventions and programming.

- Use qualitative and quantitative methods in initial assessment. Methods to be used to gather data during assessment may include the following:
  - Rapid assessment tools include (observation, key informant interviews, focus group discussions, questionnaire interviews, records review).
  - Survey tools include (community survey using prepared tools such as questionnaires-this may be complemented by Key informant, focus group discussion, records review).
- Target populations for assessment may include communities and institutions e.g health institutions etc.

## **5.1.2 Health Services Interventions - Delivery**

### **5.1.2.1 Objective**

The main objective is to reduce morbidity and mortality by ensuring delivery of appropriate health care interventions for the displaced population.

### **5.1.2.2 Recommended Tasks**

- Health services/interventions provision should be based on the elements and guided by the principles and philosophy of Primary Health Care (PHC) strategy. Target health problems that cause excess mortality including sexual and reproductive health as priority. Emphasis should be place on preventive, promotive and curative services - interventions.
- Ensure provision of quality and accessible services. Establish referral system.
- Employ and deploy personnel with appropriate qualifications and experience to implement health care interventions. Train and supervise staff. Support and adequately manage personnel.
- Standardize medical activities. The standards need to be developed and linked with national and international (sphere) standards or guidelines.

- Integrate refugee services and with local health services authorities to enhance sustainability.

### **5.1.3. Work with and Support Local Health Service Delivery Institutions**

#### **5.1.3.1 Objective**

To work with, support and strengthen local health services to deliver effective and sustainable health services for displaced and host populations.

#### **5.1.3.2 Recommended Tasks**

- Provide health service to both displaced and local populations hosting the displaced communities.
- Support local host health institutions especially (secondary and tertiary health facilities) efforts and capacity for basic and specialized emergency health interventions.

### **5.1.4. Coordination**

#### **5.1.4.1 Objective**

The main objective is to facilitate effective implementation of activities to achieve the greatest impact in the situation.

#### **5.1.4.2 Recommended Tasks**

- Establish coordinating body and liaise with key service providers/stakeholders (UNHCR, NGOs and local host governments) to avoid duplication of services.
- Establish clear leadership and spell out responsibilities of partners
- Establish good communication channels to facilitate flow and exchange of information. Hold regular meetings.
- Harmonise technical guidelines and policies to be used by partners.



## 5.2. Recommendations/Guidelines for Sexual and Reproductive Health Interventions in Emergency Refugee Settings

### 5.2.1. Safe motherhood

The majority of mothers deliver within camps with only few births occurring in health facility. Hence

- Mainstream SRH services in emergency setting. Initiate minimum initial service package (MISP) during emergency phase of intervention.
- Identify and train care providers within the community – health professionals and TBAs to provide 24 hour services.
- Equip health facilities, with adequate supply and materials for appropriate interventions.
- Ensure that transport facilities – ambulance for referrals of mothers who require major obstetrical interventions – surgical interventions i.e for Comprehensive Emergency Obstetric Care (CEOCC) is accessible.
- Sensitise the community, mothers and couples on safe motherhood issues – natal, pre natal and post

natal care. Target men and community and opinion leaders for sensitization. Ensure that women know where to obtain assistance for delivery.

### 5.2.2 Family Planning

Family planning offers dual advantages of preventing untimely and unwanted pregnancies and reducing risks of exposure against STD/HIV/AIDS, thus in emergency setting;

- Sensitise communities about family planning services. Assess community attitudes and perceptions towards family planning service. Men should be involved as key partners in family planning.
- Initiate family planning service – condom use from the initial phase of displacement and encampment.
- Ensure regular availability of and access to FP planning methods - (condoms) and other FP methods at all times.
- Promote access to family planning interventions (methods) through channels such as community-based distributors, bars and lodges and health facilities. Promote access to and use of emergency

- post coital contraception in cases of rape or unprotected sex etc.
- Train staff to be competent in the provision of family planning services.
- ### **5.2.3 Sexually Transmitted Infections/HIV/AIDS**
- Conditions of poverty, powerlessness and social instability predispose to the spread of STDS/HIV/AIDS. Hence
- Sensitise communities on risks of the various STI/HIV/ AIDS in unstable settings. Target reaching different levels of community – and target person to person and families through mass community/population sensitization.
  - Use various media for communications including posters, drama groups etc. Avail/develop health education materials that are user friendly to the community.
  - Ensure consistent availability of drugs for STDs treatment and opportunistic infections against HIV/ AIDS.
  - Ensure health facilities provide user friendly STD services (i.e private and confidential). Arrange health facilities to ensure women and youths are comfortable to access and use the services.
  - Train personnel working in the facilities in STD management to ensure effective and quality treatment/management of STDs.
  - Ensure availability of guidelines for case management of STDs-case definitions and management protocol of STDs.
  - Provide effective STD treatment and partner follow up. Integrate services of the displaced with that of host population to ensure the two populations access drugs in order to lower prevalence of cross community infections.
  - Institute voluntary counseling and testing (VCT) services. Support displaced persons to access anti retroviral drugs (ART) in established host or refugee health facilities.
  - Ensure health facilities adhere to universal methods – precautions against HIV/AIDS prevention and control.

#### **5.2.4 Gender Based Violence**

Gender based violence is often a problem but not well measured, therefore;

- Establish reporting and documentation of gender based violence in the camps settings. Sensitise community members, their leaders and service providers about the issue and establish mechanisms of reporting.
- Strengthen law enforcement and legal prosecution of perpetrators.
- Train and equip service providers, police and community leaders to take a lead in protection of community members in the prevention and sensitization about GBV.
- Provide care-intervention i.e medical, psychosocial and community based peer support to victims. Offer refresher training to medical personnel to provide effective medical and psychosocial response/care.
- Support communities especially women groups to establish networks to promote awareness, design and implement programmes to address sexual and gender based violence.
- Undertake campaigns – sensitisation about FGM and other forms of GBV. Involve community health workers, TBAs and community opinion leaders to take a lead.

#### **5.2.5 Adolescent Health**

- Provide adequate information to adolescents about sexuality and reproduction. Involve adolescents-peers health educators in SRH programmes.
- Endeavour to establish user friendly SRH services provision characterized by (being free or low cost, private and confidential, same sex providers, flexible

time of facility openings etc). The package of SRH for adolescents and teenagers should include family planning and STI management.

### 5.2.6 Package of Sexual and Reproductive Service

In emergency conflict settings, effective SRH services should;

- Provide MISP package to address SRH needs.
- Integrate reproductive health services as an integral part of essential health intervention in emergency situations.
- Support health facilities to render all elements of SRH services.

### 5.2.7 Modalities of Delivery of Sexual and Reproductive Health Services

- Implement the minimal initial service package (MISP) right from emergency phase of displacement. Establish static service points-facilities.
- Strengthen emergency health facilities to provide full range of sexual and reproductive health services. Sexual and reproductive health services should be provided in an integrated manner.
- Integrate health services provided by NGOs and government – district local health service.
- Ensure availability of transport - ambulance services to facilitate delivery of emergency and comprehensive essential obstetric care.

### 5.2.8 Information Education and Communication (IEC) and Advocacy Strategy

- Provide adequate information about SRH problems and services to displaced populations. Involved host communities as much as possible.

- Use various channels of communication including posters/pamphlets, peer groups sensitisation, drama groups etc.
- Develop culture specific and sensitive IEC materials. IEC materials should be developed in the local languages whenever feasible.

### 5.2.9 Reproductive Health Rights

- Promote awareness about sexual and RH rights. Sensitize/educate and encourage parents be to report cases of sexual rights abuse - defilement. Enforce laws – measures against perpetrators of sexual and gender base violence.
- Promote education. Support girl child education. Discourage early marriage.
- Promote IGAs for the displaced populations in order to reduce poverty. Target women groups' especially vulnerable single or female headed households.

## 5.3 Recommendations/Guidelines for Sexual and Reproductive Health in Post Emergency Refugee Settings

### 5.3.1 Safe motherhood

- Since most mothers deliver at home and only few births 1 in 3 take occur in health facility. Provide training and regular refresher courses for care providers and TBAs on safe motherhood practices.
- Sensitise the community, mothers and couples on safe motherhood issues – natal, pre natal and post natal care. Target men and community and opinion leaders for sensitization.
- Staff and adequately equip health facilities to carry out deliveries on a 24 hour basis.
- Ensure that transport facilities – ambulance for referrals of mothers who require major obstetrical interventions – surgical interventions i.e for

Comprehensive Emergency Obstetric Care (CEO) is accessible on a 24 hour basis.

### **5.3.2 Family Planning**

Given the low contraceptive prevalence rate in the district and amongst the IDPs, and the dual advantages of contraceptives – condoms – protection against unwanted pregnancy and STD/HIV/AIDS acquisition.

- Sensitise the community about correct use and the advantages of family planning. Use various channels to provide family planning services - such as through community-based distributors, bars and lodges and health facilities.
- Ensure regular or consistent availability of and access to FP planning methods - condoms and other FP methods at all times.

### **5.3.3 Sexually Transmitted Infections/HIV/AIDS**

There is high prevalence of STDs/HIV/AIDS in the district and amongst the displaced populations. Hence

- Ensure high level of awareness about various STI/ HIV/AIDS problems. Use various strategies-activities to reach different levels of community – person to persons, family and community mass sensitization. Use various media e.g including posters, pamphlets and drama groups.
- Design health facilities to ensure SRH and STD services are user friendly, private and confidential. Health facilities - services should be arranged to ensure women and youths are comfortable to use the services.
- Ensure consistent availability of drugs for STDs treatment and opportunistic infections against HIV/ AIDS.
- Train personnel working in the facilities to ensure effective and quality treatment/management of STDs.

- Provide guidelines for case management of STDs- case definitions and management protocol of STDs.
- Institute voluntary counseling and testing (VCT) services. Support IDPs to access Anti retroviral drugs (ART) available in the district.
- Institute comprehensive care for people with HIV/ AIDS. Educate individuals and families on HIV/AIDS prevention and care. Support social support systems for HIV/AIDS care and welfare services.

### **5.3.4 Gender Based Violence**

Effective sexual and gender based violence response interventions should encompass;

- Sensitization of community, their leaders and service providers about the issue and establishing mechanisms of reporting.
- Strengthening law enforcement and legal prosecution of perpetrators.
- Equipping/training service providers, police and community leaders to take a lead in protection of community members in the prevention and sensitization about GBV.
- Training health workers to provide effective – medical, psycho-social response/care.
- Provision and strengthening of social, psychosocial and community based peer support systems.
- Increase participation of IDPs especially women groups and establishment of networks in promoting awareness, design and implementation of programmes to address sexual and gender based violence.

### **5.3.5 Adolescent Health**

Effective sexual and reproductive health interventions/ response for adolescents should entail;

- Provision of adequate access to information about sexuality and reproduction.
- Ensuring friendly SRH services characterized by being free or low cost, private and confidential, same sex providers, flexible time of facility openings etc. The package SRH for adolescents and teenagers should include family planning and STI management.

### 5.3.6 Package of Sexual and Reproductive Service

In post emergency conflict settings, effective SRH services should offer;

- Comprehensive SRH services that include; Safe motherhood – prenatal, natal and post natal services. STI treatment including HIV/AIDS care includes treatment of opportunistic infection; referral services

for treatment in hospital. Adolescent health services include – family planning-condom, treatment of STIs. Family planning services – contraceptives provided include condoms.

- Integrated sexual and reproductive health services.

### 5.3.7 Modalities of Delivery of Sexual and Reproductive Health Services

- Use permanent or temporary static service points-facilities. Implement the minimal initial service package (MISP) right from emergency phase of displacement.
- Provide integrated sexual and reproductive health services. Integrate health services provided by NGOs and government – district local health service.



Strengthen emergency health facilities to provide full range of sexual and reproductive health services.

- Ensure availability of transport - ambulance services to facilitate delivery of SRH especially emergency referral services.

#### **5.3.8 Information Education and Communication (IEC) and Advocacy Strategy**

- Use a variety of channels for communication advocacy including community leaders to sensitise the masses, peer groups, drama groups, radio programme and print media such as posters and pamphlets.
- Develop and disseminate IEC materials such as posters and pamphlets. The IEC materials developed

should be adapted to the local languages. Include host communities as much as possible.

#### **5.3.9 Reproductive Health Rights**

- Promote awareness about sexual and RH rights. Sensitized and encourage parents/guardians to report cases of sexual rights abuses.
- Enforce laws – strengthen measures to punish perpetrators of sexual and gender base violence.
- Support girl child education – stay at school. Discourage early marriage.
- Promote IGAs for the displaced populations in order to empower them. Target women groups, especially single or female headed households.

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# APPENDICES

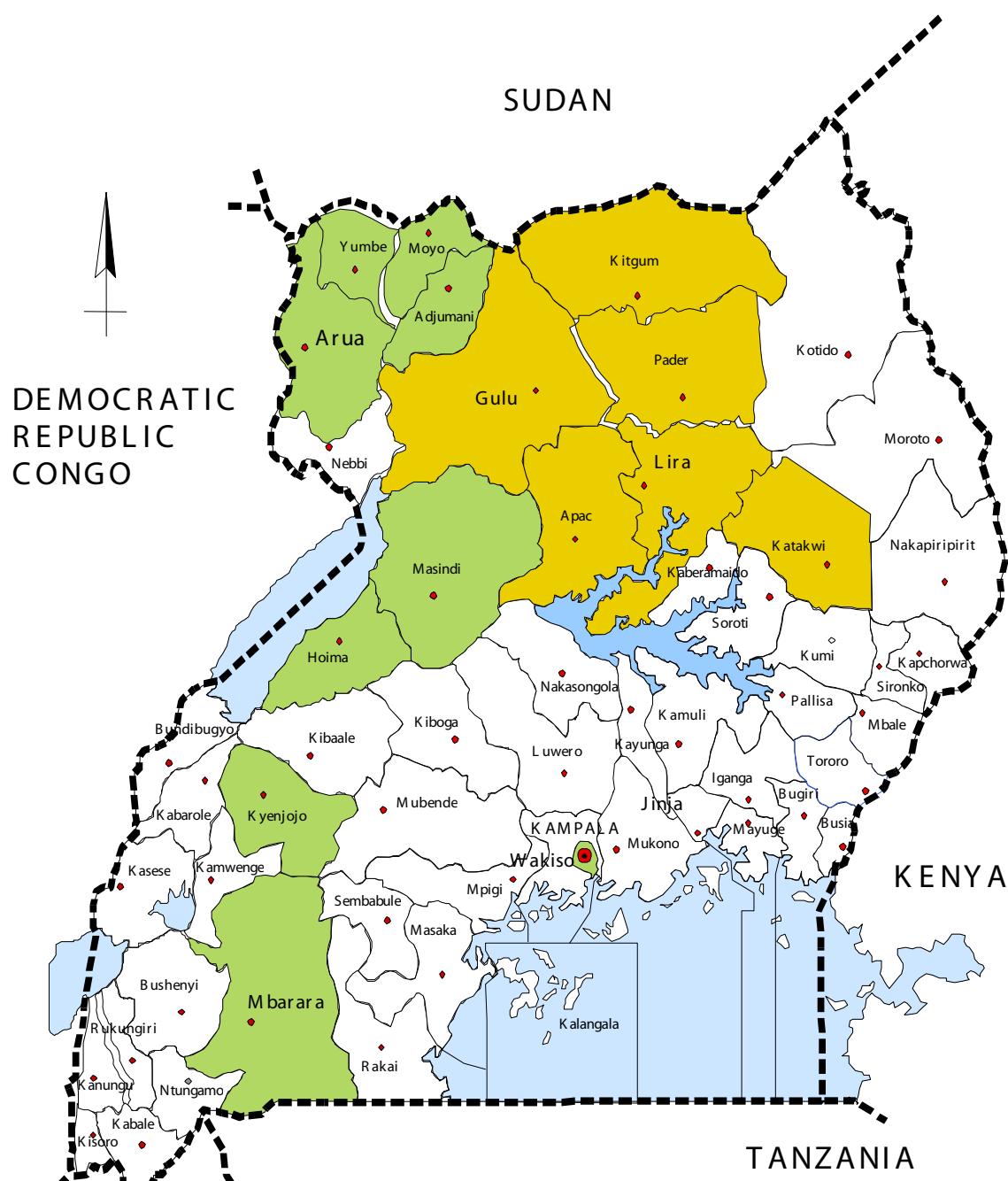
## Appendix 1: List of Key Informants Interviewed

### A. List of Key Persons Interviewed -Uganda

- |                           |                                    |
|---------------------------|------------------------------------|
| 1. Dr Dominique Timapasha | UNHCR, Kampala Uganda              |
| 2. Dr Orinda Vincent      | UNICEF, Kampala Uganda             |
| 3. Dr Achaye Godfrey      | UNICEF, Kampala Uganda             |
| 4. Ms Monica Emiru Enyou  | UNICEF, Kampala Uganda             |
| 5. Beatrice Lakot         | OCHA, Lira Uganda                  |
| 6. Dr Diana Nahaabi       | IOM Kampala                        |
| 7. Mr Micheal Kilama      | IOM Kampala                        |
| 8. Dr Onek Paul           | DMO Gulu                           |
| 9. Mrs Tamale Luguma      | DHV Gulu                           |
| 10. Mr Opwonya            | DMOs Office Gulu                   |
| 11. Mr Olando             | District Nursing Officer Gulu      |
| 12. Dr Adibaku Seraphin   | DMO Moyo                           |
| 13. Dr Richard Mangwi     | MO Moyo                            |
| 14. Dr Felix Kaducu       | Medical Superintendent Gulu        |
| 15. Mr Albert Onyuta      | Community Development Officer Gulu |
| 16. Otim Alfred           | Community Development Officer      |
| 17. Anena Irene           | Unyama IDP Camp                    |
| 18. Okwonga Alfred        | Clinical Officer Pabbo             |
| 19. Ojok Wilson           | Camp Leader, Pabbo, IDP Camp       |
| 20. Odong Phillip         | Camp Leader Unyama, IDP Camp       |

### B. List of Key Persons Interviewed - Chad

- |                               |                                  |
|-------------------------------|----------------------------------|
| 1. Ana Liri                   | UNHCR Ndjamena                   |
| 2. Nshimirima Juma            | Care Chad                        |
| 3; Madlene Evrard             | Care                             |
| 4 Roupen Alexandrian          | UNHCR Field Officer              |
| 5. Sabine Terrnet             | MSF Luxembourg                   |
| 6. Barbara Standaert          | MSF                              |
| 7. Miriam Mueni      Mutunga  | IMC                              |
| 8. Ndilenone Gotobaye         | IMC                              |
| 9. Dr Sylvain Naissem         | IMC                              |
| 10 Sam Mbuga                  | UNHCR                            |
| 11 Emmanuel Uwurukundo        | UNHCR                            |
| 12 Musa Outman                | DAR TAMA      Guereda            |
| 13 Jane Opiyo                 | IMC                              |
| 14 Dr Anthony Yousepha Lasuba | IMC                              |
| 15 Dr Ezeikel Muloway         | IMC                              |
| 16 Dr Lizette Boestra         | UNHCR                            |
| 17 Patrice Page               | UNICEF                           |
| 18 Benard Chamoux             | UNHCR                            |
| 19 Dr Razak                   | Red Crescent                     |
| 20 Dr Ali                     | Regional Health Director, Abeche |
| 21 Bichara Sousa Nguele       | ASTBEF                           |



**Refugee Affected Districts**

Arua, Adjumani, Yumbe, Moyo, Masindi, Hoima, Kampala, Kamwembe, Mbarara and Kampala

**Districts with IDPs**

Gulu, Kitgum, Pader, Lira, Apac, Katakwi and Kampala

A photograph showing several women in a classroom or workshop setting. One woman in the foreground is seated at a table, looking down at something on it. Behind her, other women are standing and talking. The room has simple walls and some equipment visible in the background.

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