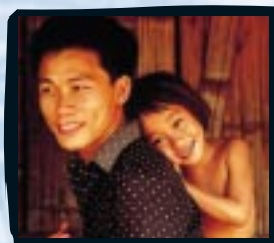
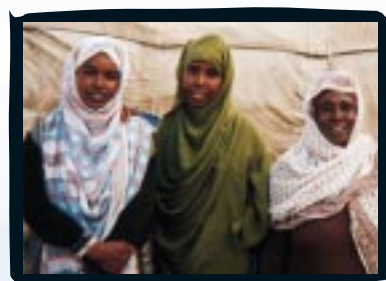
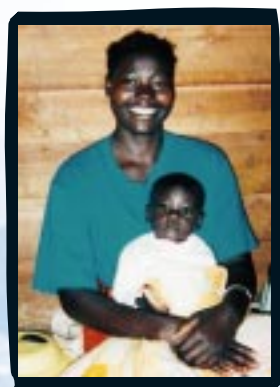


Reproductive Health

in refugee situations



an
Inter-agency
Field
Manual



Reproductive Health

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Manual**



This Inter-agency Field Manual replaces the above field-test version.

Additional copies of the Field Manual can be obtained from the agencies cited on the back cover.

Any comments can be directed to the following:

- World Health Organisation (WHO)
Department of Reproductive Health and Research
- United Nations Fund for Population Activities (UNFPA)
Emergency Relief Office, Geneva
- United Nations High Commissioner for Refugees (UNHCR)

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Reproductive health is a *right*; and like all other human rights it applies to refugees and persons living in refugee-like conditions. To exercise this right, populations caught up in conflict and living in emergency situations must have an enabling environment and access to complete reproductive health information and services so they can make free and informed choices. They also must feel comfortable and secure in discussing their most private concerns with those who seek to help them.

Quality reproductive health services must be based on refugees', particularly women refugees', needs. They must also respect refugees' various religious and ethical values and cultural backgrounds while conforming to universally recognised international human rights standards. Therefore, full information on options, and access to reproductive health services should be provided, leaving the decision to the individual.


Reproductive health care covers a wide range of services. These are defined as follows in the Programme of Action of the International Conference on Population and Development (ICPD) held in Cairo, Egypt, in September 1994: family-planning counselling, information, education, communication and services; education and services for prenatal care, safe delivery and post-natal care, and infant and women's health care; prevention and appropriate treatment of infertility; prevention of abortion and the management of the consequences of abortion; treatment of reproductive tract infections, sexually transmitted diseases, including HIV/AIDS; breast cancer and cancers of the reproductive system, and other reproductive health conditions; and active discouragement of harmful traditional practices, such as female genital mutilation.

Providing comprehensive and high-quality reproductive health services requires a multi-sectoral integrated approach. Protection, health, nutrition, education and community service personnel all have a part to play in planning and delivering reproductive health services.

The best way to guarantee that reproductive health services meet the needs of the refugee community is to involve the community in every phase of the development of those services: from designing programmes to launching and maintaining them to evaluating their impact. Only then will refugees benefit from services specifically tailored to their needs and demands; and only then will they have a stake in the future of those services.

This Inter-agency Field Manual on Reproductive Health in Refugee Situations is the result of a collaborative effort of many UN agencies, governmental and non-governmental organisations and refugees themselves. Information in this Manual is based on the normative, technical guidance of the World Health Organization. A draft of the Field Manual was first issued in 1996 and tested extensively in the field. This new version can, and should, be shaped and adapted to suit the particular circumstances and requirements of each refugee situation as it arises and evolves.

We are pleased with the progress already made in meeting the reproductive health needs of refugees and persons living in refugee-like situations; but we also know this is no time to lose momentum. We hope the Field Manual will serve to improve the health and well-being of refugees and foster more responsive and appropriate actions in the field.



Gro Harlem Brundtland
Director General
WHO



Nafis Sadik
Executive Director
UNFPA



Sadako Ogata
High Commissioner
for Refugees
UNHCR

At an Inter-agency Symposium on Reproductive Health in Refugee Situations held in Geneva, Switzerland in June 1995, more than 50 governments, non-governmental organisations (NGOs) and UN agencies committed themselves to strengthening reproductive health (RH) services to refugees. Following the symposium, an *Inter-agency Field Manual on Reproductive Health in Refugee Situations* was produced and distributed for field-testing around the world.

This 1999 revision of the Field Manual is the result of two years of field use and comprehensive field-testing conducted under the auspices of the Inter-agency Working Group on Reproductive Health in Refugee Situations. More than 100 experienced staff from 50 agencies working in refugee situations in 17 countries applied the Field Manual in their programmes and provided comments and suggestions for improving the content of the publication.

The Field Manual supports the delivery of quality RH services. Technical standards included in the Field Manual are those set by the World Health Organization. In several important areas, the Field Manual provides programmatic direction with frequent reference to additional resource materials that should be obtained and used to ensure comprehensive and reliable RH services for refugees.

Field managers of health services in refugee situations are the primary audience for the Field Manual. Community-services officers, protection officers and others working to meet the needs of refugee women, young people and men should also benefit from the guidance offered in the Field Manual.

The purposes of the Field Manual are:

- to serve as a tool to facilitate discussion and decision-making in the planning, implementation, monitoring and evaluation of RH interventions;
- to guide field staff in introducing and/or strengthening RH interventions in refugee situations, based on refugee needs and demands and with full respect for their beliefs and values; and
- to advocate for a multi-sectoral approach to meeting the RH needs of refugees and to foster coordination among all partners.

Chapter One lays the foundation for the subsequent technical chapters on reproductive health and provides the guiding principles for undertaking all RH care. It should be read carefully.

The components of reproductive health described in the Field Manual are:

- Minimum Initial Service Package
- Safe Motherhood
- Sexual Violence
- Sexually Transmitted Diseases, including HIV/AIDS
- Family Planning
- Other Reproductive Health Concerns
- Reproductive Health of Young People

ACKNOWLEDGMENTS

The entities listed contributed to this Field Manual and are among those who believe it will facilitate the delivery of reproductive health services in refugee situations.

Action Contre la Faim
African Medical and Research Foundation
American Refugee Committee
CARE
Centre for Research on the Epidemiology of Disasters
Centro de Capacitación en Ecología y Salud para Campesinos
Center for Population and Family Health – Columbia University's Mailman School of Public Health
Family Health International
International Centre for Migration and Health
International Federation of the Red Cross and Red Crescent Societies
Ipas
International Planned Parenthood Federation
International Rescue Committee
International Organization for Migration
JSI Research and Training Institute
London School of Hygiene and Tropical Medicine
Marie Stopes International
Médecins du Monde
Médecins sans Frontières
MERLIN (Medical Emergency Relief International)
Population Council
Save the Children Fund UK
United Nations Children's Fund
United Nations High Commissioner for Refugees
United Nations Joint Programme on AIDS
United Nations Fund for Population Activities
U.S. Agency for International Development
U.S. Centers for Disease Control and Prevention
U.S. Department of Health and Human Services
U.S. Department of State
Women's Commission for Refugee Women and Children
World Association of Girl Guides and Girl Scouts
World Health Organization

The UN, NGO and Government members of the Inter-agency Working Group on Reproductive Health in Refugee Situations (IAWG) are gratefully acknowledged for their continuous review of this Field Manual.



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Each collaborating agency will implement the interventions described in this Field Manual according to its mandate.

Reproductive health (RH) care should be available in all situations and be based on the needs and expressed demands of refugees, particularly women, with full respect for the various religious and ethical values and cultural backgrounds of the refugees while also conforming with universally recognised international human rights.

The above principle is the cornerstone of this Field Manual and should be the basis of all RH interventions.

Special Notes:

- ✓ This Field Manual is intended for use in refugee situations. It may also be of use in refugee-like situations, such as in situations with internally displaced persons or returnee-affected areas.
- ✓ The term “refugee” is used herein to describe the beneficiaries of RH care, regardless of their legal status.
- ✓ UNHCR defines an emergency as “any situation in which the life or well-being of refugees will be threatened unless immediate and appropriate action is taken and which demands an extraordinary response and exceptional measures.”

1

CHAPTER ONE

Fundamental Principles

Contents:

- Timely Reproductive Health Interventions
- The Complexity of Intervening
- Guiding Principles
 - Community Participation
 - Quality of Care
 - Integrating Services
 - Information, Education and Communication
 - Advocacy for Reproductive Health
 - Coordinating Activities
- Needs Assessment
- The Structure of the Field Manual

Fundamental Principles

Definition of Reproductive Health

Reproductive health is a state of complete physical, mental and social well being and not merely the absence of disease and infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

International Conference on Population and Development – Cairo 1994; Programme of Action, para 7.2

Timely Reproductive Health Interventions

Providing adequate food, clean water, shelter, sanitation and primary health care (PHC) are priority activities in any refugee emergency. These interventions help combat the major killers in refugee situations: malnutrition, diarrhoeal diseases, measles, acute respiratory infections (ARI) and malaria (where prevalent). However, RH care is also crucial for the physical, mental and social well being of any individual. As an integral part of PHC, RH care is important in overcoming such problems as:

- complications of pregnancy and delivery, which are leading causes of death and disease among refugee women of child-bearing age;

- malnutrition and epidemics, which can further diminish the physiological reserves of pregnant or lactating women, thus endangering their health and that of their child; and
- an absence of law and order, commonly seen in refugee emergencies, which, together with men's loss of power and status, leads to an increased risk of sexual violence. Violence against refugee women, rape, sexual abuse, involuntary prostitution, even physical assault during pregnancy have been found to be far more widespread than was previously acknowledged.

Some General Facts About Reproductive Health

- ✓ 585,000 women die each year—one every minute—from pregnancy-related causes. Ninety-nine per cent of these deaths occur in developing countries.
- ✓ Girls aged 15-19 are twice as likely to die from childbirth as women in their twenties. Those under 15 are five times as likely to die from childbirth.
- ✓ More than 330 million new cases of sexually transmitted diseases (STDs) occur every year, affecting 1 of every 20 adolescents.
- ✓ By the year 2000, up to 40 million people could be HIV-infected.
- ✓ 120 million women say they do not want to become pregnant, but are not using any method of family planning.
- ✓ 20 million unsafe abortions occur every year—55,000 each day—resulting in some 80,000 deaths and hundreds of thousands of disabilities.

Source: WHO—World Health Day—Safe Motherhood—1998

Unquestionably, women are most affected by reproductive health problems. For refugee women, this burden is further compounded by the precariousness of their situation.

The Complexity of Intervening

It is important that RH interventions are not only timely but also appropriate and consistent with national laws and development priorities. RH programmes affect highly personal aspects of life, so programmes must be particularly sensitive to religious and ethical values and cultural backgrounds of the refugee population.

It may not always be feasible for one organisation to implement the full range of RH services. Providing comprehensive RH services may require cooperation and coordination among agencies.

The complexities of reproductive health were discussed at the Fourth World Conference on Women (Beijing 1995). Participants listed the following as some of the reasons why many of the world's people do not benefit from reproductive health:

"... inadequate levels of knowledge about human sexuality; inappropriate or poor-quality RH information and services; the prevalence of high-risk sexual behaviour; discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives."

Platform of Action, paragraph 7.3—Beijing 1995

"Adolescents are particularly vulnerable," they concluded.

Refugees face even greater difficulties in obtaining RH services. Among them:

- The breakdown of pre-existing family support networks means that young men and women lose their traditional sources of information, assistance and protection.

- Loss of income reduces the refugees' ability to make free choices.
- Women may become solely responsible for the welfare of their families. Fulfilling the role of breadwinner often represents a great emotional and physical burden that is not adequately compensated by appropriate services.
- Attention is often focused exclusively on immediate life-saving measures; RH care is not considered a priority. (Hence the development of this Field Manual and the recommendations for the Minimum Initial Service Package—MISP—described in Chapter Two.)

Guiding Principles for Intervention

A successful RH programme requires adequate and well-trained staff, sufficient funding, and effective

- community participation
- quality of care
- integration of services
- inclusion of information, education and communication (IEC) activities
- advocacy for reproductive health
- coordination among relief agencies.

These principles are applicable to every aspect of RH assistance and to all subsequent chapters of this Field Manual.

Community Participation

Community participation is essential at all stages to ensure the acceptability, appropriateness and sustainability of RH programmes. It is necessary for empowering refugees, particularly women, to have greater control over their lives and over the services that are provided to them.

In an emergency, refugees are extremely vulnerable. It may be easy to overlook their particular needs in the urgency of providing services. Their participation is vital in ensuring that this does not happen, and that the services are adapted to the users rather than vice versa. In each situation it is necessary to identify groups and channels through which participation can be fostered. However, it is also important to recognise that the leaders may not be best placed or able to provide the information and support needed to successfully adapt RH services to the population concerned. Participation may be best achieved through the family unit.

It is only by taking into account the cultural, economic, ethical, legal, linguistic and religious backgrounds of the refugees and host country population that appropriate services can be offered to and used by refugees. By actively participating, refugees develop the sense of “ownership” over programmes that is essential for sustainability.

It is through community participation that essential information will be gathered to direct the planning of services. Such information includes:

- identification of the training needs of care providers;
- selection of appropriate sites to avoid stigmatisation of users;
- analysis of the appropriate level of privacy and confidentiality required by local customs, cultures or beliefs;
- decisions on whether primarily female staff must be used; and
- recognition of birthing preferences.

A failure to obtain such information may have a negative impact on the use of services, for example, if family members are excluded from a birth when they have an important cultural role to play at such times.

It is important that both men and women be involved in many aspects of the RH programme to promote responsible and caring

attitudes and behaviour for the benefit of all. Although men may be poorly informed about RH matters, they are often the decision-makers. Health providers need to be aware of the roles and decision-making process within the family so they can provide services effectively and in the best interests of the whole family.

Quality of Care

Quality RH services require that organisations, programmes and providers,

- use appropriate technologies and have trained staff,
- respect refugees’ rights to informed consent by providing adequate information and counselling, and
- ensure accessible services, privacy, confidentiality, and continuity of care.

These aspects of quality of care are also guiding principles of medical ethics in the protection of human rights.

Appropriate Technologies and Skills

Appropriate technologies must be selected according to internationally accepted standards. Providers must be adequately trained, equipped and supervised. Appropriate supplies must be available, clean, and, when necessary, sterile. All invasive procedures must involve infection prevention, proper use of drugs, etc. All interventions must be safe—which requires a sufficiently staffed health facility, technically competent providers, properly functioning equipment, adequate supplies, and a responsive logistics system.

Access

Primary health care (PHC) services must be available within a reasonable distance from all patients. A referral network, including transportation, to higher-level facilities should be coupled to PHC services. Patients’ access to services should not be contingent on social or cultural backgrounds nor on age, marital sta-

tus, parity, number of male children, sexual orientation, or partner or parental consent. Patients should not be required to accept one service in order to gain access to another type of service.

Informed Consent

A patient has the right to know, before any procedure is performed, what the procedure involves as well as its expected benefits, possible risks, duration of treatment, and cost to the patient or her/his family. This information must be presented to the patient in a language that s/he can understand.

Informed consent means that the patient not only has choices, but also can make an educated decision among various options. To make such a decision, the patient must know her/his condition and have ample opportunity to ask questions and receive answers from a knowledgeable provider.

Privacy

Visual and auditory privacy must be maintained during all phases of patient care—from presentation through diagnosis, testing, treatment, and counselling. Examination tables should face away from doors and windows so that a woman will not risk exposure during examination, particularly during pelvic examination. Windows should be covered, and partitions placed between examination areas. Others within the health facility should not be able to overhear the interaction between the patient and health provider.

Confidentiality

All information regarding the patient, her/his history, treatment, condition, circumstances, and prognosis is discussed only between the patient, the provider and supervisors. No staff member should share patient information with anyone who is not directly involved in the patient's care without the patient's permission. Medical records should be stored in a locked room or file cabinet to which only providers and supervisors have access. Medical records should never leave the clinic unless required for patient referral to another clinic.

Respect

All health staff should talk with patients politely and manage patient care in a compassionate and non-judgmental fashion. Patients have the right to ask questions and to expect those questions will be answered in a timely, complete and understandable manner. Patients need to know how to recognise and manage common complications of their condition, signs and symptoms indicating the need for additional medical attention, and when and how to obtain follow-up care.

Integrating Services

It is important to distinguish between different aspects of integration. Reproductive health services should be integrated into primary health care. Integration may occur in relation to the place at which services are provided or the personnel who provide those services.

The potential to integrate services provided at any particular site will depend on the skills and resources available. It is unreasonable to expect the community health worker to provide too wide a range of services. A health centre will have greater resources and more skilled personnel, and so greater integration at one site becomes possible. The referral-level facility must be able to provide services to meet all needs.

Successful integration is dependent on the quality of communication among the various personnel, at different levels, within the overall service. All personnel must be fully aware of how the system operates, what services are provided at each level, and how those who want to use the services can do so. The staff at one level must be able to provide information about all other levels. Communication must also ensure that when referrals are made between levels, adequate information is received about a patient at both ends of the service. Information must travel in both directions and must cover both the reasons for a referral and the eventual consequences of any action taken.

Good communication among levels is essential to deal satisfactorily with issues relating to support, supervision and training, all of which are essential in maintaining quality. Specific training of personnel may be necessary to ensure that the designated services can be provided at each level by appropriately skilled personnel.

RH services should be considered neither as optional nor as special projects. They should be integrated in a timely fashion within PHC and community service activities. Even when the delivery of RH services calls for special arrangements or resources, this cannot justify their postponement or neglect.

Information, Education and Communication (IEC)

Reproductive health requires knowledge and understanding about human sexuality and appropriate, adequate and accessible information.

It is important to raise the level of knowledge about reproduction and sexuality. Women, men and adolescents should understand how their bodies work and how they can maintain good reproductive health. Scientifically validated knowledge should be shared to promote free and informed choice and to counter misperceptions and harmful practices.

IEC activities are essential for sharing this knowledge. Such activities range from “one-to-one” conversations between service providers and refugees to highly developed formal campaigns.

There are also effective IEC strategies that promote community participation and individual commitment to changing behaviours.

IEC essentials can be found in Appendix One.

Advocacy for Reproductive Health

The active promotion of reproductive health should be part of all refugee assistance programmes from the outset. A lack of awareness of the issues involved in protecting and promoting reproductive health may be found in all groups involved in a refugee setting, from the providers of health care to the community they serve. This lack of awareness may become a real barrier to improved reproductive health and responsible sexual behaviour.

However, opportunities to promote RH issues may be limited. Any advocacy that is undertaken must demonstrate understanding of the culture, values and belief systems of the local population. Advocacy that is insensitive or disrespectful may be counterproductive and prompt rejection, or even reprisals, within the refugee community.

Coordinating Activities Among Relief Agencies

Coordination is needed among:

- sectors (health, community services, protection),
- implementing agencies (government, NGOs, UN agencies), and
- levels of service providers (doctors, midwives, Traditional Birth Attendants [TBAs], health assistants).

To foster this coordination, it is recommended that an individual be identified as RH Coordinator in each refugee situation. This person would assume the responsibility for overall organisation and supervision of RH activities, as well as the integration of these services within other health services.

The issue of sexual violence provides an excellent illustration of the need to coordinate among sectors. To deal with the causes and consequences of violence, health professionals must work closely with staff in the protection and community services sectors. By doing so, staff can develop detailed procedures on

appropriate care for survivors and strategies to prevent the occurrence of sexual violence.

Coordination among implementing agencies requires that, although each agency has its own expertise and range of qualified staff, there should be a standard approach used by all agencies involved. Even though an agency may not provide a full range of RH services, coordination with others would ensure that the end product is complementary and comprehensive RH care. Uncoordinated activities result in inappropriate allocations of scarce resources and reduced impact of the project.

Needs Assessment

RH services must be based on the expressed needs and demands of refugees. RH needs assessments should be carried out when the emergency situation has stabilised. This Field Manual does not give detailed guidance on conducting needs assessment, but refers the field staff to a set of tools created by the Reproductive Health for Refugees (RHR) Consortium for this purpose. (See Further Reading)

The following RH needs assessment tools have been developed by the RHR Consortium:

- Refugee Leader Questions
- Group Discussion Questions
- Survey (for analysis by computer)
- Survey (for analysis by hand)
- Health Facility Questionnaire and Checklist

These tools assist relief workers in gathering information to assess attitudes toward RH practices, local medical practices and policies, the scope of needed services and the degree to which current services provide what is needed.

The tools, which should be adapted to each situation, are designed to be used by people with field management experience and/or RH

experience to design new RH programmes, assess existing capacity and monitor services. The refugee community should be involved in the needs assessment process from the beginning. Refugees should participate in:

- conceptualising the needs assessment framework,
- site selection for the assessment,
- translation/interpretation of tools,
- interviewing fellow refugees,
- data analysis and interpretation,
- feedback to the community,
- design or redesign of the RH programme based on the needs assessment findings.

The Structure of the Field Manual

The principles that have been developed within this introduction apply to all chapters throughout the Field Manual.

Not all components of RH service provision are appropriate within the initial phases of a refugee situation. This Field Manual is intended to assist field staff in implementing such services in phases, moving from minimal to comprehensive services as the situation gradually stabilises.

In recognition of the urgency in dealing with some RH issues, Chapter Two of this Field Manual describes in detail the components of a “Minimum Initial Service Package” (MISP). It is a range of core RH activities to be carried out from the beginning of the emergency. The activities outlined within MISP should be conducted alongside other initial-phase interventions that take place in any newly identified refugee or emergency situation.

A more comprehensive package of RH interventions must then be provided as the situation stabilises. These interventions should be integrated into Primary Health Care services.

The remaining chapters of the Field Manual and the main goal of each are:

CHAPTER 2: *MISP*

OVERALL GOAL: initiate selected RH activities as soon as feasible in an emergency

CHAPTER 3: *Safe Motherhood*

OVERALL GOAL: prevent excess maternal and peri/neonatal mortality and morbidity

CHAPTER 4: *Sexual and Gender-based Violence*

OVERALL GOAL: prevent and manage the consequences of sexual and gender-based violence

CHAPTER 5: *Sexually Transmitted Diseases (STDs) including HIV/AIDS*

OVERALL GOAL: prevent and treat STDs, reduce the transmission of HIV infection, and assist in caring for those affected

CHAPTER 6: *Family Planning*

OVERALL GOAL: enable refugees to decide freely the number and spacing of their children

CHAPTER 7: *Other RH Concerns*

OVERALL GOAL: prevent excess maternal morbidity and mortality due to the complications of spontaneous and unsafe abortions and promote the eradication of Female Genital Mutilation.

CHAPTER 8: *RH of Young People*

OVERALL GOAL: promote and support reproductive health of young people

CHAPTER 9: *Monitoring and Surveillance*

OVERALL GOAL: set objectives, measure progress and make programmatic decisions based on evidence

APPENDIX One: *Information, Education, Communication*
OVERALL GOAL: promote reproductive health of refugee populations based on the refugee population's needs and desires

APPENDIX Two: *Legal Considerations*
OVERALL GOAL: provide information on reproductive rights

APPENDIX Three: *Glossary of Terms*
OVERALL GOAL: define important terms

APPENDIX Four: *Reference Addresses*
OVERALL GOAL: assist the reader in obtaining additional reference documents

Each chapter of the Field Manual begins with an overall goal and provides detailed guidance on the elements of the RH component. These elements need to be adapted to each refugee situation in close collaboration with host-country authorities. A checklist for establishing the particular RH component is provided at the end of each chapter. This list can also be used for supervising and monitoring. Further references can also be found at the end of each chapter.

This Field Manual does not address a number of other issues related to reproductive health, either because they are relatively less significant in terms of public health, or because they may be approached as in normal situations and information on the issue is abundant elsewhere. This is the case for most needs of post-menopausal women, elective abortion, reproductive tract cancers and infertility.

Further Readings

"Declaration and Platform for Action", Fourth World Conference on Women, Beijing, 1995.

"Medical Ethics and Human Rights: Guiding Principles", Commonwealth Medical Association, London, 1997.

"Programme of Action", International Conference on Population and Development, Cairo, 1994.

"Refugee Reproductive Health Needs Assessment Field Tools", Reproductive Health for Refugees Consortium, New York, 1997.

"Refugee Women and Reproductive Health Care: Reassessing Priorities", Women's Commission for Refugee Women and Children, New York, 1994.

"Reproductive Health Services During Conflict and Displacement: Guidelines for the Design and Management of Reproductive Health Programmes" (in preparation), WHO, Geneva, 1998.

Reproductive Health One and Five Day Training Packages, RHR Consortium, New York, 1998.

This Chapter describes a series of actions needed to respond to the reproductive health (RH) needs of populations in the early phase of a refugee situation (which may or may not be an emergency). The Minimum Initial Service Package (MISP) can be implemented without any new needs assessment since documented evidence already justifies its use. The MISP is not just kits of equipment and supplies; it is a set of activities that must be implemented in a coordinated manner by appropriately trained staff.

Special Note:

- ✓ The reader must refer to the relevant chapters in the Manual to properly implement the MISP.

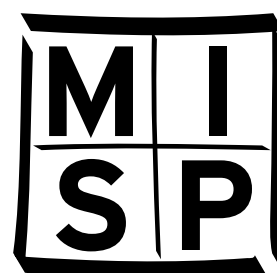
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CHAPTER TWO

Minimum Initial Service Package (MISP)

Contents:

- Objectives of the MISP
- Components of the MISP
 - Identify an organisation(s) and individual(s) to facilitate the coordination and implementation of the MISP
 - Prevent and Manage the Consequences of Sexual Violence
 - Reduce HIV Transmission
 - Prevent excess neonatal and maternal morbidity and mortality
 - Plan for the provision of comprehensive RH services, integrated into Primary Health Care, as soon as possible
- Broad Terms of Reference for a RH Coordinator/Focal Point
- Material Resources
- Monitoring and Surveillance



Minimum Initial Service Package (MISP)

The major killers in refugee emergencies—diarrhoea, measles, acute respiratory infections (ARI), malnutrition and malaria, where prevalent—are well documented. Resources should not be diverted from dealing with these problems. However, there are some aspects of reproductive health that also must be addressed in this initial phase to reduce mortality and morbidity, particularly among women.

Please remember that the components of MISP form a minimum requirement. The expectation is that the comprehensive services as outlined in the rest of this Field Manual will be provided as soon as the situation allows.

Objectives of the MISP:

- **IDENTIFY** an organisation(s) and individual(s) to facilitate the coordination and implementation of the MISP;
- **PREVENT** and manage the consequences of sexual violence;
- **REDUCE** HIV transmission by
 - ▶ enforcing respect for universal precautions against HIV/AIDS and
 - ▶ guaranteeing the availability of free condoms;
- **PREVENT** excess neonatal and maternal morbidity and mortality by
 - ▶ providing clean delivery kits for use by mothers or birth attendants to promote clean home deliveries,
 - ▶ providing midwife delivery kits (UNICEF or equivalent) to facilitate clean and safe deliveries at the health facility, and
 - ▶ initiate the establishment of a referral system to manage obstetric emergencies; and
- **PLAN** for the provision of comprehensive RH services, integrated into Primary Health Care (PHC), as the situation permits

Components of the MISP

Identify an Organisation(s) and Individual(s) to Facilitate the Coordination and Implementation of the MISP

A qualified and experienced person should be identified to coordinate RH activities at the start of the emergency response. The overall leading agency should be responsible for the designation of such a person, and the person appointed should work under the supervision of the overall Health Coordinator.

RH focal points should be designated within each camp, and within each implementing agency. These health professionals, experienced in reproductive health, should be in post for a minimum of six months, as it is likely to take this long to establish comprehensive RH services.

All relief organisations should, in accordance with their mandates, and within the framework of emergency preparedness and response, train and sensitise their staff on RH issues and gender awareness. (See *Terms of Reference for the RH Coordinator* at the end of this chapter.)

Prevent and Manage the Consequences of Sexual Violence

Sexual violence is strongly associated with situations of forced population movement. In this context, it is vital that all actors in the emergency response are aware of this issue and preventive measures are put in place. *The UNHCR Guidelines for Prevention and Response to Sexual Violence against Refugees (1995)* should be adhered to in the emergency response. Measures for assisting refugees who have experienced sexual violence, including rape, must also be established in the early phase of an emergency.

Women who have experienced sexual violence should be referred to the health services as soon as possible after the incident. Protection staff should also be involved in providing protection and legal support to survivors of sexual violence.

Key actions to be taken during the emergency to reduce the risk of sexual violence and respond to survivors are:

- design and locate refugee camps, in consultation with refugees, to enhance physical security
- ensure the presence of female protection and health staff and interpreters
- include the issues of sexual violence in the health coordination meetings
- ensure refugees are informed of the availability of services for survivors of sexual violence
- provide a medical response to survivors of sexual violence, including emergency contraception, as appropriate
- identify individual or groups who may be particularly at risk to sexual violence (single female heads-of-households, unaccompanied minors, etc.) and address their protection and assistance needs.

See Chapter Four for further information on elements of prevention and response to sexual violence.

Reduce HIV Transmission

Enforce Respect for Universal Precautions Against HIV/AIDS

Universal precautions against the spread of HIV/AIDS within the health care setting must be emphasised during the first meeting of Health Coordinators. Under the pressure of an emergency situation, it is possible that field staff are tempted to take short cuts in procedures which can jeopardise the safety of patients and staff. It is essential that universal precautions be respected. (See Chapter Five for details on universal precautions.)

Guarantee the Availability of Free Condoms

Availability of condoms should be ensured from the beginning so that they can be provided to anyone who requests them. Sufficient supplies should be ordered immediately. (See Annex 3, Chapter Five, Prevention and Care of Sexually Transmitted Diseases including HIV and AIDS for calculating condom supplies.)

As well as providing condoms on request, field staff should make sure that refugees are aware that condoms are available and where they can be obtained. Condoms should be made available in health facilities especially when treating cases of STDs. Other distribution points should be established so that those requesting condoms can obtain them in privacy.

Prevent Excess Neonatal and Maternal Morbidity and Mortality

Provide Clean Delivery Kits for Use by Mothers or Birth Attendants to Promote Clean Home Deliveries

A refugee population will include women who are in the later stages of pregnancy, and who will therefore deliver within the initial phase. Simple delivery kits for home use should be made available for women in the late stages of pregnancy. These are very simple kits that the women, themselves, or traditional birth attendants (TBAs) can use. They can be made up on site and include: one sheet of plastic, two pieces of string, one clean razor blade and one bar of soap. UNFPA also supplies this kit.

A formula, based upon the Crude Birth Rate (CBR), is used to calculate the supplies and services required. With a CBR of three to five per cent per year, there would be some 75-125 births in a three-month period in a population of 10,000. From this, a calculation can be made as to how many kits should be ordered.

Provide Midwife Delivery Kits (UNICEF or equivalent) to Facilitate Clean and Safe Deliveries at the Health Facility

In the early phase of an emergency, births will often take place outside the health facility with-

out the assistance of trained health personnel. Approximately 15 per cent of births will involve some complications. Complicated births should be referred to the health centre. The supplementary unit of the New Emergency Health Kit 98 (NEHK-98) has all the materials needed to ensure safe and clean normal deliveries. Many obstetric emergencies can be managed with the equipment, supplies and drugs contained in the NEHK-98. Obstetric complications that cannot be managed at the health centre should be stabilised before transfer to the referral hospital.

Initiate the Establishment of a Referral System to Manage Obstetric Emergencies

Approximately three to seven per cent of deliveries will require Caesarean section. Additional obstetric emergencies may need to be referred to a hospital that is capable of performing comprehensive essential emergency obstetric care. (Refer to Chapters Three and Seven for information on pregnancy and delivery complications.)

As soon as the situation permits, a referral system that manages obstetric complications must be available for use by the refugee population 24 hours a day. Where feasible, a host-country referral facility should be used and supported to meet the needs of refugees. If this is not feasible because of distance or the inability of the host-country facility to meet the increased demand, then an appropriate refugee-specific referral facility should be provided. In either case, it will be necessary to coordinate with host-country authorities concerning the policies, procedures and practices to be followed within the referral facility. The protocols of the host country should be followed, although some variation may have to be negotiated. Be sure there is sufficient transport, qualified staff and materials to cope with the extra demands.

Plan for the Provision of Comprehensive RH Services, Integrated Into Primary Health Care, as Soon as Possible

It is essential to plan for the integration of RH activities into primary health care during the ini-

tial phase. If not, the provision of these services may be delayed unnecessarily. When planning, it is important to include the following activities:

- The collection of background information on maternal, infant and child mortality, available HIV/STD prevalence and contraceptive prevalence rates (CPR). This information can be obtained from the refugees' country of origin from such sources as WHO, UNFPA, the World Bank and Demographic and Health Survey (DHS). Gathering this information could be the responsibility of the Headquarters of implementing agencies who may have ready access to these data.
- The identification of suitable sites for the future delivery of comprehensive RH services (as described in the remainder of this Field Manual). It is important to address the following factors when selecting suitable sites:
 - ▶ security both at the point of use and while moving between home and the service delivery point
 - ▶ accessibility for all potential users
 - ▶ privacy and confidentiality during consultations
 - ▶ easy access to water and sanitation facilities
 - ▶ appropriate space
 - ▶ aseptic conditions
- An assessment of the capacity of staff to undertake comprehensive RH services should be made and plans put in place to train/retrain staff. Equipment and supplies for comprehensive RH services should be ordered. This will allow comprehensive services to begin as soon as the situation stabilises.

Broad Terms of Reference for a RH Coordinator/ Focal Point

Under the auspices of the overall health coordination framework, the RH Coordinator/Focal Point should

- ✓ be the focal point for RH services and provide technical advice and assistance on reproductive health to refugees and all organisations working in health and other sectors as needed.
- ✓ liaise with national and regional authorities of the host country when planning and implementing RH activities in refugee camps and among the surrounding population, where appropriate.
- ✓ liaise with other sectors (protection, community services, camp management, education, etc.) to ensure a multi-sectoral approach to reproductive health.
- ✓ create/adapt and introduce standardised strategies for reproductive health which are fully integrated within PHC.
- ✓ initiate and coordinate various audience-specific training sessions on reproductive health (for audiences such as health workers, community services officers, the refugee population, security personnel, etc.).
- ✓ introduce standardised protocols for selected areas (such as syndromic case management of STDs, referral of obstetric emergencies, medical response to survivors of sexual violence, counselling and family planning services, etc.).
- ✓ develop/adapt and introduce simple forms for monitoring RH activities during the emergency phase that can become more comprehensive once the programme is consolidated.
- ✓ report regularly to the health coordination team.

Material Resources

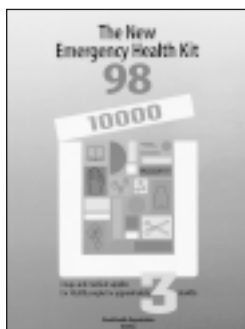
New Emergency Health Kit-98 (NEHK-98)

The revised NEHK-98 (for 10,000 people for three months) contains the following supplies to implement the MISP:

What is in the NEHK-98 to implement the MISP

- Materials for universal precautions for infection control
- Equipment, supplies and drugs for deliveries at health centres
- Equipment, supplies and drugs for some obstetric emergencies
- Equipment, supplies and drugs for post-rape management

A booklet describing the NEHK-98 and how it can be ordered is available from WHO.



Reproductive Health Kit

A RH Kit for Emergency Situations has been developed by UNFPA, in cooperation with others, for use in refugee situations. It complements the NEHK-98 and should be ordered as needed to launch the MISP and support the referral system. The RH Kit is made up of 12 sub-kits, which can be ordered separately. Materials and supplies in Subkits 3 and 6 are already available in the NEHK-98. To order RH sub-kits from UNFPA, contact the UNFPA Country Director in the country of asylum, the UNFPA Emergency Relief Office in Geneva or the UNFPA Procurement Office in New York.

The RH Kit is targeted for use in the initial acute phase of the emergency. Once the situation stabilises, procurement of RH materials and supplies should be done along with other health programme supply and drug ordering.

A booklet describing the RH Kit and how it can be ordered is available from UNFPA. (See Appendix Four for contact addresses.)



What is in the UNFPA RH Kit

- For use at primary health care/health centre level: 10,000 population for three months
 - 0 Training and Administration
 - 1 Condoms
 - 2 Clean delivery sets
 - 3 Post-rape management
 - 4 Oral and injectable contraceptives
 - 5 STD Drugs
- For use at health centre or referral level: 30,000 population for three months
 - 6 Professional midwifery delivery kit
 - 7 IUD insertion
 - 8 Management of the complications of unsafe abortion
 - 9 Suture of cervical and vaginal tears
 - 10 Vacuum extraction
- For use at the referral level: 150,000 population for three months
 - 11 A – Referral-Level Surgical (reusable equipment)
 - 11 B – Referral-Level Surgical (consumable items and drugs)
 - 12 Transfusion (HIV testing for blood transfusion)

Monitoring and Surveillance

CHAPTER TWO

During the early phase of the emergency, a limited amount of data should be collected to assess the implementation of the MISP. Information on mortality and morbidity by age and sex should be routinely collected during the early phase of an emergency. Refer to Chapter Nine for more information on these indicators.

Consider selecting MISP indicators from the following list.

MISP Indicators

- ✓ **Incidence of sexual violence:**
Monitor the number of cases of sexual violence reported to health services, protection and security officers.
- ✓ **Supplies for universal precautions:**
Monitor the availability of supplies for universal precautions, such as gloves, protective clothing and disposal of sharp objects.
- ✓ **Estimate of condom coverage:**
Calculate the number of condoms available for distribution to the population.
- ✓ **Estimate of coverage of clean delivery kits:**
Calculate the number of clean delivery kits available to cover the estimated births in a given period of time.

Checklist for the RH MISP

- ✓ **Collect or estimate basic demographic information**
 - Total population
 - Number of women of reproductive age
 - Number of men of reproductive age
 - Crude birth rate
 - Age-specific mortality rate
 - Sex-specific mortality rate
 - Number of pregnant women
 - Number of lactating women
- ✓ **Prevent and manage the consequences of sexual and gender-based violence**
 - Systems to prevent sexual violence are in place
 - Health service able to manage cases of sexual violence
 - Staff trained (retrained) in prevention and response systems for cases of sexual violence
- ✓ **Prevent HIV transmission**
 - Materials in place for adequate practice of universal precautions
 - Condoms procured and distributed
 - Health workers trained/retrained in practice of universal precautions
- ✓ **Prevent excess neonatal and maternal morbidity and mortality**
 - Clean delivery kits available and distributed
 - UNICEF midwife kits (or equivalent) available at the health centre
 - Staff competency assessed and retraining undertaken
 - Referral system for obstetric emergencies functioning
- ✓ **Plan for the provision of comprehensive RH services**
 - Basic information collected (mortality, HIV prevalence, CPR)
 - Sites identified for future delivery of comprehensive RH services
- ✓ **Identify an organisation(s) and individual(s) to facilitate the MISP**
 - Overall RH Coordinator in place and functioning under the health coordination team
 - RH focal points in camps and implementing agencies in place
 - Staff trained and sensitised on technical, cultural, ethical, religious and legal aspects of RH and gender awareness
 - Materials for the implementation of the MISP available and used

Safe Motherhood programmes are designed to reduce the high numbers of deaths and illnesses resulting from complications of pregnancy and childbirth. In too many countries, maternal mortality is a leading cause of death for women of reproductive age. Most maternal deaths result from haemorrhage, complications of unsafe abortion, pregnancy-induced hypertension, sepsis and obstructed labour. Safe Motherhood programmes seek to address these direct medical causes and undertake related activities to ensure women have access to comprehensive reproductive health services.

Causes of Maternal Mortality Globally

✓ Severe bleeding	25%
✓ Indirect causes	20%
✓ Infection	15%
✓ Unsafe abortions	13%
✓ Eclampsia	12%
✓ Obstructed labour	8%
✓ Other direct causes	8%

WHO: World Health Day–Safe Motherhood–1998

3

CHAPTER THREE

Safe Motherhood

Contents:

- MISIP and Safe Motherhood
- Safe Motherhood in Stabilised Situations
- Providing antenatal, delivery and postpartum care to the mother and immediate care of the neonate
- Support for Breastfeeding
- Integrating Services and Information, Education and Communication (IEC)
- Human Resource Requirements
- Monitoring Service Provision

Also Included:

- Mother-Baby Package Interventions
- Checklist for Establishing Safe Motherhood Services
- Prototype Home-based Maternal Record
- WHO Partograph



Safe Motherhood

In this Field Manual, Safe Motherhood includes antenatal care, delivery care (including skilled assistance for delivery with appropriate referral for women with obstetric complications) and postnatal care, including care of the baby and breastfeeding support. Sexually transmitted disease (STD)/HIV/AIDS prevention and management, family planning services, and other RH concerns should be integrated with Safe Motherhood activities and are discussed in Chapters Five, Six and Seven, respectively.

MISP and Safe Motherhood

Please refer to Chapter Two for the aspects of Safe Motherhood which must be dealt with in the initial phase of a refugee situation.

The activities within the MISP related to Safe Motherhood help prevent excess neonatal and maternal morbidity and mortality by:

- providing clean delivery kits for use by mothers or birth attendants to promote clean home deliveries;
- providing midwife delivery kits (UNICEF or equivalent) to facilitate clean and safe deliveries at the health facility; and by
- initiating the establishment of a referral system to manage obstetric emergencies.

The individual appointed as RH Coordinator should be responsible for all RH services including Safe Motherhood, to ensure optimum integration of all the various aspects of reproductive health.

Safe Motherhood in Stabilised Situations

As soon as feasible, **comprehensive services for antenatal, delivery and postpartum care must be organised.** Planning for such services should take into account existing facilities for the local population. Both refugee and local population needs should be consid-

ered. Services should be able to deal with obstetric and other medical emergencies. For obstetric emergencies, it is preferable to support host-country services rather than establish new and refugee-specific facilities that will not be maintained in the long term.

Approximately 15 per cent of pregnant women will develop complications that require essential obstetric care, and up to five per cent of pregnant women will require some type of surgery. The following ratios have been found to be successful in many situations:

- one health post/clinic with trained community health workers and traditional birth attendants (TBAs) able to identify problems and refer for every 5,000 people;
- one equipped health centre providing basic essential obstetric care for every 30,000-40,000 people;
- one operating theatre and staff, capable of performing 24 hour comprehensive essential obstetric care, for every 150,000 to 200,000 people.

To make sure that the services provided are appropriate and of the highest quality and will be fully used, it is essential to:

- identify skilled care providers involved in childbirth (physicians, midwives, experienced nurses, trained TBAs);
- provide refresher training and close supervision as indicated;
- be aware of and discuss community beliefs and practices and health-seeking behaviour related to delivery, such as position for delivery, presence of relatives for support and traditional practices both positive (breastfeeding) and harmful (female genital mutilation); and
- ensure that all refugee women and their families know where to obtain assistance for antenatal care and delivery and how to recognise signs of complications.

Antenatal care

The primary objective of antenatal care is to **establish contact with the women, and identify and manage current and potential risks and problems**. This creates the opportunity for the woman and her health care provider to establish a **delivery plan** based on her unique needs, resources and circumstances. The delivery plan identifies her intentions about where and with whom she intends to give birth and contingency plans in the event of complications (transport, place of referral, etc.).

At least three antenatal visits are recommended, ideally with the first visit early in the pregnancy. This number may vary based on national policies. Appropriate antenatal care should include:

Assessment of maternal health. This includes not only determining the pregnant woman's overall health status, but also identifying factors which may adversely affect pregnancy outcome. These factors include: age (younger than 17 or older than 40), grand multipara, significantly short stature, and obstetric history of any previous complications, including surgery. While this screening may help identify some women who will develop complications, it will not identify all of them. Thus it is critically important to identify and manage complications as they arise among all pregnant women. The home-based maternal record at the end of the Chapter should be adapted and used to record care provided to women during pregnancy.

Female genital mutilation is a particular risk in some countries (see Chapter Seven). Women who have been subjected to this procedure, especially to infibulation, should be identified during the antenatal period.

Detection and management of complications. Special emphasis should be placed on identifying the acute complications of unsafe abortions or ante-partum haemorrhages. Other complications, such as hypertensive dis-

eases, anaemia, diabetes, malaria or an STD, are less obvious and require more detailed physical examination. Treatment for existing health conditions should be undertaken. Syphilis testing is recommended at least once during pregnancy, preferably before the third trimester. Systematic testing for syphilis in pregnancy is cost-effective if the prevalence of syphilis is one per cent or more in the general population.

Screening for Syphilis in Pregnancy using RPR

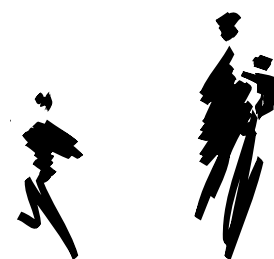
Syphilis and other STDs contribute to the transmission of HIV, maternal morbidity and negative pregnancy outcome. In a recent study of 3,591 HIV-negative Malawi women with an active syphilis rate of 3.6 per cent, 21 per cent of perinatal deaths, 26 per cent of stillbirths, 11 per cent of neonatal deaths and 8 per cent of infant deaths were attributable to syphilis.

Testing for syphilis in pregnancy can be undertaken at the antenatal clinic by using the RPR (rapid plasma reagin) test. Staff must be trained, but sophisticated laboratory equipment is not needed for routine RPR testing. Periodically, quality control of RPR testing with laboratory verification using *Treponema Pallidum* Haemagglutination test (TPHA) should be undertaken to ensure accuracy of RPR testing.

RPR testing for syphilis in pregnancy has been successfully undertaken in refugee camps in Tanzania. Prevalence of syphilis in pregnancy using RPR ranged from 7 to 20 per cent.

Observation and recording of clinical data. Height, blood pressure, search for oedemas, proteinuria and haemoglobin (if indicated by clinical signs), uterine growth, fetal heart rate and presentation should be recorded.

Maintenance of maternal nutrition. The recommended minimum nutritional requirements for a pregnant woman have been set at



2,300 kcal per day of a balanced and culturally acceptable diet. Supplementary food may be required if the basic food ration available or distributed to refugees is inadequate. The offer of supplemental food can be a good incentive to get women to attend for antenatal care. Health care providers should be alert to signs of iron-deficiency anaemia and iodine deficiency disorder (IDD).

Health education. The following topics should be part of the educational activity related to antenatal care:

- choosing the safest place for delivery;
- clean delivery;
- the major symptoms of complications (bleeding, severe abdominal pain, headache);
- where and when to seek care for complications;
- exclusive breastfeeding;
- maternal nutrition;
- STD/HIV/AIDS prevention;
- immunisation; and
- family planning.

Prevention of major diseases. Preventive measures should include: iron folate prophylaxis

(anaemia occurs in about 60 per cent of pregnant women in developing countries); tetanus toxoid immunisation; Vitamin A supplements; antimalarials (according to country policies) and anthelmintics (hookworms) in endemic areas. Iodized oil/salt may be given in areas of moderate or severe IDD and following national protocols.

Delivery Care

This Field Manual does not contain details of how to conduct deliveries. See the Further Reading list for this information.

Even with the best possible antenatal screening, any delivery can become a complicated one requiring emergency intervention. Therefore, **skilled assistance is essential** to delivery care. In the absence of midwives or nurses, TBAs (who usually perform home deliveries, often as a source of income) should be trained to identify complications, provide immediate first aid, and know when and where to refer women for additional care. It should also be remembered that:

- the first priority for a delivery is to be safe, atraumatic and clean; and
- **most maternal deaths are due to a failure to get skilled help in time** for delivery complications.

It is critical to have a well-coordinated system to identify complications and ensure their management with immediate first aid and/or referral. As a rule, the further away the referral facility, the earlier you intervene.

Delays in obtaining help may be at the community level (in identifying and referring women with difficulties); en route to the referral facility (inability to get transport, poor road conditions); or on arrival at the referral facility (absence of staff, lack of drugs or other materials). All three possibilities for delay must be minimised.

Midwives and TBAs should also take care of the newborn by: clearing the airway, keeping the baby warm, providing eye and cord care,

Vitamin A Supplementation in Pregnancy

Where Vitamin A Deficiency is endemic among children and maternal diets are low in Vitamin A, health workers should provide:

- a daily supplement not exceeding 10,000 IU vitamin A during pregnancy or
- a weekly supplement not exceeding 25,000 IU Vitamin A after the first trimester. These supplements will benefit the mother and her developing fetus with little risk of harm to either
- after the mother gives birth, she should receive 200,000 IU vitamin A.

helping mothers begin breastfeeding (and not giving any other foods or liquids to the baby), and identifying complications which require referral. Birth weights should also be measured.

Deliveries outside an equipped health facility. TBAs or family members will often assist deliveries. Therefore, early identification of midwives or TBAs within the community, their training and supervision on the proper use of clean delivery kits (clean place, clean hands, proper cord care) and identification and management of complications (when and where to refer), are essential to prevent excess maternal morbidity and mortality.

Deliveries in equipped health centres.

These health facilities, whether temporary or permanent, should be equipped with the appropriate human and material resources to take care of all but surgical cases. Wherever possible, national health facilities should be used and supported. The following basic essential obstetric care should be provided and standard protocols used to monitor and manage labour. These include:

- initial assessment, duration, use of a partograph (see Annex 2);
- assessment of fetal well being;
- episiotomy;
- special care for women who have undergone genital mutilation (see Chapter Seven);
- use of vacuum extractor;
- management of haemorrhage;
- management of eclampsia;
- multiple birth;
- breech delivery; and
- procedures for referral to next level of care, if necessary.

Protocols must be taught to health staff, publicly displayed and made available in all health centres.

Basic essential obstetric care should be performed at the health-centre level to address, or stabilise before referral, the main complica-

tions of delivery, such as ante-partum haemorrhage, eclampsia, prolonged labour, uterine rupture, post-partum haemorrhage, repair of vaginal and cervical tears, and retained placenta.

These facilities should therefore be equipped with broad spectrum injectable and oral antibiotics (ampicillin, penicillin, doxycycline, gentamicin, metronidazole), plasma expanders, anti-convulsants, oxytocics, ergometrine, analgesics, magnesium sulphate, suturing kits, "high" sterilisation techniques, gloves, syringes and needles, delivery equipment, and materials for universal precautions.

These facilities should also be able to provide for resuscitation and basic care of the newborn (e.g., management of hypothermia and hypoglycemia), including measurement of birth weight. A readily available prophylactic to prevent neonatal ophthalmia, ideally tetracycline eye ointment, should be given to all newborns.

Deliveries at referral hospitals. A referral hospital in which surgical procedures can be performed may exist in some major refugee operations. However, very often, severe complications will be managed at the nearest major health facility of the host country. In this case, try to avoid swamping the facility with the demands of the refugee population to the detriment of the local people.

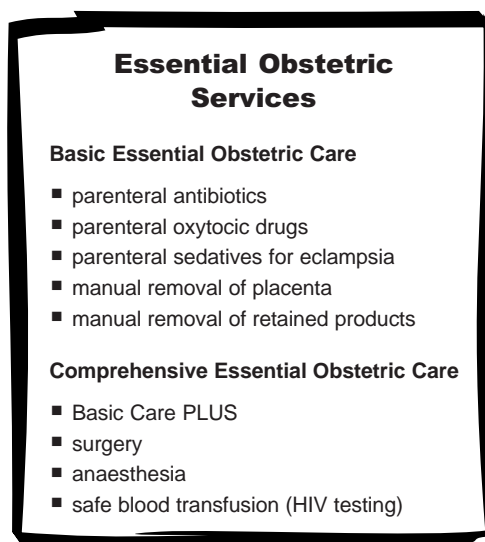
Timely and appropriate **support to the local health facility** must be given as soon as possible. The agreement and support of the Ministry of Health should be secured in order to formalise the integration and coordination of obstetric services between the refugee settlement and the local health facility.

The referral hospital should be able to perform safely comprehensive essential obstetric care, such as Caesarean sections, laparotomy, hysterectomy, repair of cervical and severe (third degree) vaginal tears, care for complications due to unsafe abortion, and safe blood transfusion.

An appropriate referral system requires referral protocols specifying when and where to refer and an adequate record of referred cases. This implies coordination, communication,



confidence and understanding between the TBAs and their supervisors (usually midwives) and between the health centre and the hospital with surgical facilities. An effective referral system will also have to take into account security, geographical and transport constraints.



Postpartum Care

Since up to 50 per cent of maternal deaths occurs after delivery, a midwife or a trained and supervised TBA should visit all mothers as soon as possible within the first 24-48 hours after birth. The midwife or TBA should assess the mother's general condition and recovery after childbirth and identify any special needs. This attention is particularly important when the woman is alone as head of the family.

The postpartum visit provides an occasion for assessing and discussing issues of cleanliness, care of the newborn, breastfeeding and appropriate methods and timing of family planning (see Chapter Six). Health providers should support early and exclusive breastfeeding, and discuss proper nutrition with the mother. Iron folate tablets should be continued and Vitamin A and iodised oil/salt should be provided when necessary.

During the postpartum visit, the health and well being of the newborn should also be assessed

and its birth weight measured. Newborns should be referred to the under-five clinic to start immunisations, growth monitoring and other well-child services.

Community Health Workers (CHW) and TBAs should be trained for appropriate referral of postpartum complications, such as haemorrhage, sepsis, perineal trauma, breastfeeding problems, and newborn complications, such as prematurity or failure to thrive, that may require additional surveillance and/or treatment.

Integrating Services and IEC

In the stabilisation phase, antenatal and postnatal services should be offered in an appropriate environment, in the same location as family planning, STD services, the "baby clinic" and any other services related to primary health care.

Some situations may benefit from a "women's house" which offers peer support, counselling and health promotion in a non-threatening environment. This resource is especially important for adolescent and new mothers. Such a place might also provide a suitable venue for small-scale income-generating or female literacy activities.

Effective dissemination of information is vital if women are to enjoy access to available services. The community's knowledge and attitudes regarding medical care during pregnancy and childbirth must be assessed. If there is suspicion and fear of medical interventions, such as hospital delivery, Caesarean section or blood transfusion, appropriate IEC activities may be necessary. New procedures, such as screening blood for syphilis, should be preceded by educational activities that explain and dispel misconceptions about the procedures. Health workers should consider inviting a companion who will be present at the time of delivery to attend antenatal clinics with the pregnant woman. Through TBAs and/or CHWs, **the refugee population, as a whole, should be made aware of the warning signs**

of impending complications in pregnancy and labour and encouraged to plan how to reach the equipped medical facility, if necessary. Given that men and older family members often make the decisions within the family, it is particularly important that educational activities target these groups.

Human Resource Requirements

A midwife or an experienced nurse is best suited to organise and supervise the Safe Motherhood programme. A midwife can effectively supervise 10 to 15 TBAs for an estimated population of 20,000-30,000.

In many societies, TBAs are usually the key people at the community level who will influence maternal and newborn care, although their influence and skills may vary from culture to culture. In general, one TBA can look after 2,000 to 3,000 refugees. With a crude birth rate of three per cent per year, this means roughly five to eight deliveries per month per TBA.

With adequate training and supervision, some experienced TBAs can:

- identify complications;
- refer women with delivery complications to appropriate medical facilities;
- provide care for normal pregnancy through labour, delivery and the postpartum period; and
- offer family planning information and services.

TBAs, however, are no substitute for a more skilled attendant at birth.

Bear in mind that **female health care providers are usually preferred to attend births.**

Training and supervision of health workers in Safe Motherhood practices should be evaluated and planned in coordination with the community (both refugee and host), NGOs and UN agencies. The nature of the training will vary depending on the services the health worker provides and the skills required for those services.

Monitoring Service Provision

Services should be continuously reviewed. Efforts should be made to collect reliable information on maternal deaths. **Every maternal death should be investigated** to determine the cause and action taken and to ensure that the referral system is responding appropriately to obstetric emergencies.

Record keeping (adapted to the literacy level of record keepers) is essential for appropriate surveillance. Home-based maternal records (see Annex 1), kept by the mother, have proven advantages.

The following is a list of suggested indicators for monitoring Safe Motherhood interventions in refugee situations. Refer to Chapter Nine for further information.

Safe Motherhood Indicators

✓ Indicators to be collected from the health-facility level

- Crude birth rate
- Neonatal mortality rate
- Stillbirth ratio
- Coverage of antenatal care
- Coverage of syphilis screening
- Coverage of trained delivery services
- Coverage of postpartum care
- Incidence of obstetric complications

✓ Indicators collected at the community level

The knowledge of the community regarding safe motherhood interventions should be assessed periodically.

✓ Indicators concerning training and quality of care

Supervisors should periodically assess the skills of health care providers to ensure quality of care of Safe Motherhood interventions.

Support for Breastfeeding

Breastfeeding is particularly important in emergency situations because of the increased risk of diarrhoea and other infections, and because the warmth and care which breastfeeding provides is crucial to both mothers and children. In these situations, it may be the only sustainable source of food for infants and young children. The well-known risks associated with bottle feeding and breast milk substitutes are dramatically increased due to poor hygiene, crowding and limited water and fuel. Since breastfeeding is also an important traditional activity for women, it can help uprooted women preserve a sense of their self-worth. For information on HIV and breastfeeding, refer to Chapter Five.

Optimal Feeding Practices in Emergencies

- **Initiate breastfeeding within one hour of birth.**
- **Promote colostrum** as a health benefit to newborns, while being sensitive to commonly held beliefs to the contrary.
- **Implement the “Ten steps to successful breastfeeding”** (1989 Joint WHO/UNICEF statement, protecting, promoting and supporting breastfeeding).
- Encourage frequent, **on-demand feeding** (including night feeds).
- **Promote exclusive breastfeeding.** On-demand breastfeeding during the first six months provides 98 per cent contraceptive protection, provided menses has not returned, and no other food is given to the baby.
- **Surrogate feeding/wet nursing** is an alternative for an orphaned child or if the mother is disabled or absent.
- **Supplement breast milk with appropriate weaning foods** starting at six months of age.
- Encourage breastfeeding well into the **second year of life** or beyond.
- **HIV-positive mothers** may need special support and counselling—see Chapter Five.
- **During a child’s illness, breastfeeding frequency should be increased**, as it should after a child’s illness so the child can catch up on its growth.
- **2,500 kcal per person per day of culturally appropriate food** is recommended as a minimum requirement for lactating women. The distribution of supplementary food to lactating women may be necessary when the diet available to the refugee population is inadequate.

Counteracting Common Misconceptions about Breastfeeding in Emergencies

- MYTH:** *Women under stress cannot breastfeed.*
- ✓ **TRUTH:** **Women under stress CAN successfully breastfeed.** Milk production is stable; but milk release (let down) can be affected by stress. The treatment for poor milk release and for low production is increased suckling and social support. The most effective support for a breastfeeding woman comes from other breastfeeding women.
- MYTH:** *Malnourished women don’t produce enough milk.*
- ✓ **TRUTH:** **Malnourished women DO produce enough milk.** It is extremely important to distinguish between true cases of insufficient milk production (very rare) and mis-

taken perceptions. Milk production remains relatively unaffected in quantity and quality except in extremely malnourished women. Malnourished women and children are best served by **feeding the mother** and letting her breastfeed the infant. By doing so, you protect the health of both mother and child. Giving supplements to infants decreases suckling and so can reduce milk production. The treatment for insufficient milk production—real or perceived—is to increase suckling frequency and duration, ensure the mother has sufficient food and liquids, and offer reassurance from other breastfeeding women.

MYTH: *Breast milk substitutes are needed during an emergency.*

- ✓ **TRUTH:** **Usually, breast milk substitutes are NOT appropriate.** There are good guidelines on the use of breast milk substitutes and other milk products in emergencies. They include the WHO International Code of Marketing of Breast Milk Substitutes (May 1981), the UNHCR guidelines on the use of milk substitutes (July 1989), and the World Health Assembly resolution 47.5 (May 1994). Under the Code, donors must ensure that any child who receives a breast milk substitute is guaranteed a full, cost-free supply for at least six months.

These guidelines include stipulations that breast milk substitutes are:

- not used as a sales inducement;
- used only for a limited target group of babies (i.e., for orphans in instances where wet nurses are not available);
- used under controlled conditions (i.e., for therapeutic feeding; never in general distribution); and
- accompanied by additional health care, diarrhoea treatment, water and fuel.

In addition, the guidelines assert that feeding bottles and teats should not be provided by relief agencies except under strict supervision; and their use should otherwise be discouraged.

These guidelines should be disseminated and followed by all agencies working in emergencies.

MYTH: *General promotion of breastfeeding is enough.*

- ✓ **TRUTH:** **Breastfeeding women NEED assistance; general promotion of breast-feeding is NOT enough.** Most health practitioners have little knowledge of breastfeeding and lactation management. Women who are displaced or are in emergency situations are at increased risk of breastfeeding problems. They need help, not just motivational messages. Health workers may need to be trained to give practical help to women who have difficulty breastfeeding because of incorrect positioning, cracked nipples or engorgement (see Further Reading). A mother's fear that she "may not have enough milk" is often a cause of early termination of breastfeeding. This (mis)perception may be intensified by the stress of an emergency situation. Health workers should encourage optimal breastfeeding behaviours, even if they require selective feeding of lactating women. Policies and services which undermine optimal feeding, such as giving food supplements to infants under six months and using bottles for Oral Rehydration Salts (ORS) delivery, should be avoided.

Checklist for Safe Motherhood Services

✓ **In Emergency Phase:**

- Provision of delivery kits: UNICEF midwifery kits for health centres and clean delivery kits for home use
- Identification of referral system for obstetric emergencies
 - One health centre for every 30,000-40,000 people
 - One operating theatre and staff for every 150,000 to 200,000 people
 - Skilled health care providers trained and functioning (one midwife for 20,000-30,000 people, one CHW/TBA for 2,000-3,000 people)
 - Community beliefs and practices relating to delivery are known
 - Refugee women are aware of service availability

✓ **Antenatal Services are in place:**

- Record systems in place (clinic and home-based maternal records)
- Maternal health assessment routinely conducted
- Complications detected and managed
- Clinical signs observed and recorded
- Maternal nutrition maintained
- Syphilis screening in pregnancy undertaken routinely
- Educational activity related to antenatal care provision in place
- Preventive medication given during antenatal services:
 - iron folate for anaemia, Vitamin A, tetanus toxoid, others as indicated (malaria)
- STD prevention and management undertaken
- Materials available to implement antenatal care services

✓ **Delivery services are in place:**

- Protocols for managing and referring complications in place and transport system functioning
- Training and supervision of TBAs and midwives undertaken
- Complications are detected and managed appropriately
- Awareness of warning signs of complications in pregnancy is widespread
- Standard protocols are used to manage deliveries
- Medical facilities are adequately equipped
- Breastfeeding is supported

✓ **Postpartum services are in place:**

- Educational activities undertaken (especially family planning and breastfeeding)
- Complications managed appropriately
- Iron folate and Vitamin A provided
- Newborn weighed and referred for under-five services (e.g., EPI, growth monitoring)

ANNEX 1: The WHO Prototype Home-based Maternal Record* (parts 1, 5 and 6)

(5) Remarks from referral centre

Date	Problem identified	Action taken/Advice

(6) Before first pregnancy and during interpregnancy period

	Breastfeeding	Menstruation	Pills	Injections	IUD	Surgical	Other	No methods	Very thin	Very pale	Malaria	Other problems	Chloroquine tablets
Jan-Mar 19													
Apr-Jun 19													
Jul-Sep 19													
Oct-Dec 19													
Jan-Mar 19													
Apr-Jun 19													
Jul-Sep 19													
Oct-Dec 19													
Jan-Mar 19													
Apr-Jun 19													
Jul-Sep 19													
Oct-Dec 19													
Jan-Mar 19													
Apr-Jun 19													
Jul-Sep 19													
Oct-Dec 19													

(1) Mother's health record

Name _____

Address _____

Date of first visit _____

Age:

18-35	below 17	above 35
-------	----------	----------

Height:

more than 145 cm	less than 145 cm
------------------	------------------

Previous History

Number of deliveries:

1	2	3	4	0	5 or more
	no				yes

Abortions:

	no	yes
--	----	-----

Oedema:

	no	yes
--	----	-----

Fits:

	no	yes
--	----	-----

Stillbirths:

	no	yes
--	----	-----

Abnormal deliveries:

	no	yes
--	----	-----

Excess vaginal bleeding after delivery:

	no	yes
--	----	-----

Labour lasting more than 24 hours:

	no	yes
--	----	-----

Low birth weight (less than 2500 g):

	no	yes
--	----	-----

Death of child during first week:

	no	yes
--	----	-----

Other health problems:

*Source WHO, reproduced by permission.

ANNEX 1: The WHO Prototype Home-based Maternal Record* (parts 2, 3 and 4)

(2) Present pregnancy LMP EDD

Up to month

3 4 5 6 7 8 9

Severe pallor:

Pitting oedema:

Vaginal bleeding:

Very thin:

Very large abdomen:

Abnormal presentation:

Weak fetal movement:

Date/Month:

BP above 140/90:

Haemoglobin below 8:

Urine-albumin:

Weight in kg:

Action taken (✓indicates done)

Food advice:

Iron tablets:

Chloroquine tablets:

Tetanus toxoid:

Advice on place of delivery:

1	2
home/hospital	

Labour/Delivery

Duration: normal head breech shoulder face prolonged

Presentation: normal breech C/S other

Type of delivery: no yes

Excess vaginal bleeding:

Baby

Date of delivery: _____

Place of delivery: home clinic hospital

Conducted by: TBA Rel. ANW RN/RM Doctor

Sex: male female

Number of babies: single twin or more

Crying: immediate delayed

Birth weight: more than 2500 g less than 2500 g

Breathing difficulty: no yes

Breastfeeding: yes no

Condition of baby: alive still-born died <7 days died 7-28 days

(3) Present pregnancy LMP EDD

Up to month

3 4 5 6 7 8 9

Sever pallor:

Pitting oedema:

Vaginal bleeding:

Very thin:

Very large abdomen:

Abnormal presentation:

Weak fetal movement:

Date/Month:

BP above 140/90:

Haemoglobin below 8:

Urine-albumin:

Weight in kg:

Action taken (✓indicates done)

Food advice:

Iron tablets:

Chloroquine tablets:

Tetanus toxoid:

Advice on place of delivery:

1	2
home/hospital	

Labour/Delivery

Duration: normal head breech shoulder face prolonged

Presentation: normal breech C/S other

Type of delivery: no yes

Excess vaginal bleeding:

Baby

Date of delivery: _____

Place of delivery: home clinic hospital

Conducted by: TBA Rel. ANW RN/RM Doctor

Sex: male female

Number of babies: single twin or more

Crying: immediate delayed

Birth weight: more than 2500 g less than 2500 g

Breathing difficulty: no yes

Breastfeeding: yes no

Condition of baby: alive still-born died <7 days died 7-28 days

(4) Present pregnancy LMP EDD

Up to month

3 4 5 6 7 8 9

Sever pallor:

Pitting oedema:

Vaginal bleeding:

Very thin:

Very large abdomen:

Abnormal presentation:

Weak fetal movement:

Date/Month:

BP above 140/90:

Haemoglobin below 8:

Urine-albumin:

Weight in kg:

Action taken (✓indicates done)

Food advice:

Iron tablets:

Chloroquine tablets:

Tetanus toxoid:

Advice on place of delivery:

1	2
home/hospital	

Labour/Delivery

Duration: normal head breech shoulder face prolonged

Presentation: normal breech C/S other

Type of delivery: no yes

Excess vaginal bleeding:

Baby

Date of delivery: _____

Place of delivery: home clinic hospital

Conducted by: TBA Rel. ANW RN/RM Doctor

Sex: male female

Number of babies: single twin or more

Crying: immediate delayed

Birth weight: more than 2500 g less than 2500 g

Breathing difficulty: no yes

Breastfeeding: yes no

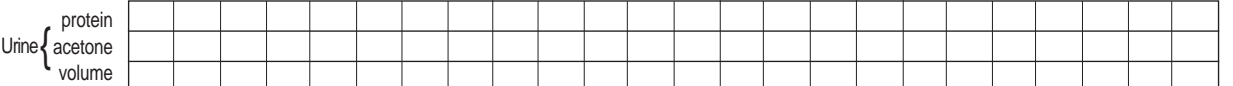
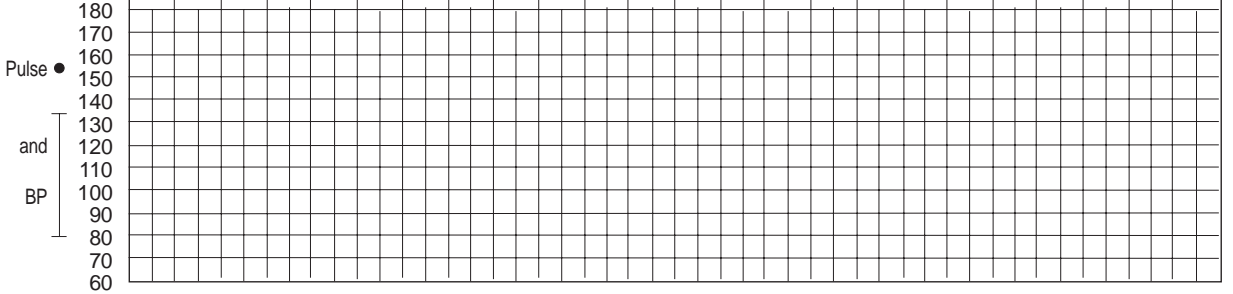
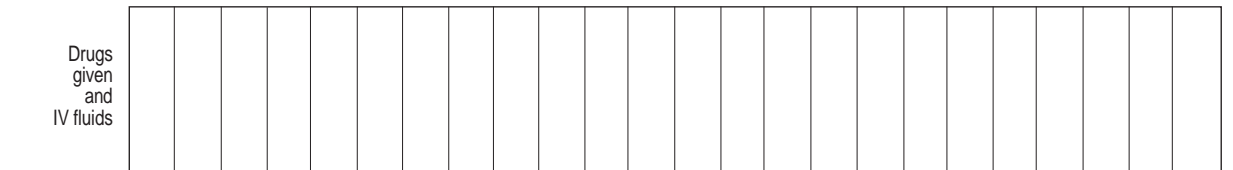
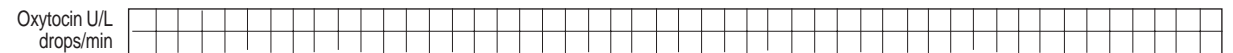
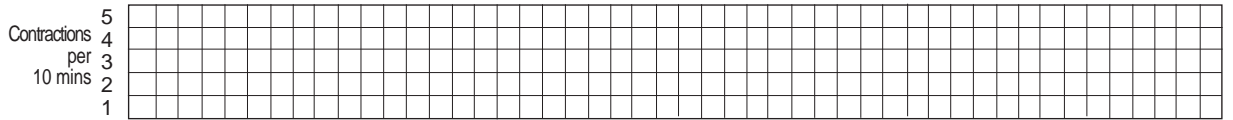
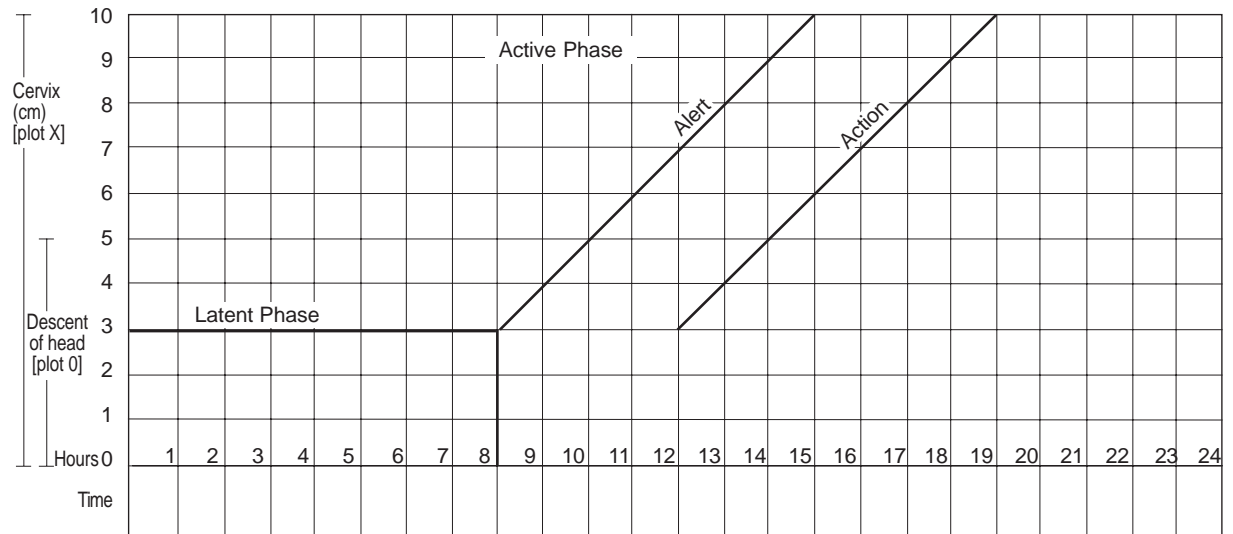
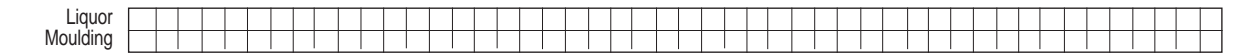
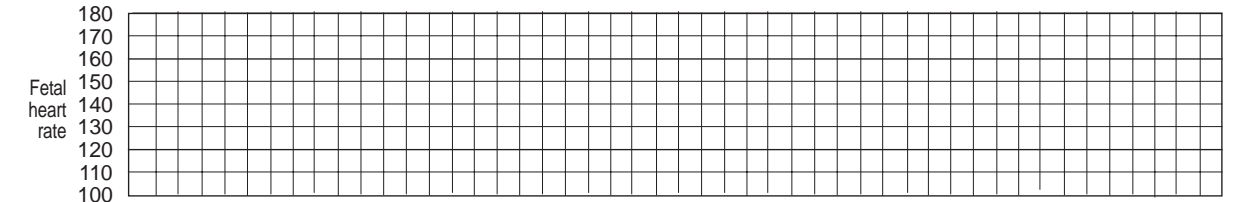
Condition of baby: alive still-born died <7 days died 7-28 days

*Source: WHO, used by permission.

ANNEX 2: Partograph

Name _____ Gravida _____ Para. _____ Hospital no. _____

Date of admission _____ Time of admission _____ Ruptured membranes _____ hours _____



Source: WHO, used by permission

ANNEX 3

Mother and Baby Package Interventions

Mother and Baby Package Interventions

1. Before and During Pregnancy

- Information and services for family planning
 - STD/HIV prevention and management
 - Tetanus toxoid immunization¹
 - Antenatal registration and care
 - Treatment of existing conditions (for example, malaria² and hookworm), according to country policy
 - Advice regarding nutrition and diet
 - Iron/folate supplementation
 - Recognition, early detection and management of complications (pre-eclampsia/eclampsia, bleeding, abortion, anaemia)
-

2. During Delivery

- Clean and safe (atraumatic) delivery
 - Recognition, early detection and management of complications at health centre or hospital (for example, haemorrhage, eclampsia, prolonged/obstructed labour)
-

3. After Delivery: Mother

- Management of complications at health centre or hospital (for example, haemorrhage, sepsis and eclampsia)
 - Postpartum care (promotion and support to breastfeeding and management of breast complications)
 - Information and services for family planning
 - STD/HIV prevention and management
 - Tetanus toxoid immunisation
-

4. After Delivery: Newborn

- Resuscitation
- Prevention and management of hypothermia
- Early and exclusive breastfeeding
- Prevention and management of infections including ophthalmia neonatorum and cord infections
- Recording of birth weight and referral of newborn for immunisations and growth monitoring

1. Two doses

2. Malaria prophylaxis to reduce low birth weight in endemic areas

Further Readings

CHAPTER THREE

“Breastfeeding Counselling: A Training Course”, WHO/UNICEF, Geneva, 1993.

“Care of Mother and Baby at the Health Centre: A Practical Guide”, WHO, Geneva, 1994.

“Essential Elements of Obstetric Care at First Referral Level”, WHO, 1991.

“HIV and Infant Feeding: Collaborative Statement by UNAIDS/UNICEF/WHO”, UNAIDS, Geneva 1997.

“Joint WHO/UNICEF/UNFPA Policy Statement on Traditional Birth Attendants”, WHO, Geneva, 1992.

Klein, Susan. *A Book for Midwives*, The Hesperian Foundation, 1995.

“Life Saving Skills Manual for Midwives”, American College of Nurse-Midwives, 3rd Edition, Washington, DC, 1997.

“Mother and Baby Package”, WHO, Geneva, 1994.

“Safe Vitamin A Dosage During Pregnancy and Lactation: Recommendations and a Report of a Consultation”, WHO and The Micronutrient Initiative, Geneva, 1998.

An increase in sexual violence in insecure situations is well recognised. **Displacement, uprootedness, the loss of community structures, the need to exchange sex for material goods or protection all lead to distinct forms of violence, particularly sexual violence against women.**

Special Notes:

- ✓ This Chapter draws much of its content from “Sexual Violence Against Refugees, Guidelines on Prevention and Response”, UNHCR, Geneva, 1995.
- ✓ Though the Chapter concentrates on sexual violence, the guidance given can be applied to other forms of gender-based violence.
- ✓ The term “victim” is used in some portions of this Chapter as a convenient shorthand despite its negative association with powerlessness. The word “survivor” is also used, where appropriate, to convey the meaning that women have survived a violation of their human rights and dignity.

4

CHAPTER FOUR

Sexual and Gender-based Violence

Contents:

- The Nature, Extent and Effects of Sexual Violence
- Causes and Circumstances of Sexual Violence
- Prevention of Sexual Violence in Refugee Situations
- Responding to Sexual Violence
- Special Issues
- Legal Aspects
- Monitoring
- Checklist for Sexual Violence Programme



Sexual and Gender-based Violence

The magnitude of the problem is difficult to determine. Even in normal situations, sexual violence often goes unreported. The factors contributing to under-reporting—fear of retribution, shame, powerlessness, lack of support, breakdown or unreliability of public services, and the dispersion of families and communities—are all exacerbated in refugee situations.

In general, field staff should act on the assumption that sexual violence is a problem, unless they have conclusive proof that this is not the case. Preventive measures should be established, and appropriate protective, medical, psychosocial and legal responses should be organised. The refugees themselves, especially women, should be fully involved in organising and reviewing protective and preventive measures and appropriate responses.

This chapter focuses on sexual violence against women. Most reported cases of sexual violence amongst refugees involve female victims and male perpetrators. It is acknowledged that men and young boys may also be vulnerable to sexual violence, particularly when they are subjected to detention and torture. Even less is known about the true incidence of sexual violence against men and boys than against women and girls in refugee situations.

The Nature, Extent and Effects of Sexual Violence

There are various forms of sexual violence. Rape, the most often cited form of sexual violence, is defined in many societies as sexual intercourse with another person without his/her consent. Rape is committed when the victim's resistance is overwhelmed by force or fear or other coercive means. However, the term sexual and gender-based violence encompasses a wide variety of abuses that includes sexual threats, exploitation, humiliation, assaults, molestation, domestic violence,

incest, involuntary prostitution (sexual bartering), torture, insertion of objects into genital openings and attempted rape. Female genital mutilation and other harmful traditional practices (including early marriage, which substantially increases maternal morbidity and mortality) are forms of sexual and gender-based violence against women which cannot be overlooked nor justified on the grounds of tradition, culture or social conformity.

Since perpetrators of sexual and gender-based violence are often motivated by a desire for power and domination, rape is common in situations of armed conflict and internal strife. An act of forced sexual behaviour can threaten the victim's life. Like other forms of torture, it is often meant to hurt, control and humiliate, while violating a person's physical and mental integrity.

Perpetrators may include fellow refugees, members of other clans, villages, religious or ethnic groups, military personnel, relief workers and members of the host population, or family members (for example, when a parent is sexually abusing a child). The enormous pressures of refugee life, such as having to live in closed camps, can often lead to domestic violence. In many cases of sexual violence, the victim knows the perpetrator.

Because incidents of sexual and gender-based violence are under-reported, the true scale of the problem is unknown. The World Bank estimates that less than 10 per cent of sexual violence cases in non-refugee situations are reported.

Two principal types of under-reporting are found in refugee situations:

- under-reporting by the victims, which can lead to distorted figures that suggest there is no problem; and
- an absence of figures relating to sexual violence within official statistics.

(The number of recently reported rape cases in stabilised refugee settings can be found in Table 1.)

It is essential to know that the problem of sexual violence is serious. Reporting and interviewing techniques should be adapted to encourage both victims and relief workers to report and document incidents. Reporting and follow-up must be sensitive, discreet and confidential so no further suffering is caused and lives are not further endangered.

In reporting, it is recommended that definitions (such as confirmed rape cases or sexual violence, in general) are provided and a rate calculated (for example, the number of reported cases per 10,000 people over a given period of time). This rate would allow for monitoring of trends and comparisons with other areas.

Sexual and gender-based violence has acute physical, psychological and social consequences. Survivors often experience psychological trauma: depression, terror, guilt, shame, loss of self-esteem. They may be rejected by spouses and families, ostracised, subjected to further exploitation or to punishment. They may also suffer from unwanted pregnancy, unsafe abortion, sexually transmitted diseases (including HIV), sexual dysfunction, trauma to the reproductive tract, and chronic infections leading to pelvic inflammatory disease and infertility.

Causes and Circumstances of Sexual Violence

Sexual and gender-based violence can occur during all phases of a refugee situation: prior to flight, during flight, while in the country of asylum, during repatriation and reintegration. Prevention and response measures must be adapted to suit the different circumstances of each phase.

In conflict situations, sexual violence may be politically motivated—when, for example, mass rape is used to dominate or sexual torture is used as a method of interrogation.

It may result from long-standing tensions and feuds and the collapse of traditional societal support. In situations in which the refugees are considered to be materially privileged compared to the local population, neighbouring groups may attack the refugees.

The psychological strains of refugee life may aggravate aggressive behaviour towards women. Male disrespect towards women may be reinforced in refugee situations where unaccompanied women and girls may be regarded by camp guards and male refugees as common sexual property.

CHAPTER FOUR

TABLE 1

Review of Reported Cases of Rape¹ in Refugee Situations Goma-Zaire, Dadaab-Kenya and Ngara, Kibondo-Tanzania 1996 and 1998

Situation	Goma	Dadaab	Ngara	Kibondo
Population	740,000	109,000	110,000	76,740
✓ Actual Rape Cases Reported (Number of Months)	140 (7)	128 (12)	24 (12)	129 (12)
✓ Adjusted Number of Rapes for 12 month period ²	240	128	24	129
✓ Year Reported	1996	1998	1998	1998
✓ Cases of Rape/10,000 population/year	3.24	11.74	2.16	17.08

¹ It is assumed that the cases reported here are confirmed rapes

² Actual cases of rapes reported for part of the year and projected for remaining months by taking the average number of rapes per month.

If men are responsible for distributing goods and necessities, women may be subject to sexual exploitation. Those women without proper personal documentation for collecting food rations or shelter material are especially vulnerable.

Women may have to travel to remote distribution points for food, water and fuel; their living quarters may be far from latrines and washing facilities; their sleeping quarters may be unlocked and unprotected.

Lack of police protection and lawlessness also contribute to an increase in sexual violence. Police officers, military personnel, relief workers, camp administrators or other government officers may themselves be involved in acts of abuse or exploitation. If there are no independent organisations, such as UNHCR or NGOs, to ensure personal security within a camp, the number of attacks often increases.

Prevention of Sexual and Gender-based Violence in Refugee Situations

A multi-sectoral team approach is required to prevent and respond appropriately to sexual and gender-based violence. A committee or task force should be formed to design, implement and evaluate sexual violence programming at the field level. Refugee representatives, UNHCR, UN partners, NGOs and government authorities should be members of this task force. Each member of the task force, representing relevant sectors/partners (such as protection, health, education, community services, security/police, site planning, etc.), should identify his/her role and responsibilities in preventing and responding to sexual and gender-based violence.

Involvement of Refugees, Especially Refugee Women

The most effective measures require that the refugee community participates in promoting a safe environment for all. Women leaders need to be involved; and women's refugee commit-

tees and groups should be established to represent women's interests and to help identify and protect those most vulnerable to sexual violence. Traditional birth attendants (TBAs) can be a valuable source of information and a channel for disseminating protection messages. It is important to have at least one trained female protection officer at the site. Host countries and international relief organisations have a responsibility to provide the refugee community with funding, technical assistance and the safety measures necessary to allow the refugees to design and implement responses to the problem.

Experience has shown that community-based groups, commonly called anti-rape or crisis intervention teams, should be established. These groups can help raise awareness of the problem, identify preventive measures and be at the forefront of providing assistance to survivors.

Information, Education and Communication

Public information campaigns on the subject of sexual violence should be launched (while respecting cultural sensitivities). Topics could include preventive measures, seeking assistance, laws prohibiting sexual violence, and sanctions and penalties for perpetrators. Pamphlets, posters, newsletters, radio and other mass media programmes, videos and community entertainment can all be used to transmit information about preventing sexual violence. The refugee community and health workers must understand the importance of the problem and have the confidence to report all cases of sexual violence as soon as possible.

Design, Location and Practical Arrangements

Refugee camps can be designed to enhance physical security. Alternatives to closed camps should always be sought. When designing and organising camp facilities, help protect refugees by:

- locating latrines, water points and fuel collection areas in accessible places;
- making special arrangements for housing unaccompanied women, girls and lone heads of households;
- locking washing facilities;
- providing adequate lighting on paths used at night;
- providing security patrols; and by
- avoiding shared communal living space with unrelated families.

Distribution of Food, Materials for Shelter and Assistance

Essential items, such as food, non-food and shelter materials, should be distributed directly to women. That way, women will not have to exchange sexual favours for these items. Women should be involved in, if not administer, the food distribution system.

Protection of Detainees

Women and men should not be detained together unless they are family members. Appropriate organisations must be allowed access to detainees to monitor their safety and living conditions.

Social and Psychological Factors

Life in refugee camps can lead to a breakdown of traditional social structures, frustration, boredom, alcohol and drug abuse, and feelings of powerlessness that may contribute to aggression and sexual violence. Therefore, educational, recreational and income-generating activities must be promoted.

Responding to Sexual Violence

The response to each incident of sexual violence must include **protection, medical care and psychosocial treatment**.

Protection

Immediately following an incident of sexual violence, the physical safety of the survivor must be ensured. All actions must be guided by the best interests of the survivor and her wishes must be respected at all times. Wherever possible, the identity of the survivor should be kept secret and all information kept locked and secure from outsiders.

Health workers should give the survivor as much privacy as she needs and reassure her about her safety. She may want a family member or friend to accompany her throughout the procedures. She should not be pressured to talk or be left alone for long periods. If the incident occurred recently, medical care may be required. The survivor should then be escorted to the appropriate medical facilities. It also may be necessary to contact the police, if the survivor so decides.

The likely course of events and all the procedures that may follow should be carefully explained to her to ensure informed consent and preparedness.

Medical Care

The key elements of a medical response to sexual violence are described below. Health care professionals must be specially trained to undertake post-sexual violence medical care. Psychosocial support should begin from the very first encounter with the survivor. A protocol should be adopted to guide the medical and psychosocial care provided to survivors.

Ensure a Same-Sex Health Worker is Present for any Medical Examination and Ensure Privacy and Confidentiality.

A doctor (or qualified health worker) of the same sex should conduct the initial examination and follow-up. The survivor should be prepared for the physical examination and perhaps accompanied (if she so wishes) by a staff member who is familiar with the proceedings, or by a family

member or friend. Strict confidentiality is essential. Staff dealing with the survivor must be sensitive, discreet and compassionate.

Take a Complete History and Do a Physical Examination.

The survivor should not shower or bathe, urinate or defecate, or change clothes before the medical examination, as evidence may be destroyed.

A detailed history of the attack should be documented, including the nature of the penetration, if any, whether ejaculation occurred, recent menstrual and contraceptive history, and the mental state of the survivor. Procedures for medical examination after rape should be established and follow national laws, where they exist.

The results of the physical examination, the condition of clothing, any foreign material adhering to the body, any evidence of trauma, however minor, scratches, bite marks, tender spots, etc., and results of a pelvic examination should be documented. Health workers should collect materials that might serve as evidence, such as hair, fingernail scrapings, sperm, saliva and blood samples.

Perform the Tests and Treatments as Indicated

The following tests may be indicated to establish pre-existing conditions: syphilis blood test, pregnancy test and HIV test.

Treatment for common sexually transmitted diseases (STDs), such as syphilis, gonorrhoea and chlamydia, may be indicated. A tetanus vaccination should be considered.

Provide Emergency Contraception, if Appropriate, Along with Comprehensive Counselling.

1. Emergency contraceptive pills (ECPs) can prevent unwanted pregnancies if used within 72 hours of the rape. As

described by WHO “emergency contraceptive pills (ECPs) work by interrupting a woman’s reproductive cycle—by delaying or inhibiting ovulation, blocking fertilisation or preventing implantation of the ovum. ECPs do not interrupt pregnancy and thus are not considered a method of abortion.” WHO acknowledges that this description does not command consensus and that some believe that ECPs are abortifacients. Women and health workers holding such belief may be precluded from using this treatment and women who request this service need to be offered counselling so as to reach an informed decision.

ECPs should not be seen as a substitute for regular use of contraceptive methods. Women should be counselled concerning their future contraceptive needs and choices.

See Annex 1 for details on using ECPs.

2. Copper-bearing IUDs can be used as a method of emergency contraception. They may be appropriate for some women who wish to retain the IUD for long-term contraception and who meet the strict screening requirements for regular IUD use. When inserted within five days, an IUD is an effective method of emergency contraception.

However, IUD insertion requires a much higher degree of training and clinical supervision than ECPs. Clients must be screened to eliminate those who are pregnant, have reproductive tract infections, or are at risk of STDs, including HIV/AIDS.

As for ECPs, some women and health workers may be precluded from using this treatment and women who request this service need to be offered counselling so as to reach an informed decision.

Provide Follow-up Medical Care

A woman should be counselled to return for follow-up examinations one to two weeks after receiving initial medical care. Health care providers should monitor her follow-up care. Fur-

ther tests and treatment, such as testing for or treatment of STDs or referral to other RH services, may be indicated during follow-up. Further visits may also be required for pregnancy and HIV testing.

Psychosocial Care

Survivors of sexual violence commonly feel fear, guilt, shame and anger. They may adopt strong defense mechanisms that include forgetting, denial and deep repression of the events. Reactions vary from minor depression, grief, anxiety, phobia, and somatic problems to serious and chronic mental conditions. Extreme reactions to sexual violence may result in suicide or, in the case of pregnancy, physical abandonment or elimination of the child.

Children and youth are especially vulnerable to trauma. Health care providers, relief workers and protection officers should devote special attention to their psychosocial needs.

Survivors should be treated with empathy, care and support. In the long term, and in most cultural settings, the support of family and friends is likely to be the most important factor in overcoming the trauma of sexual violence. Community-based activities are most effective in helping to relieve trauma. Such activities may include:

- identifying and training traditional, community-based support workers,
- developing women's support groups or support groups specifically designed for survivors of sexual violence and their families, and
- creating special drop-in centres for survivors where they can receive confidential and compassionate care. See Further Readings.

These activities must be culturally appropriate and must be developed in close cooperation with community members. They will need on-going financial and logistical sup-

port and, where appropriate, training and supervision.

Quality counselling by trained workers, such as counsellors, nurses, social workers, psychologists or psychiatrists—preferably from the same background as the survivor—should also be provided as soon after the attack as possible. Reassurance, kindness and total confidentiality are vital elements of counselling. Counsellors should also offer support if the survivor experiences any post-traumatic disturbances, if she has difficulty dealing with family and community reactions, and as she goes through any legal procedures.

The objectives of counselling are to help survivors:

- understand what they have experienced,
- overcome guilt,
- express their anger,
- realise they are not responsible for the attack,
- know that they are not alone, and
- access support networks and services.

Special Issues

Sexual Violence in Domestic Situations

Caution should be exercised before intervening in domestic situations because the survivor and/or other relatives could be subjected to further harm. If the survivor has to return to the abuser, retaliation may follow, especially if the abuser learns that the matter has been reported. Each situation needs to be individually assessed in close cooperation with colleagues to determine the most appropriate response. Health care providers may choose to refer the matter to a disciplinary committee, inform the authorities, or provide discreet advice to the survivor about her options.

Children Born as a Result of Rape

These children may be mistreated or even abandoned by their mothers and families. They must be closely monitored and support should be offered to the mother. It is important to ensure that the family and the community do not stigmatise either the child or the mother. Foster placement and, later, adoption should be considered if the child is rejected, neglected or otherwise mistreated.

Legal Aspects

The government on whose territory the sexual attack occurred is responsible for taking remedial measures, including conducting a thorough investigation into the crime, identifying and prosecuting those responsible and protecting survivors from reprisal. In all cases, the wishes of the survivor should be respected when pursuing the legal aspects of the case. Confidentiality must be ensured.

All agencies should advocate the enactment and/or enforcement of national laws against sexual violence in accordance with international legal obligations. These should include prosecution of offenders and the implementation of legal measures to protect the survivor.

The local UNHCR Protection Officer must be familiar with the national criminal and civil law on the subject of rape and sexual violence before an incident occurs so he/she will know what procedural steps should be taken and what advice should be given to survivors. (See Appendix Two.)

Monitoring

Monitoring cases of sexual violence should be a routine task of health care providers, protection officers and others, as appropriate. In addition, there should be regular assessments of the providers' ability to offer comprehensive medical and psychosocial care for rape survivors. Ideally, care should be given as soon after a rape as possible.

Sexual Violence Indicators

✓ Indicators to be collected from the health-facility level

- Incidence of sexual violence (reported cases/10,000 population)
- Coverage of services for survivors
- Timely care for survivors

✓ Indicators that might be measured annually

- Prosecution of sexual violence offenders
- Coverage of health-worker training that serves survivors of sexual violence

(Refer to Chapter Nine—Monitoring and Surveillance.)

CHAPTER FOUR

ANNEX 1

Emergency
Contraceptive Pill
Regimens**Emergency Contraceptive Pill Regimens**

- ✓ **When pills specially packed for emergency contraception are available as supplied in the New Emergency Health Kit 98, or when high-dose pills containing 0.5 mg ethinylestradiol and 0.25 mg of levonorgestrel are available:**
 - ▶ two pills should be taken as the first dose as soon as convenient but no later than 72 hours after the rape. These should be followed by two more pills 12 hours later.

- ✓ **When only low-dose pills containing 0.3 mg ethinylestradiol and 0.15 mg of levonorgestrel are available:**
 - ▶ four pills should be taken as the first dose as soon as convenient but no later than 72 hours after the rape. These should be followed by four more pills 12 hours later.

- ✓ **Emerging data indicate that alternative hormonal regimes consisting of levonorgestrel-only pills are equally effective and have significantly fewer side effects. When pills containing 0.75 mg levonorgestrel are available:**
 - ▶ one pill should be taken as the first dose as soon as convenient but no later than 72 hours after the rape. This should be followed by another pill 12 hours later.

Managing Side Effects

Nausea occurs in about 50 per cent of clients using combined ECPs and 25 per cent for those using levonorgestrel only. Taking the pills with food may reduce nausea. Routine prophylactic use of anti-emetics is not recommended in settings with limited resources. If vomiting occurs within two hours of taking ECPs, repeat the dose.

Contraindications

There are no known medical contraindications to the use of ECPs. The dose of hormones used in ECPs is relatively small and the pills are used for a short time. Contraindications associated with continuous use of hormonal contraceptives do not apply.

ECPs should not be given if there is a confirmed pregnancy. ECPs may be given when pregnancy status is unclear and pregnancy testing is not available, as there is no evidence of harm to the woman or to an existing pregnancy.

Checklist for Sexual Violence Programme

Key Interventions–Preventing Sexual Violence

- ✓ Ensure proper documentation for women
- ✓ Increase availability of female protection officers and interpreters and ensure that all officers have knowledge of UNHCR Protection Guidelines and UN Security Guidelines for Women
- ✓ Facilitate the use of existing women's groups or promote the formation of women's groups to discuss and respond to issues of sexual violence
- ✓ Improve camp design for increased security for women
- ✓ Include women in camp decision-making processes, especially in the areas of health, sanitation, reproductive health, food distribution, camp design/location
- ✓ Distribute essential items such as food, water and fuel directly to women
- ✓ Train people at all levels (NGO, government, refugee, etc.), to prevent, identify and respond to acts of sexual violence.

Key Interventions–Responding to Sexual Violence

- ✓ Develop/adapt protocols and guidelines that would limit further traumas to survivors of sexual violence
- ✓ Engage socially and culturally appropriate support personnel as a first contact with people who have been subjected to sexual violence
- ✓ Provide prompt and culturally appropriate psychosocial support for survivors and their families
- ✓ Provide medical follow-up immediately after an attack that also addresses STDs, HIV infection and unwanted pregnancy
- ✓ Establish closer links among protection officers, women's groups, TBAs and community leaders to discuss issues related to the attacks
- ✓ Document cases while respecting survivors' wishes and confidentiality.

CONFIDENTIAL**Sexual Violence Incident Report Form**

Camp: _____ Reporting Officer: _____ Date: _____

1) Affected Person:

Code(*): _____ Date of Birth: _____ Sex: _____

Address: _____

Civil Status: _____

If a Minor: Code/Name of Parents/Guardian: _____

2) Report of Incident:

Place: _____ Date: _____ Time: _____

Description of Incident:
(Specify type of sexual violence)

Persons Involved:

3) Actions Taken:Medical Examination Done: Yes No By Whom: _____

Major Findings and Treatments Given:

Protection Staff Notified: Yes No

If no, reasons given:

If yes, actions taken:

Psychosocial Counselling given: Yes No

By whom and actions taken

4) Proposed Next Steps**5) Follow-up Plan** Medical Follow-up _____ Psychosocial Counselling _____ Legal Proceedings _____Adapted from Ngara, Tanzania–HOW
TO GUIDE on Crisis Intervention
Teams* Code numbers should be used rather
than names to ensure confidentiality.

Further Readings

"Emergency Contraception: A Guide for Service Delivery", WHO, Geneva, 1998.

"Emergency Contraception Pills: A Resource Packet for Health Care Providers and Programme Managers", Consortium for Emergency Contraception, New York, 1997.

Heise, Lori L. "Violence Against Women: The Hidden Health Burden", World Bank Discussion Papers, No. 255, The World Bank, Washington, DC, 1994.

"How To Guide: Community-based Response to Sexual Violence: Crisis Intervention Teams - Ngara, Tanzania", UNHCR, Geneva, 1997.

"How To Guide: Developing a Team Approach to Prevention and Response to Sexual Violence - Kigoma, Tanzania", UNHCR, Geneva, 1998.

"Mental Health for Refugees", WHO/UNHCR, Geneva, 1994.

"Security Guidelines for Women", United Nations Security Coordination Office, United Nations, New York, 1995.

"Sexual Violence against Refugees: Guidelines on Prevention and Response", UNHCR, Geneva, 1995.

The objectives of any activity in the area of sexually transmitted diseases (STDs), including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), should be to prevent and treat STDs, reduce the transmission of HIV/STD infections, and help care for those affected by AIDS.

5

CHAPTER FIVE

Sexually Transmitted Diseases, Including HIV/AIDS

Contents:

- Introduction
- Establishing STD/HIV/AIDS Programmes
- Monitoring

Also Included:

- HIV Testing in Refugee Situations
- Mother-to-Child Transmission and HIV and Infant Feeding
- Formula for Calculating Condom Requirements
- STD Treatment Based on Syndromic Case-Management Approach
- Flow Chart on Suspected Symptomatic HIV Infections
- Essential Drugs for Management of Opportunistic Infections for HIV/AIDS
- Alternative Drugs for Treatment of STDs Based on Sensitivity Studies
- Estimating Drug Requirements and Costs for Treatment of STDs



Sexually Transmitted Diseases, Including HIV/AIDS

Introduction

STDs, including HIV/AIDS, spread fastest where there is poverty, powerlessness and social instability. The disintegration of community and family life in refugee situations leads to the break-up of stable relationships and the disruption of social norms governing sexual behaviour. Women and children are frequently coerced into having sex to obtain basic needs, such as shelter, security, food and money. In a refugee situation, populations that have different rates of HIV/AIDS prior to becoming refugees may be mixed. Also many refugee situations are like large urban settings and may create conditions that increase the risk of HIV transmission.

STDs, which are a major public health problem in most parts of the world, were largely neglected until the appearance of HIV/AIDS. Now, more attention is focused on conventional STDs (such as gonorrhoea, syphilis, chlamydia, etc.). They are among the most common, although undiagnosed, causes of illness in the world; and they have far-reaching health, social and economic consequences. STDs substantially increase the risk of HIV infection. Preventing and controlling STDs are key strategies in controlling the spread of HIV/AIDS.

The vast majority of HIV infections are sexually transmitted. Between five and ten per cent of HIV infections world-wide are estimated to be transmitted through infected blood and blood products, though this percentage is decreasing as blood for transfusions is more regularly tested for HIV. In refugee situations, it is essential to ensure that all blood for transfusion is tested and that universal precautions are enforced.

Mother-to-child transmission of HIV (MTCT), also called "vertical transmission", is the most common mode of HIV transmission in children. More than 90 per cent of HIV-infected

infants acquire their HIV infection from their mothers during pregnancy, delivery or during breastfeeding. When there is no intervention, the risk of MTCT ranges from 15 to 25 per cent in industrialised countries and from 25 to 45 per cent in developing countries. Transmission is affected by a number of factors, not all of which have been fully examined. These factors include:

- high viral-load level in the mother's blood,
- in cervio-vaginal secretions and, in breast milk, decreased maternal immune status,
- prolonged rupture of membranes (greater than four hours),
- the mode of delivery, and
- intra-partum haemorrhage.

Studies show an additional 7 to 22 per cent risk of HIV transmission through breastfeeding. Late postnatal transmission after six months of age has been described in a number of studies. (See Annex 2 on MTCT and HIV and Infant Feeding.)

Interaction between refugee and local populations is likely to occur. It is therefore vital to liaise with host countries to ensure that comparable services are provided to local populations. Failure to do so would not only be counterproductive in the effort to prevent the spread of STDs and HIV, it could also result in conflict between the two populations.

Mandatory HIV testing of refugees is sometimes requested in the mistaken belief that this will help prevent HIV transmission. Under no circumstances should mandatory testing be pursued. Mandatory testing for HIV represents a violation of human rights and has no public health justification. (See Annex 1 on HIV testing in refugee situations.)

Establishing STD/HIV/AIDS Programmes

As described in Chapter Two (Minimum Initial Service Package [MISP]), three activities should be conducted prior to any assessment in any new refugee situation (including an emergency):

- Guarantee availability of free condoms
- Enforce universal precautions against HIV/AIDS transmission in health-care settings
- Identify a person who will coordinate RH activities.

Comprehensive prevention, treatment and care services for STDs, including HIV/AIDS, should be made available to refugees at the earliest opportunity. By taking the following steps, you will ensure that the services you provide are effective.

Assessment

Conduct a situation analysis as soon as possible to help plan an appropriate and comprehensive prevention and treatment service.

The following information should be collected:

- the prevalence of STDs and HIV in the host and home country, region or area (this information is available from the national AIDS programmes, UNAIDS and WHO);
- the location of specific risk areas within the refugee community (for example, where sexual services are bought and sold, high alcohol-consumption areas, bars), to be targeted as priorities for specific activities; and
- the cultural and religious beliefs, attitudes, and practices concerning sexuality, reproductive health, STDs and AIDS. This information can be obtained through qualitative research using focus groups, interviews and, if possible, KABP (Knowledge, Attitudes, Behaviour and Practices) surveys.

It will also be necessary to:

- liaise with local health authorities to define a management protocol for STDs; and
- identify people in the refugee community who have been trained in HIV/STD prevention.

Implementation

The situation analysis will indicate what STD and HIV/AIDS interventions are required and what is feasible. The following should be included as basic elements of response to every refugee situation: universal precautions in health-care settings, safe blood transfusion, access to condoms, access to STD care, information, education and communication (IEC) activities, and comprehensive care for people with HIV/AIDS.

Universal Precautions in Health-Care Settings

Universal precautions are part of the MISP (Chapter Two) and are essential to prevent the transmission of HIV from patient to patient, health worker to patient and patient to health worker. Because people working under pressure are more likely to have work-related accidents and to cut corners in sterilisation techniques, infection-control measures adopted during crises must be practical to implement and enforce.

The guiding principle for the control of infection by HIV and other diseases which may be transmitted through blood, blood products and body fluids is that **all should be assumed to be potentially infectious**.

The minimum requirements for infection control are as follows:

- Facilities for frequent **hand washing**. Hands should be washed with soap and water, especially after contact with body fluids or wounds.
- Availability of **gloves** for all procedures involving contact with blood or other po-

tentially infected body fluids. Gloves should be discarded after each patient, or else washed or sterilised before re-use. Heavy-duty gloves should be worn when materials and sharp objects are taken for disposal.

- Availability of **protective clothing**, such as waterproof gowns or aprons. Masks and eye shields should be worn where there is a possibility of exposure to large amounts of blood.
- **Safe handling of sharp objects.** Puncture-resistant containers for sharps disposal must be readily available, close at hand and out of the reach of children. Sharp objects should never be thrown into ordinary waste bins or bags.
- **Disposal of waste materials.** People, particularly small children, struggling to survive will scavenge. It is therefore vital to make waste disposal safe. All medical waste materials should be burnt. Those items that still pose a threat, such as sharp objects, should be buried in a deep pit at least 10 metres from a water source. Medical waste should not be disposed of in communal dumps.
- **Cleaning, disinfecting and sterilising.** Pressure-steam sterilisers are recommended for cleaning medical instruments between use on different patients. If sterilisation is not available, or for instruments that are heat sensitive, instruments must be cleaned and high-level disinfected (HLD). HIV can be inactivated by boiling for 20 minutes or by soaking in chemical solutions including a five per cent solution of chlorine bleach for 20 minutes or in a two per cent glutaraldehyde solution for 20 minutes.
- **Proper handling of corpses.** It is advisable for relief workers to wear gloves and cover any wounds on hands or arms when handling corpses. The relief worker should wash thoroughly with soap and water afterwards. Special caution should be taken with body fluids as they may be potentially infectious.

- **Treating injuries at work.** In cases of injury with a sharp instrument, the wound should be washed thoroughly with soap and water. Splashes of blood or other body fluid into the mouth or eyes should be rinsed thoroughly with water or saline respectively. Further procedures to be followed after an accidental exposure to blood have been developed by Médecins Sans Frontières (MSF). Prophylactic treatment against HIV transmission, known as Post Exposure Therapy (PET), may be warranted.

Guidelines containing information about potential risks in the environment, how to protect against those risks, and what to do in case of accidents such as needle-stick injuries, cuts or blood splattering should be developed and distributed to field workers. It is equally important to provide clear information about what does not constitute a risk. The guidelines should indicate when it is appropriate to use protective clothing and why. Health workers should also be given guidance on how to avoid unnecessary injections and other procedures involving sharp instruments.

Access to Condoms

If consistently and correctly used, condoms offer effective protection against STDs, including the sexual transmission of HIV. Since many refugees have already been exposed to this message, there may be a demand for condoms in the early phases of a refugee situation. Condoms are contained in the MISP (See Chapter Two) and should be made freely available for those who seek them. Take every opportunity to raise awareness and promote condoms as a method of protection against STDs, including HIV infection. The female condom is not yet widely known; but, if available, it should be used as an additional method of protection.

Procurement of good-quality condoms:

There are many brands of condoms on the market. If an agency does not have experience in procuring condoms, it may be desirable to contact UNAIDS, UNFPA, UNHCR or WHO to facilitate the purchase of bulk quantities of

good-quality condoms at low cost. Annex 3 shows how to calculate the number of condoms required. Good-quality condoms are essential for the protection of the consumer and the credibility of the relief programme.

Condom distribution: To ensure ongoing access in refugee situations, a system of distribution must be in place. The system should include the following:

- Condoms and instructions for their use should be available on request in health facilities (especially where STDs are treated) and distribution centres (such as food and non-food item distribution areas). Staff should be trained in the promotion, distribution and use of condoms.
- Promotional campaigns should be launched at football matches, mass rallies, dance parties, theatres, group discussions, etc., to promote the use of condoms and inform the public on how and where to obtain them.
- Contacts between the refugee and local populations are likely to occur. Therefore, condoms must also be made available to the wider host community. This requires liaison with groups involved in AIDS prevention and family-planning activities in the area.
- Once the situation has stabilised, health workers must decide whether or not to continue free distribution of condoms. The introduction of some form of partial cost-recovery (social marketing) may be considered in situations where this is feasible and appropriate. When possible, the condom-distribution network can be extended to community agents, shops, bars, youth and women's groups, etc. Social marketing strategies in the host country or in the country of origin could be extended into the refugee situation.

Safe Blood Transfusion

Blood transfusions must not be done if the facilities for safe transfusion, including screening for HIV testing, do not exist. Safe blood trans-

fusion can be organised within the refugee settlement in major operations or should be arranged with local health facilities following appropriate discussions with the Ministry of Health. Should local health facilities be used, support to these structures must be assured by the refugee programme.

The likelihood of becoming infected with HIV through transfusion of infected blood is well over 90 per cent. Measures to ensure the safety of blood transfusion in refugee situations are extremely important.

The main recommendations for preventing HIV infection and other blood-borne diseases through blood transfusion are to:

- Transfuse only previously tested blood and only when clinically necessary.
- Use blood substitutes, such as simple crystalloid (physiological saline solution for intravenous administration) and colloids whenever possible.
- Collect blood from donors identified as being least likely to transmit infectious agents in their blood. Selection of safe donors can be promoted by giving clear information to potential donors on when it is appropriate or inappropriate to give blood and by using a blood-donor questionnaire. Voluntary, non-remunerated blood donors are safer sources than paid donors. Personal information given by the donor must be treated as strictly confidential.
- Provide reagents to perform HIV testing of donated blood. Screening for HIV and other infectious agents should be carried out using the most appropriate assays.
- Develop clear policies and protocols/guidelines concerning the appropriate use of blood for transfusion, the recruitment and care of donors and the safe disposal of waste products, such as blood bags, needles and syringes.
- Appoint an experienced person to be responsible for refugee-specific blood transfusion services.

Access to STD Care

Because the risk of HIV transmission is greatly increased in the presence of other STDs, early establishment and integration of STD services within general health care services is a priority. STDs and their complications, such as infertility and congenital syphilis, are a major cause of ill health and are usually grossly under-reported. The prevention of STDs involves the promotion of safer sex as well as early and effective case finding, advise on notification of partners and case management.

STD services should be user-friendly, private and confidential. Special arrangements may be necessary to ensure that women and young people feel comfortable using these services. In many societies, women will not seek treatment if the health professionals at the clinic are all male, particularly if a physical examination is required. In these situations, female health workers should provide services for women.

Appropriate and effective case management involves the following:

- training health care providers
- providing guidelines for case management, including case definition and management protocol
- consistent availability of appropriate drugs
- consistent supply of condoms
- monitoring
- identifying secondary or informal providers of STD care

Training health care providers. Health care providers, including volunteer workers, should receive training in prevention of STD/HIV/AIDS, be provided with information materials and serve as channels for the distribution of condoms. Professional health workers should be trained in the syndromic approach to STD management.

Health worker training should include the following topics:

- syndrome recognition and diagnosis

- effective treatment based on observed syndromes
- importance of confidentiality
- education for prevention/counselling focused on specific population groups
- condom promotion and provision
- partner notification and management
- monitoring

STD Case Management. Treatment of symptomatic cases should be standardised on the basis of syndromes and not dependent on laboratory analysis. A treatment protocol (consistent with national protocols) based on syndromic case management should be prepared and adopted. (See examples in Annexes 4 and 5.) The most effective drugs should be used at the first encounter.

Initial drug requirements should be based on available data from the country of origin or estimated as indicated in Annex 8. Monitoring activities will then serve to review real needs. If IEC efforts are effective, if services are user-friendly and people from outside the camp are attending the health facilities, the need for drugs may increase rapidly.

Partners of patients with an STD are likely to be infected themselves and should be treated. Each patient should be provided with contact slip(s) to be given to his/her sexual partner(s). On the basis of these slips, partners should have access to the same treatment as the patient who presented first. The process should be confidential, voluntary and non-coercive and include all sexual partners of each STD patient.

Applying a syndromic approach to STD case management allows effective care for symptomatic cases without the need for laboratory support. The exception to this is systematic testing for syphilis in pregnant women. This type of testing is cost effective even in sites where the prevalence of syphilis in the general population is as low as one per cent.

Information, Education and Communication (IEC)

Information, education and communication activities are central to a successful HIV/AIDS and STD strategy in all situations. IEC includes a variety of activities at different levels, from intensive person-to-person education to mass dissemination of information. (For further information on IEC, refer to Appendix One.)

Comprehensive Care for People with HIV/AIDS

Comprehensive care for people with HIV-related illnesses should be seen as a component of basic care in any refugee situation. This is especially important when refugees come from an area where HIV-related illnesses are a major cause of morbidity and mortality. (The WHO flow chart for suspected symptomatic HIV infection for the purpose of clinical management is provided in Annex 6.)

The elements of comprehensive care include:

- **clinical management**, involving early diagnosis of HIV-related illnesses, rational treatment and planning for follow-up care;
- **supportive care** to promote and maintain hygiene and nutrition;
- **education** of individuals and families on HIV prevention and care;
- **counselling** to help individuals make informed decisions on HIV testing, reduce stress and anxiety and promote safer sex; and
- **social support**, including information and referral to support groups, welfare services and legal advice.
- A **home-based care system**, to which people with advanced HIV infection/AIDS-related illnesses can be discharged from inpatient care, should be established early in refugee situations.

The introduction of comprehensive care for HIV/AIDS in refugee situations involves:

- sensitising health workers to HIV-related illnesses and AIDS;
- developing a policy on the role of voluntary and confidential HIV tests (with related pre- and post-test counselling) for clinical diagnosis (see Annex 1). If host countries offer voluntary counselling and testing services to the local population, initiate discussions to determine the possibility of extending these services to refugee populations;
- adapting existing clinical and nursing guidelines for case management of HIV-related illnesses in primary and secondary care in refugee settings. This should include guidelines on discharge and referral of people with HIV-related problems, either for more sophisticated care or to home-based care;
- drawing up an essential drug list for care of HIV-related illnesses and establishing mechanisms to ensure the procurement and supply of these drugs;
- training health care workers in the use of the clinical guidelines;
- introducing counselling training for health and lay workers and developing guidelines for counselling. This can be integrated into counselling for other problems related to the refugee situation. It will be helpful if staff involved in this activity are not subject to frequent rotation;
- including those people living with HIV/AIDS in training programmes;
- ensuring that HIV-related care is fully integrated into basic curative services and that prevention components (such as supply of condoms) and STD treatment are provided;
- developing community support for AIDS care by:
 - exploring community potential for stigma and discrimination;
 - exploring community capacities and commitment;

- encouraging the development and training of self-help and other community-based support groups; and
- starting community-based care and support activities, using the self-help groups that have been established.

Monitoring

Data on the number of STD and HIV/AIDS cases presenting for treatment or detected in health services are essential for planning services and as indicators of trends in STD prevalence in the community. Always suspect under-reporting of STDs and HIV/AIDS. Managers of health care programmes may want to check for the presence of informal networks of treatment for STDs, such as in local markets.

STD/HIV/AIDS Indicators

✓ **Indicators to be collected from the health-facility level**

- percentage of blood screened for HIV before transfusion and per cent found positive for HIV
- incidence of STDs
- practice of universal precautions

✓ **Indicators collected at the community level**

- outlets for condoms distribution
- knowledge of correct condom use
- condom use

✓ **Indicators concerning training and quality of care**

- training of health workers in syndromic case management
- quality of STD case management

(Refer to Chapter Nine—Surveillance and Monitoring.)

Checklist for STD/HIV/AIDS Programmes

- From MISDP
- Guarantee availability of free condoms
 - Enforce universal precautions
 - ✓ HIV/STD/AIDS situational analysis is undertaken
 - ✓ Trained people from refugee community are identified
 - ✓ Information, education and communication programmes are in place
 - ✓ Universal precautions in health settings are practiced
 - ✓ Free good-quality condoms are regularly available and accessible
 - ✓ System of condom distribution is in place
 - ✓ Safe blood transfusion services are in place, guidelines disseminated, HIV test kits available, staff trained
 - ✓ Management protocols for STDs are defined and disseminated
 - ✓ Drugs for STD treatment are on hand
 - ✓ Staff are trained/retrained on syndromic case management
 - ✓ System for partner notification and treatment are instituted
 - ✓ Voluntary counselling and testing (VCT) services are in place (as appropriate)
 - ✓ Home-based care for people with AIDS is in place
 - ✓ Counselling and support services for people with HIV/AIDS are in place

ANNEX 1
HIV Testing
in Refugee
Situations

HIV Testing in Refugee Situations

Available resources for HIV testing should be devoted, first and foremost, to ensuring a safe blood supply for transfusions. A **voluntary HIV testing and counselling (VCT)** programme is a lower priority in a refugee situation but should not be ruled out if resources are available and if these services are available in the host country or were available in the country of origin.

HIV testing to diagnose HIV-related illness may be indicated, but only if two conditions are met:

- consent, pre- and post-test counselling and confidentiality can be assured; and
- a confirmatory testing procedure is undertaken as outlined in UNAIDS Policy on HIV Testing and Counselling.

People known to be HIV infected or to have AIDS should remain within their communities or within the refugee settlements, where they should have equal access to all available care and support.

UNAIDS/WHO Position on Mandatory HIV Testing in Refugee Situations

Mandatory HIV testing in refugee circumstances, with the single exception of testing blood for transfusion, is not justified. WHO and UNAIDS have determined that such testing should not be pursued as a matter of policy.

- ✓ Identifying people with HIV/AIDS through mandatory testing does nothing to stop the spread of the virus.
- ✓ Mandatory testing is a violation of human rights, and it leaves those who are identified as HIV-positive open to discrimination and persecution.
- ✓ No negative HIV test can be assumed to have excluded the possibility of HIV infection in the person tested. There is a latent period of several weeks following infection, during which the HIV test can come up negative, but the person is still capable of transmitting the infection through unprotected sexual contact or blood. Occasionally, too, tests have shown false negative results.
- ✓ A negative HIV test offers no assurance that the person tested will not be exposed to HIV and become infected soon thereafter.
- ✓ A negative HIV test is, therefore, no reason to relax the universal precautions that health workers need to observe at all times; nor does a negative HIV test give any reason to feel that sterile procedures during medical interventions are any less important. In practice, every patient should be regarded as a potential carrier of HIV, Hepatitis B or other blood-borne infections, since testing removes none of the potential for transmitting these diseases.
- ✓ UNHCR and International Organization on Migration (IOM) issued a joint policy in 1990 which strictly opposes the use of mandatory HIV screening, and any restrictions based on a refugee's HIV status. Nevertheless, some States have adopted mandatory HIV testing for refugees and exclude those who test positive. Other States place restrictions on the admission of persons whom they know to be HIV positive or have AIDS. Although some countries have established waiver procedures, resettlement cases of refugees who are HIV positive or have AIDS are certain to be more complex than most resettlement cases.
- ✓ Resettlement considerations of refugees living with HIV are difficult and must be given special attention to avoid placing these persons at greater risk for discrimination, *refoulement*, and institutionalisation.

CHAPTER FIVE

ANNEX 2

**Mother-to-Child
Transmission and HIV
and Infant Feeding****Mother-to-Child Transmission and HIV
and Infant Feeding**

Primary prevention of HIV in girls and women of reproductive age remains the most important component of any strategy or programme to prevent mother-to-child transmission (MTCT).

For women who are HIV negative or of unknown status, breastfeeding should be protected, promoted and supported. (See Chapter Three-Safe Motherhood)

For HIV-infected pregnant women, the only interventions proven to reduce significantly MTCT of HIV are the use of antiretroviral therapy (ARV) and the avoidance of breastfeeding. Women who are known to be HIV positive should be counselled about the possibility of avoiding breastfeeding. They should consider using commercial infant formula, home-prepared formula, or a modified form of breastfeeding, such as expressing and heat treating their own breast milk. They could also breastfeed for a shorter time than usual, or find an HIV-negative wet nurse. However, most of these options are usually impractical. Studies are continuing on the effectiveness and service delivery implications of providing short-course ARV treatment which may represent a feasible intervention in some settings and for some circumstances.

In some settings, consideration could be given to providing HIV-positive mothers with breast milk substitutes and supporting its safe use. The supply of the substitute should be guaranteed for at least six months. The acquisition and distribution of breast-milk substitutes should be in compliance with the International Code of Marketing of Breast-milk Substitutes.

Considerable resources are required to prepare formula, whether commercial or home made. The mother needs water to clean equipment and prepare feeds; she needs adequate fuel to boil water to sterilise equipment and make feeds safe. She must do this six times a day, or prepare six feeds at one time and keep them cool for up to 24 hours to prevent spoilage.

This is not often practical when normal life is disrupted. If feeds cannot be mixed correctly, if equipment cannot be adequately cleaned and sterilised, or if prepared feeds cannot be stored to prevent spoilage, the risks of sickness and death to the infant may be greater than the risk of transmission of HIV through breastfeeding.

Bear in mind these considerations when counselling women. Health care providers should support women and, when possible, their families, in making the best decision on how to feed their infant given their particular circumstances. Breastfeeding may be the most appropriate and safest option.

For more information on HIV and Infant Feeding refer to the "HIV and Infant Feeding Packet" produced by UNAIDS, UNICEF and WHO, Geneva, 1998. Also refer to "Nutrition and HIV/AIDS", Sub-committee on Nutrition News, Number 17, WHO, Geneva, 1998.

ANNEX 3
Formula for
Calculating
Condom
Requirements

Formula for Calculating Condom Requirements

Condom needs can be calculated if you can estimate the following:

- The size of the target population (i.e., refugee population and adjoining areas). Roughly 20 per cent of this number represents the size of the sexually active male population.
- The percentage of males using condoms. Results from previous knowledge, attitudes, behaviour and practices (KAPB) studies can be used when they exist. If they do not exist, plan from data provided by the most reliable source and adapt according to needs.
- Plan for about 12 condoms per sexually active male per month.
- Add to the above figure 20 per cent for wastage and loss.

✓ **Example:** A baseline calculation for procuring one month's supply of condoms for an estimated refugee and adjoining population of 10,000 people, with 20 per cent of sexually active males using condoms, is as follows:

2,000	sexually active males		2,000		
20/100	20 per cent using condoms	x	0.2	=	400
12	condoms per month	x	12.0	=	4,800
20%	wastage/loss	+	0.2	=	960
	total condoms per month				4,800
	total wastage/loss			+	960
					5,760 condoms

Estimated total needs for one month:

Condoms usually come in boxes of 144, called a gross. Quantities of follow-on supplies should be modified according to the field situation (demographic profiles in refugee camps may be very different from the normal demographic profile; use rates of condoms may also vary). To avoid shortages, make sure a three-month reserve supply is available.

CHAPTER FIVE

ANNEX 4

**STD Treatment Based
on Syndromic
Approach**
STD Treatment Based on Syndromic Approach

Syndrome	Treat For
Urethral discharge	Gonorrhoea and chlamydia
Genital ulcers	Syphilis and chancroid
Vaginal discharge ¹	Gonorrhoea, chlamydia and trichomonas
Lower abdominal pain	Gonorrhoea, chlamydia and anaerobes
Inguinal bubo	as for chlamydia
Scrotal swelling	Gonorrhoea and chlamydia
Neonatal eye discharge	Neonate gonorrhoea and chlamydia

1. If a woman complains of vaginitis (itching)—treat for candidiasis.

ANNEX 5

Drugs for
Treatment
of STDs**Drugs for Treatment of STDs**

(Choice of drugs should be based on antibiotic sensitivity studies in a specific area)

Treat For	Drugs – Depending on Sensitivity Studies	Adult Dose (for uncomplicated or early infections)
Gonorrhoea	Ciprofloxacin ¹ Spectinomycin Cefixime Ceftriaxone Kanamycin Sulfamethoxazole/Trimethoprim	500 mg - single dose - oral 2 g - single dose - IM 400 mg - single dose - oral 250 mg - single dose - IM 2 g - single dose - IM 400mg/80mg - 10 tabs once daily for 3 days
Chlamydia	Doxycycline ¹ Tetracycline ¹ Erythromycin Sulfafurazole	100 mg - twice daily for 7 days - oral 500 mg - four times a day for 7 days - oral 500 mg - four times a day for 7 days - oral 500 mg - four times a day for 10 days - oral
Syphilis	Benzathine penicillin G Procaine penicillin G Tetracycline ^(1,2) Doxycycline ^(1,2) Erythromycin ²	2.4 MUs - single dose - IM 1.2 MUs - daily for 10 days - IM 500 mg - four times a day for 15 days - oral 100 mg - twice daily for 15 days - oral 500 mg - four times a day for 15 days - oral
Chancroid	Erythromycin Ciprofloxacin ¹ Ceftriaxone Spectinomycin Sulfamethoxazole/Trimethoprim	500 mg - three times a day for 7 days - oral 500 mg - single dose - oral 250 mg - single dose - IM 2 gm - single dose - IM 800mg/160mg - twice daily for 7 days - oral
Donovanosis	Sulfamethoxazole/Trimethoprim Doxycycline ¹ Tetracycline ¹ Chloramphenicol	800mg/160mg - twice daily for 14 days - oral 100 mg - twice daily for 7 days 500 mg - four times a day for 7 days 500 mg - four times a day for 2 days
Trichomonosiasis	Metronidazole ³	2 g - single dose - oral
Candidosis	Nystatin pessaries Clotrimazole or miconazole pessaries Miconazole	100,000 IU - twice intravaginally for 14 days 200 mg - once intravaginally for 3 days 500 mg - intravaginally - single dose
Bacterial vaginosis	Metronidazole ³	400-500 mg - twice a day for 7 days - oral or 2 g - single dose - oral

1–Contraindicated in pregnancy

2–For persons allergic to penicillin, but may be less effective. Close follow up is necessary to ensure a cure.

3–Contraindicated in first trimester of pregnancy

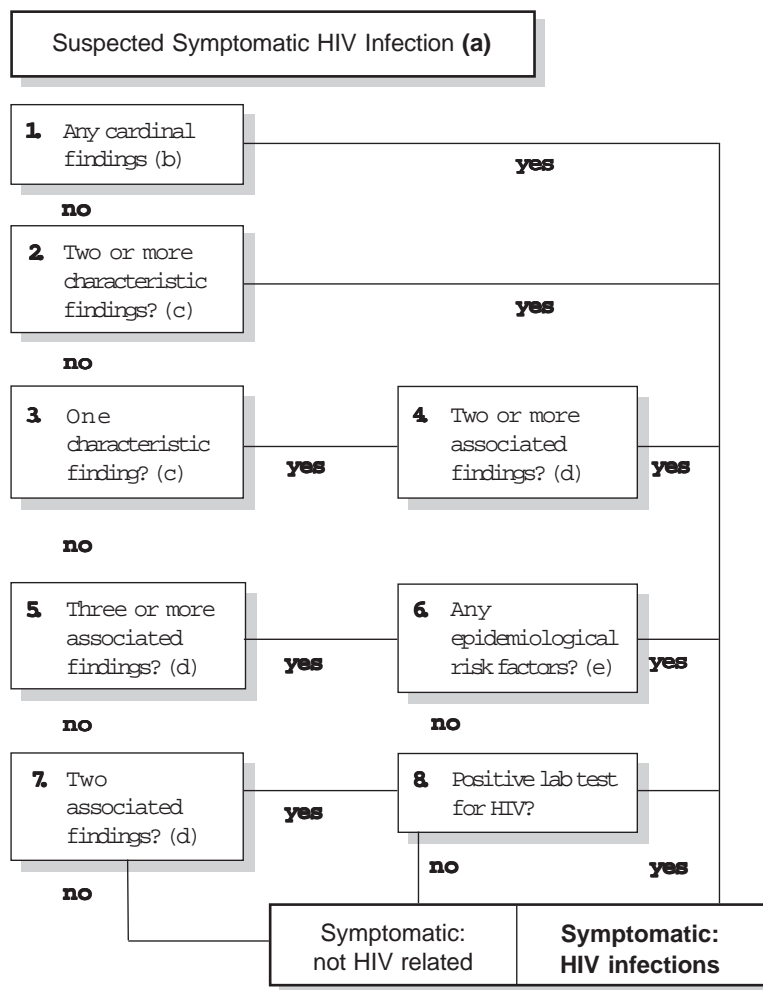
Based on: Management of STDs–
WHO/GPA/TEM/94.1 and WHO
Model Prescribing Information: Drugs
Used in STDs and HIV Infections–
WHO 1997

NOTE: Drugs for treatment of STDs are continuously revised. Health care providers should rely on the most up-to-date recommendations.

ANNEX 6

Suspected Symptomatic HIV Infections

WHO Flow Chart



Annotations:

a) The purpose is to help the health care provider to recognize the patient with symptomatic HIV infection, as an aid to clinical management. HIV testing, when available and affordable, can be used to substantiate the clinical diagnosis.

b) **Cardinal Findings:**

- Kaposi sarcoma¹
- Pneumocystis carinii pneumonia
- Toxoplasma encephalitis
- Oesophageal candidiasis
- Cytomegalovirus retinitis

c) **Characteristic Findings²:**

- Oral thrush (in patient not taking antibiotics)
- Hairy leukoplakia
- Cryptococcal meningitis (may be a cardinal finding in Africa)
- Miliary, extrapulmonary or noncavitary pulmonary tuberculosis³
- Herpes zoster, present or past, particularly multidermatomal, age 50 years
- Severe prurigo
- Kaposi sarcoma (other than as cardinal finding)
- High-grade B-cell extranodal lymphoma

d) **Associated Findings²:**

- Weight loss (recent unexplained) of more than 10% of baseline body weight, if assessable³
- Fever (continuous or intermittent) for more

than 1 month³

- Diarrhoea (continuous or intermittent) for more than 1 month
- Ulcers (genital or perianal) for more than 1 month
- Cough for more than 1 month³
- Neurological complaints or findings⁴
- Generalised lymphadenopathy (extrainguinal)
- Drug reactions (previously not seen), e.g. to thiacetazone or sulfonamides
- Skin infections (severe or recurrent), e.g. warts, dermatophytes, folliculitis

e) **Epidemiological Risk Factors:**

- Present or past high-risk behaviour:
 - drug injecting
 - multiple sex partners
 - sex partner(s) with known AIDS or HIV infection
 - sex partner(s) with known epidemiological risk factor or from an area with a high prevalence of HIV infection
 - males having penetrative sexual intercourse with males
- Recent history of genital ulcer disease.
- History of transfusion after 1975 of unscreened blood, plasma or clotting factor; or (even if screened) from an area with a high prevalence of HIV infection.
- History of scarification, tattooing, ear piercing or circumcision using non-sterile instruments.

1. Kaposi sarcoma is a cardinal finding only when: (i) intraoral lesions are present; (ii) lesions are generalised; or (iii) lesions are rapidly progressive or invasive.

2. If no other obvious cause of immunosuppression is evident.

3. The combination of fever, weight loss and cough is characteristic of both tuberculosis and AIDS.

4. Neurological complaints or findings associated with HIV infection include seizures (especially focal), peripheral neuropathy (motor or sensory), focal central motor or sensory deficits, dementia and progressively worsening headache.

Adapted from WHO/GPA/IDS/HCS/91.6 "Guidelines for the Clinical Management of HIV Infection in Adults", December 1991.

ANNEX 7

WHO Essential Drugs
for HIV/AIDS
ManagementWHO Essential Drugs HIV/AIDS
Management

Indications	Drugs
<i>Dehydration</i>	Oral Rehydration Salts
<i>Diarrhoea</i>	Loperamide
<i>Bacterial Infections</i>	Cotrimoxazole Amoxicillin Ciprofloxacin Ceftriaxone
<i>Fungal Infections</i>	Miconazole Nystatin (oral and ointment) Ketoconazole ¹
<i>Parasitic Infections</i>	Metronidazole (oral)
<i>Palliative Care and Pain Management</i>	Codeine
<i>Tuberculosis</i>	Isoniazid Rifampicin Pyrazinamide Ethambutol
<i>Clinical Depression²</i>	Tricyclics ³ Benzodiazepine Family ⁴

¹ Ketoconazole is expensive, therefore only limited supplies should be considered and only if there are enforceable criteria for its use.

² The appropriate use of anti-depressant medicine should be considered in situations where clinical depression is diagnosed.

³ Given the possibility of overdose, tricyclics should perhaps be prescribed only in 5 or less at a time and by a physician.

⁴ The use of anxiolytics (Diazepam - Benzodiazepine family) may also be considered for temporary management of severe anxiety reactions where respiration is **not** impaired (e.g., pneumocystis carinii pneumonia).

Sexually Transmitted Diseases:

Example for estimating of drug requirements
and costs for a population of 200,000

ANNEX 8**Sexually
Transmitted
Diseases**

			Treatment Protocol	Cost per treatment in US\$	Total cost in US\$
Population 15–44 years 50% of total population		100 000			
Expected % of STD (1)	5 %	5 000			
Expected % of genital ulcers	20% of (1)	1 000	benzathine benzyl- penicillin 2.4 MU 1 dose plus erythromycin, 500mg 3/day x 7 days	0.24 plus 1.68 = 1.92	1 920
Expected % of urethral discharge	50% of (1)	2 500	ciprofloxacin, 500mg x 1 plus doxycyclin, 100mg 2/day x 7 days	1.72 plus 0.17 = 1.89	4 725
Expected % of cervicitis	5% of (1)	250	ciprofloxacin, 500mg plus doxycyclin, 100mg 2/day x 7 days	1.89	473
Expected % of vaginitis	25% of (1)	1 250	metronidazole, 2gr plus nystatin 2p/day x 14 days	0.04 plus 0.50 = 0.79	988
Condoms estimate during STD management		5 000 x 12 = 60 000		US\$5.40 per 144 pieces	2 250
TOTAL US\$					10,356

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Family planning helps save women's and children's lives and preserves their health by preventing untimely and unwanted pregnancies, reducing women's exposure to the health risks of childbirth and abortion and giving women, who are often the sole caregivers, more time to care for their children and themselves.

All couples and individuals have the right to decide freely and responsibly the number and spacing of their children and to have access to the information, education and means to do so.

6

CHAPTER SIX

Family Planning

Contents:

- Preliminary Considerations
- Assessment of Needs
- Implementation of Family Planning Services
- Examples of Contraceptive Methods that May Be Provided in Refugee Settings
- Male Involvement in Family Planning Programmes
- Monitoring



Family Planning

Refugee women and men should be involved in all aspects of family planning programmes; and the programmes should be conducted with full respect for the various religious and ethical values and cultural backgrounds within the refugee community.

From the earliest stages of an operation, relief organisations should be able to respond to refugees' demand for contraceptives. As the situation stabilises, a range of safe and effective modern methods of family planning, approved by WHO, should be available. The provision of family planning services requires appropriately trained staff and a reliable supply of material and financial resources.

Preliminary Considerations

The situation in the refugees' country of origin will be an important factor influencing expectations, perceived needs and demand for family planning. Laws, infrastructure, religious and ethical values and cultural backgrounds and the training of health-care providers from the host country also have an important affect on the services that can be offered. Some women may want to continue using a contraceptive method that they used before displacement. These women's demands for continued family planning should be met as soon as possible.

Given the risk of pregnancy and exposure to sexually transmitted diseases (STDs), including HIV, that often prevails in refugee situations, condoms should be available as early as possible. (See Chapter Two – MISP.) Counselling services should also be available.

Providing a full range of family planning services will usually not be feasible until the situation has stabilised somewhat. A refugee situation is considered "stabilised" when the crude mortality rate falls below one in 10,000 per day, when there are no major epidemics, and when the "settled" refugee population is not expected to repatriate or relocate within six months.

Protocols used to manage family planning services in the country of origin may be different than those used in the host country. To the extent possible, host country protocols should be followed, although some negotiation may be necessary where differences exist.

Most family planning methods are used by women. Women have the right to confidentiality and privacy about their choice of methods. But frequently men are the decision-makers within the family unit. Where appropriate, men should be given appropriate information and encouraged to take an active role in the family planning decision-making process. This will help ensure that joint responsibility is taken for family planning decisions and will maximise acceptance of the programme within the community.

Assessment of Needs

Background information on reproductive health (RH) in the country of origin should be available from pre-existing data. Sources for this information include UNAIDS, UNFPA, WHO and other governmental and non-governmental agencies that work in reproductive health and family planning. Headquarters and regional offices should be able to provide this information to field operations.

A review of the national or other (UNFPA, NGO, bilateral, etc.) family planning programmes of the host country must be conducted to find ways and means for collaboration and to identify any differences in protocols which must be resolved. If services are made available to refugees, they should also be available to the surrounding local population on request.

The following activities will help assess the demand for family planning within a refugee population:

- Carry out an investigation of attitudes held by the refugee population concerning contraception.
- Assess attitudes and knowledge of providers from the refugee population,

including those involving traditional methods.

- Gather information on contraceptive prevalence by method in the country of origin.
- Verify in-country availability of supplies and continuity of supplies.
- Determine if refugees can use existing facilities in the host country.

The support of community, social and religious leaders should be sought before setting up family planning services. Without this support, only those willing to risk community censure may use the services. For example, in some traditional cultures, talk of women's reproductive rights may provoke opposition. But support may be given for an information, education and communication (IEC) campaign emphasising child spacing, safe motherhood and the health of women.

Discussions should be held with individual women (including leaders and traditional birth attendants [TBAs]) and women's organisations to obtain their advice on the location of service points, the timing of services at the health facilities and the level of privacy and confidentiality that will ensure maximum use.

Implementation of Family Planning Services

To ensure an appropriate and effective family planning programme, the following components must be integrated, according to the findings of the assessment:

High-Quality Family Planning Services

All RH services should be of the highest quality possible. High-quality contraceptive care involves providing women and men with safe and appropriate methods to meet individuals' and couples' needs at every stage of their reproductive lives. Accurate and complete

information should be provided, allowing women and men to select freely a method that suits their needs.

High quality means that:

- the needs of clients are assessed;
- an appropriate range of methods is provided;
- complete and accurate information about all methods is offered, thus ensuring informed choice;
- a mix of methods matches the needs of all potential clients;
- providers have the necessary technical skills to offer the methods safely (i.e., providers screen women for medical contraindications, assess STD/HIV risks, and can medically manage side effects);
- providers are trained in technically accurate and culturally appropriate counselling techniques and use them effectively;
- services are convenient, accessible and acceptable to clients;
- follow-up care to ensure continuity of services is provided; and
- an adequate logistics system ensures a continuity of supplies.

Procurement of Contraceptives and Logistics of Distribution

It is not possible to provide quality services unless an uninterrupted supply of contraceptives is ensured and staff are appropriately trained. Local supply channels should be investigated. If these are inadequate, supplies should be obtained through reliable suppliers or with support from UNFPA, UNHCR or WHO. These agencies can facilitate the purchase of bulk quantities of good-quality contraceptives at low cost.

The following are the basic steps required to manage stocks of contraceptives:

- **Select contraceptives.** Selection should be based on past use within the refugee

community, the providers' skills, and consideration for the laws, procedures and practices of the host country. Negotiation maybe necessary to resolve any differences.

- **Estimate quantities to be procured.** Estimates should initially be based on data from the country of origin and, later, on data generated within the refugee situation.
- **Set up a system for record keeping.** See section below on monitoring.
- **Set up procedures for efficiently managing the procurement, distribution and inventory of contraceptives.** Under- or over-supply may be avoided by careful organisation, primarily by appointing an individual who will assume this specific responsibility.

Planning Outlets and Opportunities for Family Planning Services

Family planning delivery sites should be accessible and convenient. Ideally, family planning services should be available at health centres, outreach health posts and through community-based distribution channels, when appropriate. Some groups, such as adolescents, unmarried women and men, may need special consideration so they feel comfortable using the services and so they can avoid the risk of stigmatisation by the community. Contraceptives should be available at the consultation point; the client should not be referred to a central pharmacy to obtain the selected method.

Counselling and family planning methods should be systematically offered to refugees after providing services related to post-abortion care, STDs or after childbirth.

Human Resource Needs

Family planning programmes should be organised and supervised by an experienced nurse, midwife or doctor and maximum use should be

made of qualified or experienced refugees or local staff. If lay workers are used for community-based distribution, they must be trained in appropriate skills and attitudes and must be supervised.

Those involved in providing family planning services must show respect for the client's opinion and for the need for confidentiality. To increase use, the provider may need to be of the same sex and cultural background as the user and have strong communication skills.

To ensure administrative, technical and referral support, there must be coordination and cooperation with the host country's family planning programme and with NGOs or UN agencies, such as UNFPA. Such cooperation will also increase the chances of sustainability of the refugee family planning programme.

Preparation of the information, education and communication (IEC) component

Counselling should always be an integral part of family planning services. Appropriate, culturally acceptable IEC materials help individuals and couples make free contraceptive choices. Information must include the benefits and constraints of different methods, and how to use them. (See Appendix One—The Essentials of IEC Programmes.)

Preparation of an adequate training programme for service providers

In many situations, there will be trained providers among the refugee population. These people should be employed to the fullest extent possible. All staff involved in providing family planning services must have adequate training on contraceptive methods and counselling, as indicated in the list below. This training should be supplemented by periodic refresher courses. On-the-job training and supervised practice are essential to ensure adequate performance and must be integral components of the supervisory programme.

The elements of an adequate training programme for service providers include:

▪ **Technical Competence**

- description of methods (including advantages and effectiveness)
- mode of action, side-effects, complications, danger signs
- appropriate groups of users and instructions for use or administration
- contraindications and drug interactions
- technical skills relating to the provision of each method (e.g., insertion of IUD or hormonal implant)
- follow-up and re-supply requirements, including ordering supplies
- record keeping

For methods that require specific technical skills—such as implants, IUDs, voluntary sterilisation and the diaphragm—providers need hands-on training in method provision and close supervision.

▪ **Interpersonal Skills**

- communication and counselling skills
- appropriate attitudes towards users and non-users and respect for their choices
- appropriate responses to rumours and misconceptions
- respect for dignity, privacy, confidentiality
- understanding of the needs of specific groups, such as adolescents, single women and men

▪ **Communication Skills**

It is important for providers to be trained in culturally sensitive, unbiased communication techniques that encourage open, interactive relationships with clients. Skills necessary for this kind of communication include listening, clarifying, encouraging clients to speak, acknowledging client feelings, and summarising what has been

said. In addition, providers should be taught strategies for effective counselling of clients about method choices in a limited time period. Providers should also be trained to use visual and other support materials and to identify clients with special needs, such as those with a high risk of STDs, post-abortion clients, breast-feeding women, adolescents, etc.

▪ **Administrative Skills**

Many family planning providers must also perform routine administrative and managerial tasks, such as record keeping, referrals and inventory control, and should therefore be trained in these activities. Training should emphasise not only the specific skills necessary to carry out these functions, but also why they are important.

Plan protocols to be used during the family planning consultation

First contact involves:

- registration and taking an individual RH history;
- physical, gynaecological and pelvic examination when indicated (for example, to ascertain whether a woman is pregnant, to investigate unexplained vaginal bleeding, to determine the presence of an STD);
- counselling regarding available methods and the user's preferred choice according to her/his STD/HIV risk;
- provision of the contraceptive method supply, as indicated;
- counselling on when and how to use the contraceptives;
- counselling on possible side effects and reassurance that she/he can return to the health facility at any time and change methods;
- scheduling a follow-up visit.

See Annex 2 for an example of the decision-making process during a first visit. Annex 3

shows an example of a checklist used at a first visit to screen female refugees for contraindications against the use of various methods. Host-country checklists may exist for each method and should be used where appropriate.

For a new user, frequent follow-up (at one month, three months and six months) gives the client opportunities to ask questions about use and any side-effects which she/he may have experienced. As the user becomes familiar with a method, he/she no longer needs frequent follow-up visits. With some methods, such as pills, condoms, and injectables, clients must make regular visits to obtain the contraceptives, so follow-up is more automatic. Whatever the frequency of follow-up visits, the user should be assured of immediate access if she/he experiences any difficulties. When arranging follow-up visits, providers must be sensitive to the literacy and numeracy of the client.

Examples of Methods That May Be Provided in Refugee Settings

Providers and users must be aware of the particularities of each method, its effectiveness, safety, side effects. They should also know its effect on the risk of STD transmission, its appropriateness for breastfeeding women and the usual length of time between discontinuation of the method and return to normal fertility. Information on the common methods is presented here. "In no cases should abortion be promoted as a method of family planning" (ICPD para 8.25).

Barrier Methods

In most refugee situations, the most important barrier method will be male latex condoms. Consistent and correct use of condoms can play the dual role of protection against STD and HIV infection and prevention of conception. They can be used alone or in combination with another method to increase effectiveness. Only water-based lubricants should be used with condoms.

Other barrier methods, such as spermicides and female condoms, may be requested by refugees who are familiar with these methods from their country of origin. If requested, every effort should be made to supply these methods.

Hormonal Contraceptives

Oral Contraceptive Pills should include at least:

- one combined oral contraceptive (COC): ethinyl oestradiol < 0.035 mg and levonorgestrel 0.15 mg;
- one progestogen-only oral contraceptive (POP): levonorgestrel 0.03 mg or norethisterone 0.35 mg.

Injectable Contraceptives could include depot-medroxyprogesterone acetate (DMPA, Depo-provera), one injection every three months, norethisterone enanthem (NET-EN) one injection every 2 months, or Cyclofem, one injection per month. Trained health professionals should administer injectables. It is recommended that only one injectable method should be used to avoid confusion and misunderstanding over the schedule for reinjection.

Supportive counselling and continued reassurance during follow-up visits will help clients tolerate common side effects, such as changed patterns of menstrual bleeding.

See Chapter Four for details about the provision of Emergency Contraceptive Pills (ECPs). National policies and the demands of well-informed users should guide the use of ECPs in refugee situations.

Copper IUDs (Intra-Uterine Devices)

IUD insertion, like sterilisation and implants, requires special training, facilities and equipment that must be in place before these methods are provided.

Women known to be infected or at high risk for an STD, including HIV, should not have an IUD inserted. For nulliparous women, an IUD is not the method of first choice.

Natural Family Planning (NFP) Methods

Natural Family Planning methods include the basal body temperature method, the cervical mucus or ovulation method, the calendar method and the sympto-thermal method. NFP is particularly appropriate for people who do not wish to use other methods for medical reasons or because of religious or personal beliefs. Counselling must be provided to both partners when choosing these methods and when practising them. The methods require initial training and regular follow-up until confidence is achieved in detecting fertility signs. Teaching these methods to potential users is relatively time consuming, and requires separate sessions for those refugees who wish to use them.

Breastfeeding

Breastfeeding is effective as a contraceptive method if a woman is exclusively breastfeeding on demand her infant (no other food being given to the baby), she is not menstruating and her infant is less than six months old. If any one of these three criteria are not met, then an additional method of contraception is advised.

Family planning methods recommended for breastfeeding mothers are:

- from delivery up to six weeks postpartum: barrier methods, postpartum IUD insertion and sterilisation;
- from six weeks to six months postpartum: barrier methods, progestin-only methods (pills, injectables, implants), IUDs, and sterilisation;
- after six months postpartum: COCs and combined injectables, and natural family planning methods.

Hormonal Implants

An implant is a long-lasting progestogen-only contraceptive. The most widely used types (Norplant and Norplant 2) consist, respectively,

of six or two silastic capsules containing the progestogen levonorgestrel. The capsules, inserted under the skin of the arm, slowly release the progestogen. These implants are effective for five years. They should only be inserted or removed by properly trained personnel.

Before using any long-term contraceptive within a refugee situation, service providers must be sure that the necessary facilities and skilled personnel exist in the country of origin to reverse or remove the method, since refugees may return home at any time. If such facilities do not exist in the country of origin, the method should not be used.

Voluntary Surgical Contraception

Both male (vasectomy) and female sterilisation are desirable methods of contraception for some clients. As a surgical method, sterilisation should only be performed in safe conditions, with the formal consent of the user and by trained personnel with the necessary equipment. Sterilisation should not be excluded especially if it is familiar to the refugees from their country of origin and is allowed within the host country.

Male Involvement in Family Planning Programmes

Men must be involved in family planning programmes to increase recognition of other RH issues, such as the prevention of STDs/HIV/AIDS, and to increase acceptance within the community. Activities might include couples counselling, condom promotion, special health facility times for men, peer-group sessions and social groups. Consideration of men's perspectives and motivation must be integral to programme activities. Contraceptive use by men enables them to share the responsibility of family planning with their female partners. Some services may need to be specifically tailored to meet the needs of male users.

Monitoring

Providers should maintain a daily activity register and individual forms to help them record information and offer effective follow-up. The following information should be recorded:

- date
- user name—or, if required for confidentiality, only a number
- user information (age, parity, address)
- method selected (and brand name)
- side effects experienced
- type of user (new, repeat, etc.)
- reason for discontinuation—dropout or changed to other method
- date of next visit (for follow-up).

Record-keeping forms should be simple and appropriate to the information gathered and to staff literacy levels. All staff should receive training in how to maintain appropriate records and be informed of how the information being collected will be useful to users and providers.

Family Planning Indicators

✓ Indicators to be collected at the health-facility level

Contraceptive Prevalence Rate (CPR). CPR is the percentage of women who are using (or whose partner is using) a method of contraception at a given point in time.

✓ Indicators to be collected at the community level

Community-based surveys could be carried out to assess the knowledge, attitudes and practices of refugees concerning family planning services.

✓ Indicators concerning training and quality of care

Regular skills training and assessments. Health personnel implementing family planning programmes should be trained and their skills assessed regularly. An indicator of this competency should be monitored at least once a year. A possible indicator to assess the skills of family planning workers is the proportion of health workers appropriately implementing family planning services.

(Refer to Chapter Nine—Monitoring and Surveillance.)

Checklist for Establishing Family Planning Services

- ✓ Assessment of attitudes of different groups undertaken
- ✓ Contraceptive prevalence in country of origin known
- ✓ Family planning services sites established with participation of refugees
- ✓ Contraceptives procured and logistics system in place
- ✓ Health and community workers trained in family planning service delivery
- ✓ Family planning record keeping system in place
- ✓ Involvement of male community undertaken

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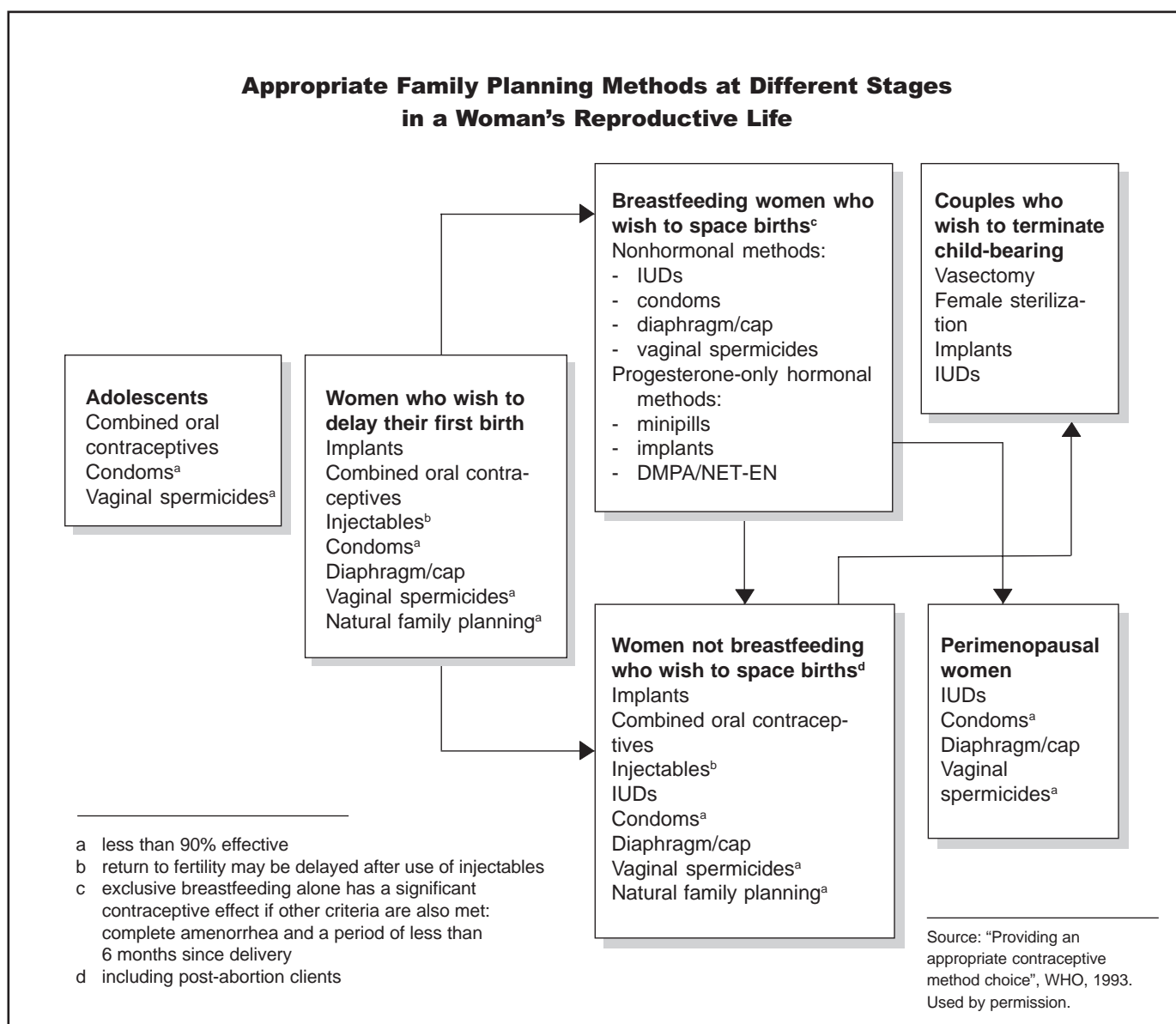
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- Providing an Appropriate Contraceptive Method Choice
- Female Sterilisation
- Vasectomy
- Breastfeeding and Child Spacing
- IUDs
- Injectable Contraceptives

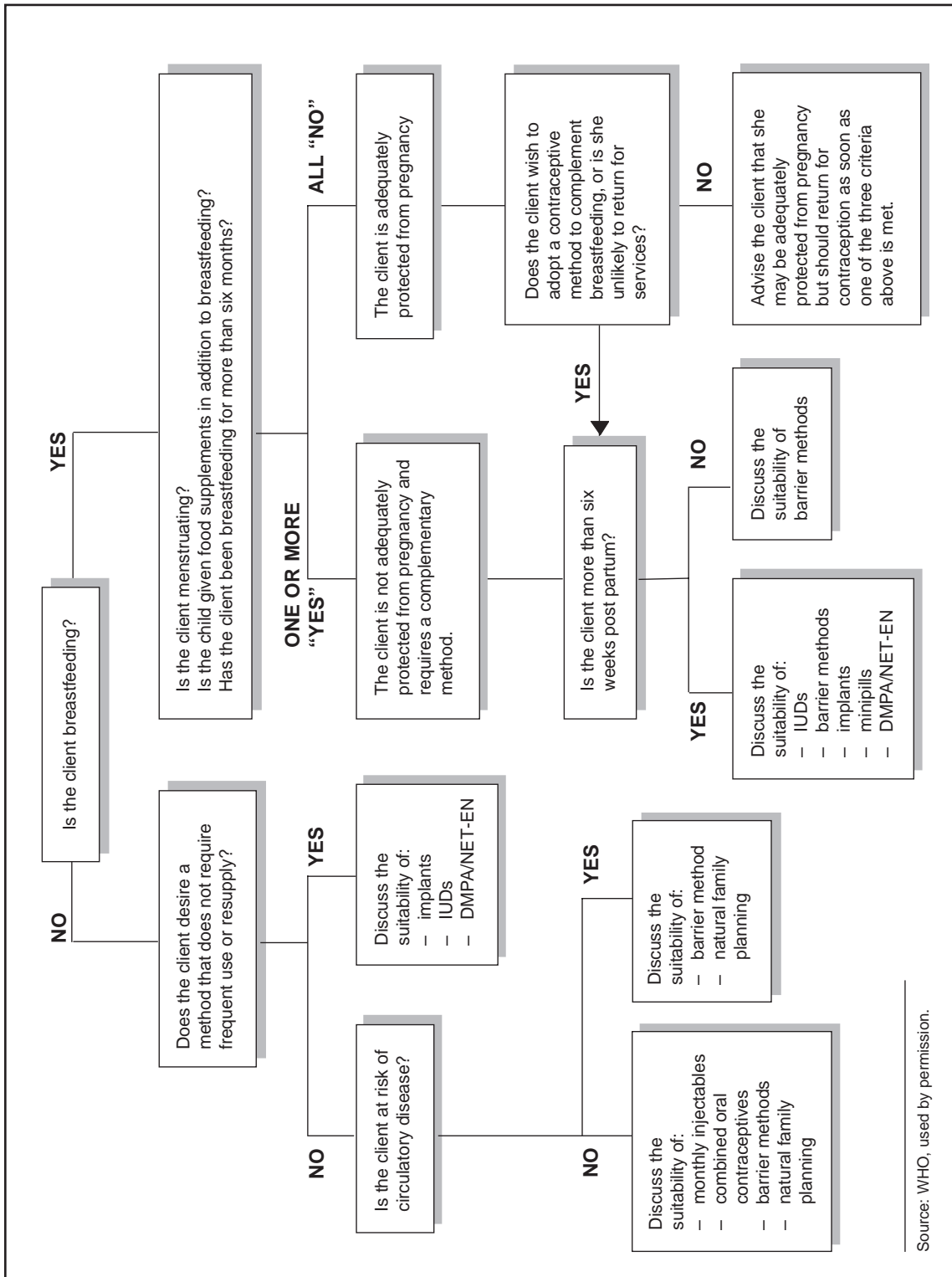
ANNEX 1

Appropriate Family Planning Methods at Different Stages in a Woman's Reproductive Life



ANNEX 2

Contraceptive
Choice Decision
Tree for Refugees
Who Desire
More Children



Source: WHO, used by permission.

ANNEX 3

Family Planning Consultation Card

Camp:		Number:	
Name:		Education:	
Address:		Age:	
Pregnancies:	Births:	Living Children:	Desired:
Age of youngest living child:		Wishes to SPACE: duration:	
Last menstrual period:		Wishes to LIMIT:	
Method(s) already used:		Affluence:	
Method desired:		Available methods	
		NO	YES
		IUD	COC
		POP	INJ*
A. ANAMNESIS			
1. Nullipara		<input type="radio"/>	<input type="radio"/>
2. Post partum < 6 weeks		<input type="radio"/>	<input type="radio"/>
3. Post abortion < 6 weeks		<input type="radio"/>	<input type="radio"/>
4. Caesarean section < 6 months		<input type="radio"/>	<input type="radio"/>
5. Diabetes not under surveillance		<input type="radio"/>	<input type="radio"/>
6. Two of the following: age > 35 years heavy smoker obesity		<input type="radio"/>	<input type="radio"/>
7. Hypermenorrhoea/dysmenorrhoea		<input type="radio"/>	<input type="radio"/>
8. Metrorrhagia		<input type="radio"/>	<input type="radio"/>
9. Medicinal treatment which could interfere with efficiency of oral contraceptives		<input type="radio"/>	<input type="radio"/>
B. HISTORY			
1. Phlebitis, arterial thrombosis, embolism		<input type="radio"/>	<input type="radio"/>
2. Extra-uterine pregnancy		<input type="radio"/>	<input type="radio"/>
3. Upper genital infection		<input type="radio"/>	<input type="radio"/>
4. Recent liver disease (< 6 months)		<input type="radio"/>	<input type="radio"/>
C. GENERAL AND GYNAECOLOGICAL EXAMINATION			
1. Yellow conjunctiva (liver malfunction)		<input type="radio"/>	<input type="radio"/>
2. Cardiac valvular pathology		<input type="radio"/>	<input type="radio"/>
3. Blood pressure above 14/9		<input type="radio"/>	<input type="radio"/>
4. Mammary tumour		<input type="radio"/>	<input type="radio"/>
5. Phlebitis, important varicose veins		<input type="radio"/>	<input type="radio"/>
6. Pregnancy		<input type="radio"/>	<input type="radio"/>
7. Upper or lower genital infection		<input type="radio"/>	<input type="radio"/>
Possible complementary exams:			
CONCLUSION:		RECOMMENDED METHOD(S)	
		METHOD RETAINED	
Date: ___ / ___ / ___		NAME _____	
		QUALIFICATION _____	
		Signature _____	

*IUD (intra-uterine device)
COC (combined oral contraceptive pill)
POP (progestrone-only pill)
INJ (injectable)

ANNEX 4

**Calculating
Contraceptive
Requirements**

Example of needs for
one year in Two Camps:
A and B

When ordering
contraceptives, always
keep in mind the time it
will take between the
date of your order and
actual receipt of the
contraceptives (usually 2
to 3 months).

Items	Population Camp A 100 000	Population Camp B 50 000	Total (both camps)	Unit costs (\$) average	Total costs (\$) per year
CONDOMS					
Target group (males): 20% of population	20 000	10 000			
Users: 20% of the target group	4 000	2 000			
12 condoms per user per month	576 000	288 000	864 000 (+20% wastage)	\$5.40 per 144 pieces	39 000
CONTRACEPTIVES					
Target group (women 15-44 yrs): 20% of population	20 000	10 000			
Contraceptive Prevalence Rate: 15%	3 000 women	1 500 women			
65% of the users prefer depoprovera (4 per year)	1 950 women or 7 800 doses	975 women or 3 900 doses	11 700 doses (+10% wastage)	\$1.5 per vial	19 300
30% of the users prefer pills (13 cycles per year)	900 women or 11 700 cycles	450 women or 5 850 cycles	19 300 cycles (+10% wastage)	\$60 per 100 cycles	11 600
5% of the users prefer IUD	150 women or 150 IUDs	75 women or 75 IUDs	225 IUDs	\$1.2 per IUD	270
					\$70 170

This Chapter does not include a discussion of all remaining reproductive health (RH) issues. It deals with two particularly serious aspects of reproductive health: managing complications of spontaneous and unsafe abortion, and eliminating the practice of female genital mutilation and caring for women who have undergone this procedure.

7

CHAPTER SEVEN

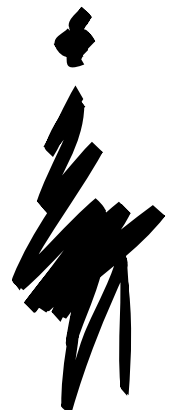
Other Reproductive Health Concerns

Contents:

- Post-Abortion Care ¹
 - Emergency Management of Post-Abortion Complications
 - Post-Abortion Family Planning
 - Links to Other RH Services
 - Monitoring and Surveillance
- Female Genital Mutilation ²
 - Scope and Definition
 - WHO classification
 - Prevention of Female Genital Mutilation in Refugee Situations
 - Care of Women with Female Genital Mutilation in Refugee Situations
 - Strategies to Eliminate Harmful Traditional Practices

¹ This section draws heavily on WHO's Clinical Management of Abortion Complications: A Practical Guide, WHO's Complications of Abortion, Technical and Managerial Guidelines for Prevention and Treatment and the Post-abortion Care: A Reference Manual for Improving Quality of Care, Post-abortion Care Consortium 1995.

² This section draws heavily upon "Female Genital Mutilation", WHO Information Kit and the WHO Management of Pregnancy, Childbirth and the Postpartum Period in the Presence of Female Genital Mutilation.



Other Reproductive Health Concerns

Introduction

Complications of Spontaneous and Unsafe Abortion

Health professionals should be able to recognise and manage the complications of spontaneous and unsafe abortions, which are major public health concerns as recognised in both the International Conference on Population and Development (ICPD) in Cairo (1994) and The Fourth World Conference on Women in Beijing (1995).

The following statement from the ICPD underpins the guidance offered in this Chapter:

“In no cases should abortion be promoted as a method of family planning. All Governments and relevant intergovernmental and non-governmental organisations are urged to strengthen their commitment to women’s health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services. Prevention of unwanted pregnancy must always be given the highest priority and every attempt should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling....where abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion. Post-abortion counselling, education and family planning services should be offered promptly, which will also help to avoid repeat abortions.”

Cairo, ICPD, 1994, paragraph 8.25

Unsafe abortion contributes significantly to the morbidity and mortality of women of reproductive age throughout the world. WHO defines unsafe abortion as “a procedure for terminating unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking minimal medical standards or both.” Every day, an estimated 55,000 unsafe abortions take place, resulting in the deaths of 200 women daily. WHO reports that up to 13 per cent of pregnancy-related deaths, world-wide, are due to unsafe abortions. In some countries, deaths due to unsafe abortion may be responsible for up to 45 per cent of all maternal deaths. Furthermore, it has been estimated that for every death, hundreds more women suffer chronic pain or disability. The most frequent complications are incomplete abortion, sepsis, haemorrhage, and intra-abdominal injury. Long-term health problems include chronic pelvic inflammatory disease, tubal blockage and secondary infertility.

Spontaneous abortion or miscarriage can result in complications that require life-saving emergency care.

Female Genital Mutilation

Female genital mutilation comprises all procedures that involve partial or total removal of the female external genitalia and/or injury to the female genital organs for cultural or any other non-therapeutic reasons. Female genital mutilation is widespread among refugee women who come from the cultures in which it is practised. While it is not required by any religion, it is a practice rooted in traditions related to gender and power inequalities entrenched in a society’s political, social, cultural and economic structures. Many women and men believe that genital mutilation is necessary for women’s health, to maintain virginity and to make them acceptable to their community.

Care provided to women who have been subjected to female genital mutilation will be improved if staff fully understand and are able

to deal with its potential consequences. Health care workers should make it a priority to eliminate harmful traditional practices, such as female genital mutilation.

Post-Abortion Care for Managing Complications of Spontaneous and Unsafe Abortion

Post-abortion care (PAC) is the strategy to reduce death and suffering from the complications of unsafe and spontaneous abortion. The elements of PAC are:

- emergency management of incomplete abortion and potentially life-threatening complications
- post-abortion family planning counselling and services
- making links between post-abortion emergency services and other RH care services.

Since incomplete and/or septic abortions may threaten a woman's life, health providers must be able to deal promptly with their consequences. As for obstetric emergencies, an appropriate referral system should be established and available 24 hours a day. (See Chapter Three.)

When planning for PAC, community needs and perceptions, including women's preferences for type and gender of PAC provider and location of services, must be solicited and considered.

Each refugee situation requires a protocol for managing post-abortion complications. Refer to Table 1 for broad guidelines on the type of facility, the composition of staff and the types of emergency post-abortion care that may be available. Factors to consider in developing the protocol are:

- staff training, qualifications and supervision to achieve minimum standards,

- supplies and equipment,
- conditions (cleanliness, space, privacy, etc.) at the health facilities,
- emergency transport system, and
- capacity of referral facility.

Where feasible, host-country health referral facilities should be used and supported.

Emergency Management of Post-Abortion Complications

Women of reproductive age experiencing at least two out of three of the following symptoms should be considered as potential patients with a threatened or incomplete abortion:

- vaginal bleeding
- cramping and/or lower abdominal pain
- a possible history of amenorrhoea (no menses for over one month)

The following steps should be taken to manage post-abortion complications:

Talk to the woman about her condition.

Any woman who presents with complications of unsafe abortion or miscarriage needs immediate high-quality care. Health care workers should be aware that women seeking such care are under severe emotional stress in addition to physical discomfort. Privacy, confidentiality and consent for treatment should be ensured.

Conduct initial clinical assessment.

The initial assessment may reveal or suggest the presence of an immediate life-threatening complication such as shock. Shock should be addressed without delay in order to prevent death or keep the woman's condition from worsening.

- ***Managing shock:*** All health personnel should know the universal measures to treat shock: do not give fluids by mouth; keep airway open; turn head and body to

one side and keep warm. Health centres should be equipped with IV fluids (saline, plasma substitutes or safe blood), systemic antibiotics and oxygen.

Complete clinical assessment.

This consists of taking a thorough RH history, performing careful physical and pelvic examinations and, when necessary, obtaining appropriate laboratory tests. A complete assessment will identify other possible complications (such as intra-abdominal injury, vaginal bleeding [light to severe], infection/sepsis and pain) leading to an appropriate treatment plan.

Manage complications.

Complications should be treated immediately by qualified personnel. Prompt referral and transfer may be needed if the woman requires treatment beyond the capability of the facility where she is seen. Her condition will need to be stabilised before she is transferred to a higher-level referral service. The following treatments may be necessary:

- **Rest:** in case of light to moderate bleeding.
- **Replacement of fluids:** in case of shock or severe vaginal bleeding, saline solution, plasma substitutes or safe blood.
- **Laparotomy/surgery:** in case of suspicion of an intra-abdominal injury. Intra-abdominal injury is commonly due to

uterine perforation, possibly as a result of an attempted abortion.

- **Uterine evacuation:** for removal of retained products of conception. First and early second-trimester incomplete abortions can be treated by vacuum aspiration or dilatation and curettage (D&C). Vacuum aspiration, manual or electric, has been found to result in fewer complications than D&C and causes less trauma to the patient. Health workers should refer incomplete abortions in the middle- or late-second trimester to a facility with surgical and full emergency backup for treatment.
- **Antibiotics:** for infection or septic shock. These are common complications of incomplete abortion. Treatment with broad-spectrum antibiotics by IV or IM is indicated.
- **Management of pain:** Appropriate pain management ensures that the woman experiences a minimum of anxiety and discomfort. Women's needs for pain management will vary, depending on their physical and emotional state.
- **Prevention of tetanus:** A tetanus vaccination should be given, as a woman may have been exposed to tetanus and her vaccination history is likely to be uncertain.

Laparotomy, surgery and uterine evacuation should be undertaken by qualified and supervised staff in appropriate and safe conditions, preferably in a host-country health facility.

Table 1
Minimum Standard for the Provision of
Emergency Management of Post-abortion Complications
By Level of Health Care Facility and Staff

Level	Minimum Staff	Emergency Care
Health Post/ Clinic	Community Health Workers, Traditional Birth Attendants (TBAs)	<ul style="list-style-type: none"> ▪ Recognition of the signs and symptoms of the complications of spontaneous and unsafe abortion and referral to facilities where stabilisation and/or treatment is available
Health Centre ¹	Health Workers Nurses Midwives General Practitioners	<p>All above activities plus:</p> <ul style="list-style-type: none"> ▪ Diagnosis based on medical history and physical and pelvic examination ▪ Resuscitation/preparation for treatment or transfer ▪ Initiation of emergency treatments (antibiotic therapy, IV fluid replacement and oxytocics) ▪ Pain control, simple analgesia and sedation, and local anaesthesia ▪ Haematocrit/Haemoglobin testing <p>If trained staff, practising minimum safe standards, and appropriate equipment are available, above activities plus:</p> <ul style="list-style-type: none"> ▪ Uterine evacuation during first trimester for uncomplicated case of incomplete abortion
Referral-Level District Hospital (usually a host-country facility)	Nurses Midwives General Practitioners Ob/Gyn Specialists Surgeons	<p>Above activities plus:</p> <ul style="list-style-type: none"> ▪ Emergency uterine evacuation through second trimester ▪ Treatment of most post-abortion complications ▪ Local and general anaesthesia ▪ Diagnosis and referral for severe complications (septicaemia, peritonitis, renal failure) ▪ Laparotomy ▪ Blood crossmatch, HIV testing and safe blood transfusions
Tertiary-level Regional or National Hospital	Nurses Midwives General Practitioners Ob/Gyn Specialists Surgeons	<p>Above activities plus:</p> <ul style="list-style-type: none"> ▪ Uterine evacuation as indicated for all incomplete abortions ▪ Treatment of severe complications (including bowel injury, severe sepsis, renal failure) ▪ Treatment of bleeding/clotting disorders

1. A health centre in a refugee situation usually provides in-patient and outpatient services, has a basic laboratory and pharmacy, and is supervised by one or more medical doctors.

Post-Abortion Family Planning

Lack of access to adequate family planning services is a major contributor to the problem of unsafe abortion. Conversely, unwanted pregnancy and, in many cases, unsafe abortion are prime indicators of the unmet need for safe and effective family planning services. In most health systems, women treated for the complications of unsafe abortions rarely receive any counselling services to prevent subsequent unwanted pregnancies. Clearly, when a woman receives care for post-abortion complications she should also receive comprehensive family planning counselling and services, if she so desires. At a minimum, all women receiving PAC should understand:

- that the prompt return of ovulation can result in pregnancy even before menses returns; and
- that there are safe contraceptive methods that can prevent pregnancy, and where those methods can be obtained.

In addition, all staff providing PAC should know how to counsel and provide family planning services.

(Refer to Chapter Six for further details on family planning services.)

Links to Other Reproductive Health Services

Linking emergency PAC services with other RH services is essential and logical, yet in much of the world these services remain distinctly separate. As a result, many women have no access to RH care and suffer poor overall health.

It is important to identify the RH services that each woman may need and offer her as wide a range of services as possible, such as:

- Treatment for reproductive tract infections
- Cervical and breast cancer screening and treatment (if applicable)

- Advice on proper nutrition
- Advice on family planning methods
- Advice about antenatal care
- Links to under-five clinics for existing children (if applicable)
- Referral for services following sexual violence
- Referral for counselling services following diagnosis as HIV-positive.

Monitoring and Surveillance

PAC services should be continuously reviewed. Managers of these services should assess the level of use of these services, review all clients' records, the availability and proper use of equipment and supplies, regularly assess specific indicators of the quality of care, identify changes or problems that occur, provide feedback to staff, and intervene to correct any problems identified.

Checklist for Post-abortion Care

- ✓ Protocol for management of complications of unsafe and spontaneous abortions is developed and used
- ✓ Staff are trained to manage complications of unsafe and spontaneous abortions
- ✓ Health facilities are equipped with appropriate materials
- ✓ Protocol for post-abortion family planning and links with other RH services are developed and used
- ✓ Reporting and monitoring system to ensure quality of care are in place

Monitoring may include: direct observation of staff at work; use of checklists (for example, to evaluate critical skills); examination of clinic records; and discussions with patients, staff and the community.

Indicators to monitor effectiveness of PAC services

- **Incidence of unsafe and spontaneous abortions:** The incidence will indicate the magnitude of the problem and point to possible underlying causes. For instance, the incidence of unsafe abortion might indicate inadequate family planning coverage for women who want to avoid or delay pregnancy.
- **Quality of PAC services:** The ability of staff to undertake all aspects of PAC should be reviewed periodically through direct observation of staff and/or review of medical records.

WHO Classification

- ✓ **Type I:** Excision of the prepuce with or without excision of part or all of the clitoris.
- ✓ **Type II:** Excision of the clitoris together with partial or total excision of the labia minora.
- ✓ **Type III:** Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).
- ✓ **Type IV:** Unclassified
 - pricking, piercing or incision of the clitoris and/or labia
 - stretching of the clitoris and/or labia
 - introcision
 - scraping (angurya cuts) or cutting (gishiri cuts) of the vagina or surrounding tissue
 - introduction of corrosive substances or herbs into the vagina
 - any other procedure that falls under the definition of female genital mutilation

Female Genital Mutilation

Scope and Definition

Female genital mutilation comprises all procedures that involve partial or total removal of the female external genitalia and/or injury to the female genital organs for cultural or any other non-therapeutic reasons. It is estimated that female genital mutilation has been performed on approximately 130 million women and girls. About two million girls risk being subjected to female genital mutilation each year. Most of the girls

and women who have undergone female genital mutilation live in 28 African countries, although some live in Asia, and in other regions.

Approximately 15 per cent of women and girls subjected to female genital mutilation undergo infibulation. Most others undergo a clitoridectomy or excision. There is a high incidence of infibulation in Djibouti, Somalia and northern Sudan, and a high rate of complications.



Infibulation is also reported in southern Egypt, Eritrea, Ethiopia, northern Kenya, Mali and Nigeria.

Physical Consequences

Female genital mutilation causes grave damage to girls and women and frequently results in serious health consequences which may include an increased individual risk of bloodborne infections such as HIV. Some of the effects are immediate; others become apparent only years later. Girls and women undergoing the more severe forms of mutilation are particularly likely to suffer serious and long-lasting complications. Documentation and studies are available on the nature of the physical short-term and long-term complications described below, but there has been little study of the sexual or psychological effects of the procedure or of the frequency with which complications occur. The mortality rate of girls and women undergoing genital mutilation is unknown as few records are kept and deaths due to the practice are rarely reported.

Usually the operation is performed on girls between four and ten years of age or younger, or, in some areas, adolescent girls. Village women, TBAs or male barbers generally perform the operation, usually without anaesthetics or antiseptics. The effects on health depend on the extent of the cutting, the skill of the operator, the cleanliness of the tools and environment, and the physical condition of the girl.

The effects of the procedure last a lifetime and may threaten not only the woman's reproductive health and well being, but also the health of her children. Health workers in refugee situations are seldom knowledgeable about the physical, psychological and social consequences of female genital mutilation, nor are they always sensitive to the cultural beliefs that support the practice.

Therefore, it is vital that field staff determine whether female genital mutilation is practised within a refugee population and identify who is responsible for undertaking the procedure.

Prevention of Female Genital Mutilation in Refugee Situations

RH programmes should include strategies to discourage female genital mutilation, emphasising the link between the practice and poor reproductive, sexual and general health in women and girls. It is vital to understand the reasons for the practice before embarking on information campaigns. Efforts to eliminate female genital mutilation can greatly be enhanced by enlisting the support of responsible community members.

The "medicalisation" of female genital mutilation (i.e., supporting health care professionals to perform female genital mutilation in health facilities under more hygienic conditions) is not acceptable in the attempt to make this procedure "safer". Medicalisation does not eliminate the harm caused by female genital mutilation and it legitimises the procedure. Health workers employed in refugee situations must be informed that their involvement in "medicalising" female genital mutilation will not be tolerated under any circumstances. Severe disciplinary measures, including possible termination of workers' contracts, should be taken if they are found to be performing female genital mutilation.

Care of Women with Female Genital Mutilation in Refugee Situations

Women who have undergone female genital mutilation, particularly Type III, need special care, especially during pregnancy, delivery and the postpartum period. When an infibulated woman gives birth, staff should be aware of the following points:

- the formation of rigid scar tissue around the vaginal opening as a result of the mutilation is likely to lead to delay in the second stage of labour, which may endanger both the woman and the baby; and
- extensive episiotomies may be needed to allow for safe delivery.

Women who have undergone infibulation need special care when using some forms of contraceptive methods, such as the IUD, and in managing the complications of unsafe and sponta-

neous abortion. Sexually transmitted diseases (STDs) are also more difficult to diagnose and women may be at a greater individual risk for bloodborne infections, including HIV.

Strategies to Eliminate Harmful Traditional Practices, including Female Genital Mutilation

The issue of harmful traditional practices, including female genital mutilation, should be approached with great sensitivity. While there are no hard and fast rules when working to prevent and eliminate these practices, the following strategies and examples may provide some guidance to field workers:

Experience has shown that the initial step in addressing harmful traditional practices is providing education and information on such practices, focusing on their negative consequences. However, action-oriented activities must follow initial awareness building.

- Campaigns to eliminate these practices are more likely to succeed and be accepted by the target population when they initially emphasise the harmful health consequences rather than the legal or human rights aspects. Laws should be seen to be protective rather than punitive and designed to prevent harm to children. This aspect should be emphasised at the community level so that the law comes to be seen as providing protection and support to the individual.
- It is necessary to have a thorough understanding of the nature and extent of the particular practice, including its roots and social consequences. Health workers can acquire this knowledge through discussions with the refugees, themselves.
- Educate target populations (both men and women), such as religious leaders, traditional leaders (chiefs, tribal elders and political leaders), teachers, TBAs and other health workers, as well as the general refugee population (including women, men and children) about the harmful health consequences of these practices. It is particularly important to educate young girls about these issues.
- Promote, provide technical support to, and mobilise resources for national and local groups that will initiate community-based activities aimed at eliminating harmful traditional practices. National committees to eliminate harmful traditional practices exist in many countries and their expertise should be tapped.
- In Kenya, local NGOs running campaigns aimed at eliminating female genital mutilation discovered that refugees were more open to discussing the topic if it was included in workshops that covered other RH issues, such as STDs, HIV/AIDS and safe motherhood, rather than if it was presented on its own. However, the campaign in refugee situations in Ethiopia began as a stand-alone model and was very successful. Only later was it incorporated into a larger RH programme. Clearly then, each programme must be tailored to the community it serves.
- In some countries, alternative income-generating activities should be devised for those who earn money through harmful practices. Traditional practitioners must also be able to find other ways to secure the respect of their community.
- Videos provide an excellent means of demonstrating the harmful effects of some traditional practices. Videos depicting a female genital mutilation operation or a woman who has not undergone female genital mutilation giving birth have proved to be very effective.
- The use of drama and other cultural activities, such as plays or songs, can also be an effective method of disseminating information on the negative effects of harmful traditional practices. Radio, local papers, and mosques may also be used to help disseminate this information.
- In the Sudan, some health workers focus mostly on men in their campaign to save girls from female genital mutilation. Men are often the primary decision-makers in the family, though they are also generally unaware of the exact nature and severity of the procedure.



- Health workers in Uganda support a “rite of passage” ceremony while trying to eliminate the harmful practices of female genital mutilation. Programmes encourage the ceremonial aspects of the “coming of age” for young women, but eliminate the “cutting” part of the process. In Sierra Leone, female genital mutilation is part of an initiation rite for women’s secret societies. These societies can be very important for women’s self-empowerment, not only because they provide a support network, but because they also provide contacts for income-generating activities. While it is important to encourage groups that empower women, it is equally important to encourage initiation ceremonies that do not require female genital mutilation.
- The importance of educating girls and women cannot be overstated. The incidence of harmful traditional practices, such as female genital mutilation and early childhood marriage, decreases as female literacy increases. Therefore, promoting and supporting female education, both the enrolment of girls in schools and adult literacy, should be a priority.
- Growing immigrant populations in industrialised countries have brought female genital mutilation with them to countries where it had not been practised. UNHCR discourages informing refugees, before resettlement, of the criminalisation of the practice in resettlement countries. Experience has shown that if told prior to departure, mass female genital mutilation operations may be conducted in the country of asylum before resettlement occurs. When refugees are resettled to countries that have laws against female genital mutilation, the authorities of the resettlement country should be encouraged to inform refugees of these laws upon their arrival.

Field staff are advised to plan carefully their strategy for eliminating harmful traditional practices in conjunction with the refugee community, implementing partners and any other relevant UN organisations. It is important to work with the refugee community to ensure measures taken are as effective as possible.

Local NGOs, host communities, and the government, which may already have active campaigns in the country, could also be involved.

Monitoring and Supervision

Monitoring the change in female genital mutilation practices in a community is very difficult. Programmes should monitor complications experienced by women during birth and investigate any deaths that may be related to female genital mutilation. Health care providers, both in health facilities and in the community, should be supervised and monitored routinely to ensure that they are not practising female genital mutilation.

Further Readings

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- “Complications of Abortion: Technical and Managerial Guidelines for Prevention and Treatment”, WHO, Geneva, 1995.
- “Female Genital Mutilation: Findings from the Demographic and Health Surveys Program”, Macro International Inc., Washington, DC, 1997.
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- “Policy Paper on Eradication of Harmful Traditional Practices”, UNHCR, Geneva 1997.
- “Post-abortion Care: A Reference Manual for Improving Quality of Care”, Post-abortion Care Consortium, JHPIEGO Corporation: Baltimore, MD, 1997.
- “Post-abortion Family Planning: A Practical Guide for Programmes Managers”, WHO, Geneva, 1997.

Growing up is stressful and challenging in the best of times. For those young people living as refugees, the stresses are much greater. Their transition to adulthood is often made more difficult by the absence of the usual role models and the breakdown of the social and cultural system in which they live. They may have gone through personal trauma themselves, including armed conflict, violence, insecurity, sexual abuse, harm to or loss of family members, disruption of schooling or employment, of friendships, and of family and community support.

The definitions of children, adolescents and adults may change from culture to culture. Health workers must adapt the definitions they use to suit the specific refugee situation in which they are working. Whether an adolescent has assumed the roles and responsibilities of an adult is also a reflection of the culture and the refugee situation. When working with young people, the cultural, ethical and religious values of the refugee community must be respected.

Defining Children and Young People

- ✓ **Children** **0-18 years**
Convention on the Rights of the Child
- ✓ **Adolescents** **10-19 years**
UNFPA, WHO, UNICEF
- ✓ **Youth** **15-24 years**
UNFPA, WHO, UNICEF
- ✓ **Young People** **10-24 years**
UNFPA, WHO, UNICEF

8

CHAPTER EIGHT

Reproductive Health of Young People

Contents:

- Young People in Refugee Situations
- Principles in Working with Young People
- Assessing the RH Needs of Young People
- Responding to the RH Needs of Young People
- Community-based Programmes
- Monitoring and Supervision



Reproductive Health of Young People

Young people have special needs in all circumstances; and each age group within this population has different problems and requirements. In refugee situations, where it is difficult enough to set up basic reproductive health (RH) services for the entire community, health providers will also have to consider and address the special needs of young people. But young people are tremendously flexible, resourceful and energetic. They can help each other through peer counselling and peer education, and they can provide care to others and assist health providers as volunteers.

Young People in Refugee Situations

Young people often have an easier time adapting to a new situation than their parents do. They learn how to “work the system” quickly. In trying to understand their special circumstances and meet their needs, it is helpful to remember the following:

- **Adolescence is a time for learning about close relationships.** In normal situations, much of this information is gained from peers and from role models in the young person's family and community. These people may not be available in refugee settings. As respected adults in the lives of young people, male and female service providers may become important role models and should be aware of their potential influence.
- **Young people often lack a well-developed future orientation. This can be reinforced by refugee or displaced status.** Projects that provide these young people with a reason to look to the future may also help them consider the consequences of unsafe sexual activity and the need to take responsibility for their actions.
- **The behaviour of young people in refugee or displaced situations may not be subjected to the same kind of scrutiny as it would be under normal circumstances.** The separation from one's

hometown, one's elders and one's traditional culture may create a situation in which risky behaviour is less socially controlled. Thus there is a greater risk of early teen pregnancy, sexually transmitted diseases (STDs), drug abuse, violence, etc.

- **Young people are not a homogeneous group.** Young women and young men face very different problems and opportunities. Young women are much more vulnerable to common RH problems and they invariably bear most of the consequences. Also, young people aged 10 to 14 years have different needs than those aged 16 to 18 or 20 to 24. And different cultures have different expectations for youth in these different age groups. For example, in some cultures, marriage is acceptable/expected for a 14-year-old girl; in many other cultures, it is not.
- **In many countries with high STD/HIV prevalence, the most vulnerable group is young women.** The AIDS epidemic is exacerbating the health risks that young women face. Their lack of power over their sexual and reproductive lives compounds the risks of unwanted pregnancy, unsafe abortion and STD/HIV infection, all of which are likely to occur more frequently in refugee situations.

Reproductive Health Needs of Adolescents

The background characteristics of young people, including their religion, cultural upbringing, place of origin (rural or urban), and level of education will, to some extent, define their needs. However, basic RH needs include:

- information on sexuality and reproductive health
- access to family planning services
- prenatal and post-abortion care
- safe delivery
- treatment of unsafe abortions
- diagnosis and treatment of sexually transmitted diseases

- protection from sexual abuse
- culturally appropriate psychosocial counselling and/or mental health services
- negotiating skills

Principles in Working with Young People

The primary principle in working effectively with young people is to promote their participation. Although this principle applies to the provision of RH services in adult populations, it is particularly important for young people. As a group, young people often have a “culture” of their own, with particular norms and values. They may not respond to services designed for adults. They are at a stage in life where they need to develop a sense of control over their bodies and their health. At the same time, since they are young and relatively inexperienced, they need guidance that is both sensitive and reassuring. The best way to encourage young people to participate is to develop a partnership between them and the providers with proper regard for parental guidance and responsibilities. Services will be more accepted if they are tailored to the needs as identified by young people, themselves.

Other principles to remember:

- **Service providers must understand the cultural sensitivities surrounding the provision of information and services to young people.** To the extent possible, community leaders and parents should be involved in developing programmes targeted at young people. Service providers with deep cultural knowledge (especially if the provider is part of that culture) are more likely to provide services acceptable to the community than those considered “outsiders”.
- **Programmes should identify and encourage peer leadership and communication.** Peers are usually perceived as safe and trustworthy sources of information.
- **It is essential to have links between health and community services.** Links

between health and community services are necessary to ensure that young people get the appropriate treatment for problems which might be revealed through one service but require additional assistance from another service (e.g., sexual violence or unsafe abortion).

- **Young people need privacy.** The problems that bring them to a service provider often make them feel ashamed, embarrassed or confused. Though space may be at a premium in a refugee camp, it is important for providers to try to create the most private space possible in which to talk to young people.
- **Confidentiality must be guaranteed.** Service providers need to maintain confidentiality in their dealings with young people and be honest with them about their health problems.
- **In most cultures, the gender of the service provider is important.** A young person should be referred to a provider of the same sex.

RH Services for Young People Should:

- ✓ be “user-friendly”
- ✓ have competent staff who are friendly, welcoming, and non-judgmental
- ✓ promote trust and confidentiality
- ✓ be free or low cost
- ✓ be easily accessible
- ✓ have flexible hours
- ✓ be located in attractive facilities
- ✓ offer same-gender providers

Assessing the RH Needs of Young People

In the absence of information specific to the young people, providers must assume that many of the common problems cited above may be worse in the refugee situation. The disruption of health and education services and general state of disorder imply a lack of protection and supervision, increased sexual violence, and a greater need to exchange sex for food, shelter, safe passage and protection. It is important to obtain information about a young person's history of STDs and pregnancy status, unsafe abortion, rape and other forms of sexual abuse. Health care providers should also be aware of a young person's knowledge about and access to any form of contraception, and his/her beliefs, attitudes, perceptions and values.

More specifically, it is important to gather information about:

- cultural norms related to sexual relationships and rites of passage into adulthood (including harmful traditional practices, such as female genital mutilation)
- current norms/practices/perceptions/attitudes related to sex
- typical patterns of adult authority over adolescent behaviour within the camp
- services available to young people (and applicable restrictions) and the degree to which the refugee community understands this availability
- perceptions of camp staff/service providers related to providing RH services to young people
- young people's perceptions of their RH needs

This information can be gathered through camp records, interviews and focus group discussions and possibly through simple survey techniques. (Some further guidance is found in Appendix One on IEC.)

Responding to the RH Needs of Young People

Young people need basic information about sexuality and reproduction. They also need to learn how to protect their reproductive health. In many refugee settlements, formal education ends after primary school. Therefore, information about reproductive health must be communicated in creative ways. Any organised activity for youth—sports, video showings, handicraft “clubs”—may provide an opportunity for disseminating important health information to participants.

It has been proven that sex education leads to safe behaviour and does not encourage earlier or increased sexual activity. (See UNAIDS document in Further Reading.) Therefore, young people should be informed about STD/HIV/AIDS and early pregnancy, and appropriate advice and supplies should be made available to them. Young people need to develop certain skills to be able to make informed, responsible decisions about their sexual behaviour. They need to be able to resist pressure, be assertive, negotiate, and resolve conflicts. They also need to know about contraceptives, such as condoms, and feel confident enough to use them. Peer counselling and peer education can be very effective in strengthening these skills and attitudes.

Young girls who do not attend school and who are destined to marry immediately after the start of menstruation may be particularly difficult to reach. However, their society may allow a community worker to visit the girls at home and discuss health matters relating to preparations for parenthood.

Rape may be the reason an adolescent first approaches health services. Many victims of rape and sexual abuse are girls, but boys are also vulnerable to sexual violence. Young people who have been sexually abused need immediate health services and access to a safe environment.

In refugee situations, adolescent girls and boys may be forced into selling sex simply to sur-

vive. Refugee-community members should be involved in identifying ways to protect girls and women from sexual violence and coercion. One possible protective measure is to ensure that women administer the distribution of food and shelter. (See Chapter Four—Sexual Violence.)

If an adolescent is pregnant, it is vital to provide her with good antenatal care, since young women, especially those under 15 years of age, are prone to complications of pregnancy and delivery. Many young pregnant women will resort to unsafe abortion. They will need special care if complications from an unsafe abortion develop. Information about family planning must be readily displayed and available to help keep unwanted pregnancies to a minimum. (See Chapter Six - Family Planning).

Adolescent boys engaging in homosexual intercourse should be taught how to prevent STD/HIV. However, IEC messages related to STDs should not label this behaviour in a way that may stigmatise the boys (e.g., as homosexual), but should refer to the behaviour as “men having sex with men” or “same-gender sex”.

Psychological trauma resulting from refugee experiences may make young people reluctant to seek services related to their sexual health. But they do need to know that these services are available to them, that they will receive care and support if they want it, and that they will not be judged or punished in any way. Information about the services could be displayed in places where young people gather or provided through other activities or social services.

Psychosocial support and counselling should be provided by trained counsellors whenever needed, but particularly in cases of sexual abuse and unwanted pregnancy.

Community-Based Programmes

Ideally, a person with experience in RH services for young people should participate in the

needs assessment and planning of the programmes. Young people from all age groups should be identified, as quickly as possible, to help design the programmes and eventually to take a leadership role.

When an assessment of current needs and available resources has been made, the group of service providers and young people who are assembled to develop the programme can consider the project objectives and develop the corresponding activities. Planners should define simple mechanisms for collecting information that can later be used to measure the project's impact. That information will also guide any modifications made to the programme. Young people should be involved in evaluating and modifying the programme.

RH services for young people are more effective and acceptable when they are linked to other activities or settings, for example recreation or work. Youth centres, developed in some refugee settlements, offer a place for young people to learn, play and receive health services. In other refugee settings, young people have access to health services during special hours, usually after school or after work. Young people need their own physical spaces for social interaction. These may be the best venues for providing health services.

Monitoring and Supervision

RH programmes should be monitored to ensure young people have access to health services and health care providers are caring for young people without stigmatising them.

To be sure young people are attending health services and being targetted with health information, many RH indicators should be measured by age and sex break down. See Chapter Nine for select indicators for young people.

Further Readings

“A Picture of Health: A Review and Annotated Bibliography of the Health of Young People in Developing Countries”, WHO, Geneva, 1995.

“Action for Adolescent Health: Towards a Common Agenda”, recommendations from WHO, UNFPA, and UNICEF, 1997.

“Coming of Age: From Facts to Action for Adolescent Sexual and Reproductive Health”, WHO/FRH/ADH/97.18, Geneva, 1997.

“Counselling Skills Training in Adolescent Sexuality and Reproductive Health: A Facilitator’s Guide”, WHO, Geneva, 1993.

“Refugee Children: Guidelines for Protection and Care”, UNHCR, Geneva, 1994.

“Technical Report of the WHO/UNFPA/UNICEF Study Group on Programming for Adolescent Health”, WHO, Geneva, 1997.

“The Impact of HIV and Sexual Health Education on the Sexual Behaviour of Young People: A Review Update”, UNAIDS, Geneva, 1998.

“Working with Young People in Sexual Health and HIV/AIDS: A Resource Pack”, AHRTAG, London, 1996.

Surveillance and monitoring are basic elements of programmes for both comprehensive reproductive health (RH) and general health care. The person who coordinates RH activities should ensure timely and appropriate inclusion of RH data and indicators in the general health-reporting system.

9

CHAPTER NINE

Surveillance and Monitoring

Contents:

- A System Framework
- An Eight-Step Approach to Surveillance and Monitoring
- Overview of Data Sources
- RH Indicators
- Reference Rates and Ratios for RH Indicators
- Sample Worksheet for Monthly RH Reporting

The Five Essential Components of a Monitoring System:

- 1** definition of essential data to collect, including case definitions¹;
- 2** systematic collection of data;
- 3** organisation and analysis of data;
- 4** implementation of health interventions based on the data; and
- 5** re-evaluation of interventions.

¹ A case definition is "a set of standard criteria for deciding whether a person has a particular disease or health related condition." Criteria can be clinical, laboratory or epidemiologic.

Surveillance and Monitoring

The aims of monitoring are to:

- identify high-risk groups;
- identify the most serious and/or the most prevalent conditions; and
- monitor the trends of these conditions and the implementation and impact of interventions.

System Framework

This Chapter explains how to develop a system to collect and use essential RH data. The system starts when a refugee situation occurs and no existing services are present. It is described in chronological order and in order of priority. The scheme can be adapted and altered to respond to different situations.

Most RH surveillance should be integrated into the overall health-information system (HIS). During a refugee emergency, keep the HIS simple and limited to the most important causes of morbidity and mortality. Step 1 (of the eight-step approach described below) suggests the essential data relevant to reproductive health which staff should try to collect in the early phase. When more comprehensive services are available, other data can be incorporated (as described in subsequent steps).

Surveillance and monitoring of both health status and service delivery involve defining measurable programme **objectives** (what the programme will strive to achieve) and using indicators to measure progress toward achieving those objectives. An **indicator** is a measurement that, when compared to either a standard or desired level of achievement, provides information regarding a health outcome or a management process. Indicators are measurements that can be repeated over time to track progress toward achievement of objectives.

In this Manual, we use a simple framework for objectives and indicators.

Impact objectives target changes in mortality and morbidity expected to result from programme activities.

Outcome objectives target changes in knowledge, attitudes, behaviours, or in availability of needed services or commodities that result from programme activities. They relate directly to the priority intervention (e.g., HIV/STD prevention, child spacing), the target population (e.g., women of reproductive age), or those charged with caring for the target population (such as health care workers and family members).

Process objectives specify the actions needed for programme implementation, and correspond to various activities (such as training, supply of drugs and equipment, and health education) necessary to achieve the intended outcomes and impact.

Note that this Chapter presents mainly core impact and outcome objectives. Managers can develop additional items (especially process objectives) according to the populations, available resources, and working environments.

A selection of indicators is presented at the end of each chapter and the complete list of suggested indicators is presented at the end of this chapter. The RH Coordinator should select one or more indicators based on programme objectives. Before the indicator can be calculated, data will have to be collected for the numerator and denominator. Standard measures should be used when possible for comparison purposes, such as expressing some rates per 1,000 population. In some refugee settings, preliminary objectives may have to focus on setting up a system to collect information on births and neonatal deaths, for example, before the indicator neonatal mortality rate can be calculated. Once the neonatal mortality rate is calculated, this indicator can be followed monthly or for some specified time period, in order to monitor outcomes from the safe motherhood programme.

The following is an example of the evaluation framework:

	PROCESS	OUTCOME	IMPACT
Objectives	100% of community health workers trained to recognise and refer obstetric complications	100% of women with obstetric emergencies are referred in a timely manner and their complications managed appropriately	Maternal and neonatal mortality and morbidity reduced by ____%, in ____ year
Indicators	% of health workers able to recognise and refer obstetric complications	% of women with obstetric emergencies who received appropriate management	Reduction of neonatal mortality by ____%, in ____ year

An Eight-Step Approach to Surveillance and Monitoring

1. Collect Basic Demographic Data

Collect the following RH-related data as soon as possible.

- Total population (by age and sex)
- Number of births
- Crude birth rate
- Age and sex specific mortality rates
- Number of women/men of reproductive age
- Number of pregnant women
- Number of lactating women

In addition to using information provided by refugee workers, estimates might be made using registrations, or through community-based surveys (mortality, nutritional or household). Information from the country of origin of the refugees should also be obtained and used as estimates (for example, the Crude Birth Rate in the country of origin).

2. Define a System of Simple and Essential Data Collection

During programme design and implementation, programme planners should have established measurable objectives. Based on these objectives, determine which indicators will be used and what information is needed to calculate the indicators, and establish case definitions (such as those for live births and stillbirths) so that indicator measurements are clear. Next, determine the logical data flow, including time periods and reporting schedule. Identify people responsible for data collection, including refugees (see Step 3 below). Finally, incorporate into the routine programme/camp health-information forms, the data needed to calculate the RH indicators. (See Sample worksheet for RH reporting—Annex 6.)

Possible sources of data are:

- Daily birth or delivery reports. At minimum, the reports must include age of the mother, place of delivery, mode of delivery (vaginal, caesarean section), sex, birth outcome (live, stillbirth), and birth weight. If over- or under-reporting is suspected, cross check the information with the esti-

mated number of pregnant women or with the agency responsible for distributing rations.

- Clinic-based log books or registries for antenatal care, referrals, family planning, and STD syndromic case management as part of the out-patient log book. Women seeking care for the complications of unsafe or spontaneous abortions should also be tracked through clinic and hospital-based registration/log books.
- Health facility records, community reporting, cemetery records and referral facilities records outside the refugee situation. These should be used to track maternal and neonatal deaths.

Other sources of data include community surveys, case investigations, laboratory reports and community outreach-worker reporting.

3. Identify, Organise and Train Workers from the Refugee Community for Data Collection

Begin by identifying those refugees with midwifery skills and/or trained traditional birth attendants (TBAs), including those already providing services, who can be trained to collect data. Otherwise, community members will have to be recruited. Organise these workers (by geographical sector, for example) and have them report to a key person and place. Organising them this way will help gain access to and knowledge about the pregnant and lactating women in the population and provide a communication system to help refer women with serious complications related to pregnancy, delivery, the post-partum period or spontaneous or unsafe abortion. Conduct training on the objectives and flow of data collection, case definitions, completion and timely submission of collection forms, and on the use of the data to improve programmes.

4. Implement Specific Reporting Procedures

Experience has shown that several specific areas of RH monitoring and surveillance have not been routinely conducted in refugee situations. These include investigations of each maternal death and reporting on cases of sexual violence.

Investigating Maternal Mortality

Investigating the causes of maternal deaths can help identify gaps in services and the need to improve referral procedures for obstetric complications. By reviewing cases, health care providers can strengthen their skills in identifying the early warning signs of obstetric emergencies. Camp staff should investigate deaths due to pregnancy (direct maternal mortality) and deaths of pregnant women caused by the effects of pregnancy on pre-existing conditions (indirect maternal mortality). Both types of information are essential, since direct mortality is often underestimated. The goal is to determine which deaths were caused by pregnancy or childbirth, or by complications or the management thereof, and how deaths can be prevented in the future.

Points to be investigated include:

- time of onset of life-threatening illness;
- time of recognition of the problem and time of death;
- timeliness of actions;
- access to care, or logistics of referral; and
- quality of medical care until death.

The information may come from grave watchers, hospital/health-post staff or from community reports. Verbal autopsy, which has been used in certain refugee situations, has proved relatively successful when medical records are unavailable.

Reporting Rape/Sexual Violence

The person responsible for addressing sexual violence can devise an appropriate tracking

system, in collaboration with camp authorities and health care workers. Survivors of sexual violence may be seen in health facilities or reported by TBAs, community workers or other key informants. Since sexual violence is sensitive and usually under-reported, note all reported cases or suspected cases. Confidentiality of survivors must be ensured.

5. Analyse the Data

Analyse the data to address the problems raised by the programme objectives.

- Calculate rates, ratios and proportions, and prepare tables, graphs and charts. Compare these rates with expected values or reference rates. Trends are more important than point estimates.
- Prioritise the most important health problems as judged by cause-specific morbidity and mortality.
- Identify the subgroups at highest risk for health problems by person, place and time (such as by age and sex).
- Identify the factors potentially responsible for morbidity and mortality. For example, a high number of reported cases of genital ulcer disease among adolescent women could indicate a need to target them for syphilis prevention and treatment.
- Share data analysis with service providers and the community.

6. Implement Programmes Based on the Analysis

- Use the data to develop feasible, effective and efficient strategies for achieving the programme objectives.
- Implement the selected strategies and a system to monitor their progress.

7. Assess Programme Progress

- Assess programme progress by confirming whether programme objectives have been met.

- Prepare and distribute summary reports to all interested persons, agencies and host-country authorities, as indicated.
- Reassess programme objectives, indicators and interventions. Indicators can be evaluated in terms of their accuracy, completeness, relevance and timeliness.

8. Improve Assessment Capability and Surveillance Systems According to Need

As disease incidences change, the situation stabilises and service provision becomes more comprehensive, the surveillance system may need to be adapted. The system may need to be expanded to include more conditions in the list of reportable illnesses. Programmes can add or change indicators, or they can add sources and methods of data collection.

List of Annexes

- Annex 1** RH Indicators for Early Phase
- Annex 2** RH Indicators in Stabilised Phase
- Annex 3** RH Reference Rates and Ratios
- Annex 4** Reference Rates and Ratios for RH Indicators
- Annex 5** Estimating Number of Pregnant Women in a Population
- Annex 6** Worksheet for Monthly RH Reporting
- Annex 7** Summary of RH Indicators

ANNEX 1
RH
Indicators
for Early
Phase

Programme/Component Objectives	Indicator	Type	Definition (numerator/denominator)	Data use, Remarks, Important Assumptions
MINIMUM INITIAL SERVICE PACKAGE (MISP) – THESE INDICATORS ARE APPLICABLE TO BOTH THE EARLY AND STABILISED PHASES				
1) SV prevention: Reduce the incidence of reported SV from ___% to ___%.	Incidence of sexual violence	Impact	$\frac{\text{Number of incidents of SV reported in the specified time period}}{\text{Total population}} \times 10000$	<p>Consider providing age and sex-specific incidence rates.</p> <p>A case definition of Sexual Violence needs to be developed.</p>
2) Universal precautions: 100% of health facilities will have adequate supplies to carry out universal precautions against HIV/AIDS transmission.	Supplies for universal precautions	Outcome	$\frac{\text{Number of health facilities with adequate supplies to carry out universal precautions}}{\text{Number of camp service delivery points}} \times 100$	<p>Measures the effectiveness of distribution system for supplies related to universal precautions.</p> <p>Each service must define "adequate supply" based on the number of potential exposures.</p>
3) Condom distribution: Distribute supplies of condoms adequate for at least ___% of the total population.	Estimate of condom coverage	Outcome	$\frac{\text{Number of condoms distributed in specified time period}}{\text{Total population}} \times 1000$	<p>Measures whether condom supplies are adequate.</p>
4) Intra-partum care: Distribute sufficient clean delivery kits for ___% of pregnant women.	Estimate of coverage of clean delivery kits	Outcome	$\frac{\text{Number of clean delivery kits distributed}}{\text{Estimated number of pregnant women}} \times 100$	<p>Measures whether women in late pregnancy have access to clean delivery kits.</p> <p>May have to estimate number of pregnant women (see Chapter 9, Annex 5)</p>

Programme/Component Objectives	Indicator	Type	Definition (numerator/denominator)	Data use, Remarks, Important Assumptions
SAFE MOTHERHOOD				
1) Maternal and child health status: Reduce the neonatal mortality rate by ____%.	Neonatal mortality rate	Impact	Number of live born infants who die < 28 days of age in the specified time period $\frac{\text{Number of live births in the specified time period}}{\text{Total number of live births in the specified time period}} \times 1,000$	Measures the overall health status of new-borns.
2) Maternal and child health status: Reduce the rate of live born infants weighing <2,500 gms., from ____% to ____%.	Low birth weight percentage	Impact	Number of live born infants weighing <2,500 gms in the specified time period $\frac{\text{Total number of live births (with birth weight recorded) in the specified time period}}{\text{Total number of live births in the specified time period}} \times 100$	Measures the health status of pregnant women and the adequacy of antenatal care. Birth weights also identify infants at higher risk who may need special care.
3) Maternal and child health status: Reduce the rate of live born infants weighing <1,500 gms., from ____% to ____%.	Very low birth weight percentage	Impact	Number of live born infants weighing <1,500 gms in the specified time period $\frac{\text{Total number of live births (with birth weight recorded) in the specified time period}}{\text{Total number of live births in the specified time period}} \times 100$	Measures the health and nutritional status of pregnant women, and can help detect disease outbreaks in a camp.
4) Maternal and child health status: Reduce the number of infants born dead from ____% to ____%.	Stillbirth ratio	Impact	Number of infants of 22 gestation weeks or greater or greater than 500g who are born dead in the specified time period $\frac{\text{Total number of live births and stillbirths in the specified time period}}{\text{Total number of live births in the specified time period}} \times 100$	A general measure of pregnancy outcome. May be elevated during outbreaks of diseases such as malaria or syphilis. Verify definition of stillbirth based on national policies.
5) Maternal and child health status: 100% of reported maternal deaths are investigated according to established guidelines, and the results are disseminated to health staff.	Investigation of maternal deaths	Process	Number of reported maternal deaths which are investigated according to established guidelines, and the results of which are disseminated to health staff $\frac{\text{Total number of reported deaths of maternal deaths}}{\text{Total number of reported deaths of maternal deaths}} \times 100$	Measures the programme's capacity to identify all maternal deaths and to determine the risk factors that contribute to those deaths. Assumes that: a) both indirect and direct maternal mortality events are investigated, to reduce under-reporting; b) a protocol for investigations is in place.

CHAPTER NINE

ANNEX 2/1

RH
Indicators
for Stabilised
Phase

The list of indicators provided in Annex 2 has been developed as a "master list". It is the responsibility of the RH Coordinator to select from this list indicators that should be assessed in a given situation. The indicators selected should be based on the objectives of the RH programme in each situation. Targets set for each objective should be based on knowledge of the actual situation or information from country of origin where possible.

ANNEX 2/2
RH
Indicators
for Stabilised
Phase

Programme/Component Objectives	Indicator	Type	Definition (numerator/denominator)	Data use, Remarks, Important Assumptions
6) Antenatal care: Trained personnel will attend to all pregnant women at least once.	Coverage of ante-natal care	Outcome	Number of women delivering in the specified time period who had attended antenatal services (at least once). $\frac{\text{Number of live births in the specified time period}}{\text{Number of live births in the specified time period}} \times 100$	Measures whether pregnant women are receiving minimal antenatal visits. * This indicator is measured at the time of birth.
7) Antenatal care: 100% of pregnant women will be screened for syphilis before delivery.	Coverage of syphilis screening	Outcome	Number of women delivering in the specified time period who had been tested for syphilis during the pregnancy $\frac{\text{Number of live births in the specified time period}}{\text{Number of live births in the specified time period}} \times 100$	Measures whether pregnant women are being screened for syphilis. * This indicator is measured at the time of birth.
8) Antenatal care/STD prevention: Reduce the percentage of pregnant women who test positive for syphilis from ___% to ___%.	Syphilis infection among pregnant women	Impact	Number of pregnant women screened for syphilis in the specified time period who tested positive for syphilis $\frac{\text{Number of pregnant women who were tested for syphilis in the specified time period}}{\text{Number of pregnant women who were tested for syphilis in the specified time period}} \times 100$	Measures how common syphilis infection is among pregnant women, and the potential for congenital syphilis. There is a possible bias if syphilis testing is not systematic. Is only valid if all pregnant women are tested.
9) Antenatal care: The incidence of unsafe and spontaneous abortions should be less than ___%	Incidence of unsafe and spontaneous abortions	Impact	Number of unsafe and spontaneous abortions before 22 weeks of gestation or below 500g in the specified time period. $\frac{\text{Number of live births in the specified time period}}{\text{Number of live births in the specified time period}} \times 1000$	Measures effectiveness of antenatal care in preventing early pregnancy loss. Also is measure of women's general health.
10) Antenatal care: At least ___% of women delivering is adequately vaccinated with tetanus toxoid.	Tetanus vaccination coverage	Outcome	Number of women delivering in the specified time period who had been adequately vaccinated with tetanus toxoid $\frac{\text{Number of live births in the specified time period}}{\text{Number of live births in the specified time period}} \times 100$	Measures whether women of reproductive age are being vaccinated with tetanus toxoid. * This indicator is measured at the time of birth. Neonatal tetanus cases should also be reported.

Programme/Component Objectives	Indicator	Type	Definition (numerator/denominator)	Data use, Remarks, Important Assumptions
11) Intra-partum care: Reduce the incidence of obstetric complications from ___% to ___%.	Incidence of obstetric complications	Impact	Number of obstetric complications in the specified time period $\frac{\text{Number of live births in a specified time period}}{\text{Number of live births in a specified time period}} \times 1000$	Measures the coverage and outcome of antenatal and obstetric care. Cause-specific rates can be calculated for various obstetric emergencies such as ruptured uterus, eclampsia, or haemorrhage.
12) Intra-partum care: 100% of women with obstetric emergencies will be treated in a timely and appropriate manner.	Management of obstetric emergencies	Outcome	Number of women with obstetric emergencies who are treated in a timely and appropriate manner in the specified time period $\frac{\text{Total number of women with obstetric emergencies in the specified time period}}{\text{Total number of women with obstetric emergencies in the specified time period}} \times 100$	Measures the quality of obstetric care. Case definitions for various obstetric emergencies need to be developed.
13) Intra-partum care: A trained health worker will attend at least ___% of deliveries.	Coverage of trained delivery services	Outcome	Number of women who deliver in the specified time period who are attended by a trained health worker $\frac{\text{Number of live births in the specified time period}}{\text{Number of live births in the specified time period}} \times 100$	Measures whether trained health workers attend deliveries. Trained health workers could include staff in facilities and hospitals, etc. (TBAs are not included in this category, per WHO guidelines.)
14) Intra-partum care: At least ___% of women of reproductive age can name at least two danger signs of obstetric complications.	Knowledge of danger signs of obstetric complications	Outcome	Number of women of reproductive age who can name at least two danger signs of obstetric complications $\frac{\text{Number of women of reproductive age who can name at least two danger signs of obstetric complications}}{\text{Number of women of reproductive age}} \times 100$	Measures whether women can identify danger signs of obstetric complications, which can facilitate referral for proper care.
15) Intra-partum care: % of deliveries performed by Caesarean section will be at acceptable standards (depending on the physical characteristics of refugee women).	Caesarean section percentage	Outcome	Number of women delivered by Caesarean section in the specified time period $\frac{\text{Number of women delivering in the specified time period}}{\text{Number of women delivering in the specified time period}} \times 100$	Measures access to emergency surgical obstetric services. Caesarean section rates will depend on the physical characteristics of refugee women (e.g., pelvic size is hereditary and will affect these rates).

CHAPTER NINE

ANNEX 2/3

RH
Indicators
for Stabilised
Phase

ANNEX 2/4
RH
Indicators
for Stabilised
Phase

Programme/Component Objectives	Indicator	Type	Definition (numerator/denominator)	Data use, Remarks, Important Assumptions
16) Intra-partum care: 100% of women with complications due to unsafe and spontaneous abortions will be treated in a timely and appropriate manner.	Management of complications due to abortions	Outcome	Number of women with complications due to abortions who are treated in a timely and appropriate manner, in the specified time period $\frac{\text{Number of women with complications due to abortions who are treated in a timely and appropriate manner, in the specified time period}}{\text{Total number of women with complications due to abortions, in the specified time period}} \times 100$	Measures the quality of care for complications due to unsafe and spontaneous abortion.
17) Post partum care: At least ___% of women will receive at least one post partum visit within ___ days.	Coverage of postpartum care	Outcome	Number of women who have delivered in the specified time period who have received at least one postpartum visit within ___ days $\frac{\text{Number of women who have delivered in the specified time period who have received at least one postpartum visit within ___ days}}{\text{Number of live births in the specified time period}} \times 100$	Measures whether women receive postpartum visits. Time period can be up to 42 days following delivery. Factors determining the timing of the visit include: incidence and type of obstetric complications, the percent of low birth weight births, the proportion of home deliveries, and the neonatal mortality rate, among others.
18) Post partum care: At least ___% of new-borns will receive BCG and Polio vaccinations within first month of life.	Vaccination coverage for BCG and Polio in new-borns	Outcome	Number of new-borns who receive BCG and Polio by first month birthday $\frac{\text{Number of new-borns who receive BCG and Polio by first month birthday}}{\text{Number of live births during specified period}} \times 100$	Measures the extent to which new-borns receive first vaccinations early. It is also used as indicator of quality of postpartum care.

Programme/Component Objectives	Indicator	Type	Definition (numerator/denominator)	Data use, Remarks, Important Assumptions
SEXUAL VIOLENCE				
1) SV response: Provide basic psychosocial and medical services to 100% of reported SV survivors.	Coverage of services for SV survivors	Outcome	Number of reported SV survivors who receive basic set of psychosocial & medical services in the specified time period $\frac{\text{Number of reported SV survivors}}{\text{Number of reported SV survivors}} \times 100$	Measures whether SV survivors receives critical services. Assumes protocols for psychosocial and medical services are defined and disseminated.
2) SV response: ___% of SV survivors will present for care within 3 days of an event.	Timely care for SV survivors	Outcome	Number of SV survivors who present for care within 3 days of an event in the specified time period $\frac{\text{Number of reported SV survivors in a specified time period}}{\text{Number of reported SV survivors in a specified time period}} \times 100$	Measures the ability of patients to access services quickly, including emergency contraception.
3) SV response: Prosecute at least ___% of identified offenders in reported SV cases.	Prosecution of SV offenders	Outcome	Number of identified SV offenders who are prosecuted in the specified time period $\frac{\text{Number of reported cases of SV in a specified time period}}{\text{Number of identified SV offenders who are prosecuted in the specified time period}} \times 100$	Measures whether security forces can effectively apprehend and prosecute offenders. Assumes that survivors have made the choice to take legal actions. Assumes guidelines and procedures are defined for prosecuting offenders.
4) SV response: All designated health workers are trained to respond to SV survivors.	Coverage of health worker training in serving SV survivors	Process	Number of designated health workers trained (or retrained) within the past 2 years to provide services to SV survivors $\frac{\text{Number of designated health workers}}{\text{Number of designated health workers}} \times 100$	Measures the number of health workers who can potentially service SV survivors.

“Designated health worker” is defined as those workers who will be providing a particular service.

ANNEX 2/6
RH
Indicators
for Stabilised
Phase

Programme/Component Objectives	Indicator	Type	Definition (numerator/denominator)	Data use, Remarks, Important Assumptions
STDs including HIV/AIDS				
1) Safe blood provision: 100% of blood drawn for transfusion will be screened for HIV.	Blood screening for HIV	Outcome	Number of blood samples drawn for transfusion that are screened for HIV in the specified time period $\frac{\text{Number of blood samples drawn for transfusion in the specified time period}}{\text{Total population}} \times 100$	Measures blood safety for transfusion. Assumes HIV test kits are available and used correctly. % of blood which tested positive could also be reported
2) STD control: Reduce the incidence of STDs from ___% to ___%.	Incidence of STDs	Impact	Number of cases of STDs reported in a specified time period $\frac{\text{Number of cases of STDs reported in a specified time period}}{\text{Total population}} \times 1000$	Measures a programme's potential impact on the incidence of STDs. Optimally, age, sex and syndrome rates could be calculated.
3) STD control: ___% of patients with STDs will be assessed, treated and counselled according to protocol.	Quality of STD case management	Outcome	Number of patients with STDs assessed and treated according to protocol $\frac{\text{Number of patients with STDs assessed and treated according to protocol}}{\text{Number of patients with STDs}} \times 100$	Measures the quality of STD case management. Assumes STD case management protocols and appropriate drugs in place. Requires observation of skills as part of supervision.
4) STD control: All designated health workers will be trained (or retrained) to manage STD cases appropriately.	Training in STD case management	Process	Number of designated health workers trained to manage STD cases according to protocol $\frac{\text{Number of designated health workers trained to manage STD cases according to protocol}}{\text{Number of designated health workers}} \times 100$	Measures the extent of STD case management training for health workers. Assumes STD case management protocols and appropriate drugs in place.
5) Universal precautions: ___% of health workers will carry out universal precautions.	Practice of universal precautions	Outcome	Number of health workers who demonstrate use of universal precautions $\frac{\text{Number of health workers who demonstrate use of universal precautions}}{\text{Number of health workers}} \times 100$	Measures whether health workers comply with universal precautions. Requires observation of skills as part of supervision.
6) Condom use: Condoms will be available for distribution in 100% of potential outlets.	Outlets for condoms distribution	Outcome	Number of potential outlets with condoms available for distribution $\frac{\text{Number of potential outlets with condoms available for distribution}}{\text{Number of potential outlets}} \times 100$	Measures the effectiveness of condom distribution systems. List of potential outlets needs to be developed, but could include health facilities, bars, and outreach workers.

Programme/Component Objectives	Indicator	Type	Definition (numerator/denominator)	Data use, Remarks, Important Assumptions
7) Condom use: ___% of persons in target population will recognise a condom, know its preventive effects, and will be able to describe how to use it correctly.	Knowledge of function and correct condom use	Outcome	Number of persons in target population who recognise a condom, know its preventive effects, and can describe how to use it correctly $\frac{\text{Number of persons in target population}}{\text{Number of persons in target population}} \times 100$	Measures the impact of a community-education programme about condom use on knowledge.
8) Condom use: ___% of persons in target population will report condom use at last intercourse with a non-regular partner.	Condom use with non-regular partners	Outcome	Number of persons in target population reporting condom use at last intercourse with a non-regular partner, within a specified time period $\frac{\text{Number of persons in target population who report having had intercourse with a non-regular partner, within a specified time period}}{\text{Number of persons in target population who report having had intercourse with a non-regular partner, within a specified time period}} \times 100$	Measures the impact of a community-education programme about condom use on behaviour

CHAPTER NINE

ANNEX 2/7

RH
Indicators
for Stabilised
Phase

ANNEX 2/8
RH
Indicators
for Stabilised
Phase

Programme/Component Objectives	Indicator	Type	Definition (numerator/denominator)	Data use, Remarks, Important Assumptions
FAMILY PLANNING				
1) Family planning: At least ___% of women of reproductive age will use a method of contraception.	Contraceptive prevalence rate (CPR)	Outcome	Number of women of reproductive age using any method of contraception $\frac{\text{Number of women of reproductive age}}{\text{Number of women of reproductive age}} \times 100$	Measures what per cent of women is using contraception. Knowledge of the CPR in country of origin will assist in setting this target.
2) Family planning: All health workers who provide family planning services will be trained (or retrained) to provide appropriate family planning services.	Coverage of family planning training	Outcome	Number of health workers who provide family planning services and who were trained (or retrained) in the past 2 years to provide family planning services $\frac{\text{Number of health workers who provide family planning services}}{\text{Number of health workers who provide family planning services}} \times 100$	Measures extent of family planning training provided to health workers.
3) Family planning: At least ___% of sexually active refugees will demonstrate appropriate knowledge about family planning.	Community knowledge concerning family planning	Outcome	Number of sexually active refugees able to site major messages about family planning $\frac{\text{Number of sexually active refugees targeted for family planning messages}}{\text{Number of sexually active refugees}} \times 100$	Measures knowledge of family planning in the population and is based on the major messages given during awareness activities.
4) Family planning: All contraceptive service delivery points will maintain a minimum of 3 months' supply of each of combined oral contraceptive pills, progestin-only pills, and injectables.	Contraceptive supply	Outcome	Number of service delivery points which maintain a minimum of 3 months' supply of each of combined oral contraceptive pills, progestin-only pills, and injectables $\frac{\text{Number of service delivery points}}{\text{Number of service delivery points}} \times 100$	Measures effectiveness of contraceptive supply distribution system.

Programme/Component Objectives	Indicator	Type	Definition (numerator/denominator)	Data use, Remarks, Important Assumptions
REPRODUCTIVE HEALTH OF YOUNG PEOPLE				
1) Young people and STDs: Reduce the incidence of STDs among young people from ___% to ___%.	Incidence of STDs in young people	Impact	Number of reported cases of STDs among young people in the specified time period $\frac{\text{Number of reported cases of STDs among young people in the specified time period}}{\text{Total number of young people}} \times 1,000$	Measures a programme's potential impact on the incidence of STDs among young people. Need to define age group for young people relevant to local situation.
2) Young people and safe motherhood: Reduce the percentage of all births that occur to young women from ___% to ___%.	Young women birth percentage	Impact	Number of live births to young women in the specified time period $\frac{\text{Number of live births to young women in the specified time period}}{\text{Total number of live births in the specified time period}} \times 100$	Measures how common births are among young women. Need to define age group for young women relevant to local situation.
3) Young people and family planning: At least ___% of sexually active young people will use a method of contraception	Contraceptive prevalence rate among young people	Outcome	Number of sexually active young people who use a method of contraception $\frac{\text{Number of sexually active young people who use a method of contraception}}{\text{Total number of sexually active young people surveyed}} \times 100$	Measures what per cent of sexually active young people are using contraception.
4) Young people and STDs/HIV: At least ___% of sexually active young people will report condom use at last intercourse.	Condom use among young people	Outcome	Number of sexually active young people reporting condom use at last intercourse $\frac{\text{Number of sexually active young people reporting condom use at last intercourse}}{\text{Total number of sexually active young people surveyed}} \times 100$	Measures the impact of a community-education programme about condom use on young people's behaviour.
5) Quality of care: ___% of young people receiving adequate care according to protocol.	Quality of reproductive health services for young people.	Outcome	Number of young people who are assessed, treated and counselled according to protocol during specified time period $\frac{\text{Number of young people who are assessed, treated and counselled according to protocol during specified time period}}{\text{Total number of young people seeking services at health facility during specific time period}} \times 100$	Measures the quality of reproductive health services for young people. Requires observation of skills performance as part of supervision.

ANNEX 2/9

RH
Indicators
for Stabilised
Phase

ANNEX 3

RH Reference
Rates and
Ratios**RH Reference Rates and Ratios**

The figures shown here have been collected from various sources and cover different periods. They are intended to give estimates of what may be expected in some populations. These figures are not to be used as definitive baseline rates or as rates to be achieved. They merely indicate the possible range and may assist with resource planning and with targeting specific programmes.

Abortions	10-15%	of all pregnancies may spontaneously abort before 20 weeks gestation
	90%	of these will occur during the first three months
	15-20%	of all spontaneous abortions that occur require medical interventions
Hypertensive Disorder of Pregnancy (HDP) or Pre-eclampsia	5-20%	of all pregnancies will develop HDP
	5-25%	of all primigravida pregnancies will develop HDP
Labour and Delivery Complications	15%	of all pregnancies will require some type of intervention at delivery
	3-7%	of all pregnancies will require a Caesarean section
	10-15%	of all women will have some degree of cephalo-pelvic disproportion (higher in poorer socio-economic populations)
	10%	of deliveries will involve a primary postpartum haemorrhage (within 24 hours of delivery)
	0.1-1.0%	of deliveries will involve a secondary postpartum haemorrhage (occurring 24 hours or more after delivery)
	0.1-0.4%	deliveries will result in uterine rupture
	0.25-2.4%	of all deliveries will result in some type of birth trauma to the baby
	1.5%	of all births will have a congenital malformation (does not include cardiac malformations diagnosed later in neonatal period).
	31%	of these malformations will result in death.

Data Sources

WHO Collaborating Centre in Perinatal Care and Health Services Research in Maternal and Child Health, Pregnancy and Infant Health Branches, Division of Reproductive Health, NCCDPHP, Centers for Diseases Control and Prevention, Atlanta, GA., 30333 USA

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CHAPTER NINE

ANNEX 4

Reference Rates and Ratios for RH Indicators

Reference Rates and Ratios for RH Indicators				
Regional Indicators				
Indicator	Sub-Saharan Africa	South East Asia and Pacific	Industrial Countries	(1)
Safe Motherhood				
Crude birth rate (per 1000 population)	44	26	13	
Neonatal Mortality Rate (per 1000 live births)	53	36	5	
Perinatal Mortality Rate (per 1000 live births)	83	51	8	
Maternal mortality ratio (per 100,000 live births)	971	447	31	
Infant mortality rate (per 1000 live births)	97	50	14	
Coverage of Antenatal Care (%)	63	65	95	
Low birth weight percentage (per 100 live births)	16	15	6	
Births attended by trained health personnel (%)	42	53	99	
Institutional Deliveries (% of live births)	20	41	98	
Unsafe Abortion (1000 women 15-49)	26	15	1	
Anaemia in Pregnant Women (%)	52	57	18	
Coverage of Tetanus vaccination (Preg. Women)	46	49	–	
STDs, including HIV/AIDS				
STD Incidence Rate (per 1,000 population)	254	160	77	
AIDS cases (per 100,000)	94	80	27	
Family planning				
Contraceptive prevalence rate	15.9	53.2	70.5	
Others				

Reference – UNDP Human Development Report - 1997 and World Health Report 1996

(1) Complete this table with country-specific information either from host or country of origin.

ANNEX 5
Estimating
Number of
Pregnant
Women in a
Population

Estimating Number of Pregnant Women in the Population If Total Population is 100 000				
If CBR is (per 1,000 population)	55	45	35	25
a) Estimated number of live births in the year	5500	4500	3500	2500
b) Estimated live births expected per months (a/12)	458	375	292	208
c) Estimated number of pregnancies that end in stillbirths or miscarriages (estimated at 15 per cent of live births = $a \times 0.15$)	825	675	525	375
d) Estimated pregnancies expected in the year (a + c)	6325	5175	4025	2875
e) Estimated number of women pregnant in a given month (70 % of d)*	4400	3600	2800	2000
f) Estimated % of total population who are pregnant at a given period	4.4	3.6	2.8	2

* this is a weighted estimate of full-term pregnancies plus those pregnancies that terminate early

Sample Worksheet for Monthly Reproductive Health Reporting

Month:

Camp Name:

Total Pop:

Agency:

Pop of
Women 15-49:

1 – Safe Motherhood – Ante-natal Care	<19 years	>19 years	Total
1a: Number of antenatal visits - First Time			
1b: Number of antenatal visits - Repeat			
1c: Total antenatal visits			
1d: Number of women treated for complications of abortions			
1e: Number of pregnant women screened for syphilis			
1f: Number of pregnant women screened for syphilis testing positive			

Indicators	rates
– Antenatal coverage: estimated (1a/2e) [This is an estimate – see 2j below]	
– Incidence of complications of unsafe and spontaneous abortion (1d/2e)	
– Coverage of syphilis screening (1e/2e) [This is an estimate – see 2l below]	
– Prevalence of syphilis infection in pregnant women (1f/1e)	

2 – Safe Motherhood – Delivery	hospital	h.centre	home	total
2a: Number of births attended by trained staff				
2b: Number of births NOT assisted by trained staff				
2c: Number of births				
2d: Number of stillbirths				
2e: Number of livebirths				
2f: Number of low birth weight (<2500 gms)				
2g: Number of livebirths who die <28 days (neonatal deaths)				
2h: Number of obstetric emergencies managed				
2i: Number of maternal deaths				
<i>Number of women giving birth this period who received</i>				
2j: Antenatal care services (1-3 Visits)				
2k: Adequate Tetanus Toxoid Vaccination				
2l: Screened for Syphilis				

ANNEX 6/2
Worksheet
for Monthly
Reproductive
Health
Reporting

Indicators	Rates
– Crude Birth Rate ($2e/\text{total population} \times 1000$)	
– Neonatal Mortality Rate ($2g/2e \times 1000$)	
– Low Birth Weight Rate ($2f/2e \times 100$)	
– Stillbirth Rate ($2d/2e \times 1000$)	
– Births attended by trained personnel ($2a/2e \times 100$)	
– Coverage of antenatal care ($2j/2e \times 100$)	
– Coverage of syphilis screening ($2l/2e \times 100$)	
– Incidence of obstetric complications ($2h/2e \times 1000$)	

3 – Safe Motherhood – Post-natal Care	No.
3a: Number of women visiting post-natal care services (within 6 wks of birth)	
Indicator – Post-Natal Care Coverage Rate – ($3a/2e \times 100$)	

4 – Sexual Violence	No.
4a: Number of cases of sexual violence reported	
4b: Number of cases receiving medical care with 3 days	
Indicators	
Incidence of sexual violence ($4a/\text{total population} \times 10\,000$)	
Timely care for survivors of sexual violence ($4b/4a \times 100$)	

5 – STDs including HIV/AIDS	No.		
5a: Number of units of blood transfused			
5b: Number of units of blood for transfusion tested for HIV			
5c: Number condoms distributed			
5d: Number of cases treated for STDs (total by age, sex and syndrome)			
Syndromic Case Management	Male	Female	Total
– urethral discharge			
– genital ulcers			
– vaginal discharge			
Total			

CHAPTER NINE

ANNEX 6/3

Worksheet
for Monthly
Reproductive
Health
Reporting

STD/HIV Indicators	Rate
– Blood screening for HIV ($5b/5a \times 100$)	
– Condom coverage (estimate – $5c/ \text{total population} \times 1000$)	
– Incidence of STDs (total – $5d/ \text{total population} \times 1000$)	
(STD incident rates could also be calculated by sex, age and syndrome)	

6 – Family Planning				No.
6a: Number of users of modern methods of family planning				
By Method	Registered beginning of month	New acceptors this month	Total end of month	
COCs				
Injectible				
POPs				
IUDs				
TOTAL				
Indicator - Contraceptive Prevalence Rate ($6a/WRA \times 100$)				

7 – Training		
Type of Training in RH	Type of Health Worker	Number
a.		
b.		
c.		

Further Readings

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Information, Education and Communication (IEC) Programmes

The essentials of IEC

Information, education and communication (IEC) combines strategies, approaches and methods that enable individuals, families, groups, organisations and communities to play active roles in achieving, protecting and sustaining their own health. Embodied in IEC is the process of learning that empowers people to make decisions, modify behaviours and change social conditions. Activities are developed based upon needs assessments, sound educational principles, and periodic evaluation using a clear set of goals and objectives. IEC activities should never be developed or implemented independently from a broader reproductive health programme that is being designed and executed in the country. IEC activities not only need to have an appropriate context in which they are shaped, but it is crucial that health services providers be prepared to respond to any demand that may be created as a result of effective IEC activities. The influence of underlying social, cultural, economic and environmental conditions on health are also taken into consideration in the IEC processes. Identifying and promoting specific behaviours that are desirable are usually the objectives of IEC efforts. Behaviours are usually affected by many factors including the most urgent needs of the target population and the risks people perceive in continuing their current behaviours or in changing to different behaviours.

Health information can be communicated through many channels to increase awareness

and assess the knowledge of different populations about various issues, products and behaviours. Channels might include interpersonal communication (such as individual discussions, counselling sessions or group discussions and community meetings and events) or mass media communication (such as radio, television and other forms of one-way communication, such as brochures, leaflets and posters, visual and audio visual presentations and some forms of electronic communication).

Good communication between users and providers of any service is essential; but it is especially important when providing RH services, given the sensitive nature of some of the issues that are addressed (such as sexual violence, female genital mutilation, and providing contraceptives to adolescents). Accordingly, IEC approaches must be carefully and appropriately designed and selected.

Although good “one-to-one” communication at the point of service provision is essential for transmitting information and building trust with the client, communication with other individuals and groups within the community is also vital. It is through such communication networks that service providers can obtain information about users’ needs, priorities and concerns. Such informal information gathering is the first step in assessing needs (which can be supplemented by other more formal means – see section below). It also helps providers better understand the specific setting and context in which they are working, which will be useful in the later development of IEC approaches, messages and materials.

a1

APPENDIX One

Information, Education and Communication (IEC) Programmes

Contents:

- Essentials of IEC
- Counselling and the Role of the Counsellor
- Steps in Developing Materials for an IEC Activity
- Undertaking a Reproductive Health (RH) Needs Assessment
- Field tools for Conducting RH Needs Assessments
- Links to Providing Services, Support and Follow-up

These types of conversations, or passing on information by “word-of-mouth”, has been shown to be one of the most effective communication channels for acquiring knowledge and promoting desired changes in behaviour. Evidence of this is the speed with which rumours spread and the force of their impact. Field staff should not ignore these informal opportunities to educate the public through casual conversation with people in the community.

Once a refugee situation stabilises, it becomes appropriate to consider the development of more elaborate and formal IEC strategies. This requires serious thought and significant allocation of time and resources. The steps involved in the development of IEC are outlined here, but this is not intended to be an exhaustive guide. More in-depth information and details can be found in the items listed in Further Reading. Whatever materials and formal programmes are developed, it is important to ensure that the different aspects are coordinated, and that the content of any messages and the media used to convey those messages are complementary. It is also vital to ensure that people are provided with the necessary support and resources to act in the manner advised.

Communication

Communication can be both verbal and non-verbal.

In **verbal communication**, the tone of voice can communicate feelings and emotions that are as significant as the words being spoken. Accordingly, it is important to choose words that do not offend in any way and that are easily understood. One should avoid using trigger words, jargon, medical or other sophisticated terms. The use of particular languages may be important in reaching all sections of a community (women may speak fewer languages than men, for example).

In **non-verbal communication**, body position, gestures and facial expression, often referred to as “body language”, can communicate as

much as words. It is often through such body language that we express our attitudes towards an issue, a person or a person’s behaviour. Service providers must become skilled in interpreting the body language of users as this may assist them in understanding users’ needs and concerns more fully. Service providers must also be aware of their own body language and the signals they may be unknowingly sending to users (e.g., movements or expressions that indicate fatigue, boredom, fear, frustration, indecision). It is important that the attitude conveyed by the service provider be compassionate and non-judgmental.

Service Users

Good communication skills are necessary to ensure that good-quality services are provided and that service users are satisfied. It is

Good communication skills could include the following:

- ✓ effective, “active” listening in which the provider gives small verbal or non-verbal feedback that indicates to the client that (s)he is being heard and understood;
- ✓ rephrasing what the client has said to make sure it is correctly understood;
- ✓ asking open-ended questions, asking the client to answer questions with more than one word answers;
- ✓ making eye contact;
- ✓ providing complete attention;
- ✓ not being curt or showing a condescending attitude toward the client.

through communication that trust and rapport are established between the provider and user of a service. Emotional support and the communication of concern and understanding by health staff are often as crucial in providing quality services as is clinical care. If there is a strong provider-user relationship established in this way, it becomes easier to move towards open dialogue on more sensitive aspects of reproductive health.

Other Individuals and Community Groups

Beyond communication with service users, it is necessary to open a dialogue with influential individuals and groups within the community. Such individuals and groups will need to be identified as early as possible. The nature and intention of services should be explained to them and their concerns and priorities discovered and understood. This will not only help make the services more appropriate to the clientele being served, but it will help garner family and community support for the client in the reproductive health behaviour being promoted. The following are some pointers for identifying such individuals and groups:

- Familiarise yourself with the community with the help of someone who lives in the environment of the refugees and who provides them with some service, advice or protection.
- Identify individuals who are most important in the social structure of the community with which you are working. They can be existing formal leaders (elected or appointed), but, more often than not, they are informal leaders. This can be done by asking many people in the community. As certain individuals are named repeatedly, it will become clear that they are the true leaders.
- Identify individuals who have some influence within the community, people whose opinions are respected. They will make suggestions about how to approach people and work with them effectively. They

can also serve as role models for desired behaviours and actions.

- Provide these individuals with very clear information about what your intentions are, what you plan to do, and how they can contribute as partners. Be specific about what they will gain from working with you and allowing you access to the community.
- Provide them with input about your plans before you proceed, and secure their willingness to participate and to support your efforts.

APPENDIX One

Counselling

Counselling is a key component of an IEC programme. In the best of circumstances, a good counsellor is compassionate and non-judgmental, is aware of verbal and non-verbal communication skills, is knowledgeable concerning RH issues, and is respectful of the needs and rights of the users. In a refugee situation, there is often a poor counsellor-to-client ratio, emergencies are common and the local environment is not conducive to counselling. However, at a minimum, counsellors should strive to ensure that every service user has the right to the following:

- **Information:** to learn about the benefits and availability of the services.
- **Access:** to obtain services regardless of gender, creed, colour, marital status or location.
- **Choice:** to understand and be able to apply all pertinent information to be able to make an informed choice, ask questions freely, and be answered in an honest, clear and comprehensive manner.
- **Safety:** a safe and effective service.
- **Privacy:** to have a private environment during counselling or services.
- **Confidentiality:** to be assured that any personal information will remain confidential.
- **Dignity:** to be treated with courtesy, consideration and attentiveness.

- **Comfort:** to feel comfortable when receiving services.
- **Continuity:** to receive services and supplies for as long as needed.
- **Opinion:** to express views on the services offered.

Although the **GATHER** method of counselling may appear simplistic, it is complete and thorough:

- G**reet users
- A**sk users about themselves
- T**ell users about the service(s) available
- H**elp users choose the service(s) they wish to use
- E**xplain how to use the service(s)
- R**eturn for follow-up

The Role of the Counsellor

The counsellor's role is to provide accurate and complete information to help the user make her/his own decision about which, if any, part of the services (s)he will use. The role of the counsellor is not to offer advice or decide on the service to be used. For example, the counsellor will explain the available family planning methods, their side effects and for whom they are considered most suitable. The user then makes a decision, based on the information given, about which method she/he wishes to use.

Effective counselling requires understanding one's own values and not unduly influencing the user's by imposing, promoting or displaying them, particularly in cases where the provider's and the user's values are different.

Undertaking a Needs Assessment

Be careful never to assume that you know what refugees need or want in their lives or from your projects.

To plan effective interventions, you must find out what refugees think and know about various issues, including their ideas about: what causes sickness and disease and what maintains health, health care, traditional medicine, and reproductive health. It is important to build a relationship of trust and mutual respect in order to get accurate and complete information about sensitive issues such as sexual and reproductive matters.

It is usually necessary to use multiple methods in undertaking a thorough needs assessment. Focus groups, individual interviews or Knowledge, Attitude, Behaviour and Practice (KABP) surveys can be valuable ways to gather information and help develop systems, activities, materials or messages to support RH interventions. Only after there is an accurate picture of the refugee community's knowledge, attitudes, behaviours, expectations and aspirations surrounding reproductive health can you determine what programme and messages might be best suited to its needs.

RH interventions and IEC activities and materials should be based on relevant research conducted through the use of quantitative (how many) and qualitative (what, why and how) methods. Research and discussions should be seen as an integral and ongoing part of planning and implementation.

Quantitative:

- Use available incidence or prevalence rates of targeted problems.
- Knowledge, Attitude, Behaviour and Practice (KABP) Surveys use a series of closed- and open-ended questions to determine what people in a community know, think, believe or do in relation to their reproductive health. Findings are

presented in the form of percentages of people who think or do a certain thing. These surveys require many respondents that are randomly selected from the community. Interviewers are needed to implement the survey and they must be trained. This is generally considered an expensive and time-consuming method. Also, this kind of survey does not usually gather information about what inhibits or promotes certain behaviours, since those factors may arise from the context in which people live and not from their knowledge and attitudes.

Qualitative:

- Individual interviews allow the researcher to get deeper insights into a person's thoughts and feelings. Using an interview guide, interviewer and respondent talk at length about the respondent's feelings about a specific service or issue. If trust is established and confidentiality ensured, the interviewer can often get very valuable information about the interviewee and the community, information that might not otherwise be revealed.
- Focus Groups are in-depth discussions, usually of one to two hours in length, with a small group of people. Members of the Focus Group should have something in common with each other (age, sex, and experience) in the expectation that this will make it easier for them to talk together. They are representatives of the target group in that they are deliberately chosen. The intention is to make sure different groups within the community are represented within the Focus Group, or that several Focus Groups are held with members drawn from various sectors within the community. Discussions are lead by a facilitator who follows a prepared guide that allows for probing into the thoughts and feelings of group members. This method is often considered cost-effective, as many people are gathered together at one time to express their opinions. Findings are presented in the form of comments or extracts from interviews, which illustrate

what people are thinking about certain topics, or why they engage in a particular activity.

Field Tools for Conducting RH Needs Assessments

The Reproductive Health for Refugees Consortium¹ has field-tested and finalised five RH needs assessment tools. These are

- Refugee Leader Questions
- Group Discussion Questions
- Survey for Analysis by Computer
- Survey for Analysis by Hand
- Health Facility Questionnaire and Checklist

The purpose of these tools is to assist relief workers in refugee/displaced person settings in gathering information to assess attitudes toward RH practices and local medical practices/policies, the extent of needed services and the degree to which current services provide what is needed.

It is important to note that not all tools will be appropriate for all refugee situations. The order in which the tools are used may also vary. In general, refugee leaders are consulted before any information is gathered from the larger population. This is often followed by group discussions, key informant interviews and facilities review. In some situations, a survey may be conducted but this is often dependent upon resources, time, skills of available staff and whether or not the level of effort required by a quantitative survey is warranted. A clear needs assessment objective will help field workers decide which tools are appropriate for their particular situation.

The information provided by the tools must be reviewed in the context of the broader objective of the needs assessment. Any tool used should be adapted to the local situation and resources available. Judgement is required by those applying the tools. In many cases, other resources may exist to support the needs assessment and these should be used. Exam-

APPENDIX One

The RHR Consortium comprises American Refugee Committee, CARE, Center for Population and Family Health, Columbia University's Mailman School of Public Health, The International Rescue Committee, JSI Research and Training Institute, Marie Stopes International and the Women's Commission for Refugee Women and Children.

ples of additional strategies for collecting information include: camp registration records (information on women's ages, marital status, and sometimes pregnancy); clinic, health centre and/or traditional birth attendant records; in-depth interviews with representatives from UNHCR, UNFPA, Ministry of Health and NGO staff; camp health coordinating committees and NGO logistics officers; and structured observation at different times of the day and night in the refugee community.

Steps in Developing IEC Activities

The information gathered through the needs assessment provides the framework for the development of suitable IEC activities. Any activities and materials must always be culturally sensitive and appropriate. These are the major steps you should follow when designing an IEC activity:

- Conduct a needs assessment.
- Set the goal. This is a broad statement of what you would like to see accomplished with the target audience in the end.
- Establish behavioural objectives that will contribute to achieving the goal.

An objective must be SMART:

Specific (what and who)

Measurable (something you can see, hear or touch – usually expressed with an action verb)

Area specific (where)

Realistic (achievable)

Time-bound (when)

- Develop the IEC activities and involve as many other partners as possible. After their successful implementation, you should be able to have a significant impact on achieving the behavioural objectives.
- Identify potential barriers and ways of overcoming them.
- Identify potential partners, resources, and other forms of support for your activities and gain their sustained commitment.
- Establish an evaluation plan.

The indicators should determine the level of achievement of the behavioural objectives. Having such specific indicators makes evaluating and monitoring the progress and impact of the activities much easier. Additionally, process indicators could be established to track to what extent and how well the planned activities have been carried out.

IEC Messages

- Develop IEC messages. A good message is short, accurate and relevant. It will make, at the most, 3 points. It should be disseminated in the language of the target audience and should use vocabulary appropriate for that audience. The message tone may be humorous, didactic, authoritative, rational or emotionally appealing. It may be intended as a one-time appeal or as repetitive reinforcement. It is often necessary to develop several versions of a message depending on the audience to whom it is directed. For example, differing information about contraceptive services will be relevant to women who already have three or four children already, from that which would be appropriate for adolescents who are just beginning to be sexually active. Their needs and priorities are different, so the IEC materials used with each group must also differ. Find out if materials already exist in the host country or country of origin, and if appropriate, use these instead of developing new ones.

- Pre-testing, by trying out the materials with small groups from your larger target audience, is an essential part of developing messages and educational materials. It is through pre-testing that you will ensure that people understand the message as intended. Pre-testing may need to be repeated frequently until you are sure your information is being conveyed as desired.
- Determine suitable methods and channels of action and communication. Once the target audience is identified and researched and the key messages have been chosen, it is time to decide which media and combinations of information channels will reach the target group. Both formal and informal groups can be targeted. Different channels do different jobs. Each has its own strengths and weaknesses, depending the role it will take in the communication programme. The choice of messages and media will be influenced by many factors: cost; literacy levels; artistic style within the community; familiarity with, and extent of penetration of a particular medium for both service providers and users; and availability of the medium in the target population's community.

The development and refinement of messages and the choice of the communication channel or medium are inseparable. Very different messages will be developed for different media, for example radio, stories, poems, songs, posters or flip charts, for the nature of the medium affects what messages can be successfully used. The skills of those using the materials must also be considered. It may be necessary to provide training to those staff expected to use the materials. For example, it is important to recognise that placing a picture or poster on a clinic wall at which people may or may not look is quite different from using a series of pictures in the form of a flip chart as an educational tool in a group setting.

The following are some suggestions for key messages on technical topics that may be shared. These are presented as examples only and are shown out of context. The choice

of any message will, in reality, be context-specific; often a group of messages will be decided upon, rather than just one.

Sexual Violence:

- The importance for women to seek medical care as soon as possible
- Where to go for counselling if it is available
- How to prevent it, particularly in collaboration with others in the community

Safe Motherhood:

- The reasons why it is important for women to seek prenatal care
- The need to and how to identify obstetric complications and refer immediately
- The reasons it is important to breastfeed exclusively and the importance of maternal nutrition

Sexually Transmitted Diseases (STDs)/HIV/AIDS:

- How to use condoms and how to dispose of them safely
- How HIV is and is not transmitted
- Means of prevention
- Common signs and symptoms
- Where to receive counselling
- Where to receive treatment
- Where to go for support services
- Why it is important to inform and involve all sexual partners

Family Planning:

- How and where to obtain reproductive health services, including contraceptive supplies
- Where to get information or counselling
- How adequate birth spacing contributes to healthy families

Reproductive Health of Young People:

- How young people can protect themselves through safe sex
- Delay and patience is a positive value and that there are other ways to have fun
- Young people need to take responsibility for their own health
- High-risk behaviours may result in long term, unwanted consequences

Links to Providing Services, Support and Follow-up

For IEC of any kind to be effective it must be linked with the availability of support and resources so target audiences can act in the manner which is being recommended. It is therefore essential that the content of any IEC programme accurately reflect the nature and quality of the services provided. Logistical support must be adequate to ensure the necessary supplies (material and human) are consistently available and adequate training should be provided to health workers to support inter-personal communication and community follow-up. People must be able to act on the advice contained in the IEC messages and materials.

Further Readings

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Debus M. *Methodological Review: A Handbook for Excellence in Focus Group Research*, Washington, DC, Academy for Educational Development, 1988.

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“Developing Health Promotion and Education Initiatives in Reproductive Health: A Framework for Action Planning”, WHO, RHR, Geneva, 1998.

“Facts for Life”, UNESCO/UNICEF/WHO.

“Guide to Planning Health Promotion for AIDS Prevention and Control”, WHO AIDS Series 5, Geneva, WHO, 1989.

“Refugee Reproductive Health Needs Assessment Field Tools”, RHR Consortium, 1997.

“Tools for Project Evaluation: A Guide for Evaluating AIDS Prevention Interventions”, Family Health International, AIDSTECH/Family Health International, Durham, NC, 1992.

Legal Considerations:

Refugee Rights Related to Reproductive Health

Reproductive Health Rights Based on International and Human Rights Instruments

Refugees are entitled to the protections outlined in the 1951 Convention relating to the Status of Refugees, and its 1967 Protocol, as well as in other relevant international human rights declarations and treaties, including:

- the Universal Declaration of Human Rights,
- the Covenant on Civil and Political Rights,
- the Covenant on Economic, Social and Cultural Rights, and
- the Convention on the Elimination of All Forms of Discrimination Against Women.

Reproductive rights embrace many of the human rights recognised in these documents. Other, more recent, documents, particularly the 1994 Cairo Programme of Action of the United Nations International Conference on Population and Development (ICPD) and the Beijing Platform for Action of the 1995 World Conference on Women, reflect broad international consensus on the issue of reproductive rights. Reproductive health (RH) care may also be safeguarded by national laws, which extend government responsibility for such care beyond international obligations. The policies of the host country should guide the implementation of RH care in refugee situations and humanitarian actors should familiarise themselves with these policies.

The following is a brief overview of basic principles related to reproductive health that are

contained in international human rights declarations and treaties. These principles apply to all persons, including refugees, without discrimination.

- **The right to the highest attainable standard of physical and mental health**

Sexual and reproductive health are essential elements of the right to health, as they cannot be separated from men and women's overall well-being and their right to the "*enjoyment of the highest attainable standard of physical and mental health*". International human rights law recognises that health represents an important factor in the realisation of the right to an adequate standard of living, including adequate food, clothing, housing, water and sanitation. States parties to the Conventions in which this right is described are obliged to take measures that ensure "the reduction of the stillbirth-rate and of infant mortality and the healthy development of the child", and "the creation of conditions which would assure to all medical service and medical attention in the event of sickness".

- **The right to the survival and development of the child**

States parties to the Conventions are obliged to ensure, to the maximum extent possible, the survival and development of the child. In this context, the threat to women's lives posed by the lack of RH care affects the health and development of children.

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APPENDIX Two

Legal Considerations:
Refugee Rights Related to Reproductive Health

- **Obligation on States to take measures to abolish traditional practices prejudicial to the health of children**

States shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children. These include the practices of female genital mutilation and early childhood marriage, which not only harm girls, but may also adversely affect their future offspring.

- **The right of equal access to health care**

States parties to the Conventions shall take all appropriate measures to eliminate discrimination against women in the field of health care to ensure, on a basis of equality of men and women, access to health care services, including those relating to family planning.

- **The equal right to reproductive choice**

Men and women have the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.

- **The right to education**

Everyone has the right to education. In particular, women have equal rights with men to specific educational information to help ensure the health and well-being of their families, including information and advice on family planning. The best interest of the child shall be the guiding principle of those responsible for his/her education and guidance; that responsibility lies in the first place with the parents. Adequate information and counselling are critical to enabling refugees to make informed choices about their reproductive health.

- **The right of men and women of marriageable age to marry and found a family**

The World Health Organization recommends that the minimum age for girls to marry should be 18 years.

- **The betrothal and the marriage of a child, as defined by national legislation, is specifically prohibited**

Early maternity is often an immediate result of early childhood marriage and can have adverse effects on the physical development of the mother and her child.

- **The rights of the family special protection**

The family, as the natural and fundamental group unit of society, is entitled to the widest possible protection and assistance, particularly for its establishment and while it is responsible for the care and education of dependent children.

- **Special rights in relation to motherhood and childhood**

These are special provisions for pre- and postnatal health care for women and children.

- **The right to enjoy the benefits of scientific progress**

Everyone has the right to enjoy the benefits of scientific progress and its applications, which should also be interpreted to encompass reproductive health.

Pregnancy

There are special rights pertaining to pregnant and lactating women articulated in international documents (see above). The issue of termination of pregnancy, however, is highly controversial. In most countries, national laws

and policies regulate the termination of pregnancies. Where the matter is regulated, due regard must be paid to the laws and policies of the host country. In many countries where abortion is normally highly restricted, it is nonetheless permitted under certain conditions when a pregnancy results from rape, incest, or threatens the life of the woman.

(Refer to UNHCR Guidelines on Preventing and Responding to Sexual Violence against Refugees, specifically Chapter 4, “Legal Aspects of Sexual Violence”. These guidelines provide a clear and comprehensive analysis of the legal framework governing the prevention of sexual violence in the refugee context.)

Sexual Violence

Sexual violence against refugees is a global problem and constitutes a violation of human rights as enshrined in international declarations and treaties:

- **The right to life, liberty and security of person**
- **The right to freedom from torture and cruel, inhuman or degrading treatment and punishment**
- **Children’s right to freedom from all forms of physical or mental violence**

The Geneva Conventions and their Protocols, which are among the foundations of international humanitarian law, also apply to refugees, returnees and internally displaced persons in times of armed conflict. These laws offer protection to all civilians, particularly women and children, against various forms of sexual violence, including mutilation, forced prostitution, sexual abuse and rape.

Regional human rights laws applicable in Europe, the Americas and Africa similarly protect the rights to personal dignity and integrity and prohibit degrading treatment or punishment and violence against women.

National laws also usually protect against sexual violence. The government on whose territory the sexual attack occurred is responsible for taking diligent remedial measures, including conducting a thorough investigation into the crime, identifying and prosecuting those responsible, and protecting victims from reprisals.

Cairo Programme of Action of the 1994 United Nations International Conference on Population and Development (ICPD)

Although not legally binding, the Cairo ICPD Programme of Action is an important step in recognising reproductive rights internationally. It represents the political consensus of 184 nations.

The ICPD Programme provides for individuals *to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so*. It also includes *the right of all to make decisions concerning reproduction free of discrimination, coercion and violence*.

Furthermore, it expresses *the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law*.

The Beijing Platform for Action of the 1995 World Conference on Women

Also not legally binding, it nonetheless represents international consensus in endorsing many of the commitments made in the ICPD Programme of Action and specifies action to be taken by States, international bodies, donors, non-governmental organisations and others.

Further Readings

Cook, Rebecca J. "Human Rights and Reproductive Self-Determination", 44 AM U. L. Rev., 975, 1995.

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"Rights Awareness Training Programme", UNHCR, Geneva, 1997.

"Sexual Violence against Refugees: Guidelines on Prevention and Response", UNHCR, Geneva, 1996.

"Women of the World: Laws and Policies Affecting Their Reproductive Lives: Anglophone Africa", CRLP and International Federation of Women Lawyers (Kenya Chapter), New York, 1997.

Glossary of Terms

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APPENDIX Three

Glossary of Terms

antenatal care coverage

Percentage of women attended at least once during pregnancy by skilled health personnel because of their pregnancy.

birth weight

The first weight of the fetus or newborn obtained after birth. This weight is best measured within the first hour of life before significant postnatal weight loss occurs.

case

A person in the population or study group identified as having a specific health problem or disease of interest.

case definition

A set of standard criteria for deciding whether a person has a particular disease or health-related problem. Criteria can be clinical, laboratory or epidemiologic.

case-fatality rate (CFR)

The probability of death among diagnosed cases of a specific health problem or disease. The CFR is defined as number of deaths due to the disease in a specified time period divided by the number of cases of the disease during the same period.

cause-specific death rate

The number of deaths attributable to a specific disease in a given population in a given time period (usually expressed per 100,000 persons per year).

contraceptive prevalence rate (CPR)

Percentage of women of reproductive age who are using (or whose partner is using) a contraceptive method at a given point in time. In practice the CPR is generally

reported on women who are currently married or in union, which should be stated accordingly.

crude birth rate (CBR)

The number of live births in a given period per 1,000 people in the same period. Usually expressed per year.

crude death rate (CDR)

The number of deaths per 1,000 people in a given year.

deliveries attended by skilled health personnel

Percentage of deliveries attended by skilled health personnel irrespective of outcome (live birth or fetal death).

- **skilled health personnel or skilled attendant** Doctors (specialist or non-specialist), and/or persons with **midwifery skills** who can diagnose and manage obstetrical complications as well as normal deliveries. (Traditional birth attendants, trained or untrained, are not included.)
- **person with midwifery skills** A person who has successfully completed the prescribed course in midwifery and is able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period. This person is also able to conduct deliveries alone, to provide lifesaving obstetric care, and to care for the newborn and the infant.

epidemiology

The study of the patterns of human disease, health and behaviours.

fetal death (deadborn fetus)

Death prior to the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy. The death is indicated by the fact that after such separation, the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

incidence rate (IR)

The number of new cases of a health problem or disease in a specified time that occurs in a population at risk of the disease in the same time period. The rate is expressed per 100, 1,000, 10,000 or 100,000.

live birth

The complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which after such separation, breathes or shows other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered liveborn.

low birth weight

Less than 2,500 g (up to and including 2,499 g).

maternal death

The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. Maternal death is subdivided into two groups:

- **direct obstetric death** Those deaths resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium), from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above.

- **indirect obstetric death** Those deaths resulting from previously existing disease or disease that developed during pregnancy and which was not directly the result of obstetric conditions, but which was aggravated by the physiologic effects of pregnancy.

maternal mortality rate

The number of maternal deaths per 100,000 women of reproductive age (15-49).

maternal mortality ratio

The number of maternal deaths per 100,000 live births during the same time period.

neonatal mortality rate

Number of deaths in the neonatal period during a given time period per 1,000 live births during the same time period.

neonatal period

Commences at birth and ends 28 completed days after birth. Neonatal deaths (deaths among live births during the first 28 completed days of life) may be subdivided into early neonatal deaths, occurring during the first seven days of life, and late neonatal deaths, occurring after the seventh day but before 28 completed days of life.

perinatal period

Commences at 22 completed weeks (154 days) of gestation (when birth weight is normally 500 g) and ends seven completed days after birth.

perinatal mortality rate

Number of deaths in the perinatal period during a specified period of time per 1,000 total births (live births plus fetal deaths) during the same period of time.

post-neonatal mortality rate

Number of deaths after 28 days up to, but not including, one year of age during a given time period per 1,000 live births during the same period.

pre-term

Less than 37 completed weeks (less than 259 days) of gestation. Pre-term births are also referred to as premature births.

prevalence rate

The proportion of the population that has the health problem or disease under study. The prevalence rate is expressed as the number of existing cases of the disease at a specified point in time in the total population. The ratio is expressed per 100, 1,000, 10,000 or 100,000.

proportion

A fraction where the numerator is a subset of the denominator.

random sampling

A method of selecting a sample whereby each element in the population has an equal chance (probability) of being selected for the sample.

rate

A measure of the frequency of some event in a defined population at a specified time. In a rate, the numerator is a subset of the denominator. The rate is expressed per 100, 1,000, 10,000 or 100,000.

ratio

A measure of the frequency of one group of events relative to the frequency of a different group of events (e.g., maternal mortality ratio is the number of maternal deaths per 100,000 live births). The ratio is expressed per 100, 1,000, 10,000 or 100,000.

relative risk

A measure of the incidence of a condition in those exposed to a particular factor in relation to the incidence of that condition in those not so exposed.

spontaneous abortion or miscarriage

A fetal death in early pregnancy. At what gestational age (point in pregnancy) a miscarriage becomes a stillbirth for reporting purposes depends on the country's policy.

stillbirth

A fetal death in late pregnancy. At what gestational age (point in pregnancy) a miscarriage becomes a stillbirth for reporting purposes depends on the country's policy.

surveillance

A dynamic process in which data on the occurrence and distribution of health or disease in a population is collected, organised, analysed and disseminated.

total fertility rate

The number of children who would be born per woman, if the woman was to live to the end of her child-bearing years and bear children at each age in accordance with prevailing age-specific fertility rates.

unsafe abortion

"A procedure for terminating unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking minimal medical standards or both" (WHO).

vital statistics

Data collected from continuous or periodic recording or registration of all "vital events", such as births, deaths, marriages and divorces.

women of reproductive age (or women of childbearing age)

Refers to all women aged 15 to 49 years (WHO).

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Reference Addresses

Reference Addresses

Contact addresses from which you can obtain cited reference documents and other information

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Appropriate Health Resources & Technologies Action Group - AHRTAG

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E-mail: ahrtag@gn.apc.org

Centers for Disease Control and Prevention

International Emergency and Refugee Health Branch

Mailstop F-48, 4770 Buford Highway
Atlanta, Georgia 30341 USA
Fax: 770 488 7829
E-mail: baw4@cdc.gov
Website: www.cdc.gov

International Federation of the Red Cross and Red Crescent Societies

17, chemin des Crets, Case postale 372
1211 Geneva, Switzerland
Fax: 41 22 730 0395
Website: www.ifrc.org

International Planned Parenthood Federation

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Website: www.ippf.org

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Save the Children Fund UK

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London SE5 8RD UK
Fax: 44 171 703 2278

Teaching Aids at Low Cost - TALC

PO Box 49 St Albans
Herts AL1 5TX UK
Fax: 44 1727 846 852

UNAIDS, Information Centre

1211 Geneva 27, Switzerland
Fax: 41 22 791 4187
E-mail: unaids@unaids.org

UNFPA - Contact local country offices or

220 East 42nd Street
New York, NY 10017 USA
Fax: 212 297 4915

or

UNFPA Emergency Relief Office

9 Chemin des Anemones
1219 Geneva, Switzerland
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E-mail: unfpaero@undp.org
Website: www.unfpa.org

UNHCR - Centre for Documentation for Refugees

Case postale 2500
1211 Geneva 2 Switzerland
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E-mail: cdr@unhcr.ch
Website: www.unhcr.org

UNICEF

Three United Nations Plaza
New York, NY 10017 USA
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World Health Organization

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Website: www.worldbank.org

APPENDIX Four

Action Contre la Faim
African Medical and Research Foundation
American Refugee Committee
CARE
Centre for Research on the Epidemiology of Disasters
Centro de Capacitación en Ecología y Salud para Campesinos
Center for Population and Family Health - Columbia University
Mailman School of Public Health
Family Health International
International Centre for Migration and Health
International Federation of the Red Cross and Red Crescent Societies
Ipas
International Planned Parenthood Federation
International Rescue Committee
International Organization for Migration
JSI Research and Training Institute
London School of Hygiene and Tropical Medicine
Marie Stopes International
Médecins du Monde
Médecins sans Frontières
MERLIN (Medical Emergency Relief International)
Population Council
Save the Children Fund UK
United Nations Children's Fund
United Nations High Commissioner for Refugees
United Nations Joint Programme on AIDS
United Nations Fund for Population Activities
U.S. Agency for International Development
U.S. Centers for Disease Control and Prevention
U.S. Department of Health and Human Services
U.S. Department of State
Women's Commission for Refugee Women and Children
World Association of Girl Guides and Girl Scouts
World Health Organization

