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Foreword

Reproductive health care covers a wide range of issues: pregnancy and childbirth; the protection of women, children, adolescents and men from emotional, physical and sexual abuse; family planning counselling and services to prevent unwanted pregnancies and the sequelae of unsafe abortion; the treatment and prevention of sexually-transmitted diseases including HIV/AIDS; and the discouragement of harmful traditional practices. The provision of reproductive health services should be based on the needs of the population, with particular attention being paid to vulnerable groups, such as women and adolescents. The sociocultural values of the community should be respected, and reproductive health services for communities experiencing the trauma of conflict and displacement ought to be considered as much a human right as the basic essentials of shelter, food, water and sanitation.

The World Health Organization is a member of the Inter-Agency Working Group on Reproductive Health in Refugee Situations which has supported the development and publication of *Reproductive health in refugee situations—an inter-agency field manual*. This manual is based on WHO norms and guidelines and addresses technical issues related to reproductive health.

The present manual, *Reproductive health during conflict and displacement: a guide for programme managers*, is designed to complement the Inter-agency Field Manual by providing a tool that defines how to develop practical and appropriately-focused reproductive health programmes during each phase of conflict and displacement—pre-conflict, conflict, stabilization and post-conflict. The Department of Reproductive Health and Research—in collaboration with nongovernmental organizations and other WHO programmes (Violence and Injury Prevention, Women's Health, and Emergency and Humanitarian Action)—has built upon the technical norms outlined in the *Inter-agency field manual* to develop this complementary manual. The manual has been field-tested in a variety of refugee settings and is intended for use by national and international programme managers.

This is the first edition of *Reproductive health during conflict and displacement: a guide for programme managers* and, in order to know if it meets your needs, we should be grateful for feedback from the agencies, organizations and individuals who use this Guide. Please help us to identify its strengths and weaknesses; we welcome your suggestions for improvement. Your contributions will enable us to continue our work in the Inter-Agency Working Group, including the development of a comprehensive set of tools which will be firmly based on the challenges of developing and managing reproductive health programmes in any phase of conflict and displacement.

Please send your comments to the Team Coordinator, Development of Norms and Tools, Department of Reproductive Health and Research, World Health Organization, Avenue Appia 20, 1211 Geneva 27, Switzerland.

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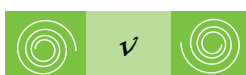
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This chapter describes the different phases of conflict and displacement, and the different ways that populations may respond to conflict.

1.2 The phases of conflict and displacement

1.1 People's reaction to conflict

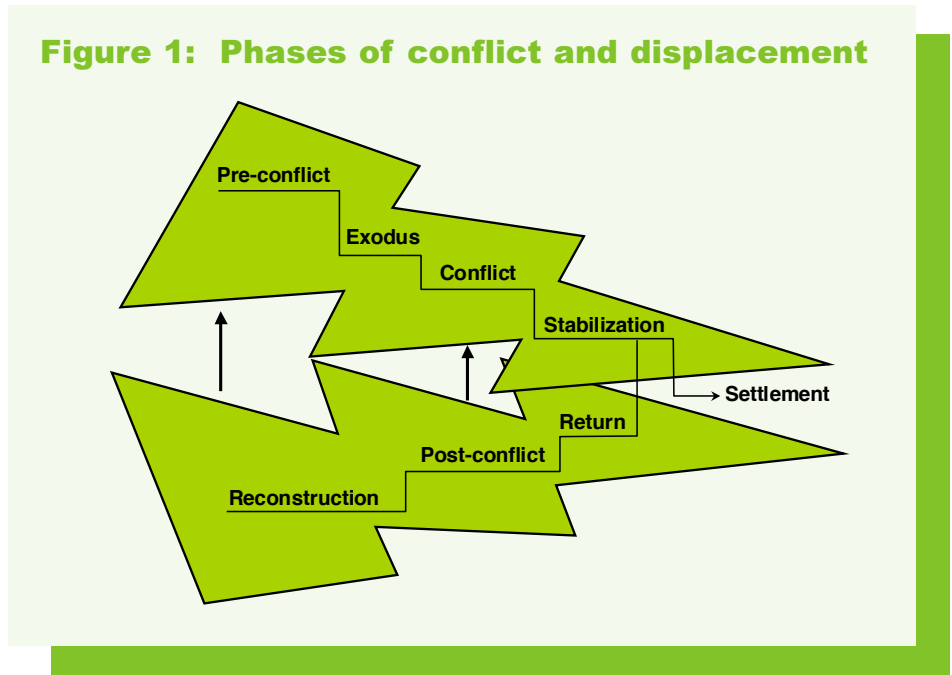
People's reaction to armed conflict generally depends on the degree to which their physical and economic security and safety are adversely affected. Within a conflict situation, there are individuals, families and groups who:

- remain in their home areas ("stayees");
- are displaced from their homes but remain within the boundaries of their country of origin (internally displaced persons);
- cross an international border to escape the conflict (refugees).

However, the artificial nature of these labels must be recognized: the labels often have more meaning for the organizations that are providing assistance than they do for the people themselves. Such labels may give a false impression of categories of people with common needs.

Internally displaced persons can be found in settings similar to refugee camps. They may also find themselves cut off from humanitarian assistance because of conflict or because of official denial of their existence or their needs.

From the point of view of giving assistance to the displaced, it is useful to think in terms of the four phases: pre-conflict, conflict, stabilization and post-conflict. This book follows such a structure. Figure 1 outlines in simplified



form the various phases of conflict and displacement.

Phase 1—Pre-conflict

This stage occurs before the outbreak of full-scale conflict. It is generally characterized by deteriorating economic and social circumstances, civil disturbance and growing instability.

Phase 2—Conflict

Conflict can go through intermittent phases of relative stability and intense fighting.

Relative stability enables health care providers to offer a more comprehensive range of services as outlined in Section C.

Intense fighting will limit the range of reproductive health services that can be offered, as outlined in Section B.

Flight involves the mass migration of people who have fled from their homes in search of safety. During the journey people may suffer extreme hardship and may arrive at the place of sanctuary in very poor physical and emotional condition.

The Emergency phase involves the initiation of a humanitarian response to the needs of displaced and refugee populations. The purpose is to provide a secure environment to meet people's basic needs for shelter, food, water, sanitation and health care. The emergency phase is generally characterized as a period in which chaos is gradually replaced by structure and organization in order to meet people's basic needs.

HORN OF AFRICA

"Refugee flows in the Horn have taken place across international boundaries which are more or less irrelevant to the cultural and economic relations of local people ... The division of the present population of the Ogaden and northern Somalia into refugees and returnees is more a requirement imposed by aid agency mandates than a reflection of the living conditions, motivations and objectives of the people themselves ... Not only is the distinction between refugees and returnees more or less meaningless for many local people in the Ogaden and Somalia, but it also diverts the attention of outsiders from the economic and cultural continuities which underpin their survival strategies. It is precisely these strategies which need to be supported and strengthened through the provision of assistance to the population as a whole."

*Refugees returning home,
UNRISD, Geneva,
March 1993*

Phase 3— Stabilization

Stabilization occurs when the initial emergency has passed, people have reorganized themselves into families and communities, and facilities to meet basic needs are well established. Life returns to some level of normality. Stabilization can also be defined as having occurred when the mortality rate has fallen to less than 1-2 per 10,000 per day.

Phase 4—Return and post-conflict

Return. This is when refugees or internally displaced persons may

return to their country or area of origin, either spontaneously or as part of a planned resettlement.

Post-conflict. This is a period of reconstruction and of the reintegration of returnee and stayee communities.

This chapter gives an overview of reproductive health and the impact of conflict and displacement on the reproductive health of women, men and adolescents.

2.1 What is reproductive health?

Even in stable settings, reproductive morbidity and mortality are a major problem. The World Bank's *World Development Report 1996*, developed jointly with WHO, found that reproductive ill-health accounts for approximately 36% of the total disease burden among women of reproductive age (15-44 years) in developing countries compared to an estimated 12.5% in men (see Figure 2). For women, three groups of diseases make up the 36%—pregnancy-related deaths and disability, sexually transmitted infections (STIs) and HIV.

Reproductive health is about more than just the reproductive organs, and more than just reproduction. It is about how social and sexual behaviours and relationships affect health and create ill-health. It is relevant to both men and women, and to persons of all ages. Too often reproductive health has been considered as relevant only to child-bearing women of reproductive age (15-44 years). It is true that women bear by far the greatest burden of reproductive health problems and that biological, social, cultural and economic factors increase a woman's vulnerability to reproductive ill-health. But reproductive health has to be understood within the context of relationships

between men and women, communities and society, since sexual and reproductive behaviours are governed by complex biological, cultural and psychosocial factors.

The general health of men and women will always reflect earlier reproductive life events since at each stage of life an individual's needs differ. It must be recognized that there is a cumulative effect across the life span of poor reproductive health (see Figure 3). Reproductive health therefore requires that a continuum of care be provided to meet the health needs of individuals throughout their life span.

2.2 The challenges of reproductive health

Good reproductive health starts from childhood. For example, a female child who is malnourished from birth or subjected to harmful traditional practices enters adolescence and adulthood with anaemia, physical anomalies and

possible psychosexual trauma related to the traditional practice. This can increase the probability of obstetrical problems during pregnancy and childbirth. It may also contribute to sexual problems, fear and abuse in a relationship. Effective reproductive health care addresses these problems from birth with appropriate and culturally sensitive education and health care programmes.

Sexually active adolescents who lack accurate knowledge about reproduction and access to reproductive health services including contraception cannot protect themselves from pregnancy and STI/

REPRODUCTIVE HEALTH: WHO GOALS

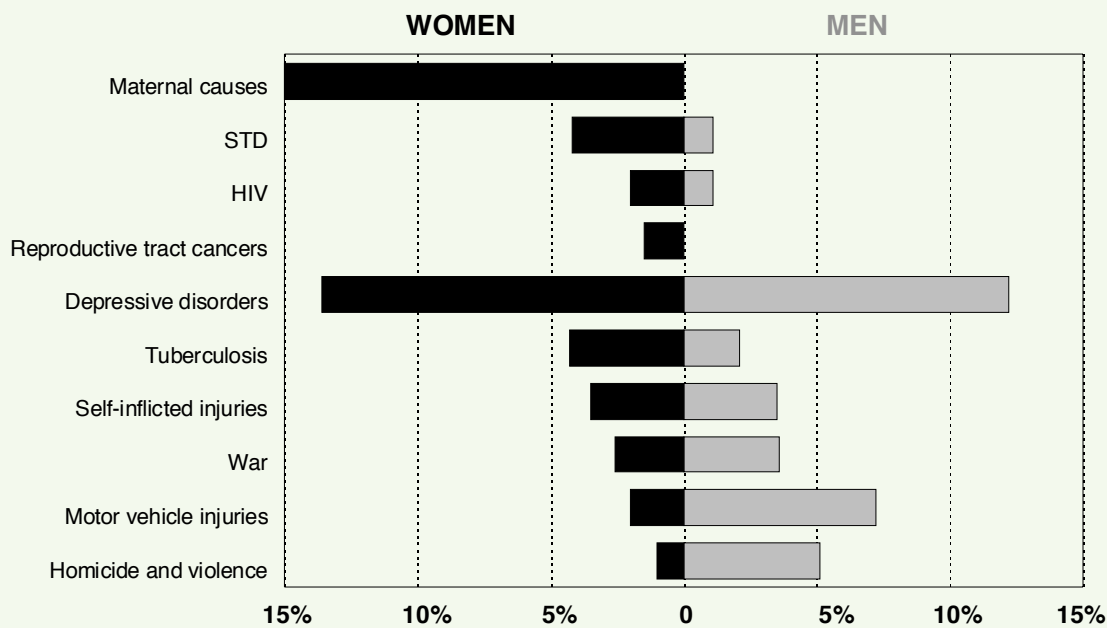
People should be able to exercise their sexual and reproductive rights in order to:

- experience healthy sexual development and maturation and have the capacity for equitable and responsible relationships and sexual fulfilment;
- achieve their desired number of children safely and healthily, when and if they decide to have them;
- avoid illness, disease and disability related to sexuality and reproduction and receive appropriate care when needed;
- be free from violence and other harmful practices related to sexuality and reproduction.

Source: *Reproductive health: meeting people's needs* (WHO/RHT/98.17)



Figure 2: Burden of disease



Source: The Global Burden of Disease, WHO, 1996

HIV. Data indicate that adolescent girls are particularly vulnerable to sexual abuse and rape, and cultural norms may impose early marriage and childbearing. Pregnancy and childbirth in adolescence carry considerable risks. Girls aged 15-19 years are twice as likely to die in childbirth than women in their 20s, and adolescents account for an estimated 5 million of the 20 million unsafe abortions that occur every year.

Many of these abortions may be unsafe since adolescent girls tend to delay seeking abortion and postpone seeking treatment for complications, especially where abortion is illegal. This adds to the burden of ill-health that adolescents bring to adulthood. Adolescents must have access to education and health care programmes that help them to understand the value of healthy sexual and social behaviours in order to postpone the onset of sexual activity, delay childbearing and protect themselves from unwanted pregnancies and STI/HIV.

Sexually active men and women, regardless of whether they are married or single, require

access to information and services that allow them to protect themselves against unwanted pregnancy and the transmission of STI/HIV. Globally, 120 million couples have unmet needs for family planning, and each year women around the world experience 75 million unwanted pregnancies. As a consequence of unwanted pregnancy there are approximately 50 million abortions each year and some 20 million of these will be unsafe. Two hundred women die daily as a consequence of unsafe abortion and there are untold levels of severe morbidity as a direct result of abortion-related complications. Unwanted pregnancies can be reduced by improving access for men, women and adolescents to high quality gender-sensitive information and services that offer a range of contraceptive methods appropriate for people at different stages of their lives.

Pregnancy and childbirth bring their own particular problems. Every day, 1600 women in developing countries die from the complications of pregnancy and annually, more than 300 million—a quarter of the female adult

population—suffer some degree of morbidity. In addition to maternal mortality, half of all the 8 million infant deaths in the first month of life are due primarily to inadequate maternal care during pregnancy. The majority of maternal and neonatal mortality and morbidity could be prevented if women were healthy when they became pregnant and had access to basic medical care during pregnancy, childbirth and the postpartum period.

HIV, the virus that causes the acquired immunodeficiency syndrome (AIDS) continues to spread around the world. Estimates by WHO and the Joint United Nations Programme on HIV/AIDS (UNAIDS) indicate that by the end of 1999 more than 34.3 million people were infected with HIV and that 43% of these HIV-positive adults were women. Approximately 16,000 people are infected daily with this virus and around half of these infections are in the 15-24 year-old age group.

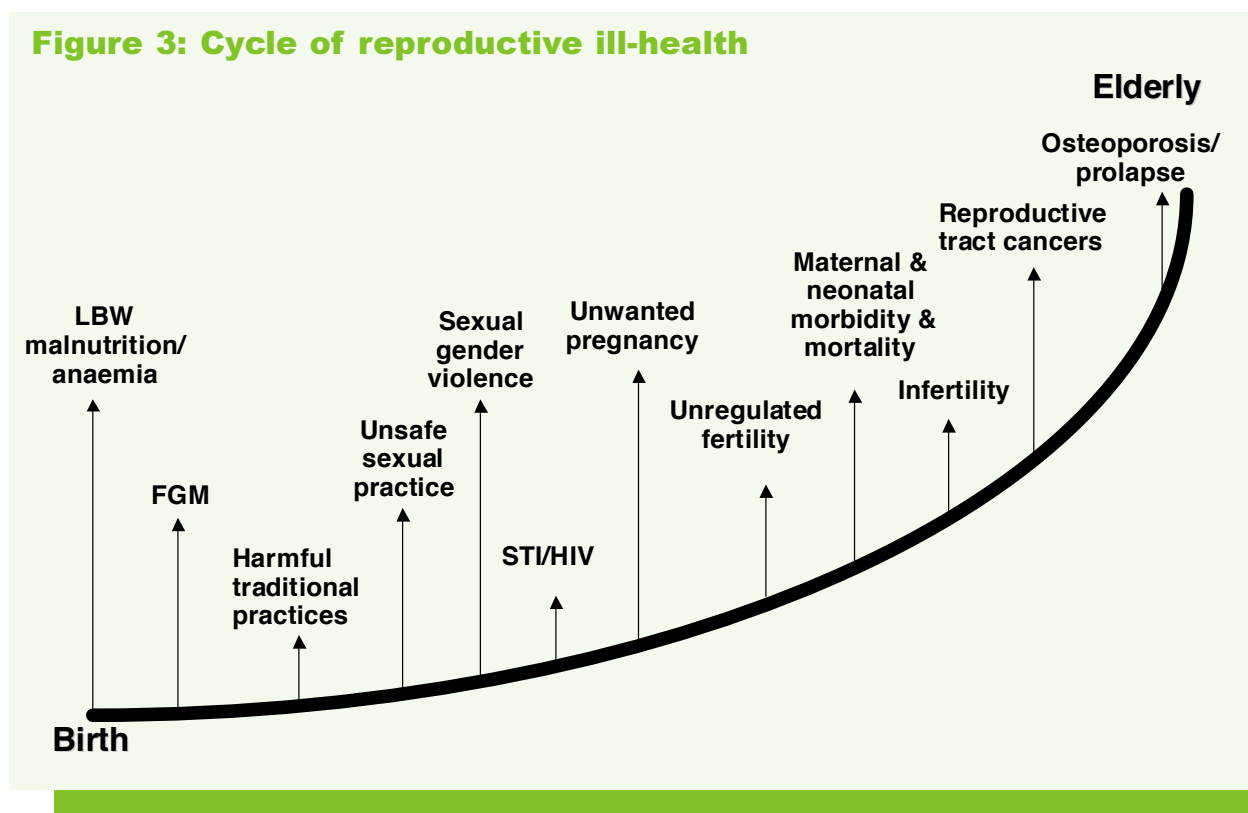
In addition, some 330 million new cases of curable STIs occur annually. Women are socially and biologically more vulnerable to STIs and HIV than men. Biological factors increase

women's susceptibility to infection and the transmission of most STIs, including HIV, is more efficient from male to female than from female to male. STIs in women are frequently asymptomatic and women must bear the sequelae of untreated disease, such as pelvic inflammatory disease (PID), abortion and infertility. In the presence of untreated STIs the rate of transmission of HIV increases significantly. The importance of treating STIs as a means of preventing the transmission of HIV should not be neglected (see Table 1).

Services for the prevention and control of STIs, including HIV, should be incorporated into reproductive health care programmes, supported by energetic information campaigns and gender-sensitive promotion of condom use.

Transmission of HIV from an infected mother to her infant also results in increased morbidity and mortality in young children, undermining child survival efforts. Some 600,000 children were infected with HIV in 1997, mostly through their mothers before or during birth or through breastfeeding. In addition, some 8.2 million children around the

Figure 3: Cycle of reproductive ill-health



world have lost their mothers due to AIDS.

The cumulative effects of reproductive ill-health extend into later life with such diseases as cervical cancer and osteoporosis.

Social, cultural and economic factors that increase vulnerability to reproductive ill-health include:

- restrictions on information about sexuality, contraception, disease prevention, condoms and health care;
- harmful traditions such as ritual intercourse with a male relative after the death of the husband, female genital mutilation, ritual scarification, tattooing and bloodletting;
- early marriage;
- inability to negotiate safe sexual practices;
- discrimination against women in education, employment and social status;
- laws that reinforce women's economic dependence on men and reliance on prostitution, including child prostitution for economic survival;
- war, famine, natural disasters, political oppression, poverty and displacement.

2.3 The impact of conflict and displacement on reproductive health

Armed conflict and displacement have a profound negative impact on the reproductive health of women, men and adolescents. Poverty, loss of livelihood, disruption of services,

Table 1: Selected aspects of reproductive ill-health

Category	Annual estimates (Worldwide 1996-2000)
Couples with unmet family planning needs*	120 million
Maternal deaths†	0.5 million
Severe maternal morbidity†	20 million
Perinatal mortality†	7.6 million
Unsafe abortion†	20 million
People living with AIDS*	34.3 million
People newly infected with HIV*	5.4 million
Curable sexually transmitted diseases†	333 million
Female genital mutilation†	100-140 million

† Annual numbers
* Total numbers

Sources: see Appendix X—Bibliography

breakdown of social support systems, and acts of violence combine to destroy health. There is a pressing need for comprehensive reproductive health care to be made available to refugees, displaced persons and populations affected by conflict, for reasons of equity, justice and human rights (refer to Appendix I—Human Rights). However, conflict and displacement are usually accompanied by a diminished capacity to respond to these needs, and this situation may be further aggravated by inappropriate responses.

- Violence against civilian populations, and acts of gender-based and sexual violence against women and girls (including mass rape), are increasingly common features of war and conflict. This has profound physical and psychological consequences for the women who have been raped, for their families and for future generations.
- As the situation stabilizes in displacement and post-conflict settings, there may be pressure on women to give birth to replenish the population. In some cases this may coincide with women's own desire to replace children who have died or disappeared.

- Fertility rates may increase to very high levels, with women at high obstetrical risk having many pregnancies at close intervals.
- Couples may not have access to family planning services, resulting in an increase in the number of unwanted pregnancies and possibly unsafe abortions.
- There may be an increase in traditional practices, such as some harmful traditional birth practices in order to replace lost health care services; and female genital mutilation in an attempt to maintain cultural and religious identity.
- The spread of STI/HIV is fastest in the conditions of poverty, powerlessness and social instability that accompany conflict and displacement. In addition, mass migration may bring a population of low STI/HIV prevalence, with little knowledge of these infections or how to protect themselves, into contact with populations of high prevalence.
- The reproductive health care needs of men, adolescents and minority groups may be neglected.
- The overwhelming sense of loss (of home and family) and lack of hope for the future may affect the mental health of women, men and adolescents and can lead to an increase in risk-taking behaviours.
- Young, single, widowed or disabled women may be at particular risk of sexual violence.
- The breakdown of family and social networks can leave many households headed by women, who may be forced to offer sex in exchange for food, shelter or protection.
- Women's authority to control their own reproductive lives may be eroded by the social changes associated with conflict and displacement.
- Women may be pressured to become pregnant to replace the depleted population.
- Access to health care facilities that meet reproductive health care needs is often lacking.

Impact on men

In relation to reproductive health, men need to be considered as service users, as decision-makers affecting women's reproductive health and, in some instances, as perpetrators of violence against women.

■ **Men as users of reproductive health services**

Given the increased risks of contracting STIs and HIV/AIDS during conflict and displacement, it is vital that education on safe sex, condom distribution, STI services and HIV/AIDS counselling services are accessible and acceptable to men as well as women. Men and boys may be victims of

Impact on women

The fact that women bear children exposes them to a range of potential problems that men do not experience. The reasons for women's greater vulnerability are not only physical but also social. During conflict and displacement, women's physical and social vulnerability increases.

- Stress and malnutrition endanger the health of pregnant and lactating women and their children.
- The extended network of family support during pregnancy and lactation is lost.
- Traumatized women may have no practical or emotional support.

Educating men to bring about changes in attitudes and behaviour in relation to reproductive health, sexuality and decision-making in relationships is slow work, requiring deep insights into male attitudes.

Given the far greater burden of reproductive ill-health that women bear, there are strong arguments for focusing limited resources on "women-centred" reproductive health programmes.

However, given the power that men exercise in most cultures over decisions about women's reproductive health, there is a growing perception of the need to focus resources on changing not only men's attitudes but also their behaviour in relation to reproductive health.



sexual violence, and services should be oriented to respond to this need. Through community education, men should also be actively encouraged to use family planning services, and to support their partners during pregnancy and breastfeeding.

- **Men as decision-makers within families**

In many cultures, men have the final say with regard to reproductive health decisions within families—decisions about condom use, family planning, spending on health care, and whether their wives receive antenatal or emergency obstetric care. During conflict and displacement, men who lose traditional roles and status may become more aggressive and dominant within the family setting, reducing women's authority still further.

- **Men as decision-makers at community level**

Men also influence women's reproductive health in their roles as community, religious and political leaders. There may be opposition from male community leaders to the provision of some reproductive health services, such as family planning or services for unmarried adolescents.

- **Men as perpetrators of violence against women**

During conflict and displacement, violence against women may increase, not only in acts of war, but also within families and communities. Reproductive health programmes must attempt to address this problem, working in conjunction with community and religious leaders.

Impact on adolescents

During conflict and displacement, new adolescent reproductive health needs are created. New challenges therefore arise:

- The breakdown of social networks is particularly damaging to adolescents because these networks provide the emotional and psychological support to guide their sexual development. The absence of traditional

forms of guidance in the transition to adulthood may result in earlier and increased risk-taking behaviour.

- The boredom, hopelessness, uncertainty, insecurity and frustration of refugee life can also result in risk-taking behaviour. Besides unsafe sexual activity, other risk-taking behaviour includes tobacco, drug and alcohol abuse, poor nutrition, and violence inflicted both by and on adolescents. The desire to plan for the future may diminish, affecting adolescents' motivation and ability to take the necessary steps to avoid STIs, HIV and unwanted pregnancy.
- Adolescent girls (both married and unmarried) who become pregnant may find

SEXUAL AND REPRODUCTIVE HEALTH OF ADOLESCENTS

- Adolescents are not a homogenous group. The needs of adolescent boys and girls, younger and older adolescents, married and unmarried girls, urban and rural adolescents, adolescents in families and unaccompanied adolescents, street children and child prostitutes will differ greatly.
- Adolescence is characterized by experimenting with different experiences, such as sex and drug use. This experimentation is frequently combined with lack of knowledge and skills to understand the risk and make healthy choices.
- Adolescents—especially, but not only, adolescent girls—are particularly vulnerable to the risk of contracting STIs, including HIV/AIDS. Due to lack of knowledge or fear they are less likely to seek treatment of STIs and are more likely to develop complications.
- The risk of serious complications during pregnancy and childbirth is much higher for girls in the 12-19 age group. The social costs of pregnancy for unmarried adolescent mothers may be very high and their infants face more health risks than the babies of older women.
- When adolescents seek abortions, they are more likely to obtain clandestine abortions, or to delay seeking abortion until late in the pregnancy and tend to delay seeking treatment for abortion related complications. They therefore account for a very high proportion of abortion complications.
- Adolescent girls and boys may be victims of violence and sexual abuse, and they may lack the power and skills to refuse to have sex.

themselves without the support to cope with pregnancy, childbirth and raising a child.

- The risks of unsafe abortion may be exacerbated when both social support networks and health services are disrupted.
- In peacetime, young adolescent girls, whether married or single, run the highest risk of sexual violation. In conflict and displacement, this situation is likely to be aggravated.
- Unaccompanied minors, whether boys or girls, are especially vulnerable to violence and other forms of sexual exploitation. They may turn to prostitution in order to survive. They are also far more vulnerable to other forms of high-risk behaviour, including substance abuse, and to poor health in general.
- The ideas of aggressive masculinity inculcated in child and adolescent soldiers can have a profound and long-term negative impact on their own reproductive health and on that of the communities with which they come into contact.

Impact on the capacity to respond to reproductive health care needs

Along with increased reproductive health needs, there is a diminished capacity within the health service, community and family to respond to these needs.

For example:

- family and community networks of support and protection may be lost;
- poverty and loss of livelihood reduce the capacity of individuals and families to protect their health, including their reproductive health;
- within a conflict zone, existing health services and structures may have been destroyed, health personnel may have fled or been killed, and international aid may not be able to reach the affected population;
- emergency obstetric facilities may have been destroyed, or may have become inaccessible;

- where health services continue to function, the needs of combatants may be given precedence over the needs of non-combatants.

Inappropriate institutional responses to reproductive health needs

Apart from traditional maternal and child health services, the reproductive health of women, men and adolescents is frequently neglected among refugees and internally displaced persons. It may not be considered a priority, and in some instances reproductive health problems may even be compounded by inappropriate institutional responses. The reasons for this may include the following:

- In the emergency phase of a humanitarian response, attention is necessarily focused on acute life-saving interventions. Less visible problems such as STIs, HIV/AIDS, female genital mutilation, the complications of unsafe abortion, gender-based and sexual violence and other traumas are frequently neglected.
- If the emergency approach of the initial response continues long after the initial emergency has passed, the less visible problems may continue to be neglected in the stabilization phase.
- The gender approach needed for successful reproductive health interventions may be lacking at institutional level, or it may be disregarded in an emergency situation.
- Different relief agencies may provide different vertical services for different population groups. This will meet some, but not all, reproductive health care needs.
- Relief workers may be neither aware of reproductive health needs nor trained to meet those needs.
- Relief workers may not know how to develop and plan an integrated programme of reproductive health care. Also, relief organizations and health personnel may not have the knowledge, skills or attitudes



needed for the slow-paced, participatory approaches that are required to bring about changes in sexual behaviour and reproductive health.

- Relief workers may be reluctant to raise sensitive issues relating to reproductive health. Few health personnel may have experience in dealing with the victims of sexual violence.
- Services may sometimes be provided in ways that do not respect the dignity of the recipients and their right to make free and informed choices. Alternatively, there may be opposition to the provision of some reproductive health services for religious or cultural reasons.

These guidelines attempt to address each of these issues so that high-quality, comprehensive reproductive health services can become a reality for populations affected by conflict and displacement.

ZAMBIA

"The children behaved as if they were older than their age. They tended to start drinking and smoking at an early age and girls as young as nine behaved like adolescents."

*Source: Surviving violence: a recovery program for children and families.
Geneva, International Catholic Child Bureau, 1995, p. 50*

EL SALVADOR

"Most of the adolescents among the refugees were children when they arrived in their country of asylum seven or eight years ago. If the problem of adolescence is difficult in "normal" terms or in a society at "peace", it is even more so for individuals who have been taken from their country and uprooted in the midst of anguish and fear, in the midst of the violence of war. Before fleeing, many of those children saw their relatives and neighbours die, and even on the way to refuge they lived through the ordeal of hunger, exhaustion, cold and more violence. Psychologists agree that traumas experienced in early childhood give rise to problems in adolescence in the form of personality disorders, anxiety and feelings of not being understood. One worrisome problem, for example, is the suicide rate among adolescent refugees."

*Source: Candray R.
Vulnerable woman: displaced or refugee. 1994*

This chapter outlines the guiding principles that should govern the provision of reproductive health services during all phases of conflict and displacement. These guiding principles should be emphasized in the training of all relief workers, even when the bulk of operations are not related to reproductive health.

3.1 An integrated approach

Reproductive health cannot be looked at in isolation. It affects and is affected by all aspects of the lives and health of women, men and adolescents. It is related to all other aspects of primary health care, including mental health, nutrition, water and sanitation, and with environmental care, education, employment opportunities, culture, and social and economic status. During armed conflict, the greatest impact on reproductive health may sometimes be achieved through "health-supporting" activities rather than through interventions aimed explicitly at reproductive health.

These guidelines therefore emphasize an integrated approach. Reproductive health is treated as an integral component of primary health care, and the solutions to reproductive health needs are sought both in the health sector and elsewhere. This includes recognizing the empowerment and education of women and girls as key determinants in improving their health, and supporting and promoting women's groups. Among refugees and displaced persons, an integrated approach means including

the interactions between host and displaced communities in programme planning. It also means that wherever possible vertical programmes, such as maternal and child health, family planning, and STI/HIV control and prevention, should be linked or integrated to ensure that reproductive health care needs are met by the provision of a holistic service.

Coordination of response

As part of an integrated approach, close collaboration is necessary between partners providing health care to those affected by conflict and displacement. This will save resources, improve logistics, avoid gaps in coverage and prevent duplication of effort. The tendency to vertical delivery of reproductive

health services even in stable settings makes the need for close coordination doubly important to avoid wasting resources.

3.2 A gender approach

The word "gender" is used to describe those characteristics of men and women that are socially constructed, in contrast to those that are biologically determined. In applying a gender approach to health, WHO goes beyond describing women and women's health in isolation but brings into the analysis the differences between women and men. A gender approach examines how these differences determine differential exposure to risk, access to the benefits of technology and health care, rights and responsibilities, and control over one's life.

INDIA

"The women in the village were asked what interventions would be of greatest assistance to them. They carried out a task analysis, showing how long they spent in each of their daily activities. This demonstrated that they worked 18 hours every day, and their most time-consuming tasks were collecting fuel and grinding corn. As a result they requested pressure cookers and a village corn mill. The men of the village however were against this. They felt that food cooked in pressure cookers and grain which is not milled by hand is less nutritious and does not taste so good. They also felt that the women were not as short of time as they claimed, but spent too much time chatting. The rural development team then asked the men to carry out a task analysis for their wives. When the men added up the time needed for each activity and found how many hours the women spent working each day they were amazed. They then visited other villages where people used pressure cookers and mills and found that the food was, after all, acceptable."

Source: Gosling L, Edwards M. Toolkits: a practical guide to assessment, monitoring, review and evaluation. Save the Children, 1995, p. 35



The importance of a gender approach in programme planning and development is increasingly being recognized. However, there is still a strong tendency to neglect gender roles and relationships in emergencies. This can lead to women, adolescents or marginalized groups becoming more vulnerable rather than less as a result of the humanitarian response. If the humanitarian response is truly to benefit all sections of a community, and if reproductive health services are to successfully meet the needs of all, a gender approach is needed during each phase of conflict and displacement. This means not only paying attention to the needs of women, but also examining the relationships between women and men, the structure of society and the impact that conflict has on the roles of groups within that society. For instance, the authority that older men formerly held may be lost to a younger generation of soldiers, women may have to assume more responsibility for what were traditionally male activities, children may be expected to emulate the behaviour of adults, and girls may have to assume roles that make them more vulnerable to sexual harassment or inhibit their development.

The examples in this section demonstrate what a gender approach means in practice. One comes from an account of a long-term development project in India. It illustrates how, both by listening to women and addressing the relationships between men and women, programmes can be developed to meet

women's immediate needs and improve their position in society.

It is vital to explore how gender relationships change as a result of conflict or displacement. This experience can have a marked impact on men's and women's attitudes to all aspects of reproductive health, such as family planning, motherhood, extramarital sex, sexual violence and so on.

Gender training

If reproductive health programmes are to be based on a gender approach, there needs to be an awareness of gender on the part of health workers in the field, on the part of programme managers, and on the part of policy-makers and donors. Gender training is designed to promote such awareness. It enables people to examine their personal experiences and to realize how the neglect of a gender perspective has in the past disadvantaged men and, particularly, women. Such training also introduces participants to the tools of gender analysis and planning.

A unique feature of emergencies is that policy-makers, programme managers and health service providers are often from a culture that is different from that of the affected population. As attitudes to reproductive health and to men's and women's roles in society vary greatly between cultures, there is a need for outsiders to be aware of their own (culturally-based)

FORMER YUGOSLAVIA

"Most commonly, in situations of militarisation, traditional gender ideals are stressed: men's "masculinity" is called on to encourage them to take up arms in defence of their country, ethnic group or political cause—and in defence of "their" women. Women become the bearers of the culture that the men are fighting to defend and thus what is "feminine" and appropriate behaviour for women may be redefined. For example, in former Yugoslavia, women are assigned the mythical roles of "Mother Juvoica" (the mother who sacrificed nine sons to the homeland, without tears) and "Daughter of Kosovo" (the daughter who tends injured soldiers).

The manipulation of gender ideology as part of the process of militarisation can lead to the erosion of women's human rights and restrictions on their mobility. The holding up of women as symbolic bearers of caste, ethnic or national identity can expose them to the risk of attack. The widespread occurrence of rape in times of conflict has been seen as directly related to the position of women in communities as bearers of cultural identity. The rape of women in conflict situations is intended not only as violence against women, but as an act of aggression against a nation or community."

*Source: Byrne B.
Gender, conflict and development,
Vol. 1: Overview.
Brighton, Institute of
Development Studies, 1995*

attitudes and beliefs in these areas. These issues also need to be addressed in gender training for emergencies.

It is recommended that all relief agency staff receive at least some gender training before being sent to the field.

3.3 Quality of care

WHO has defined the core elements of quality of care as follows:

- promotion and protection of health through preventive services (including counselling and education);
- ensuring accessibility and availability of services;
- ensuring acceptability (including cultural acceptability) of services;
- ensuring standards of practice and technical competence of health care providers;
- ensuring the availability of essential supplies, equipment and medication;
- respectful, non-judgmental client-provider interactions, information and counselling for the client and referral when necessary;
- involvement of clients in decision-making;
- comprehensive holistic care integrated into primary health care services;
- continuous monitoring of services;
- ensuring cost-effectiveness and the appropriate use of technology.

High quality of care in reproductive health services may seem unattainable in especially difficult circumstances, such as during armed conflict or emergencies. However, evidence from stable settings indicates that quality of care is critical to the more efficient and effective use of limited resources and to increasing access to and use of reproductive health services. Quality is therefore an issue that should be addressed in any setting where health care services are provided.

Conflict and displacement may create constraints on finances, logistics or security that can put severe limits on the quality of care that can be provided. This may mean that a particular intervention will neither be effective in meeting reproductive health needs, nor cost-effective. In these circumstances, choices have to be made as to whether a particular service component should be provided. This issue is looked at under "Identify priorities" and "Select the best strategy to achieve objectives" in Section C, Chapter 11.

Adherence to the highest ethical standards

Adherence to the highest ethical standards is an essential component of the quality of care during conflict and displacement. Services should be provided in ways that ensure respect for privacy, confidentiality and freedom of choice, and that ensure equity of care to all groups. In any situation these are key issues and can be difficult to achieve. In situations of conflict and displacement they may be even more difficult to attain, but at all times an explicit attempt should be made to strive for the highest ethical standards.

Equity of care

Equity of care to all—irrespective of gender, ethnic group, religion or caste—means ensuring that services are available, accessible and acceptable to all marginalized and vulnerable groups, for example, people without immediate family or relatives, adolescents and other groups with special needs such as unaccompanied women, unaccompanied minors and disabled persons.

3.4 Protection of human rights

Human rights violations during conflict and displacement, including acts of gender-based and sexual violence, must be documented, reported and prosecuted for reasons of justice



(refer to Appendix I). This will be a deterrent to future violations and will affirm the humanity of the victims. The role of organizations and health workers in this respect is dealt with in Section E, and referred to in Sections B and C.

3.5 Staff support

Managers of organizations working with refugees and displaced persons have an obligation to prioritize support for their staff, particularly those working with victims of rape or other trauma. Whether carers come from within the community or from agency staff, there are very real risks of burnout and vicarious traumatization when working with victims of trauma. It is vital that carers are aware of their own experiences and feelings, and this should form part of their training. Other strategies that help are:

- all carers should be trained, well briefed and debriefed;
- working in pairs when doing group counselling or visiting people in their homes;
- meeting with a support team or with a "buddy" for personal and professional support;
- receiving supervision and support from a professional counsellor to improve their skills and discuss difficult situations.

3.6 A participatory approach

When speed is considered vital, community participation in decision-making may be given low priority. Where community members are consulted, it may seem that the most efficient way to gather information is to talk to the official community leaders who are almost always men. This can occur despite the fact that most of heads of households in many refugee or displacement settings are women. It is also common for male decision-makers to be more at ease talking with male community leaders.

"Relief programmes are significantly enhanced if the people affected are actively involved in all aspects of planning, implementation, and evaluation of relief programmes. While it may not be easy to institute effective consultation mechanisms in the initial stages (of an emergency), an attempt should be made to establish the principle of consultative planning, and then build on imperfect beginnings. It is more difficult to try to reorient programme priorities and methodologies that have already established their top down momentum."

Source: The Oxfam handbook of development and relief, Vol. 2 Oxford, Oxfam, 1995, p. 908

Moreover, women from communities affected by crisis or displacement may feel unable to voice their needs and concerns to men. It is important to consider approaching individuals and groups in a socially and culturally acceptable manner. For example, it would be wrong for a man to approach women who are traditionally in purdah. The views of these women are important, but a culturally acceptable approach must be found for speaking to them.

Failure to seek out and respond to women's needs may lead to deterioration of women's position relative to men, it may place women at risk of violence or sexual exploitation, and it may give rise to inefficient and inequitable relief distribution systems. Women are often far more knowledgeable about health and nutrition needs than male community leaders. Health interventions that do not draw on women's knowledge will fail to meet not only women's needs but also the needs of their children and of the entire community. In addition, the opinions of adolescents and of marginalized ethnic groups are also frequently ignored, resulting in neglect of their needs. Participation of all sectors of the community is therefore vital.

These guidelines emphasize that a participatory approach should be an integral part of all aspects of the response to reproductive health needs. The community should be involved in the initial programme assessment, at

the planning phase and in the implementation, monitoring and evaluation of reproductive health programmes. This approach will ensure respect for the culture and traditions of the community.

Opposition to reproductive health services from within a community

Some groups within a community may oppose the provision of some aspects of reproductive health services, such as family planning or services for unmarried adolescents. It is important to assess the nature and extent of such opposition before proceeding with contentious services, even if members of the community have expressed a need for such services. Particularly in conflict settings, opposition to services may be expressed violently and may put the lives of health workers and others at risk. Women's or other community groups may be able to identify not only the risks involved in providing contentious services but also some possible solutions. In some circumstances, it may be possible through dialogue and advocacy to move to a position where community leaders are facilitators of service provision rather than barriers to it.

"Denying all the empirical evidence that most refugees experience protracted exile, the conventional approach to humanitarian assistance is relief-driven rather than developmental, emergency rather than long term."

*Source: Zetter R.
Enhancing the capacity of local
NGOs in refugee assistance:
experience from Malawi and
Zimbabwe.
Refugee Participation Network,
May 1995, p. 19*

3.7 Support for coping strategies

In all societies, individuals and communities have different strategies they adopt in order to survive in times of crisis. Most people affected by conflict, whether stayees or displaced, survive by their own efforts rather than as a result of outside interventions or aid. For example, it has been suggested that food aid meets only 10% of needs in emergency situations, with most food needs being met through local coping strategies.

Where outside assistance is available and can reach the affected population, it should be firmly based on supporting and strengthening people's coping strategies. This is because:

- this is likely to be the most efficient way of assisting individuals and communities;
- the knowledge, capacities and coping strategies of the people themselves are their chief means of survival and hope for the future.

To undermine these coping strategies is to undermine a community's long-term capacity for recovery, peace building and reconciliation. Ideally, humanitarian relief during conflict and displacement should be channelled through organizations that have a good knowledge of the affected community and its survival strategies, and that understand of the roots of conflict.

These organizations may be government bodies, rebel groups, women's groups, United Nations organizations or international NGOs with experience of development work with the affected community before the conflict. It is imperative that relief organizations that are new to a particular country or community rely on organizations and groups with local experience in order to identify and support (rather than undermine) community coping strategies. Relief agencies should avoid imposing their own beliefs and ideology, but should accept the culture and religion of the people.

3.8 A development approach

Both conflict and displacement are frequently protracted. A relief approach to humanitarian assistance, with an emphasis on rapid decision-making and response, is essential in the early days of a crisis. Too often, however,



crisis management style continues to be used long after the time of crisis is passed.

These guidelines emphasize that programme planning and implementation should be based on a development approach to the greatest extent possible during all phases of conflict and displacement. In practice this means that the principles of community participation, a gender approach, consultative planning, empowerment of communities and attention to long-term sustainability must be supported at all levels of an organization, and should be actively promoted in the field. One important aspect of sustainability that is emphasized in the guidelines is the provision of a level of care that is appropriate to local standards and that is in line with local norms and practices.

3.9 A public health approach

Violence against women, children, adolescents and vulnerable groups is now being recognized and treated as a preventable public

health problem. There is also a growing perception that political violence, including armed conflict, should be treated as a public health problem, and that health practitioners should treat war as a particular kind of "societal disease". This means that health practitioners should study the causes of war, document its impact on physical, social and mental health, investigate preventive measures, take whatever action is in their power (as individuals and through professional bodies) to prevent the "disease", and develop strategies to treat its effects.

To date, relatively little has been documented on specific reproductive health needs arising during conflict or on simple and successful strategies for meeting those needs. This kind of information (including information on strategies that have not been successful) would be invaluable for the future. One way to share such information would be for field staff to include reports of reproductive health interventions in conflict settings in their feedback on these guidelines.

This chapter describes measures that can be taken during peacetime, during periods of instability when armed conflict appears to be imminent, and during flight in order to lessen the negative impact of conflict and displacement on reproductive health.

4.1 Conflict reduction and vulnerability reduction

- Health policy-makers, health managers and health workers can help reduce conflict within communities by ensuring equity to all groups in access to health resources.
- Health policy-makers, health managers and health workers can actively promote non-discriminatory attitudes towards marginalized groups.
- As individuals, health workers can also act as role models by demonstrating attitudes of tolerance, non-violence and non-discrimination within their communities.
- Community health workers can be trained to work with the communities they serve to develop conflict resolution skills.
- Participatory development programmes that empower women and marginalized groups also have the effect of decreasing their vulnerability to the impact of conflict. (The most powerless are most vulnerable to the impact of conflict and displacement because they do not have access to or control of the financial resources, education or information that can reduce their vulnerability.)
- Women's groups that create networks of support for women should be promoted and assisted.
- Efforts on the part of health workers, community workers and women's groups to change attitudes and behaviour in relation to domestic violence may also bring about changes in attitudes to gender-based violence during conflict.

4.2 Preparations during peacetime

Health worker training during peacetime

- During peacetime, the training of all health workers should include raising awareness of the health needs that can arise during armed conflict, and of conflict as a public health problem. This training should emphasize the health worker's role and responsibilities in prevention, treatment and documentation of this "disease".
- Training should cover, at an appropriate level, the reproductive health needs that can arise as a result of conflict, including the reproductive and mental health needs of those who suffer sexual violence.
- Training should also include knowledge of human rights instruments relating to the protection of civilians during armed conflict, including protection from gender-based violence (refer to Appendix I). It should cover ethics, with clear guidelines forbidding the involvement of medical personnel in torture, and the principles of non-discrimination and equity of care.
- Senior staff in government departments, NGOs and United Nations organizations working in emergency settings should also receive training on the reproductive health and gender issues associated with conflict and displacement, as well as the management skills needed to respond to these needs.

Emergency preparedness: planning

- Emergency preparedness plans are developed in order to minimize the adverse effects of a disaster (such as armed conflict, mass displacement, or natural disasters) and to ensure that the organization and delivery



of the emergency response is timely, appropriate and efficient.

- Plans should be developed by all organizations working in unstable regions. They should be part of long-term development strategies rather than being introduced as a last-minute response to the threat of conflict.
- Plans should be flexible and should be continually reviewed and updated as circumstances change. They should be set in motion as soon as there are warnings that conflict is imminent.
- A strong gender perspective should be incorporated into emergency preparedness plans. Women as well as men should be consulted in the development of plans. For each component of the plan, the question should be asked: is this likely to increase or decrease the vulnerability of women, men, adolescents, children, marginalized groups, or different ethnic groups?
- Emergency preparedness plans should be based on identified coping strategies of the community.

Emergency preparedness: information gathering

- Gathering information on reproductive health before the outbreak of armed conflict will do much to assist in programme planning after conflict starts. Ideally such data would include information on morbidity and mortality related to reproductive health, on available services (e.g. family planning services) and on attitudes to sexuality and relationships, family planning, HIV/AIDS, and gender-based violence.

Emergency preparedness: essential supplies

- If conflict or mass displacement threatens, the material resources required to respond must be made ready. Establishing regional reserves will reduce transport times.

Condoms should be included as a matter of course, along with the New Emergency Health Kit and Clean Delivery Kits.

- In times of growing instability, health programmes at community level should make it a point to find pregnant women in order to issue them with Clean Delivery Kits, provide education on their use and information on how to recognize and respond to an emergency situation. Where possible, women should be fully immunized against tetanus.
- Contraceptive pills and condoms can be issued for a longer period (e.g. six months rather than three months). Women should be offered the choice of receiving an injectable contraceptive if they wish.

Emergency preparedness: staff recruitment and training

- Skills in reproductive health should be considered when recruiting staff, and information on reproductive health skills should be included in the human resources database of humanitarian organizations.
- All staff (not only health workers) who are to work with persons who are affected by conflict or who are displaced should be trained in gender awareness and provided with a basic understanding of reproductive health needs of men, women and adolescents during conflict and displacement. They should also be aware of how to work in coordination with reproductive health services, even if most of their work is not directly related to reproductive health.
- This training should ideally be part of a predeparture orientation package. A number of training materials have been developed that can be used for predeparture or on-site orientation on reproductive health and gender (see Appendix X—Bibliography).

4.3 The Flight

The flight

If mass displacement occurs—whether due to conflict, famine or other causes—displaced populations, including pregnant women, are usually without any health care services. Families may become separated, and women and girls may be at risk of gender-based and sexual violence from soldiers, border guards, bandits and others.

The exodus is usually spontaneous, unplanned and chaotic, particularly if it is due to war or conflict, and protecting reproductive health can be difficult.

- Every effort should be made to keep family and clan units together during the exodus.
- Advocacy is needed to raise awareness at national and international levels of the risks of gender-based and sexual violence during the exodus, and of the fact that rape and other acts of violence against civilians are human rights violations.
- Once an exodus starts, the presence of international observers at border crossings and other points along the route may be a deterrent to gender-based and sexual violence and could help with information gathering and the delivery of care.

The sanctuary

When those who have fled arrive at a place where they can be reached by humanitarian assistance (the "sanctuary", which may sometimes become a formal reception centre), the following minimum reproductive health interventions should be provided:

- Attempt to identify pregnant women, birth attendants and midwives. Issue pre-packaged "Clean Home Delivery Kits", and instructions on their use, to all pregnant women. Issue multiple kits to birth attendants and midwives.
- Even if the sanctuary or reception centre is temporary, examine the site to see if there are ways to make it safer for women, to protect them against gender-based and sexual violence. (Since the sanctuary sometimes becomes a longer-term camp for refugees or displaced, safety should be established as early as possible.)
- Consider providing emergency contraception through health professionals for victims of rape (see the notes on the Core Package in Section B, Chapter 5).

If the site becomes permanent, the full Core Package should be implemented as soon as possible.



This chapter describes a Core Package of simple and efficient interventions to reduce reproductive health related mortality and morbidity during intense periods of armed conflict and the emergency phase of a population displacement. It also describes the materials and supplies needed to implement the Core Package. The complexities of operating during armed conflict are addressed in Section B, Chapter 7.

5.1 The Core Package of reproductive health interventions

The Core Package is a desirable minimum package of interventions for meeting basic reproductive health needs during armed conflict. Table 2 summarizes the key components of the package while Table 3 lists the materials and supplies needed to implement it. For fuller details, refer to *Reproductive health in refugee situations—an inter-agency field manual*.

The other key public health interventions of the emergency phase response (water, food, sanitation, shelter and preventive and curative

care focused on reducing the incidence of malnutrition, measles, diarrhoeal diseases, malaria, and ARI) are described in detail in other resource materials (see Appendix X—Bibliography).

The provision of emergency contraception and of condoms can be highly contentious in many cultures. Ideally such services would be introduced to a community only after a careful and thorough assessment of needs and attitudes, and in the closest consultation with the community in question.

It must however be remembered that reproductive ill-health must be viewed from a public health perspective and in emergencies the need for these services may be so great that it becomes necessary to introduce them before a detailed assessment has been carried out. If this is the case, it is vital that as much information as possible is gathered about attitudes to these issues. This information must be used to plan how these services will be delivered to the community without provoking a backlash that could make it difficult to develop reproductive health services in the future.



Table 2: Core Package of reproductive health interventions*

To prevent excess neonatal and maternal morbidity and mortality

- Through community health workers and clinics, distribute Clean Delivery Kits to all pregnant women and birth attendants. Make sure people know how to use them.
- Supply health facilities and midwives with professional midwife delivery supplies from the New Emergency Health Kit. Set up a system to replenish these kits.
- If possible, identify a referral facility to which obstetric emergencies can be referred. Establish mechanisms for referral and organize transportation.
- Through community leaders, pregnant women and birth attendants, start community education on indications for referral.
- Ensure that all relief agency staff are familiar with the guidelines on support of breastfeeding in emergencies (see Appendix II). Ensure that all relief agency staff implement these guidelines.

To prevent and manage response to gender-based/sexual violence

- (Refugee/displaced) Plan site of camp, administration of camp, and distribution of assistance so as to minimize risks to women.
- Alert all staff to risks of violence against women and of the importance of referring victims to the health services for medical treatment and counselling.
- Provide emergency contraception (from the New Emergency Health Kit), and information on its use, to doctors and nurses in clinics (refer to Appendix XI for list of suppliers and Appendix V for information).
- Refer victims of violence to protection services (if these exist).
- Collect data on suspected and confirmed gender-based and sexual violence as part of the emergency health information system.

To enforce universal precautions against HIV

- Train all health workers, and all non-health workers assisting in health care, in universal precautions.
- Ensure soap, gloves, aprons, gowns and facilities for sterilization are available.
- Establish system for safe disposal of sharps and contaminated waste materials (incineration or burial).

To reduce transmission of STI/HIV by making condoms freely available

- Make condoms available through appropriate channels, as identified by key informants during rapid assessment (e.g. clinics, food distribution network, and community workers). Ensure relief workers and adolescents are included in target audience. Educate community on availability of condoms.

To ensure blood transfusion is safe

- If facilities are available for blood transfusion, guidelines on safe blood transfusion must be followed, see Appendix X—Bibliography.

To meet pre-existing family planning needs

- Provide basic family planning services, i.e. condoms and combined oral contraceptives, to doctors and nurses in clinics, in order to meet spontaneous demand.

To meet needs for menstrual protection

- With women in the community, assess the need for menstrual protection and identify methods to meet this need.

Table 3: Materials and supplies to implement the Core Package*

The New Emergency Health Kit

The kit provides the drugs and medical supplies for 10,000 people for approximately 3 months. It is designed to meet the primary health care needs of a displaced population without medical facilities, or a population with disrupted medical facilities in the immediate aftermath of a disaster.

- The kit includes supplies for professional midwifery care and emergency contraception.
- Clean delivery kits, condoms and basic family planning supplies are not included in it and must be ordered separately according to need. They can be ordered from UNFPA Reproductive Health Kits.

Emergency contraception

A small quantity of emergency contraception is included in the New Emergency Health Kit for victims of rape (see Appendix XI for a list of suppliers and Appendix V on Emergency Contraception).

Clean Delivery Kits

Clean Delivery Kits are for use in isolated or difficult circumstances. They can be made up on site or procured from UNFPA. Clean Delivery Kits consist of a square metre of plastic sheet, a bar of soap, a razor blade, a length of string, and a pictorial instruction sheet.

With an estimated crude birth rate of 3% per year, a population of 10,000 persons would be expected to have 25 births a month. When calculating how many Clean Delivery Kits you need, always include a margin for wastage.

Condoms

Good quality condoms are essential both for the protection of the consumer and the credibility of the relief programme. They should be of good initial quality, protected by impermeable foil wrapping, and properly stored (protected from rain and sun in particular). The procurement officer responsible for bulk purchases in emergencies should require a certificate with each shipment verifying that they have been quality tested on a batch-by-batch basis by an independent laboratory. Condoms can be purchased through an intermediary supplier such as UNFPA, WHO or IPPF (see Appendix XI for list of suppliers).

Provision of contraceptives to meet spontaneous demand

Although an information, education and communication campaign to attract new users of family planning services should not be a priority during the emergency phase, both combined oral contraceptives and condoms should be available for previous users, i.e. women and men who were using these methods before the displacement.

Menstrual protection

Without menstrual protection, women and adolescent girls may not be able to move about in public to reach health services, food distribution, etc. However, disposable menstrual pads are bulky to transport and are expensive. Distributing pieces of absorbent cloth to women and girls may be sufficient, provided soap and water are available to wash them.

* For fuller details of the Minimum Initial Service Package (MISP), refer to the inter-agency field manual on *Reproductive health in refugee situations*.

Universal precautions

Universal precautions are a simple, standard set of procedures to be used in the care of patients at all times to minimize the risk of transmission of bloodborne viruses, including HIV. Universal precautions consist of: handwashing, use of protective clothing such as gloves, safe handling of sharp instruments, safe disposal of medical waste including sharps, and decontamination and sterilization of instruments and equipment.

The main risks to relief workers are: injury with a needle or sharp instrument that has been contaminated with blood; exposure of open wounds to infected blood (HIV is not transmitted through unbroken skin); and splashes of infected blood or body fluids onto mucous membranes and eyes.

The main risks to patients are: contaminated instruments (e.g. needles, syringes, scalpels etc. that are re-used without being adequately disinfected or sterilized), transfusion with contaminated blood, and exposure of open wounds to infected blood.

Preventing HIV infection through blood transfusion: main recommendations

- Transfuse only in life-threatening circumstances and when no alternative is possible.
- Use blood substitutes whenever possible, such as simple crystalloids (physiological saline solutions for intravenous administration) and colloids.
- Collect blood from donors identified as being least likely to transmit infectious agents in their blood. Promote the selection of safe donors by giving clear information to potential donors on when it is appropriate or inappropriate to give blood, and by using a blood donor questionnaire. Blood from voluntary non-remunerated donors is safer than blood from paid donors.
- Those who give blood under pressure or for payment are less likely to reveal reasons why they may not be suitable donors and therefore present a potentially greater risk of transmitting infection. This applies also to family members who may be under pressure to give blood to a relative.
- Personal information given by the donor must be treated as strictly confidential.
- Test all donated blood. Screening for HIV and other infectious agents should be carried out using the most appropriate assays. Rhesus testing and simple ABO compatibility testing should also be carried out.

This chapter describes how the Core Package can be adapted to local needs based on the findings of a health assessment. It also highlights the importance of coordination and community participation from the earliest stages of an emergency.

6.1 Coordination

The Core Package is a desirable minimum package of interventions for meeting basic reproductive health needs during armed conflict. Table 2 summarizes the key components of the package while Table 3 lists the materials and supplies needed to implement it.

The other key public health interventions of the emergency phase response (water, food, sanitation, shelter and preventive and curative care focused on reducing the incidence of malnutrition, measles, diarrhoeal diseases, malaria, and ARI) are described in detail in other resource materials (see Appendix X—Bibliography).

- From the outset, a designated lead agency should coordinate the assessment, planning and implementation of the response in the emergency phase. (In refugee situations this is usually UNHCR; in conflict or displaced settings it may be WHO or UNICEF or another United Nations agency.)
- One person should be designated to act as the focal point for reproductive health. This person should have a strong commitment to reproductive health, experience of participatory approaches and of emergencies, and awareness of the importance of a gender approach to reproductive health.
- Joint assessments will prevent local officials and community leaders from being swamped with requests for time and information. Joint assessments also enable agencies to develop plans that are compatible and have a more comprehensive view of the needs of the population. Good coordination reduces wastage, when

resources and supply lines are shared by all the organizations involved in the humanitarian response. Coordination also facilitates the development of integrated rather than vertical reproductive health services.

At inter-agency coordination meetings, the reproductive health focal point can advocate with non-health colleagues for the use of a gender approach in needs assessment and for all sectors to take measures to prevent gender-based and sexual violence.

6.2 Community participation

Measures to facilitate community participation in implementing reproductive health during emergencies include:

- involving both married and single women, men and adolescents, from all sectors of the community in the assessment and planning process;
- being sensitive to the people's traditions and culture, and using their formal and informal communication channels to involve the community (particularly women);
- facilitating the establishment of a health consultative group and a women's consultative group to formalize the involvement of members of the community in decision-making. The members of the consultative groups should be nominated by the community (make sure that marginalized groups and adolescents are included).

Every effort must be made to develop programmes based on as much community participation as possible. Such programmes are far more likely to respond to community needs. The principle of community participation should not be discarded just because it is difficult to implement fully. Changing the orientation of programme development to community participation is difficult if the principle has not been accepted from the outset.



6.3 Adapting the Core Package to local needs: assessment and planning

In any emergency situation, a rapid health assessment will be conducted before starting a humanitarian response. The reproductive health checklist that follows (Table 4, overleaf) should be incorporated into any rapid health assessment. The answers to the questions on the checklist will provide the information needed:

- to adapt the Core Package to local circumstances;
- to plan gender and age-sensitive responses to the emergency;
- to establish a baseline for monitoring core reproductive health indicators;
- to lay the foundation for comprehensive services.

Some questions on the checklist will not apply in displaced settings, and some will not

apply in conflict settings. Before conducting the assessment, review the checklist and alter it as necessary to take account of local circumstances.

The assessment team

- There must be a gender balance with at the very least one woman on the assessment team.
- All members of the team should be alert to the need to actively seek out and listen to single and married women and adolescents from the community and to encourage them to express their needs and concerns, which may be quite different from those of the male community leaders.

Marginalized groups

- The team should ensure that marginalized groups are identified and included in the assessment, such as adolescents, orphans and children alone, handicapped and the elderly.

Women as key informants

- The team's key informants should include women as well as men (e.g. birth attendants, female health workers from the community, leaders of women's groups, or official female community leaders). As the primary care providers, women may know far more about the needs for water, sanitation, health and nutrition than male community leaders.
- Special culturally sensitive efforts should be made to meet with women at times and places that are convenient for them.
- Every effort should be made to find female interpreters.
- While women should not be excluded from general meetings, at least one women-only meeting should be held between the female team member(s), a female interpreter, and women from the affected community. Even in the women-only meeting, some women may have difficulty expressing themselves and articulating their needs (particularly in relation to sensitive or taboo issues).

FORMER YUGOSLAVIA

"We went around and asked if there were any problems, and everyone said no. And I said "Wait, let me talk to the women". And the issues came up. No sanitary towels. No proper, private bathing space to wash. Gynaecological problems. No underwear. These were things they had never said. Talking about underwear to a man—of course they had never said it."

IRAQ

"When a few refugees took over food distribution after days of utter confusion, we thought we'd achieved a lot. Later however, UNHCR staff realized that food was not going to families headed by women. Only then did they notice that all the distributors they had appointed were men. The result: malnutrition, exploitation, suffering."

Source: Marshall R. Refugees, feminine plural. Refugees, 1995, 2

Key to sources of information for the reproductive health checklist (Table 4)

CEN	Census/camp registration/demographic survey	PRE	Health records from prior to the emergency or from the country or area of origin
NPS	Non-probability sampling survey (if no census results are available)	HR	Reports from surveillance system if in place; review of records from hospitals and clinics serving the population
NA	Nutrition assessment	IM	Interviews with managers of existing health facilities
VA	Visual assessment of the site	OBS	Observation of health facilities
KI	Interviews with key informants		



Table 4: Reproductive health checklist for emergencies

Question	Source	Use of information in planning
Demographic characteristics		
<ul style="list-style-type: none"> ➤ Total target population (e.g. conflict-affected/refugee/displaced/targeted vulnerable group) disaggregated by age and sex. 	CEN NPS	To calculate quantities of the New Emergency Health Kit, of Clean Delivery Kits, of condoms and of contraceptives.
<ul style="list-style-type: none"> ➤ Vulnerable groups, numbers and characteristics (e.g. lone female heads of households, unaccompanied minors). 	CEN NPS	To identify and target groups with special needs for protection, distribution of materials etc.
Background information on reproductive health		
<ul style="list-style-type: none"> ➤ Beliefs and traditions relating to pregnancy (e.g. food taboos), to childbirth (where deliveries are carried out, who attends), to breastfeeding (including changes in response to emergency). 	KI	To adapt Core Package interventions (e.g. to adapt community education about emergency obstetric referral services to community beliefs and practices;
<ul style="list-style-type: none"> ➤ Beliefs and traditions relating to HIV/AIDS and condom use. 	KI	and to plan where and how to make condoms available.
Nutritional status		
<ul style="list-style-type: none"> ➤ Evidence of malnutrition in children (disaggregated by age and sex), and of micronutrient deficiencies in pregnant and lactating women. 	VA NS	To ensure that rations and supplementary rations reach vulnerable groups, to provide supplementary rations to pregnant and lactating women if indicated;
<ul style="list-style-type: none"> ➤ Traditional foods and methods of food preparation as reported by women (individual or community kitchens, utensils etc.). 	KI	and to plan for the provision of food, utensils for food preparation and arrangements for cooking that are as close as possible to the needs identified by women.
Mortality and morbidity		
<ul style="list-style-type: none"> ➤ Mortality and morbidity rates disaggregated by age and sex, including documented and informal reports of women dying in childbirth, and of neonatal morbidity and mortality. 	HR KI	To plan preventive and curative health care aimed at reducing maternal and neonatal morbidity and mortality; to provide a baseline for monitoring changes in morbidity and mortality;
<ul style="list-style-type: none"> ➤ Documented and informal reports of gender-based and sexual violence. 	HR, KI	and to monitor the incidence of gender-based violence.
<ul style="list-style-type: none"> ➤ Documented and informal reports of complications of unsafe abortion. 	HR, KI	

Social organization

- What are the past and present social structures of the population?
- In refugee/displaced settings, is the population grouped in traditional villages, clans etc. within the camp or settlement?
- What is the status of women? What are the traditional roles and responsibilities of women and men in relation to health care, water, shelter, sanitation and fuel collection?
- What are the preferences of different groups for the location and opening times of reproductive health services? What are the preferences for mechanisms for distribution of food, shelter and relief supplies?
- Are there cultural prohibitions on women's freedom of movement, or on women being attended by a male health worker?
- Are there formal or informal women's groups? How does information pass between women in the community?
- What are the levels of literacy among the population, and among women?
- Which languages are spoken by different groups?

KI

To provide services, community education and distribution of supplies in a way that builds on and takes advantage of existing social structures;

KI
PRE

to develop gender-sensitive reproductive health services and methods of distribution of supplies; to plan location and opening times of the clinic and other services;

KI
PRE

and to identify the most effective ways to disseminate information among different groups in the community, including information on the availability of emergency contraception.

Gender-based and sexual violence

- Do women report feeling safe by day? Do they feel safe by night? Do they feel safe in the surrounding area, when gathering water or fuel, or when using health services?
- What measures do women and men from the community identify to improve general security, and to protect women from gender-based and sexual violence?
- What community structures exist to support unaccompanied women?

KI

To plan the site and delivery of health and non-health services (and in refugee/displaced settings, to plan the camp or settlement), in order to create a safe environment that gives priority to the protection of women;

and to develop strategies for the protection of vulnerable groups and individuals based on community identified solutions.



Question	Source	Use of information in planning
Existing resources: methods of distribution of food and non-food supplies		
<ul style="list-style-type: none"> ➤ If food and non-food supplies are already being distributed, are women involved in the distribution? Are they satisfied with the mechanisms of distribution? 	KI	To plan the most efficient and gender-sensitive mechanisms for distribution of food, shelter and relief supplies;
<ul style="list-style-type: none"> ➤ Do vulnerable and marginalized groups report that food and other supplies are reaching them? 	KI	
<ul style="list-style-type: none"> ➤ Do women and adolescent girls have access to menstrual protection? 	KI	
<ul style="list-style-type: none"> ➤ If not, what inexpensive methods are easily available and acceptable to women? 		
Human resources among the population		
<ul style="list-style-type: none"> ➤ How many health professionals (doctors, nurses, midwives, clinical officers, medical assistants etc.) are there within the community? How many have reproductive health skills (e.g. obstetrics, midwifery, and family planning skills)? 	KI	To plan staff recruitment and training, the organization of health workers in the community and in clinics, and the setting up of a referral system for emergency obstetric care.
<ul style="list-style-type: none"> ➤ Which languages do they speak? 		
<ul style="list-style-type: none"> ➤ Are health workers familiar with universal precautions against HIV/AIDS, or with emergency contraception? 		
<ul style="list-style-type: none"> ➤ How many health professionals are women? 		
<ul style="list-style-type: none"> ➤ How many birth attendants are in the community? What other community health workers are there? How many are men, how many are women? What is their training? Are birth attendants familiar with the Clean Delivery Kit? Are community health workers familiar with STI/AIDS prevention messages? 	KI	
<ul style="list-style-type: none"> ➤ Are there women's groups and women's group leaders, social workers etc. who can help meet reproductive health needs? 	KI	
<ul style="list-style-type: none"> ➤ How many interpreters are there who can assist health personnel who do not speak the language(s) of the community? 	KI	
<ul style="list-style-type: none"> ➤ What are health workers' and birth attendants' preferences with regard to the referral system, the siting of clinics and the reporting mechanisms? 	KI	

Emergency obstetric referral facility

- Is there an existing health facility in the immediate locality or the district which can respond to obstetric emergencies?
- Is there an obstetrician, surgeon, and anaesthetist on duty 24 hours a day?
- Are on-call services for care of complicated deliveries and for obstetric surgery available 24 hours a day?
- Are blood testing and transfusion facilities, water and electricity supplies, and stocks of equipment and medicines adequate?
- Can a communication system be established with the facility?
- How long will it take for a patient to be transported to the facility?
- Is it safe for health workers and patients to travel to the facility by day, and by night?
- If not, can safe passage be negotiated with parties to the conflict?
- Does the facility have the capacity to respond to the increased demand from the displaced population? What forms of material support would be needed to enable the facility to respond to increased demands?

IM,
OBS

In collaboration with managers of local and district health services, to develop a referral system for emergency obstetric care;

and to identify forms of support needed by the referral facility.

If there is no accessible referral facility in the locality, priority consideration must be given to establishing emergency obstetric services to serve the population.

Information on reproductive health prior to displacement/outbreak of conflict

- Strength and coverage of reproductive health programmes (e.g. safe motherhood, family planning, AIDS/STI education, condom use).
- Information on reproductive health related knowledge, attitudes and behaviour in the population (e.g. related to antenatal care, HIV, adolescent sexuality).
- Incidence of reproductive health related morbidity and mortality (e.g. HIV/AIDS/STI, maternal and neonatal mortality, and complications of abortion).

PRE
KI

To provide a baseline against which to compare information gathered during the conflict. Comparison with data from neighbouring countries with similar pre-conflict health indicators can also be used to assess the impact of the conflict on reproductive health.

Note: Ideally, this information should have been gathered as part of the emergency preparedness response (see Section B, Chapter 4).



This chapter describes the process required to organize and deliver the key components of the Core Package.

7.1 Human resources

Staff recruitment and training

- As well as the reproductive health coordinator, the emergency response team should include at least one midwife (or a nurse with midwifery skills).
- Special efforts should be made to employ or train female health workers. Aim for a 50:50 ratio of male to female.
- The competency level of all health workers should be assessed and they should receive training in universal precautions and the procedures they will be expected to undertake.
- Ideally, interpreters should be included in the training given to health workers.
- All relief agency staff should be briefed on the risks to women of gender-based and sexual violence.
- All relief staff should also be briefed on policies in support of breastfeeding in emergencies (Appendix II).
- Even during emergencies, training on reproductive health should include "quality of care" issues such as confidentiality, counselling skills and practice in discussing sexuality, relationships and reproduction.
- High priority must be given to supporting volunteer, local, national and international staff working with traumatized communities in difficult circumstances. This applies particularly to those working with victims of gender-based and sexual violence.

7.2 Service delivery

Clinic- and community-based services

- In consultation with health workers from the community, plan health delivery systems. Organize health workers, including birth attendants, in clinics and in the community.
- From the outset, clinics should be organized so that all primary health care services, including all reproductive health services, are fully integrated.
- If a delivery unit is set up, it must have a clean water source, good sanitation and security both for women from the community and for expatriate/national nurses and doctors on call at night.

Referral services

Setting up a referral service that is open 24 hours, seven days a week, requires:

- agreement and support of local or district hospital personnel and of government officials;
- a midwife and/or doctor on call, arrangements for transport and fuel, arrangements for the security of health workers and patients;
- education of pregnant women, birth attendants and community members in recognizing when to refer (haemorrhage, infection, eclampsia, prolonged/obstructed labour, complications of unsafe abortion);
- in consultation with community leaders, setting up of a system for contacting the referral service and for transporting patients.



7.3 Information, education, communication

During the emergency phase, information, education and communication (IEC) messages related to reproductive health are not intended to bring about change in attitudes or behaviour. Rather they should, in a culturally sensitive manner, remind people of what they already know and inform the community what services are available.

For IEC campaigns to be successful, it is essential to recognize the importance of women's role as informal educators and to make sure that messages targeted at community members reach women as well as men. Information about reproductive health services can be passed to the community through the health consultative group and the women's consultative group, through birth attendants, through megaphone announcements and through radio messages.

Basic IEC messages

Basic IEC messages for the emergency phase will include:

- who the providers of care for pregnant women are and how they can be contacted;
- education for pregnant women, birth attendants, community members and families in recognizing and referring emergencies (haemorrhage, infection, eclampsia, prolonged/obstructed labour, complications of unsafe abortion);
- how to access referral services;
- (for health workers) universal precautions against HIV;
- the importance of breastfeeding;
- information about emergency contraception and where it is available (possibly through women-only meetings);
- where condoms are available;
- the need for blood donors, and procedures for donations.

7.4 Management of supplies

WHO's New Emergency Health Kit supplementary unit provides the medicines and supplies needed to implement the Core Package for a population of 10,000 for three months. Condoms, contraceptives and Clean Delivery Kits are not included. These can be obtained from UNFPA Reproductive Health Kits.

Demographic information gathered as part of the rapid assessment, along with data gathered through the health information system, should enable an order to be placed for medicines and supplies for the second three-month period.

7.5 Prevention of gender-based and sexual violence

Strategies to prevent gender-based and sexual violence must be incorporated into the planning of **all** programmes from the earliest days of an emergency. The focal point for reproductive health has a key role in advocacy with colleagues in other sectors for attention to be paid to the following:

Create gender-sensitive management and administration structures

- Include women from the community in all decision-making. Prioritize protection of women against gender-based and sexual violence in all programme planning. As far as possible ensure that women retain control of traditional areas of responsibility (e.g. water, food, sanitation).
- Consult with women in planning distribution of food, water, shelter materials and firewood. Ensure that women can receive all forms of assistance independently. Make sure they are not forced to offer sex in exchange for rations, other forms of assistance, or physical protection. Ensure that lone women heads of households and

other vulnerable groups receive supplies and assistance.

- Consider distributing directly to women rather than through male heads of households. Consider having distribution administered by women (note, however, that this can be counterproductive; in some settings, women chosen to distribute items have themselves become subject to intimidation and attack).
- If community members are required to register for any form of assistance, ensure that women are registered as individuals. Make sure they have full documentation and direct access to all forms of assistance.
- Recruit female staff for sensitive positions (e.g. protection officers, medical officers, interpreters, and security staff).

Prioritize conflict reduction and resolution

Efforts to reduce the level of conflict within and between communities may help to reduce the overall level of violence, including gender-based and sexual violence. In particular, the way in which humanitarian aid is delivered can reduce or exacerbate tensions. Measures to reduce conflict include:

- establishing forums for conflict resolution between different factions in the community;
- in refugee/displaced settings, giving priority to assistance for and dialogue with local (host country) communities to avoid jealousies and hostility developing towards the refugee/displaced community;
- ensuring equity in service distribution;
- being culturally sensitive and not imposing ideologies, practices or beliefs.

Plan site and layout to provide maximum safety and protection

- Avoid establishing camps close to the border of the country of origin, or in areas that are unsafe (e.g. subject to banditry).
- Site latrines and washing facilities so that women do not have to walk to isolated areas, especially at night. Provide lighting if possible. Explore ways to reduce risks to women when gathering firewood or water, or when working on the land. Provide security patrols by day and night, preferably with female security officers.
- Replicate the community's preferred physical and social organization and conserve original communities from the country of origin. Avoid unrelated families having to share communal living and sleeping space. Provide secure accommodation for vulnerable persons (e.g. unaccompanied women and girls, lone female heads of households).

Advocate at national and international levels

Preventing acts of gender-based and sexual violence during armed conflict and displacement largely depends on creating an environment in which these acts are seen as unacceptable. At national and international levels, there is a need:

- to advocate for greater awareness of the risks of gender-based and sexual violence in times of conflict, and of gender-based and sexual violence as a human rights violation;
- to press for warring parties to recognize international conventions on the protection of civilians in war time;
- to maintain an international presence as a deterrent to human rights violations, not



only for refugees but also in settings of conflict and displacement;

- to monitor, document and report human rights violations;
- to create precedents for the punishment of perpetrators of these crimes.

7.6 Monitoring and evaluation

As soon as health services are established, a system for monitoring the health of the community and the services being provided should be put in place. Monitoring of reproductive health needs to be fully integrated within this monitoring system.

The following is the minimum reproductive health related information that should be collected during the emergency phase (all health information should be disaggregated by age and sex):

- numbers of live births;
- neonatal mortality rate;
- "women dying in childbirth";
- incidence of rape, both suspected and confirmed (suspected and confirmed cases of rape should be recorded from the first days of an emergency in order to facilitate future planning, even if there is no time for individual follow-up during the emergency phase);
- consumption of medicines and supplies from the New Emergency Health Kit, and also of condoms, Clean Delivery Kits and contraceptives.

Sources of information

- A reporting system should be established within clinics and hospitals. Reporting on reproductive health should be integrated in the general health information system.
- Birth attendants and community health workers should report on births, deaths and

incidences of gender-based and sexual violence in the community.

- Information on deaths should be gathered from gravediggers, undertakers and makers of shrouds and coffins. "Women dying in childbirth" and neonatal deaths should be included as categories of deaths. (A more sophisticated surveillance system needs to be developed to measure true maternal mortality.)

CONFLICT REDUCTION IN REFUGEE AND DISPLACED SETTINGS

On the basis of experience working in situations of conflict, the International Federation of Red Cross and Red Crescent Societies has highlighted five ways to reduce tension and to improve security for aid workers in refugee and displaced relief operations.

- **Open and continuous dialogue with the beneficiary community.** When agencies take time to explain clearly what they are doing, how the aid system works and what refugees will get, problems of confrontation and misunderstanding decline.
- **True partnership with host-country and refugee nationals in relief operations.** Where local people are involved as equals alongside foreign relief workers, there is much less tension.
- **Experienced and older staff.** Age makes a difference. With age comes experience and a more cautious attitude towards unnecessary risk. Community leaders tend to trust older people more.
- **Committed long-term agenda.** Agencies that demonstrate commitment to the refugees and plan for long-term involvement gain the trust of the people more easily than those that leave once the first flood of funding dies down.
- **Clear humanitarian agenda.** It is hard to separate humanitarian issues from political and military ones, particularly in the minds of those who have suffered at the hands of political and military forces. Agencies that keep to a clear and open humanitarian agenda are less likely to be targeted with violence than those with a broader mandate.

Source: World Disasters Report, IFRCRC, Geneva, 1995

This chapter gives an overview of the complexities of providing interventions in armed conflict settings and summarizes the impact of armed conflict on reproductive health needs and services. The chapter then examines the issues involved in coordinating reproductive health activities, developing community participation, gathering information, planning programmes and delivering services during armed conflict. It also describes the concept of health as a "bridge to peace".

8.1 The complexities of providing interventions

Given the many disadvantages associated with displacement and particularly with large camps, donors and relief agencies have been more willing in recent years to provide assistance to people remaining within areas of conflict. It is therefore increasingly important to address the reproductive health needs of these populations.

Because of the diversity of situations that may be called "armed conflict", it is not possible to describe a single package of reproductive health interventions for all conflict settings. In some settings, the Core Package of interventions described in Section B, Chapter 5 may be as much as is possible to aim for, given the intensity of the conflict, the level of destruction or the inaccessibility of the population.

However, some conflicts are low-grade and extremely protracted, sometimes lasting for decades. In this kind of conflict there may be prolonged periods of relative stability. In such situations, it may be possible to move towards more comprehensive services. Management responses will need to be creative and flexible: the services that can be provided and the ways in which this can be done will change over time and from area to area within a country or locality.

When the opportunities for provision of reproductive health services are limited by armed conflict, the greatest impact on reproductive health needs may sometimes be achieved

through "health-supporting activities" rather than through explicit reproductive health interventions. Examples of health-supporting activities include economic support and income-generation programmes, gender-sensitive programme design and implementation, and provision of health-supporting goods and services (e.g. shelter, food, water, sanitation).

Development approaches during conflict

"The high profile disaster relief programme—with its dramatic public appeal, rapid assessment and special funding procedure—conveys the unspoken message that the appropriate NGO response to conflict is an emergency programme. Despite many years of war, such palliative, "short-term" emergency projects still account for the greater part of NGO response to conflict in Ethiopia, Sudan, Uganda, Angola and Mozambique."

Source: Agerbak L.
*Breaking the cycle of violence:
doing development in
situations of conflict.*
Development in Practice, 1991,
1:151-158

The protracted nature of armed conflict requires a flexible response that is a combination of relief and development approaches: to remain in an emergency mode of response throughout a prolonged conflict can result in needs not being met, local capacity being undermined and even the conflict being made worse. The situation of women and marginalized groups may be made worse by such an approach.

An approach needs to be adopted whereby opportunities for capacity-building, self-reliance, community participation, peace-building, training and skills transfer etc. are actively sought out and developed, even during the early days of a conflict or during periods of intense violence. Supporting survival strategies and using health as a bridge to peace are essential components of a strategy of "development in conflict".



Table 5: Impact of armed conflict on reproductive health needs

Impact on health in general

- Loss of harvests, animals, seeds; scorched earth policies; malnutrition, micronutrient deficiencies.
- Injuries and fatalities associated with warfare; landmine injuries.
- Spread of communicable diseases. Reappearance of previously controlled diseases (e.g. malaria).
- Massive mental trauma and psychosomatic disorders, stress-related diseases.

Safe motherhood, breastfeeding, emergency obstetrics

- Pregnant women vulnerable to poor food, water, sanitation.
- Breakdown in programmes of vaccination for women and children.
- Possible increased incidence of pregnancy complications. Pregnant women unable to travel to referral facilities for emergency obstetric care; increased maternal and neonatal mortality; increased numbers of orphans.
- Resurgence of harmful birth practices with breakdown in health services.
- Breastfeeding problems due to stress, malnutrition and breakdown in support systems.
- Previously safe bottle-feeding practices become unsafe as water supply and sanitation deteriorate.
- Hypothermia of newborns in cold climates.
- Unwanted/abandoned babies/infanticide as a result of rape. Neglect of children by mothers who have been traumatized.

STI/HIV/AIDS

- Increased mobility of civilian population and of military.
- Increased number of sexual partners, and of unprotected sexual activity. Increased incidence of rape, forced prostitution, prostitution for economic survival.
- Development of fatalistic attitude towards HIV/AIDS, particularly among adolescents.
- Neglect of people with AIDS, increasing numbers of AIDS orphans.

Gender-based and sexual violence

- Mass rape, rape camps, military sexual slavery, forced prostitution, forced "marriages", forced pregnancies. Multiple rapes, gang rape, rape of young girls.
- STI/HIV/AIDS, mutilation or damage to the genitals, miscarriage. Violent physical assault and injuries, death.
- Psychological impacts, social ostracism, unwanted pregnancy, unsafe abortion, abandoned children, infanticide, neglect/stigmatization of children born as a result of rape.
- Resurgence of female genital mutilation and other harmful traditional practices to reinforce cultural identity.
- Women forced to offer sex in exchange for food, protection, shelter etc.
- Continuing/increased incidence of domestic violence.
- Rape, castration and other forms of sexual violence against men and boys.
- Victims of sexual violence unable or unwilling to seek assistance.

Family planning

- Women's/couples' desire to postpone pregnancy because of insecurity and fear.
- Desire for shift to methods requiring fewer clinic visits.
- Societal pressure on women (or desire of women themselves) to reproduce in order to replace lost family members.

Social changes impacting on reproductive health

- Increased burdens on women as carers. Increased numbers of orphans and unaccompanied children.
- Massive psychological trauma. Lack of safe and supportive environment for emotional healing. Long-term negative impact on reconciliation and community reconstruction.
- Militarization of society. Aggressive masculinity valued and inculcated in soldiers, including child and adolescent soldiers.
- Changing gender roles. Changing norms in relation to sexuality, marriage.
- Breakdown of extended family and community networks of support. Breakdown in traditional forms of guidance for adolescents.

Table 6: Impact of armed conflict on reproductive health services

Health-supporting/social infrastructure

- Disruption in supplies of clean water, adequate food, electricity, heating fuel.
- Sanitation and vector control disrupted.
- Breakdown in local government, community self-policing, protection against gender-based and sexual violence.
- Transport (roads, vehicles, fuel) disrupted, destroyed or diverted to military use.

Health service infrastructure

- Neglect, destruction or looting of hospitals and health centres, medicines, equipment and supplies (health services may be specifically targeted).
- Lines of communication and referral disrupted.
- Staff may be threatened or killed.
- Disruption in supply of medicines, delivery kits, contraceptives, condoms, equipment, and spare parts.
- Health information systems break down. Data on needs not available for planning.

Health policy

- Public funds diverted towards defence and away from reproductive health. Health resources diverted to care of military and war-wounded.
- Breakdown in central government policy-making, coordination, regulation of NGOs. Verticalization of reproductive health services. Increased dependency on aid, increased donor control of policy.
- Breakdown in channels for community participation in planning and policy-making.
- Coercive policies aimed at increasing or decreasing the populations of specific groups.
- Perception (by health workers, managers, policy-makers) of reproductive health care as low priority need during conflict.
- Gender-blind emergency responses increase women's vulnerabilities.

Health service activities

- Conflict, landmines and curfews limit community access to health centres and referral facilities, including emergency obstetric facilities.
- Breakdown in diagnosis and care of complications of pregnancy.
- Health workers unable to stay overnight in hospital/delivery unit to provide 24-hour emergency obstetric referral service.
- Curative care emphasized over preventive care. Shift from public to unregulated private sector health care. Urbanization of health services. Increased costs to users due to transport costs, privatization of care etc.
- Health programmes (e.g. health education, antenatal care, immunization, community-based distribution, contact tracing, partner notification) disrupted.
- Diversion of hospital beds, surgical and laboratory facilities to the care of combatants.
- Possible increase in incidence of complications of unsafe abortion due to breakdown in family planning services.
- Decline in quality of care (e.g. due to lack of time and privacy for consultations and client education, and lack of adequate referral service for complications). Diminished attention to groups with special needs (e.g. adolescents).
- Breakdown in standards for HIV-testing for blood transfusion. Lack of adherence to universal precautions during emergencies.
- Health workers inexperienced in responding to new reproductive health needs associated with conflict (e.g. physical and mental health needs of female and male victims of gender-based and sexual violence). Health workers inexperienced in dealing with complications of pregnancy without adequate referral service backup, or in recognizing and treating new or previously rare conditions (e.g. malnutrition, anaemia, malaria, neonatal tetanus).
- Taboos surrounding gender-based and sexual violence impede development of appropriate response.

Human resources

- Health workers displaced, injured or killed (may be targeted).
- Remaining health workers demoralized, without adequate support, supervision or payment. Training disrupted.
- Conflict, landmines, curfews etc. limit access of health workers to the community.
- Shortage of midwives, obstetricians, anaesthetists and paediatricians for emergency obstetric and neonatal care.
- Difficulty attracting health workers to peripheral/conflict zones.
- Increasing reliance on international health staff (who may be evacuated from conflict zones at short notice).



PALESTINE

"(Some) felt that to wait for the end of the occupation was a prescription for further stagnation and paralysis: the task was to get on and develop their own society despite the occupation ... It was women who mobilized first ... They started projects in progressive pre-school education, income generating activities and training in management and decision-making."

Source: Longland T.
*Development in conflict situations:
The occupied territories.*
Community Development Journal,
1994, 29(2):135

8.2 The impact of armed conflict on reproductive health and on gender relations

Tables 5 and 6 are compiled from currently available information on the impact of conflict on health and reproductive health in a variety of conflict settings. Table 5 summarizes some of the possible impacts of armed conflict on individual and community reproductive health needs, while Table 6 looks at impacts on the health-supporting infrastructure, on health policy, on human resources and on reproductive health service activities.

8.3 Coordination of response during armed conflict

During armed conflict there are often many organizations offering humanitarian assistance in a situation of decreased regulation. While there may be a functioning government or *de facto* government with varying capacity to coordinate and regulate activities, in some conflict settings the structures of government may have disintegrated entirely. Where this is the case, humanitarian organizations must coordinate their own activities in order to avoid duplication, waste and neglect. This can be done

either through an UN-mandated body with responsibility for coordination of assistance or through a consortium of NGOs, as in the example concerning Ghana.

A lead reproductive health organization should be designated, with responsibility for coordinating the activities of different organizations. It should also ensure that the various reproductive health activities are integrated with each other and with other elements of health service delivery. In particular, it should identify mechanisms by which interventions to meet reproductive health needs can be incorporated with other interventions. For example, "days of peace" (see 8.8) for the immunization of children can be used as an opportunity to immunize pregnant women, to distribute Clean Delivery Kits to pregnant women and to resupply birth attendants and community midwives.

8.4 Community participation

Armed conflict presents major challenges to community participation in programme design. Communities may simply be inaccessible because of high-intensity violence, military groups may silence dissenting voices, and the need for speed may seem to override the need for consultation. Women can be particularly disadvantaged in this situation. The importance of using a participatory approach from the first days of the emergency response was explained in Section A, Chapter 3.

Consulting with groups outside the military leadership (e.g. women's groups, elders etc.) can have the double advantage of ensuring that responses meet real needs while also strengthening the position of non-military elements within the community. Conflict can also create opportunities for improved community participation in programme planning. When outsiders can no longer travel to field sites to "deliver" services, the initiative for implementing appropriate responses can return to the community.

Supporting individual and community coping and survival strategies

Supporting individual and community coping and survival strategies becomes critical during armed conflict. It empowers communities by building on their strengths, and it can also make communities less dependent on outside inputs for survival. While some of the strategies listed below also apply at other times, it is during periods of armed conflict that they may be most critical.

Some of the ways by which reproductive health can be supported indirectly include:

- support for families and communities to remain in their home areas during conflict, avoiding displacement which cuts people off from customary economic survival strategies, health care and community support;
- support for families and clans to remain together as much as possible so that women and girls are not left without male support and protection against violence;
- income-generation programmes targeted at women in order to increase their access to and control of reproductive health resources, including their capacity to pay for contraceptives and their bargaining power within relationships;
- a gender-sensitive approach in all programmes to ensure that women, girls and marginalized groups are not disadvantaged by the way assistance is delivered.

Other more direct ways of supporting individuals and communities to protect their own reproductive health during armed conflict include:

- identifying and supporting existing structures of service delivery;
- identifying and supporting strategies for self-care during conflict (e.g. if contraceptives, condoms and antibiotics are

GHANA

"Responding to relief and rehabilitation in the conflict area became a huge task for any one NGO, and so a consortium of NGOs was formed to pull all resources together from various NGOs in Ghana. For each sector, such as agriculture or peace initiatives, one NGO was identified as the lead agency. The consortium also offered protection against accusations of partisanship and created a strong voice for lobbying government."

Source: Purganosa B. quoted in Oxfam's Work in conflict situations: workshop report, Birmingham, Jan 29 - Feb. 2, 1996. Oxford, Oxfam, 1996

- bought through private "pharmacies", traders can be trained in their appropriate use, and these outlets can be used for community education);
- identifying health workers with training in clean delivery, obstetric first aid and emergency obstetric care; support with materials and supplies and provide additional training as needed;
- providing all pregnant women with clean delivery kits and teaching them how to use them; With health workers from the community, identifying other responses to reproductive health needs which can be delivered through existing community resources;
- identifying and supporting, through indigenous women's groups, ways in which women traditionally protect themselves against different forms of gender-based violence;
- supporting women or couples who wish to avoid pregnancy during periods of danger and instability by identifying, with women and men in the community, methods for distributing contraceptives that ensure maximum accessibility during conflict (e.g. through community health workers/volunteers, through women's groups and through private commercial outlets);



- identifying, in a similar way, outlets for condom distribution and STI/HIV/AIDS prevention messages;
- establishing with indigenous women's groups links with international women's groups in order to provide protection, publicity, and material and moral support;
- providing advocacy at local, national and international levels for greater awareness of the risks of sexual violence in times of conflict, and of sexual violence as a human rights violation.

8.5 Information gathering during armed conflict

During armed conflict, there are particular challenges to information gathering. These include:

- Peacetime systems for information gathering, analysis, policy-making, planning and coordination of response may disintegrate.
- There may be poor coordination and communication between humanitarian organizations.
- Pre-conflict data on reproductive health may be lacking.
- There may be a tendency to delay consideration of gender issues until after the emergency has passed. This may be combined with blindness to reproductive health issues, such as gender-based violence and family planning needs.
- It may be difficult to estimate population denominators for morbidity and mortality data where there are mass displacements and in-flows of population.
- The changing nature of armed conflict, with periodic exacerbations and remissions, requires constant monitoring of affected populations to ensure appropriate responses.
- Difficulties in access, the need for speed of response and the disruption in routine

methods of data collection can mean that compromises in scientific rigour have to be made.

- Data on the impact of armed conflict and on the scale of human rights abuses, including rape during wartime, are frequently manipulated for political ends by the various parties to the conflict.
- Humanitarian organizations may feel compelled to respond to needs identified by the media without first conducting their own assessment to identify the true needs and priorities among different population groups.
- Health workers and programme managers may be greatly overextended. There may be a lack of trained personnel to gather information; volunteer workers carrying out assessment, monitoring and evaluation activities will need intensive training, supervision and support.
- Staff may be put at risk by the process of information gathering, particularly if they are identified with one of the parties to the conflict.

Strategies for meeting the challenges

Assessment methods need to be devised that provide sufficiently valid data in order to initiate relief activities. The basic principles that apply are:

- information gathering by multidisciplinary teams;
- gender awareness on the part of all assessment team members;
- the use of women as assessors and as key informants;
- the use of a combination of qualitative and quantitative assessment methods (i.e. observation, review of existing documents and records, and key informant interviews);
- the use of triangulation (i.e. cross-checking of data to confirm accuracy of information).

During armed conflict, consideration also needs to be given to the following:

- Assessment, monitoring and evaluation should be led by members of the community or by organizations or groups with a knowledge of the community from the pre-conflict era, and with an understanding of the roots of the conflict.
- Ideally, a coordinated assessment of all communities within a conflict-affected region or country should be carried out simultaneously using standardized assessment tools. Information gathered should be shared between organizations and there should be a coordinated analysis of results and targeting of worst affected communities within a country or region.
- Where not all communities can be reached, a limited number of representative sentinel sites may have to be chosen to represent a region or population group. However, data based on small numbers need cautious interpretation. Care must be taken in generalizing beyond the study setting itself. Whatever method is used, it is important to ensure that marginalized groups, particularly

groups that are out of favour with the government or ruling group, are not neglected.

- Assessment and monitoring of programme impact should be ongoing. Key indicators should be selected for monitoring and evaluation of the impact of reproductive health programmes. Clear criteria should be established at the outset for terminating or continuing involvement.
- Good systems of communication should be established for rapid analysis and dissemination of information to all parties. Ideally, a coordinated countrywide health information system should be established which could be maintained in the aftermath of the conflict and which will provide information of use in the post-conflict reconstruction period.
- Careful selection of key informants and triangulation are vitally important to offset the tendency to bias and manipulation of data during armed conflict.

What information to collect

The depth of assessment of reproductive health needs that can be carried out during armed conflict will depend on the time and human resources available and the access to communities. In a more stable situation (e.g. during a low-grade, protracted conflict), it may be possible to conduct a more in-depth assessment, closer to that described in Section C, Chapter 10. Before conducting an assessment it is important to search for existing information which may have been gathered prior to the conflict or by other agencies.

Specific issues that need to be addressed in armed conflict settings will include:

- **What reproductive health needs have been created by the conflict?** It is important to differentiate between the impact of the conflict on reproductive health and chronic needs that existed prior to the conflict. In the first instance, assistance will need to be targeted at meeting needs created by the

"Data on war-related health damage are highly political. As a result, each party to the conflict has its own reasons for collecting and presenting figures in a particular way. This virtually guarantees that many of the data published are highly biased—in some cases to assert that fewer injuries and deaths occurred than in reality, in others to assert the opposite. It is crucial to understand where the data come from and how the estimates were arrived at in order to build an accurate picture of what has occurred. Triangulating data of different sorts, from different sources, may be required to build an accurate estimate of true experience."

*Source: Zwi AB.
Numbering the dead:
counting the casualties of war.
In: Bradby H. (ed.) Defining
violence. Aldershot, Avebury, 1996*



conflict. During protracted conflicts it may be appropriate to begin to address chronic unmet needs.

- **What information is available on reproductive health from the pre-conflict period?**
- **What were the pre-existing levels of knowledge (on the part of health workers and community members) about different aspects of reproductive health?** Pre-conflict levels of knowledge will limit what services can be provided if opportunities for community education are limited.
- **How has the conflict affected health services and health infrastructure?** How has the physical infrastructure (roads, health centres, referral facilities) been affected by the conflict? Are services accessible? How have health information and management systems been affected? What health workers are still working or available to work in the community? Are any community outreach services still functioning? What resources and capacities exist among community members? What are the coping and survival strategies employed within the community? Is outside assistance already reaching the community? What forms does this take?
- **How has the community changed as a result of the conflict?** Have there been major displacements or influxes of populations? Have there been increases in numbers of unaccompanied women and children, unaccompanied minors, widows and disabled? Have there been shifts in the centres of power and decision-making within the community? Are there groups with a stake in peace-building whose position might be strengthened by being used as a channel for assistance?
- **What are the reproductive health needs of combatants (including boy soldiers)?** Is it possible to find a way to provide education about STI/HIV/AIDS, to provide condoms and to treat STIs among this group without compromising neutrality?

Using the information

As well as assisting in programme planning, data collected during armed conflict have important uses in drawing attention to the human cost of war (e.g. in terms of increased maternal and neonatal mortality) and to human rights violations, including gender-related violations. This information can become a powerful advocacy tool in peace negotiations, in negotiating limits on fighting (e.g. zones of peace), and in seeking agreement from warring parties to international conventions on the protection of civilians and on the protection of the rights of women and children.

Data can also serve to draw international attention and support (including financial support) to the plight of civilians caught in armed conflict. The power of such international support was seen during the war in the former Yugoslavia where the solidarity of women's groups in other countries moved beyond humanitarian and emergency assistance and into the area of women's rights.

8.6 Planning

In planning responses to meet reproductive health needs during armed conflict, management strategies need to be developed that take into account the fast-changing and unpredictable nature of conflict settings:

"Visible inputs may serve to attract violence if opposing forces seek to control more resources, perhaps through looting and/or aiming to undermine their opponent's attempts to gain legitimacy through development ... Communities (need to be) involved in discussions regarding alternative inputs and ... encouraged to voice their perception of risk."

*Source: Macrae J et al.
A healthy peace? Rehabilitation and development
of the health sector
in a "post"-conflict situation:
the case of Uganda.
London School of Hygiene and Tropical
Medicine, 1995, p. 64*

- Goals and expectations should be realistic, and organizations need to be flexible, recognizing the need for a certain amount of "learning by error".
- Systems must be developed that allow for a rapid response to changing needs. Authority for decision-making should be decentralized as much as possible and field staff need to be actively supported in decision-making by headquarters.
- Excellent communication systems should be established, and communications protocols must be clearly defined.
- A willingness to share with and learn from experiences of other organizations is essential in order to avoid repeating mistakes and wasting resources.
- Outside agencies should weigh carefully whether or not to become involved in a conflict setting in the first place. The cost of emergency inputs is often enormous and the impact can be small. There must be clear criteria for terminating or continuing involvement.
- The process of negotiating with warring parties for safe passage and for programme approval can raise issues about neutrality and impartiality. Each organization should define its own position clearly and keep field staff fully informed about what is expected of them.
- Clear guidelines and procedures for staff security should be established with the host government and, where possible, with insurgent groups. This will usually be coordinated by a United Nations body.
- If any of the warring parties is opposed to any component of a reproductive health programme (e.g. family planning services) the risks to staff must be carefully assessed.
- There should be an early shift from an emergency orientation to long-term development-oriented planning.

Identifying priorities, selecting best strategies

The following questions should be asked as part of the process of identifying priorities during armed conflict:

- What **security risks** accompany the proposed interventions? The risks to community members and to local, national and international staff need to be evaluated.
- Are the proposed interventions and the manner in which they will be delivered likely to **strengthen or undermine individual and community coping and survival strategies**?
- Are the proposed interventions and the manner in which they will be delivered likely to **reduce or to exacerbate the underlying causes of conflict**?
- Are the proposed interventions **sustainable** if outside inputs are withdrawn (e.g. evacuation of international staff)? Can strategies be selected to ensure maximum independence from outside assistance in the shortest possible time?
- Can an acceptable level of **quality of care** be assured? Even during armed conflict, the uptake of reproductive health services will depend to a degree on client satisfaction with the way services are provided. If the quality of care is so low as to make services unacceptable, resources will be wasted.

8.7 Service delivery

In conflict settings, it is better to identify and support existing structures for health service delivery rather than set up new ones. These structures may include government-run health services, and health services run by rebel governments, as well as structures for local government, women's groups and community groups. Assessment of available options for service delivery should include an assessment of security for both health workers and patients, as well as of the facility itself and of its capacity.



Programmes should be developed in ways that make them as independent of outside inputs as possible. Training of local staff in management of services should be given priority. Rapid or modular training programmes may need to be devised or adapted from existing resources. Negotiated periods or zones of tranquillity can be used to conduct training courses. Training can also be planned to coincide with natural periods of tranquillity, such as an annual rainy season that causes fighting to cease.

8.8 Health as a bridge to peace

Negotiations on health can provide a "neutral ground" where warring parties can meet. The process of negotiation can foster links between the warring parties and may contribute to a climate of negotiation on non-health issues. Organizations involved in meeting the health and reproductive health needs of conflict-affected communities may be able to maximize opportunities for such negotiations.

It is imperative that a very clear agenda is developed in advance of negotiations on health, and that discussions remain focused on technical issues. If the focus is allowed to shift towards non-health issues, the neutral space created by health is lost. Thus, in order to be successful as a bridge to peace, the aim of negotiations must remain firmly focused on improving the health of the communities affected by the conflict.

A word of caution is necessary concerning reproductive health and "health as a bridge to peace" initiatives. Some aspects of reproductive health may present difficulties for one or more parties to a conflict. There may be moral or religious objections (e.g. to family planning or to condom use). In particular, family planning can become a political issue during armed conflict, when it may be seen as a method of population control. Likewise, discussion of violence, including gender-based and sexual violence, can become highly politicized. If this is the case, the negotiations are more likely to be drawn away from technical considerations.

For this reason, aspects of reproductive health, which are broadly agreed upon, should be chosen for negotiations involving different parties to the conflict. Measures to promote safe motherhood or to support breastfeeding are usually (though not always) less contentious.

Reproductive health can also lend itself to collaborative efforts between women's groups from opposite sides of the conflict. It may be possible to establish links between these groups, although it may still be necessary to negotiate with military authorities so that women's groups can meet together safely.

Supporting groups with a stake in peace-building

In developing health initiatives, dialogue should be sought with groups and organizations committed to negotiation and cooperation. Their involvement in health issues

NICARAGUA

"The war paradoxically led to some positive changes in the health system. Among these were more efficient use of resources, better organization, priority setting, and increased administrative decentralisation ... Health facilities and health workers were targeted by the Contras. Construction of health posts in many outlying areas ceased because of the danger to construction workers and the inability to defend the posts from attack. Still, construction of some new hospitals, health centres and health posts continued in some areas under attack. These facilities were usually located in areas close to main roads and therefore defensible, and formed the backbone of the new health system in these areas ... Where a doctor-centred medical system was not possible due to the war, the system of rural health volunteers became more important than ever before. It was only the brigidistas (community health workers), with backup from technicians and professionals in the rural primary health network, who could provide ongoing assistance in war-affected areas."

Source: Garfield RM.
War related changes in health and health services in Nicaragua.
Social Science and Medicine, 1989,
28(7):669-696

HEALTH AS A BRIDGE TO PEACE INITIATIVES

- The "Health: A Bridge for Peace" initiative developed by the ministries of health in Central America during the 1980s, with the support of the Pan American Health Organization, involved common health planning and implementation, and was a significant force in reducing conflict in the area.
- In the Measurement for Peace initiative in Liberia, the same problems were studied by health workers on both sides of the conflict, using the same methodology and a common framework for analysing data and identifying priorities.
- In the 1980s the idea emerged of children as a "conflict-free zone", i.e. children should be protected from harm and provided with the essential services to ensure their survival and well being. Since 1983, several "corridors of peace" have been negotiated in the midst of a number of bloody conflicts. The first occasion was in El Salvador in 1985 when the government and the rebels agreed to stop fighting for three "days of tranquillity" in three consecutive months, during which 20,000 health workers immunized 250,000 children. This process was repeated every year until the end of the war six years later. Similar principles have been applied in Uganda (1980), Lebanon (1987) and Afghanistan (1988-1989). In Sudan, eight "corridors" of relief were created in 1989, allowing more than 100,000 metric tons of food and 4000 tons of medical supplies to be delivered and 90,000 children to be immunized in the war area.

can strengthen the power and status of these organizations within communities. Seeking out the opinions of women, elders and others who have a stake in peace-building can increase their influence and begin to counter the militarization of society.

Non-discrimination

A strict policy of non-discrimination in the provision of health services can reduce tensions created by inequality and can foster communication and interaction between members of different communities using the health services. Donor bodies and international organizations can also support equality and justice by making aid conditional on a policy of non-discrimination.

Armed conflict: special considerations

Witnessing for peace

Health workers in conflict zones can play a powerful role as witnesses for peace. However, such a role can also place them in great danger. This said, the presence of international staff in conflict zones can serve a powerful "witness function", reassuring beleaguered populations that they have not been forgotten, and possibly restraining warring parties from perpetrating human rights abuses. The activities of health workers in documenting the health impact of armed conflict can be a powerful tool for advocacy with warring parties and can mobilize international pressure to end the conflict. However, the safety of staff must remain paramount.

Conflict reduction versus conflict exacerbation

During armed conflict, no intervention can be considered neutral. In some way, every intervention will either contribute towards the building of peace or exacerbate the level of conflict. Every proposed intervention must be assessed from this perspective, based on a deep

"Relief can prolong wars by providing material assistance, directly or indirectly to the army or other forces controlling a particular area, by directly providing food, or other assistance to armies or tolerating diversion of resources by providing income, renting vehicles, premises or staff and by paying fees and taxes. Strategic protection is also provided when the military or political objectives of the controlling authority coincide with the logistical requirements of the humanitarian operation, such as keeping roads, airfields and ports open, maintaining supplies to garrison towns-cum-relief shelters."

*Source: African rights, 1994, pp. 4, 13
In: Byrne B.
Gender, conflict and development,
Vol. 1: Overview.
Brighton, Institute of
Development Studies, 1995*



understanding of the community, the culture and the roots of the conflict. There is no simple solution, but the fundamental principle must always be to do good rather than harm.

This chapter describes the comprehensive reproductive health services that should be established as the situation stabilizes. The delivery of services should be in accord with the guiding principles laid out in Section A and prioritized according to need and resources. Section C can also be applied to the provision of comprehensive reproductive health services during protracted low-grade conflict.

During the stabilization phase of a refugee or displacement setting, mortality rates begin to decline as curative and preventative health care services are established. Among refugee women, fertility rates may begin to exceed traditional birth rates prior to flight. STIs and HIV/AIDS may become significant in morbidity statistics as other epidemic diseases are brought under control. High-risk sexual behaviours may increase, as family and social networks break down. The number of women with complications of unsafe abortion and the number of abandoned babies may be high, especially if rape was common during the earlier phases. Harmful traditional practices such as female genital mutilation may be resumed to try to re-enforce cultural identity.

The transition from emergency phase to stabilization phase will not be clearly defined. However, as a general rule, the situation can be described as stable when:

- there are no longer major health problems such as severe malnutrition or epidemics;
- mortality rates have declined to less than 1-2/10,000 per day;
- the population is relatively stable without large influxes of very sick or malnourished people needing special care.

9.1 Comprehensive reproductive health services

What is meant by "comprehensive" services will vary around the world. The standard of care aimed for should be at the level of care available

within the host country or region. Table 7 describes a level of services that would be appropriate in most resource-poor settings. This table can be adapted so that it is in line with local needs, local resources and local standards of care.

The table is intended to be used as an aid in programme planning. It is based on the WHO publication *Care of mother and baby at the health centre: a practical guide* and on *Reproductive health in refugee situations—an inter-agency field manual*, which describes in detail the components of reproductive health to be delivered in stable refugee settings. These resource materials should be referred to for further details on each of these programme components. The relevant technical guidelines for the implementation of the activities listed here are included in the Appendix X—Bibliography.

9.2 Coordination

A special feature of refugee and displacement settings is the number and variety of local, national and international agencies and non-governmental organizations (NGOs) that may be involved in the response. In addition, there is a tendency in the area of reproductive health towards "vertical" programmes and multiple service providers (e.g. with family planning, maternal/child health and STI treatment programmes planned and implemented independently of each other).

Coordination and cooperation between the multiple partners involved in reproductive health service provision is essential to avoid unnecessary duplication of efforts and waste of resources, and to ensure that all partners are working towards common goals. Coordination needs to be fostered in a number of areas:

- with the host country government and NGOs;
- between the various international and NGOs providing health services to the refugee or displaced population;



- between the health sector and other sectors;
- between outside service providers and the administrative structures within the refugee population.

Coordination with the host country

Reproductive health services for the refugee/displaced population should be rooted in the structures and practices of the host country, and must be within the law of the host country. The aim should be to provide a sustainable level of care that is appropriate to local standards. Where the host country's health services are well developed, health services should be structured along local lines, training for birth attendants should be modelled on host country curricula, protocols for treatment of STIs should follow national protocols, and so on. To achieve this end, strong links should be established and developed with Ministry of Health officials in the host government. In some cases, free supplies of condoms, contraceptives, vaccines and other medicines may also be available through the Ministry of Health.

Close links should also be established at the local and district levels (e.g. with the District Medical Officer and District Public Health Nurse). These links at local level are necessary for:

- integrating services into local structures;
- achieving equity in the care provided to local and refugee/displaced populations;
- smooth running of emergency obstetric and other referral services;
- appropriate support to local health services.

These aims can best be achieved by inviting local health managers to participate in planning of reproductive health services for the refugee/displaced population.

NGOs that are involved in reproductive health within the host country may be a useful source of supplies, IEC materials and expertise. Women's groups may also be willing to support

and network with women's groups in the refugee/displaced population, particularly in the area of protection and support of victims of gender-based and sexual violence. These links should be exploited to the full.

Coordination between agencies/ organizations

Ideally, good inter-agency coordination should have been established during the emergency phase. Mechanisms for coordination and inter-agency communication should be strengthened as the stabilization phase progresses.

A reproductive health coordinator should have been appointed during the emergency phase. As the situation stabilizes, he or she will be responsible for the overall development of comprehensive reproductive health services and for coordination with other programme managers. This will ensure a multisectoral approach to meeting reproductive health needs.

Ideally, all reproductive health services should be implemented by one agency. Where a number of agencies are involved, responsibilities and relationships between them should be clearly defined (in writing) from the outset. Under the leadership of the reproductive health coordinator, managers of these agencies should work closely to foster teamwork between staff working in clinics and in the community.

Coordination between the health sector and other sectors

Reproductive health is not just a health issue. Security, camp administration, distribution of food and other supplies, education, employment and income-generation, sports and recreation programmes, use and misuse of alcohol: all of these will affect the reproductive health of women, men and adolescents in a refugee or displaced population. In particular, the empowerment of women is a prerequisite for successful reproductive health programmes.

Table 7: Comprehensive reproductive health services

SAFE MOTHERHOOD: To reduce maternal and neonatal mortality and morbidity

Antenatal care

All pregnant women to attend antenatal clinics at least four times during pregnancy, for antenatal care, health education, and early detection and management of complications of pregnancy

- Establish daily antenatal clinics in all health centres, at times suited to the needs of pregnant women. Ensure that antenatal services are accessible and acceptable to all groups, including adolescent girls, unmarried women and women of different ethnic groups. Register all pregnant women at the clinics.
- Screen women for poor obstetric history, nulliparas <17 years (especially if single), short nulliparas at risk of CPD, and grand multiparas.
- Use home-based maternal records and be prepared as complications can occur at any time during pregnancy.
- During each antenatal visit:
 - take the blood pressure; examine for oedema and proteinuria; and assess uterine growth, foetal heart rate, presentation, anaemia and nutritional status;
 - provide iron and folate supplementation to all pregnant women and explain why and when it should be taken;
 - provide tetanus toxoid immunization (at least two doses during pregnancy);
 - treat existing conditions including hookworm and malaria (provide malaria prophylaxis in holoendemic areas according to country policy);
 - prepare a birth plan and review at each visit.
- Test all pregnant women for syphilis before 16 weeks and again in the third trimester. Treat positive cases and partners, and sero-positive babies.
- If available, offer voluntary testing for HIV, but only if pre-test and post-test counselling and support services are available, refer to the component on HIV/AIDS.
- Equip the health centre on site for, and train health workers in, the early detection and management of complications of pregnancy (abortion, ectopic pregnancy, PID, UTI, pre-eclampsia, eclampsia, anaemia, syphilis, antepartum haemorrhage, prolonged rupture of membranes, malpresentation, multiple pregnancy).
- Through TBAs, health care providers and midwives, educate women, families and communities on:
 - the need for early and consistent antenatal care and good maternal nutrition;
 - the need to plan for a clean, safe delivery;
 - the need for an institutional delivery when indicated;
 - how to recognize and respond to the main complications of pregnancy and delivery;
 - breastfeeding;
 - birthspacing/family planning.

Intrapartum care

For all women to have access to clean, safe delivery attended by a skilled health worker

- Continue to provide all pregnant women with Clean Home Delivery Kits (see Section B) and information on how to use these kits.
- Provide Clean Delivery Kits. Train, support and supervise TBAs and health care providers in performing clean deliveries and caring for the newborn, particularly resuscitation, thermal control, cord care, early recognition of infection and breastfeeding.
- Equip the health centre and train health workers in the active management of labour, including use of the partograph to monitor labour and delivery.
- Provide emergency obstetric care which involves early identification of complications, immediate first aid and/or management and/or referral (see below).
- Train health care providers on how to register births and deaths.
- If possible, try to establish a confidential "no name, no blame" investigative analysis of all maternal deaths in order to find out and address the social, cultural and health care barriers that contributed to the death.



Postnatal care of the mother

For all women to receive basic postnatal care through home visits and referral for complications

- Arrange for all women to receive a postpartum visit from a TBA, health care provider or midwife within 24 hours of delivery for assessment of complications, for advice and education on care of the newborn and on care of the breasts and genitals, for support of breastfeeding (see below), for advice on family planning, and for other forms of practical and material support as needed.
- Target vulnerable groups and individuals for additional postnatal support (e.g. women with complicated pregnancies or deliveries, women with their first baby, unaccompanied women and adolescent girls).
- Train TBAs, health care providers, midwives and families in the recognition, referral and follow-up of postnatal complications.
- Equip the health centre for management of postnatal complications (puerperal sepsis, fever, postpartum haemorrhage, perineal trauma, breast engorgement, and anaemia).

Postnatal care of the newborn

To provide postnatal care to all newborn infants

- Train TBAs, health care providers and midwives in care of the newborn, including resuscitation, cord care, thermal control, eye care (tetracycline eye ointment or silver nitrate drops within one hour of birth), weighing the baby, and advising the mother on care of her baby.
- Train TBAs, health care providers and midwives in the recognition, referral and follow-up of problems (sickness/abnormalities) in the newborn.
- Provide BCG and first polio immunizations as soon as possible after birth to every infant.

Support of breastfeeding

To promote, protect and support early, exclusive (up to six months), and sustained (up to two years) breastfeeding

- Draw up a clear, written breastfeeding policy for communication to all staff, relief agencies and donors. Establish clear guidelines on when and how infant formula should be used; if at all (see Appendix II).
- Develop IEC and training materials based on community beliefs and practices about breastfeeding and weaning.
- Train all health workers in how to promote, protect and support early and exclusive breastfeeding.
- Facilitate breastfeeding support networks within the community. Refer mothers in special need for additional support and counselling.
- Encourage and support wet-nursing.
- Draw up and disseminate clear guidelines on HIV infection and breastfeeding (see Appendix II).
- Provide at least 2400 kcal per day to every pregnant and lactating woman through general or supplementary ration.

EMERGENCY OBSTETRIC CARE: To ensure recognition, early detection and management or referral of complications of pregnancy and delivery (haemorrhage, eclampsia, prolonged/obstructed labour, puerperal sepsis, complications of unsafe abortion)

- Establish a referral service. Identify a referral centre for the management of complications beyond the capacity of on-site services. Draw up written agreements on procedures for communicating with the referral centre, on protocols for referral, on notes to accompany patients, on procedures for discharge, on methods of payment or on other supports for the referral centre.
- If no referral service is available off-site then on-site facilities must be established to provide emergency obstetric services.
- Draw up a rota for doctors and midwives to provide 24-hour on-call cover. Designate vehicles and drivers for a 24-hour ambulance service. Ensure fuel supply.
- Equip the health centre on-site for, and train health workers in, the initial management of complications and the provision of obstetric first aid before referral.
- Ensure that emergency obstetric services, including services for responding to complications of abortion, are accessible and acceptable to all groups of women and to adolescent girls.
- Train TBAs and health care providers in recognizing complications of pregnancy and delivery and in obstetric first aid.
- Through TBAs, health care providers and midwives, conduct an IEC campaign (for pregnant women, their families and the general community) on recognizing signs of complications and on the need to refer.
- Help communities establish methods for alerting the referral service and for transporting women to the health centre or referral centre.

Complications of abortion

To manage the complications of spontaneous or induced abortion and to reduce the incidence of unsafe abortion

- Identify and establish links with a host country facility that can respond to the complications of spontaneous and unsafe abortion.
- If no such facility exists, train staff to deal with complications of first trimester abortions, and provide facilities in Type II health centre for vacuum aspiration of retained products, antibiotic therapy, treatment of shock.
- Refer complications of second trimester abortions, abdominal sepsis, trauma, uterine perforation and missed abortion to emergency obstetric referral facility.
- Train staff to provide non-judgmental and confidential postabortion education, counselling and family planning services. Ensure that all services relating to the complications of abortion and postabortion counselling are confidential, available and accessible to all in need, including unmarried women and adolescents.
- Train TBAs, health care providers and midwives in, and conduct a community IEC campaign on, the dangers of unsafe abortion, the availability of family planning services and on the recognition and referral of abortion complications.
- Emergency contraception can be provided for women who have had unprotected intercourse, according to established protocols and as long as they are not already pregnant.
- To reduce recourse to unsafe abortions, where elective abortion is legal, establish links with an appropriate health care facility (Type II health centre for first trimester, district hospital for first and second trimesters). If no such facility is available, consider training staff on-site in the provision of manual vacuum aspiration (MVA) for first-trimester abortion (however, see footnote*).

* Given the particularly sensitive nature of this aspect of reproductive health, it is vital to be aware not only of the legal position within the host country, but also whether there is likely to be violent opposition from within the refugee or displaced community. Opposition to services is looked at in Section A, Chapter 3, and Section C, Chapter 9.



MENSTRUAL PROTECTION: To ensure that women and adolescent girls are not restricted in access to services due to a lack of menstrual protection

- With women and adolescent girls from different ethnic groups, identify ways of meeting needs for menstrual protection, e.g. providing women with absorbent cloths and sewing materials to make pads, belts etc. If a non-disposable method is used, soap must also be provided for washing.

GENDER-BASED AND SEXUAL VIOLENCE: To prevent and respond to gender-based and sexual violence

Prevention

To reduce the incidence of gender-based and sexual violence and exploitation through gender-sensitive policies and the support of community-identified measures for prevention

- Create gender-sensitive management and administration structures. Plan site and layout of camp or settlement to provide maximum safety and support for women. Prioritize conflict reduction and resolution.
- With women's groups (including groups representing younger women and different ethnic groups) and with male community leaders, religious leaders etc., identify causes of and possible solutions to ongoing gender-based and sexual violence and exploitation within families and communities, and between communities. Support women and communities in implementing preventive measures.
- Develop a community IEC campaign on gender-based and sexual violence in collaboration with female and male key informants (refer to Appendix VII).

Medical response

To provide a confidential, sensitive and culturally appropriate medical response to victims of gender-based and sexual violence

- Include gender-based and sexual violence in the training of all health workers. Include interpreters in this training.
- Develop protocols for a confidential and sensitive medical response to gender-based and sexual violence. Ensure that services are acceptable and accessible to all groups in the community.
- Provide emergency contraception through health centres. Train health workers in the use of emergency contraception, and in contraindications against use.
- With key informants from the community, develop an IEC campaign to inform women about the availability and use of emergency contraception, including time limits on its use.
- Establish a system for referral to other services (protection, legal, social services, counselling etc.) that respects the victim's confidentiality and right to decide what action should be taken.
- Through women's groups and informal networks, inform women in the community about the medical services that are available for victims of gender-based and sexual violence.

Psychosocial response

To meet the psychosocial needs of survivors of gender-based and sexual violence by building on individual and community capacities

- With key informants from the community, identify the most effective and culturally appropriate ways to respond to the psychosocial need of survivors of sexual violence.
- Collaborate with mental health/psychosocial support/social services in developing psychosocial responses.
- Develop culturally appropriate professional counselling services alongside the community-based response.
- Identify and support community resources that can assist in the psychosocial response. In particular, support or facilitate the establishment of psychosocial support and activity groups.

Female genital mutilation

To prevent female genital mutilation and to provide appropriate medical care to women and girls for health complications arising from the practice

- Identify groups within the refugee/displaced community where female genital mutilation occurs.
- In close collaboration with key informants, develop culturally appropriate IEC messages and materials for community education about the practice and its consequences (see Appendix VII).
- Include information about the health consequences of female genital mutilation (see Appendix X) in the training of health workers (including expatriate or national doctors, nurses or midwives who may be unfamiliar with the practice).

FAMILY PLANNING: For women, men and adolescents from the community to understand and regulate their own fertility safely and effectively and to reduce the incidence of unwanted/mistimed pregnancies and the transmission of STI/HIV

Family planning services existed

If results of the needs assessment indicate a pre-existing knowledge of and demand for family planning services within the community

- Recruit a senior health care provider experienced in reproductive health and the provision of family planning service provision, to manage the service and to train and supervise staff.
- Integrate family planning services into curative and preventive health services. Ensure confidentiality and accessibility for all groups, including unmarried women, adolescents and men. Integrate services with maternity, postabortion, emergency contraception and STI services.
- In clinics, as a minimum provide condoms and at least one combined oral contraceptive, progestin-only pill, injectable method and emergency contraception.
- As services develop, broaden the method mix to meet the community's needs and preferences, within the constraints of health workers' skills, available equipment and supplies. Also consider the security and stability of the population before adding methods that require aseptic techniques and long-term follow-up (e.g. IUDs and implants).
- Establish a referral system to local/host country family planning services for methods not available on-site (e.g. IUD insertion, subdermal implants, sterilization).
- Train community-based distributors, TBAs and health care providers to promote family planning within the community; to distribute condoms, combined oral contraceptives and spermicides; and to recognize and refer complications of method use to the clinic.
- Promote safe sexual practices and condom use to reduce the transmission of STI/HIV.

Family planning services did not exist

If the needs assessment indicates a lack of previous knowledge, lack of demand for, or opposition to family planning services within the community

- Continue to provide Core Package service to meet spontaneous demand.
- Through discussion with key informants, focus group discussions etc., explore the attitudes of different groups to contraception, contraceptive decision-making, family size etc.
- In collaboration with key informants, develop an IEC campaign to promote birth spacing/family planning (e.g. focusing on birth spacing and birth timing as important health measures for mother and child). Target opinion formers as well as potential users (refer to Appendix VII).
- As demand for family planning services increases, develop services as above.



STI/HIV/AIDS: To reduce the transmission of STIs and HIV/AIDS, to treat STIs effectively, and to provide care for people with HIV/AIDS

Safe blood transfusion

To prevent the transmission of HIV through blood transfusion

- Follow WHO/UNAIDS recommendations for preventing HIV transmission through blood transfusion.
- Provide reagents for testing of all donated blood. (If blood is being collected and tested in a local hospital, provide material and technical support as needed to cope with increased demand.)
- Conduct an IEC campaign to educate the community on the need for blood donors, and on who should donate. Collect blood from donors identified as being least likely to transmit infectious agents in their blood.
- Provide confidential pre-test and post-test counselling for all donors or establish a system for unlinked anonymous testing.
- Provide staff training on the appropriate use of blood for transfusion, recruitment and care of donors, pre-test and post-test counselling, confidentiality, and safe disposal of waste products.

Universal precautions

To prevent HIV transmission through enforcement of universal precautions

- Develop guidelines and train all health workers in universal precautions.
- Provide equipment and supplies for staff and patient protection, for sterilization, disinfection, cleaning and safe disposal of sharps and waste.

Prevention of sexual transmission

To prevent/reduce sexual transmission of STIs and HIV/AIDS

- Through key informants and focus group discussions, identify target audiences (including adolescents, unaccompanied minors, local populations, commercial sex workers, relief agency staff, police and military etc.) and develop culturally appropriate IEC messages on STIs and HIV/AIDS, safer sexual behaviour, correct use of condoms, treatment of STIs (including the need for partner notification), and attitudes to and care of people with AIDS.
- Through community education classes and women's groups etc., provide opportunities for women, men and adolescents to explore attitudes to sexuality and decision-making within relationships and to explore ways that women and girls can protect themselves from STIs and HIV/AIDS.
- Distribute condoms and actively promote correct condom use, identifying the most appropriate channels and outlets for each target group (e.g. food distribution, community health workers, women's groups, recreation facilities, bars etc.).
- Promote social activities, recreation and employment to alleviate boredom, especially among adolescents.

STI management

Manage STI cases effectively

- Provide confidential STI case management through all health facilities. Ensure that services are accessible and acceptable to all groups (see above, Prevention).
- In early stages, standardized WHO STI treatment protocols may be used. Local antimicrobial sensitivities should be determined as soon as possible and the standardized protocols adapted in line with local sensitivity patterns and host country treatment protocols.
- Train staff in syndromic case management (i.e. syndromic diagnosis, treatment, confidentiality, education and counselling, condom promotion, partner notification and follow-up) and in referral of complicated cases.
- Ensure a consistent supply of drugs and condoms.
- Develop a confidential, voluntary, noncoercive system for partner notification (e.g. contact slips for all sexual partners).
- Test all pregnant women for syphilis (see above, Antenatal care).

HIV/AIDS counselling

Through HIV/AIDS counselling, to give psychosocial support to those whose lives have been affected by HIV and to further reduce transmission

- Develop clear guidelines on HIV testing. If diagnostic testing is offered, ensure that confirmatory test and pre-test and post-test counselling is available.
- If counselling and a confirmatory test are not available, diagnostic tests for blood transfusion should be anonymous and unlinked. Results of tests should not be given to the donor.
- Train staff in pre-test and post-test counselling, emphasizing voluntary testing and confidentiality of results.
- Provide ongoing support for people who have tested HIV positive (e.g. through support of community counsellors and self-help groups).

Care of people with HIV/AIDS

To provide comprehensive care for people with HIV/AIDS through clinics and inpatient services and through support for community-based home care for HIV/AIDS patients and their families

- Train health workers in clinical recognition and case management of AIDS, use of essential drugs for care of HIV-related illness, nursing care, counselling, and patient and family education.
- Integrate HIV-related care into basic curative services.
- Facilitate the development of community-based self-help care and support groups.
- Train and organize community-based health workers. Liaise with social services to support women and families caring for people with HIV/AIDS and caring for AIDS orphans.



LABORATORY SERVICES: ALL SERVICE COMPONENTS

- Provide the following reproductive health related laboratory services (services marked with * can be provided through a side laboratory in a Type II health centre):
 - preparation and staining of thin blood films;
 - thick blood films for malaria parasites;
 - total and differential leukocyte count;
 - estimation of haemoglobin (* with haemoglobinometer);
 - haematocrit;
 - detection of glucose in urine (* with urinalysis dipstick);
 - detection of ketones in urine (* with urinalysis dipstick);
 - detection of proteins in urine (* with urinalysis dipstick);
 - detection of bile pigments in urine;
 - detection of urobilinogen in urine;
 - blood cross-matching;
 - collection and storage of blood;
 - HIV/AIDS rapid assay (diagnostic: sufficient for testing blood for transfusion);
 - HIV/AIDS confirmatory test;
 - HBsAg test;
 - syphilis test.
- Establish confidential laboratory reporting systems and train laboratory staff in the need for confidentiality.

NUTRITION: To promote better nutrition of groups with special needs (under-fives and pregnant and lactating women) and groups at risk of neglect (girl children and adolescents)

- Ensure that women retain traditional patterns of access to and control of food supplies and food production (agricultural land, implements etc.).
- Where rations are provided, establish an equitable food distribution system to ensure that women, children, particularly girl children and all other vulnerable groups receive a full ration.
- Provide women-identified, culturally acceptable foods and methods for preparation of food.
- Ensure at least 2200 kcal per day of a balanced diet to every pregnant woman and 2400 kcal for lactating women, through general or supplementary ration.
- Taking into account community beliefs and practices regarding nutrition, food taboos etc., develop IEC messages and conduct community education on the nutrition needs of groups with special needs.

One advantage of a camp setting is that it can be much easier to form links between services, and this needs to be exploited to the full. Formal and informal links can be established between different sectors, at both community and programme management levels.

Awareness of these links can assist in:

- gathering information on reproductive health from a broad range of sources;
- reaching target groups with IEC campaigns;
- generating political support for reproductive health services;
- improving intersectoral collaboration in the development of services;
- protecting men, women and children from gender-based and sexual violence.

9.3 Community participation

In refugee and displacement settings, community participation is essential so that interventions that are implemented are appropriate to people's needs. It is also vital in order to foster a sense of ownership and control on the part of the community, rather than a sense of dependency and helplessness. A community's greatest resource is the people in it. Most communities are able to help themselves through a disaster if they are given the opportunity to do so. A crisis can even provide an opportunity for people to take on new challenges, to learn new skills, and even to make positive changes in their lives.

Reproductive health interventions should be built on the community's existing capacities and coping mechanisms (particularly in the prevention of and psychosocial response to gender-based and sexual violence). Such interventions are more likely to be sustainable if they do not rely excessively on outside expertise and solutions.

A gender approach should underpin all efforts to maximize community participation.

An understanding of the culture and of the relationships in families and communities—between women and men, between adults and adolescents, between powerful and marginalized groups, and between different ethnic groups in a refugee setting—is necessary in order to ensure that women, adolescents and marginalized groups are actively involved in decision-making at all times. Not only the official community leaders should be involved.

Attitudes and beliefs in the areas of mental health, sexuality and relationships between men and women differ from one culture to another. Reproductive health programmes must be built on a thorough knowledge and understanding of these attitudes. This can only come from the members of the refugee or displaced community themselves.

However, there are obstacles to making community participation in reproductive health a reality in refugee and displaced settings and these should be addressed.

Relief orientation on the part of donors, relief agencies and staff

Working with communities and fostering participation is a development approach. It is slow and requires long-term commitment on the part of staff, agencies and donors. Commitment to participatory approaches and to long-term planning should be a prerequisite for all relief staff, agencies and donors in the area of reproductive health.

Lack of experience in participatory approaches

The social structures within a community may be greatly damaged by crisis or displacement. There may be a lack of democratic structures through which community members can express themselves. Moreover, the community may have become so dependent on outside solutions that it has developed a "learned helplessness" and people no longer believe that they can help themselves. Women in particular



may have difficulties since they may have no prior experience of influencing their own lives or of participating in decision-making. Other groups may be marginalized because of their age, caste, race, political views or disability.

It may be necessary to facilitate the development of community structures within the refugee community and to begin community education in participatory processes, problem solving, decision-making and leadership, particularly among women, adolescents and marginalized groups (e.g. through the Training for transformation series). In refugee settings, programmes such as these are more likely to be developed through social services rather than through health service networks. However, the reproductive health coordinator can support and establish links with such projects, or lobby for their development where they do not exist.

Opposition to reproductive health interventions

No community is homogenous: what some people see as a priority need may conflict with what others see as necessary or desirable. Differences may be more marked in the area of reproductive health than in any other area of health care. Family planning services, promotion of condom use and provision of emergency contraception are three of the most contentious areas. However, emergency obstetric interventions such as caesarean section, episiotomy and blood transfusion can also provoke opposition.

These differences should be addressed for two reasons: so that programmes will have the broadest base of community support possible,

and so that the lives of service providers and users do not come under threat. In some circumstances, it may be possible, through a process of education, dialogue and mutual respect, to enlist the active support of traditional leaders who were originally opposed to a particular reproductive health intervention. Gaining the support of political or religious leaders can mean that services can be actively promoted and made freely available to all who need them.

Where it is not possible to gain this support, the advantages of providing or promoting a contentious service should be weighed carefully. For example, in the case of family planning, the middle ground of providing the service but not actively promoting it in the community may be an acceptable compromise.

"A problem arises when agencies and planners support groups outside the existing power structure, thus running a serious risk of alienating the existing elite. If common ground is not found and compromise achieved, confrontation may develop. There have been instances in which lives have been lost because of the polarisation brought about by a programme.

In most communities, leadership patterns are historically and culturally determined. If these patterns are not recognized or are deliberately or unwittingly ignored, experience suggests that programmes have little chance of being accepted or utilised at any level in the community. Programmes that have had some success in achieving their stated objective of providing health services on the basis of community participation have mostly had the support of local leaders."

*Source: Rifkin SB.
Community participation in maternal/child
health and family planning programmes.
WHO, Geneva, 1990*

This chapter describes the framework for conducting a needs assessment. This forms part of a series of steps (assessment, planning, implementation, monitoring and evaluation) which is the continuous planning cycle required to manage reproductive health care programmes effectively.

Through this process, answers are sought and found to a series of questions:

- Where are we now? - Assessment
- Where do we want to go? How will we get there? - Planning
- Are we on track? Are we going in the right direction? - Monitoring
- Have we arrived where we wanted to go? If not, why not? - Evaluation

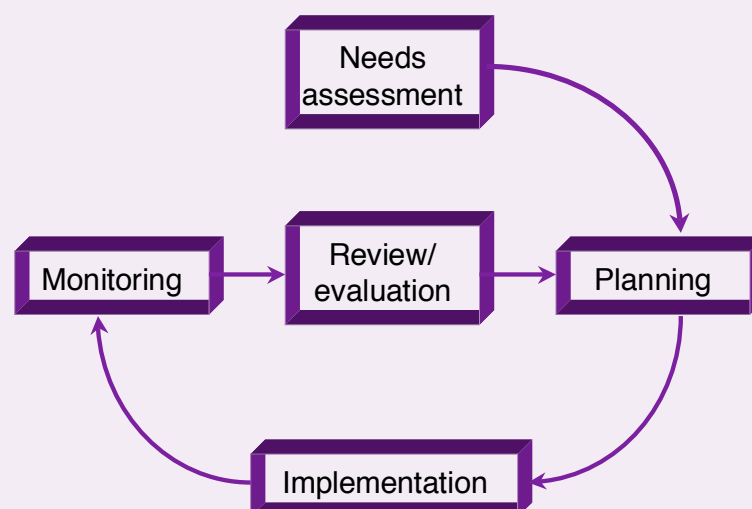
However, a number of tools that may be particularly useful in refugee/displaced settings are:

- The *Guidelines for rapid participatory appraisal to assess community health needs: a focus on health improvements for low-income urban and rural areas* is designed for use in resource-poor settings and with limited expertise. It has been adapted to form the framework for the assessment outlined below.
- The *Refugee reproductive health needs assessment field tools* was developed specifically for use in refugee settings by the Reproductive Health for Refugees Consortium. Five reproductive health needs assessment tools have been developed:

Refugee leader questions, Group discussion questions, A survey for analysis by hand, A survey for analysis by computer, and A health facility questionnaire and checklist.

- *The Safe motherhood needs assessment* can be adapted for use in refugee or displaced settings. It has four parts: *Guidelines, Model forms, A trainer's manual* and *A surveyor's manual*. It includes detailed survey forms, questionnaires and guidance on how to assess facilities, infrastructure, personnel, services and client satisfaction, as well as guidance on analysis and interpretation of results.

Figure 4: The programme spiral



10.1 Assessment

A number of manuals and guidelines on rapid participatory methods of assessment, and on the assessment of reproductive health needs, are listed in the Appendix X—Bibliography, and Appendix III. Most are designed for use in non-refugee settings and require some degree of training or expertise in assessment methodologies in order to be used successfully.

- *People-oriented planning at work* is a gender-based analysis of activities and resources oriented to use in refugee settings.

Details of each of these publications can be found in the Appendix X—Bibliography.

Prior to planning and undertaking an assessment, it is important to find out and review sources of information that are already available. This is particularly important in a



stabilized refugee or displacement setting as some assessments may already have been undertaken by various organizations. This type of secondary research will provide a clearer perspective of what essential information is needed, the methodology that should be used, and the time, money and human resources required to undertake the assessment.

10.2 Framework for conducting an assessment

This section describes a framework for conducting an assessment using basic resources and non-specialist expertise. One of the pre-existing tools can be used to aid in developing questionnaires, survey forms etc. Appendix III and Appendix IV give an overview of the categories of information to be gathered as part of a needs assessment. It should not be seen as an assessment questionnaire; its function is to guide the assessor to areas that should be explored when planning an assessment.

The framework described here is basic. It is desirable to have more detailed information when planning IEC campaigns on specific topics (e.g. family planning or HIV/AIDS education). It is recommended that funding be sought for a permanent member of staff or a temporary consultant with expertise in this area. The more detailed and professional the assessment and analysis, the more useful and accurate the information gathered will be.

The aim of the assessment is to gather relevant information quickly, in order to identify:

- the unmet reproductive health needs of the community (in identifying the needs of the community, there is a risk that needs which have been previously defined by outsiders such as donor organizations or service providers will be attributed to groups within the community; the "felt needs" of the community may be very different);
- the composition of the community and information on relationships and attitudes will help to identify appropriate approaches

that can be used for the delivery of reproductive health care services;

- the interventions that can be put in place to meet these needs (Table 7, Section C, Chapter 9 is essentially a list of standard reproductive health interventions; the needs assessment can determine how these interventions can be implemented in a particular setting);
- the resources that exist to meet the community's needs (both within and outside the community).

It is recommended that the reproductive health assessment be integrated into a general needs assessment. This saves time for the health team, puts reproductive health needs in the context of the community's other needs and encourages the development of more integrated programmes. The rapid health assessment checklist described in Appendix III should be reviewed before proceeding. Any unanswered

Framework for conducting an assessment

- Decide when to conduct the assessment.
- Review available sources of information, decide what information is already known and what information is needed.
- Decide how to obtain the information.
- Draw up a plan of action; estimate the cost and time frame.
- Identify and train the assessment team.
- Collect the information.
- Analyse the information.
- Review the findings, identify needs, possible interventions and resources.
- Provide feedback on the outcome of the assessment to all stakeholders involved in it.

questions from the emergency phase assessment should form the starting point of this more thorough assessment.

The following steps are suggested as a framework for conducting the assessment:

Decide when to conduct the assessment

- Ideally, an assessment of reproductive health needs should be carried out within six months of the start of operations. Actual timing will depend on local circumstances.
- If the situation remains unstable, it may be necessary to carry out the assessment in phases, focusing initially on known critical or life-threatening issues such as emergency obstetrics or gender-based violence.
- Assessment must always be an ongoing process. Health workers, counsellors, health committees and women's groups should provide ongoing information and feedback to the programme manager on changing reproductive health needs.
- The need for openness to new information and for flexibility in planning is especially important in reproductive health. This is because community members may initially be reluctant to discuss sensitive topics. Creating an atmosphere of trust is crucial so that women, in particular, feel ready to talk freely about their needs.

Decide what information is needed

- Appendix III lists the categories of information that can be gathered during a reproductive health assessment in a refugee or displacement setting. The list is based on the "information pyramid" used in rapid participatory appraisals. Appendix IV gives further information on using the pyramid in gathering and analysing information.
- The exact questions to be asked will depend on local circumstances. Resources and expertise are generally limited so it is necessary to be selective in deciding what information to collect. For each proposed question, ask:
 - Is the information essential for our local needs?
 - Does the information already exist?
 - Can the information be easily collected?

- Will the information be worth the time and energy spent on gathering it?
- Can the information be easily analysed?
- Will the information be directly useful in programme planning?
- If the host community and the displaced community are intermingled, the assessment should look at the needs and resources of both communities.
- If no census or registration information is available to construct a demographic profile of the population, it may be appropriate to undertake a demographic survey in order to have accurate denominators for planning and monitoring.

The importance of identifying and collecting information about different groups and subgroups of the population is illustrated in the box on Thailand at the end of this chapter. It shows how the needs of adolescents can vary widely, even within one refugee camp.

Decide how to obtain the information

- Information should be gathered through both quantitative and qualitative assessment methods. This is particularly important in the area of reproductive health.
- Three fundamental tools can be used when no specialist expertise is available:
 - review of existing records and documents;
 - observation;
 - interviews with key informants.
- "Triangulation" (cross-checking of data) is the technique by which simple methods of data collection can produce information that is relatively bias-free and accurate. Triangulation means confirming the accuracy of information either by asking several people from different backgrounds the same question, or by obtaining information from more than one source.
- For each question asked or item of information sought, identify a method for



Sources of information

Review of existing records and documents

- This will include:
 - data from the health information system on reproductive health related morbidity and mortality, clinic attendance, etc.;
 - data on consumption of medicines and supplies;
 - data from host country health services, clinics etc.;
 - data from previous surveys, the registration system, a census or a demographic survey;
 - data from the community's country or place of origin (incidences of disease, previous exposure to services and information, results of surveys including KABP surveys, previous health education, IEC materials).
- As well as the health information system in the camp or settlement, possible sources of information are ministries of health, education, social services, women's affairs, the WHO national or regional office, UNHCR, UNFPA etc.
- It is important to be very selective in gathering data from records and documents. Collect only information that will be of direct use in programme planning.
- Information should be disaggregated by age and sex.

Observation

- Observation is useful both for the new information it provides and as a means of confirming or contradicting information gathered from other sources.
- Members of the community, and staff, who work in and with the community, will have already gathered a great deal of information through observation in the course of their everyday work.
- Information can be gathered on:
 - the physical environment, security, sanitation, sources of water, fuel etc.;
 - clinics, equipment, service provision, staff performance;
 - the activities of men, women and children (see UNHCR's "People-oriented planning at work").

Interviews with key informants

- Key informants are people in a community (or working with a community) who, because of their official position or informal leadership, have access to information about the community, rather than individual views about community problems. For this reason, they can be seen as representatives of a range of opinions held by the community. Through one-to-one interviews with key informants, information can also be gathered on sensitive or potentially controversial issues, and acceptable ways of dealing with these issues can be explored.
- Key informants may be from the community or may be outsiders working with the community, such as:
 - youth leaders, women's group leaders;
 - TBAs, midwives, doctors and other health workers, traditional healers;
 - religious leaders and other community leaders;
 - teachers, social workers, counsellors;
 - relief agency staff;
 - programme managers;
 - host country health officials (e.g. the district public health nurse or district medical officer);
 - policy-makers.
- Key informants should be carefully selected for their ability to represent accurately a broad range of views. Aim for a small number of "high quality" key informants. This will make analysis easier. Community-oriented staff often make the best informants.
- Key informants from the community should be chosen to represent the knowledge and opinions of adolescent girls and boys, adult men and women, married and unmarried men and women, and members of different ethnic groups and castes.
- "Emerging leaders" tend to be progressive in their opinions and open to change. It is important that some key informants can represent more conservative attitudes, and the views of any influential opposition that may exist.
- A question guide should be prepared in advance to remind the interviewer of the areas that need to be covered in the interview. Questions should be simple and open-ended. The same questionnaire can be used with different key informants from the community (this simplifies analysis), although separate question guides may be needed for certain key informants with specialist information (e.g. the manager of health services in the host community).
- Meetings can also be held with groups of key informants. These meetings need not be as structured as focus group discussions (see Glossary). They can be informal discussions between health workers and others working in the area of reproductive health aimed at reviewing and comparing impressions of the reproductive health needs of the refugee/displaced population.

collecting the information and a second method or source for cross-checking.

Draw up a plan of action

- Develop a plan of action and a timetable before conducting the assessment. Ensure that time is set aside not only for gathering information but also for planning, training, analysis of the data and review. Without such a plan, it is easy to expend time and energy gathering large amounts of information that will never be used.
- Estimate the costs of undertaking the assessment and fix a time frame for each activity.

Identify and train the assessment team

- The assessment team should be kept small and manageable with the appropriate gender balance. It should be composed of both refugee/displaced and agency staff. Community-oriented health workers, community development workers, social workers and teachers should be considered in order to provide a range of insights.
- Team members should be chosen for their openness and ability to reflect faithfully what they see and hear (rather than their own beliefs).
- Ideally the interviewer and the respondent should be peers in terms of gender, age, ethnicity, marital status, educational standard etc. People are far more likely to speak openly to someone with whom they identify.
- If translators are needed, they should also be peers of the respondent. While women may be willing to talk openly with a woman from a different culture, they are far less likely to do so if they must talk through a male translator.
- At least one day should be set aside for training. This can be done through a

participatory workshop. Before interviewing key informants, team members should:

- learn about and practise active, non-judgmental listening skills;
- become aware of their own attitudes and prejudices, and how these can colour what they are willing to hear and report.
- Translators should be considered full team members and should participate fully in training.

Collect the information

- The health manager or reproductive health coordinator is usually in the best position to review records and documents, while other team members conduct interviews and observations.
- It is best if team members are in pairs when interviewing key informants. One can conduct the interview while the other records responses. A tape recorder can be used if available and if acceptable to the respondent. If neither of these options is possible, time should be set aside immediately after the interview to add details to the interviewer's notes.
- Key informants may themselves have been the victims of rape or other forms of trauma. They may become distressed if the subject comes up during the interview. For this reason, it is advisable to have back-up counselling available to both key informants and interviewers.

Analyse the information

All members of the assessment team should undertake analysis of the information. Each member will be able to contribute individual impressions and expertise. Information from documents, interviews and observations should be compared and any discrepancies noted. These should be discussed with key informants during the review, and information sources may need to be checked for accuracy.



The "information pyramid" described in Appendix IV can be used to guide the analysis.

Documents and reports

- Only information that is of direct use in planning reproductive health services should be included in the analysis.
- Information should be assessed for accuracy (e.g. reports from a well run clinic will be useful, whereas information from a poorly run clinic should be used with caution and cross-checked against other sources).
- Information that has not been disaggregated for age and sex should be treated with caution as it may mask wide variations and inequities.

Interviews and observations

- Analysis of information from interviews and observations should be kept simple. Interview and observation notes should be reviewed and responses/observations summarized. Responses to each question from different key informants should be grouped together and compared.
- There is no need to try to quantify how often an opinion was expressed. It is enough to note that a particular opinion was repeated or stressed by a number of sources.

Review findings, identify needs, possible interventions and resources

- Review the findings of the assessment with the key informants so that discrepancies (e.g. between information gathered through observations and through interviews) can be discussed and clarified.
- At the end of the analysis and review, the assessment team should be able to list:
 - the unmet reproductive health needs of the community;
 - possible interventions to meet these needs;
 - the resources available, within the community and from outside the community, to meet these needs;

- composition of the community and information on relationships and attitudes towards reproductive health.

Feedback

Feedback on the outcome of the assessment should be provided to all involved stakeholders. It provides information that can be used to advocate for the provision of reproductive health services, support funding proposals and provide the rationale for agreeing and developing appropriate strategies, and levels of co-ordination. People should be able to see or experience a change in service provision as a result of the assessment.

THAILAND: CAMP PANAT KIKHOM

"Two distinct cultural groups have inhabited Camp Panat Kikhom over its 20 year history: i) the Hmong from Laos and ii) the lowland Laotians and Vietnamese. The differing characteristics of these two groups had striking implications for the types of reproductive health care needed by adolescents..."

The Hmong were characterized as more traditionally patriarchal and less educated than their Vietnamese peers. Polygamy was practised and girls married early in their teens and bore children soon afterwards. Fertility was higher among this group and women were usually unwilling to make family planning decisions without the permission of their husbands. The reproductive health needs of adolescent focused primarily on safe pregnancy care. Most women did not practice family planning until they had achieved their desired family size.

The adolescents in the Vietnamese group were more likely to be unmarried. Often they were minors whose parents were either left behind in the country of origin or who had moved on to a new settlement country. Without a parent close by there was no traditional source of sex education. Young people often relied on peers or some of the more trusted service providers for their information on pregnancy and STI prevention. The service providers acknowledged that among this group there were some difficulties with unintended pregnancies, STI/AIDS and drug abuse, but these did not seem to be overwhelming problems."

*Source: Waszak C, Tucker B.
The reproductive health needs of
adolescent refugees.
Refugee Participation Network, 1995, 20*

This chapter describes the planning phase and answers two key questions: **where do we want to go, and how shall we get there?**

From the assessment, a list of the reproductive health interventions that would be desirable will have been drawn up. However, funding and other constraints will limit which needs can be met and which interventions can be implemented. Priorities and best strategies should be selected.

The following framework for planning will help guide the process of developing a realistic project proposal, starting from the needs identified through the assessment.

Framework for planning

- Estimate costs.
- In coordination with other agencies and community groups, identify priorities and areas of collaboration.
- Define programme objectives.
- Select best strategy to achieve objectives.
- Draw up detailed plan of action.
- Discuss plan of action with key members of staff and community and revise if necessary.
- Prepare project proposals and budget (refer to Appendix VI).

11.1 Estimate costs

A rough estimate of the comparative costs of the different possible interventions is needed in order to set priorities. (More detailed costing will be needed later on when preparing a budget.) The capital cost of equipment, training materials and construction should be assessed, as should the recurring costs of salaries, medicines and supplies for the day-to-day running of the programme. (Appendix VIII lists cost categories for health service planning). Sources of potential donations (e.g. condoms, contraceptives, and vaccines) should also be identified. The optimal way to establish the programme should be assessed since it may be possible for the

interventions to be linked to existing services and for costs to be shared between programmes.

11.2 Identify priorities

Priorities should be continually reviewed as the population structure, needs, and availability of funding and other resources change. (The core reproductive health package has already been defined. In a situation of continuing instability the aim should be to continue to provide these services.) Prioritization of activities should be coordinated with other organizations, agencies and community groups, as they may be able to contribute to particular activities.

The following questions should be asked about each of the proposed interventions in order to identify which should be given priority.

What will be the likely impact (either positive or negative) of the proposed activities?

- How common is the problem that the activity proposes to address? (*E.g. a very high birth rate may indicate the need for high priority to be given to both safe motherhood and family planning activities.*)
- How serious is the problem? Is it life-threatening? (*E.g. high use of brothels by men or male adolescents, combined with a low awareness of HIV/AIDS and/or low condom use.*) Does it cause severe morbidity? (*E.g. serious maternal morbidity resulting from poor emergency obstetric care.*)
- Does the problem have secondary health, social or human rights implications? (*E.g. long-term health effects of female genital mutilation, social problems of AIDS orphans, human rights violations associated with gender-based violence.*)
- What effect will the proposed activities have on the community's confidence in the agency and the reproductive health services? (*E.g. good maternity services can create an atmosphere of trust and partnership between the community and the agencies, and this in*



turn can facilitate the introduction of more potentially controversial activities at a later date.)

- Is the proposed activity likely to have any negative effects? Can anything be done to avoid these? (*E.g. introducing modern methods of family planning can result in the erosion of traditional taboos on intercourse after childbirth. If the supply of modern methods cannot be assured both during the period of displacement and after the return, the long-term impact could be a negative one. One solution could be to promote only those methods that can be sustained with a lower level of technical expertise, i.e. condoms and pills.*)
- Will the proposed intervention contribute to capacity-building within the community or will it foster dependency? What will be the long-term benefits to the community, for instance in terms of skills transfer? (*E.g. training adolescents as peer educators or as health workers will have long-term positive impacts on community capacities.*)

How feasible are the proposed activities?

- Are the supplies of material resources and trained staff sufficient to guarantee high quality of care?
- Are services already in existence, which can be built upon, or must new services be established? (*E.g. is there in the host country an infrastructure of family planning services which can be used?*)
- Are staff already available to implement the proposed intervention, or will recruitment and/or training be necessary? Does the agency have expertise in training?
- How reliable is the system of logistics and supply? Can weaknesses be identified and improved?
- If the objective is to change behaviour, how likely is it to succeed? (*E.g. interventions to*

Framework for conducting an assessment

- Decide when to conduct the assessment.
- Review available sources of information, decide what information is already known and what information is needed.
- Decide how to obtain the information.
- Draw up a plan of action; estimate the cost and time frame.
- Identify and train the assessment team.
- Collect the information.
- Analyse the information.
- Review the findings, identify needs, possible interventions and resources.
- Provide feedback on the outcome of the assessment to all stakeholders involved in it.

promote condom use by adult commercial sex workers may have a higher probability of success than similar interventions among young street children.)

- How sustainable is the proposed intervention? (*Is it comparable to services available within the host country? Could it be handed over to and sustained by host country health services or NGOs? Will it depend on continuing outside inputs, particularly of skilled personnel? Can these be assured?*)
- Is there sufficient long-term commitment by the agency to monitor and maintain the proposed activity? (*Activities aimed at changing behaviour, e.g. AIDS prevention or introduction of family planning services, require long-term commitment.*)
- How likely are interruptions such as conflict, displacement, return, evacuation, or rainy season? What is the likely impact of such interruptions on the proposed intervention? (*E.g. insertion of IUD or implants should not be undertaken if further population displacement is likely.*)

What is the likelihood of securing the funds for the proposed intervention?

- What is the estimated cost of the intervention compared with other proposed interventions? What proportion of the population will be served? Will costs be one-off or recurring? (*E.g. the initial cost of equipment for IUD insertion may be high, but the recurring costs will be relatively low.*)
- Have funds already been allocated for the proposed intervention? If not, are donors likely to support the intervention? (*Some donors may not wish to support family planning programmes or other elements of reproductive health, while other donors may be enthusiastic about supporting these activities.*)
- Are donors willing to commit to long-term funding for long-term programmes?
- If medicines or supplies must be imported, will currency fluctuations affect the ability to keep the activity under-way?

What is the strength of socio-political support?

- What is the extent of political/legal/religious/cultural support for the proposed intervention on the part of:
 - the target groups for the proposed intervention;
 - traditional decision-makers in families (e.g. husbands, fathers, older women);
 - official leaders of the displaced community, including religious leaders;
 - unofficial leaders, opinion formers;
 - health workers (displaced, national, expatriate);
 - relevant national or international bodies and NGOs;
 - the government of the host country;
 - proposed donors?
- If there are negative attitudes, can they be overcome through advocacy and education?

(E.g. family planning may be seen by beleaguered communities as a political tool to limit population size. Setting a long-term goal of community education and of building confidence in health service providers might be an appropriate priority, rather than expanding family planning services in the short term.)

Using the answers to the above questions, the matrix in Table 8 can be used to determine which activities should be prioritized.

Each proposed intervention is graded high (H), medium (M) or low (L) according to the likely impact, the technical feasibility, the likelihood of securing funds and the level of support. The manager must decide what weight to give to each score.

The matrix is an aid to decision-making, not a mathematically precise tool. The total score for each intervention is entered in the final column. Interventions that score low or medium priority may be implemented as resources or circumstances allow, or a new intervention may be planned to remove existing impediments (e.g. through fundraising or education).

11.3 Define programme objectives

Once programme priorities are identified, clear objectives should be defined for each component of the reproductive health programme. Objectives should be "SMART": Specific, Measurable, Achievable, Relevant and Time-bound. Objectives should also be flexible in order to respond to changing needs.

Objective: All pregnant women will receive at least four antenatal visits.

11.4 Select the best strategy to achieve objectives

There may be a number of strategies for achieving a given objective. The best strategy should be selected by comparing a number of variables.



Relative cost

In stable non-refugee settings in developing countries, the less costly approaches are integrated, multipurpose services, trained auxiliary health care workers, outpatient services, local anaesthesia, use of non-disposable supplies (e.g. drapes, gloves, syringes) and use of locally manufactured equipment and supplies (if of good quality).

Vertical, free-standing services, specialized medical staff, inpatient services, general anaesthesia, disposable supplies, and imported equipment and supplies are usually the more costly options. Strategies that can be delivered through sharing of resources between programmes and agencies also help to reduce costs (e.g. shared use of logistic supply lines).

Host country practices

As far as possible strategies should be chosen which are within the policy framework and in accordance with how reproductive health services are provided in the host country. Such strategies are more likely to be appropriate to local standards of care; will facilitate integration of services with host country health structures; and in the long term will facilitate handing over of services to local NGOs or government bodies.

Impact on capacity-building

Strategies should rely on and strengthen the capacities and coping mechanisms of the community, and should add to the pool of skills within the community.

Impact on local populations, health services and economy

Strategies should have a positive impact on the host population and should improve

relationships between host and refugee communities. Attention should also be paid to the impact on the local health services and economy. For example, providing free health services to refugees can drain resources from local services. High salaries paid to health professionals can create a "brain drain" from host country health services.

"Delivery of care at the lowest feasible level with arrangements for effective referral of complicated cases is generally the least expensive arrangement from a number of perspectives, including transportation, use of specialists and women's time."

Source: Complications of abortion: technical and managerial guidelines for prevention and treatment.
WHO, Geneva, 1995

Sustainability

Long-term sustainability of funds and outside resources should also be considered. (In the early days of an emergency, funds are often relatively freely available, and projects may be started that are inappropriately large, expensive or sophisticated.) Have realistic financial expectations and plan accordingly.

Best service provider

Where a number of agencies are involved in providing reproductive health services, it should be decided which is the best agency to provide a particular service. This should depend on the orientation, expertise and experience of the agencies rather than the interests of individuals. The lead agency should coordinate such decisions.

11.5 Develop a detailed plan of action

Table 9 shows an example of a planning framework. For each objective, use a problem-solving planning process with team members to draw up a plan of action that includes the following details:

Table 8: Selecting priorities

Proposed intervention			Positive impact			Technical feasibility			Likelihood of securing funding			Socio-political support			Overall priority		
H	M	L	H	M	L	H	M	L	H	M	L	H	M	L	H	M	L

Table 9: Planning framework

Objective: _____

Intervention (what?)	Key activities (how?)	Inputs required	Time frame (when?)	Responsibility (who?)	Expected outcome	Monitoring (indicators)



- the interventions that will be undertaken;
- how they will be carried out;
- who will do them;
- when they will be done (the timetable);
- the inputs of supplies, equipment, personnel, training etc. that will be required;
- the indicators for monitoring and evaluation and the strategies for gathering information which will be used.

11.6 Review plan of action with key members of staff and community

Before drawing up a proposal and budget, review the selected priorities and plan of action with members of staff and with key informants from the community.

11.7 Prepare project proposals, project plan and budget

If funds already exist to support programme activities, it is important to prepare a plan of action, adjust the budget and justify the proposed changes to project activities using the outcome of the assessment.

If funds do not exist or additional funds are required, a project proposal must be written and submitted for funding.

Appendix VI gives guidelines for preparing a project proposal (however, some donors will have their own format for proposals).

Modern health system management favours budgeting by defined programmes rather than under general headings. Such programme budgeting is more appropriate for planning and evaluation. Usually, the proposal and budget for reproductive health programmes are presented as part of the overall health proposal. However, if a donor is particularly attracted to funding reproductive health programmes, these should

be highlighted and the budget presented separately. Some donors may be interested only in projects related to women's health or reproductive health.

11.8 Monitoring and evaluation

Monitoring is the systematic and continuous collecting and analysing of information about the progress of a piece of work over time. It answers the questions: are we on track and are we going in the right direction?

Evaluation is assessment at one point in time. It concentrates on whether the objectives of a piece of work have been achieved and what impact has been made. It answers the questions: have we arrived where we wanted to go and, if not, why not? Evaluation may be done by insiders (the staff and community in the camp or settlement) or by outsiders.

Strategies for monitoring and evaluating the reproductive health programme should be included in the plan of action. Indicators should be selected, targets for achievement should be set, and ways of collecting information on the indicators should be identified.

Selecting indicators

The health manager must be selective in deciding what data to collect. The amount of information collected should be kept to a minimum. Data that will not be used should not be collected. Ideally, indicators should be set in the field by the people who will be collecting and using the information.

The ideal solution in a refugee or displacement setting may be to use the same reproductive health indicators in the camp or settlement as in the local/host country health services. Reporting can then be linked to host country reporting systems. The Ministry of Health may require this, especially if services are closely linked or if supplies are provided through the host country health service.

Two questions to ask in selecting indicators are: will the information be useful, and will it be easy to collect?

Will the information be useful?

Will the indicator provide information that is of direct use in the field? Will it aid day-to-day decision-making? Will it aid long-term programme planning?

For example, measuring maternal morbidity to assess programme impact can be problematical, as it can be difficult to define, interpret, measure and classify obstetric morbidities. It is simpler to establish process indicators that determine access to and the quality of service delivery. For example, 80% of all pregnant women will attend antenatal care four times, trained birth attendant at every delivery.

- Monitoring indicators should allow the manager to:
 - follow the progress of planned activities;
 - follow trends in reproductive health morbidity and mortality;
 - know if programmes are running smoothly, identify problems and solve them promptly;
 - give feedback to staff on progress towards objectives.
- Indicators are also needed that will allow the impact and effectiveness of the plan of action and of individual interventions to be evaluated, and to show whether objectives are being achieved. This will include evaluating changing knowledge, attitude, beliefs and practices in the community.
- Quality of care needs to be monitored and evaluated. Staff supervision should monitor performance, levels of competency and satisfaction with services (see below).

Will the information be easy to collect?

It should be possible to collect the information easily and accurately. Sophisticated indicators beyond the capacity of the staff who will be collecting the information will waste time and may provide misleading data.

- Staff should be involved in defining reproductive health indicators that are meaningful to them. They will be more likely to collect accurate information if they are interested in doing so and feel that it has a purpose. All staff should be trained how to collect information and should understand how the information they collect is analysed and used to improve the quality of services they offer.
- It should be possible to collect the information through existing/routine information sources. It is neither necessary nor advisable to set up a separate reproductive health reporting system. Information on reproductive health should be gathered through the general health information system.
- Staff should either be involved in analysing and interpreting the data or should at least receive feedback on the data they collect.

Estimating denominators

Many of the quantitative indicators require a denominator (e.g. total population, total women of reproductive age, total live births). These denominators allow for comparison of the indicator over time and between different sites. However, getting reliable denominators can be difficult in refugee and displacement settings. People may be widely dispersed, there may be continuing population movements, and there may be political opposition to carrying out a census. Average population profiles are obtainable from WHO to aid setting denominators where accurate figures are not available (refer to the Appendix X—Bibliography).

Ways to gather information

The following means can be used for collecting information:

- periodic (daily/weekly/monthly) reports from clinic- and community-based services (possibilities for gathering information from the community should be fully exploited;



- TBAs, health care providers and midwives can report on live births, stillbirths, low birth weight and numbers of pregnant women; if TBAs are illiterate, use pictorial reporting forms; in all cases, forms should be simple and appropriate to staff);
- reports of consumption of supplies, stock management and timeliness of deliveries;
 - review of clinic records and periodic audit of specific clinic records;
 - surveys (large-scale surveys are time-consuming and expensive, and are more useful for evaluating changes over longer periods of time, e.g. in knowledge, attitudes, beliefs and practices);
 - exit interviews to monitor client satisfaction and appropriateness of care;
 - facilitative supervisory visits to observe clinical skills, counselling skills, managerial skills, health education skills, performance audits and case audits;
 - observation and assessment of clinic facilities, waiting areas, patient flow and patient contact times;
 - interviews with key informants (community members and staff);
 - focus group discussions;
 - regular staff meetings (with both agency and refugee/displaced staff);
 - reports of critical incidents (e.g. breakdowns in the emergency obstetric referral system);
 - confidential ("no name, no blame") investigative analysis of maternal deaths.

Analysing and using the information

A two-way health information system (HIS) should be developed to provide both information to the manager for programme monitoring and planning, and feedback to health workers on progress towards objectives. Staff should be involved in analysing and interpreting the data to monitor trends in service delivery and the quality of care. This establishes a participative problem-solving process for improving the service.

Staff meetings and opportunities for reporting critical incidents are an essential component of an information system. One person should be designated as the focal point for the entire HIS, with the reproductive health coordinator being responsible for collating information on reproductive health.

Information gathered through the HIS should be analysed swiftly and results fed back to those who are in a position to respond (i.e. staff, community leaders, camp managers, government officials). Such information is useful for mobilizing national and international support and funding for reproductive health.

Results of periodic evaluations are used to review the plan of action, recommend changes and redefine objectives. The indicators should be reviewed as part of the evaluation process. Indicators that are not useful or are too difficult to collect should be discarded or changed. Also, as programmes change, new indicators will be needed.

This chapter discusses issues that must be considered in order to provide quality reproductive health care services.

Quality of care issues to consider

1. Human resources
2. Steps in managing training programmes
3. Service delivery
4. Special service delivery
 - Laboratory services
 - Psychosocial support services
 - HIV/AIDS counselling
5. Information, education and communication (IEC)
6. Management of supplies/equipment

12.1 Quality of care

High quality of care is essential if reproductive health services are to be fully utilized. It is likely to lead to a more efficient use of resources because the health benefit of interventions will be greater.

A framework for quality of care includes the following:

Technical competence of health care providers

Providers must be technically competent in clinical techniques and should observe accepted standards and protocols. The standards and protocols used in refugee settings should be in line with host country standards and protocols, where these exist. Protocols may need to be developed to respond to particular reproductive health needs which health workers are unfamiliar with, such as rape, domestic violence, emergency contraception, and harmful traditional practices, such as female genital mutilation in girls and pregnant women. Technical competence of health care providers depends on clear guidelines for clinical treatment, regular training, periodic

assessment, if necessary retraining and adequate supportive supervision.

Norms and standards for the equipment and drugs needed at each level of care should be established and availability of both should be assured.

Availability of services

Reproductive health services should be available, accessible and acceptable to all who need them. In refugee and displaced settings, this may include mothers with children, unmarried women, older women, women confined to their homes, disabled women, adolescent boys and girls, unaccompanied minors, street children, schoolgirls, girls not in school, married and unmarried girls, married men, fathers, single men, disabled men, soldiers and police, commercial sex workers, and relief agency staff.

Barriers to availability include:

- services not provided;
- laws or regulations forbidding the provision of services to certain groups (e.g. people below a certain age, unmarried people);
- the need for spousal or parental consent;
- cultural and/or religious constraints;
- curfews and enforced limitation on movement;
- refusal of health care workers to provide a service;
- inappropriate service times.

Regulations limiting availability may take the form of the laws of the host country, the cultural prohibitions of the community or the policies of NGOs. Health care providers within an organization may also refuse to provide services to certain groups.

While host country laws must be respected, other barriers to availability may be surmountable through staff training and recruitment, education and advocacy among community and religious leaders, and selection



of NGOs so that a comprehensive range of reproductive health services is available.

Accessibility of services

Services should be accessible to all that need them. Even if services are in theory available to a certain group, they may not be accessible for a number of reasons.

Barriers to access include:

- *Services are considered to be for a particular group only.* For instance, a traditional MCH programme that focuses only on pregnant women who are already mothers will exclude large numbers of people in need of other kinds of reproductive health care.
- *Opening times are inconvenient.* Opening times should be targeted to the needs of different groups (e.g. school-going adolescents may not be able to use daytime services, and men may not be able to use services at the same time as women).
- *There may be fragmented vertical services offered on specific days and at specific times.* Ideally, all services should be offered daily. If this is not possible, offer all services targeted at women and children on the same day (e.g. under-five clinic, antenatal clinic, family planning clinic, STI clinic) so that clients do not need to make multiple trips to use different services.
- *Services may be badly located.* Clinics should be sited as close as possible to the people they serve and in places where women feel safe. Treatments and procedures should be provided by the person at the most peripheral level of the health care system able to perform them competently, with adequate back up from referral services. Community outreach services should be provided for women who are confined to their homes by custom (e.g. by purdah, during the postpartum period, or because of disability).
- *Services may be too costly.* While services are usually free in refugee settings, at least initially, the cost of a service can also be

measured in time lost from work, whether this is paid work or the work of fetching water or fuel.

- *Health care providers may deter people.* If health care providers have a reputation for not treating individuals with respect, people will be reluctant to use the services.

Acceptability of services

Services may be available and accessible but still not utilized because:

- they are not acceptable to the target groups they aim to serve;
- clients may not trust the quality of the services;
- there may be a social stigma attached to using a service (adolescents in particular may fear being seen by people they know when using reproductive health services);
- health workers show harsh or judgmental attitudes;
- clients may prefer to consult health workers of the same sex;
- clients may fear, or know, that consultation will not be private or that health workers will not maintain confidentiality (clients/patients must feel secure that their discussions with health workers will not be overheard, and that details of their private lives will not be revealed in public);
- waiting times are too long and contact time too short.

In addition, services must be provided in a way that is culturally acceptable. In refugee settings, managers and health workers should be aware of what is acceptable in the culture of the displaced community.

To ensure that services are accessible and acceptable to all, members of target groups must fully participate in programme design (i.e. involving the adolescents, women or men for whom the services are intended in the development of the service). In addition, barriers

to care should be identified through interviews with key informants.

Strategies to protect confidentiality include the following.

- Clinics should be designed so that all consultations are as private as possible. Selecting some services and consultations for special treatment (e.g. STI treatment, counselling for victims of violence) can destroy rather than protect confidentiality. To provide privacy, one room can be divided into sub-units. Each sub-unit can be made into a small-screened nursing station.
- Confidentiality should be a part of staff training. Attitudes to confidentiality, privacy and the rights of individuals and the community vary between cultures. In training, staff should explore their own attitudes to confidentiality and the effect that breaking it may have on clients' willingness to use reproductive health services. Not only clinical but also laboratory, protection and social service staff should receive training.
- Confidential record-keeping systems should be set up (particularly for results of HIV testing and for records relating to gender-based violence). Code numbers rather than names may be used, or records may be kept under lock and key with limited access.

Promotion and protection of health through preventive services

This includes community IEC campaigns and one-to-one education and counselling in the community and in clinics. Clients should have the opportunity to talk to health care providers and should be offered guidance on health problems identified. Counselling is a critical component of the health care service.

Quality of client-provider interaction

Providers must treat clients with respect, be responsive to their needs and avoid judgmental

attitudes. Adherence to the highest ethical standards is an essential component of the quality of care. Services should be provided in ways that ensure respect for privacy, confidentiality and freedom of choice, and that ensure equity of care to all groups. In any situation these are key issues and can be difficult to achieve. In situations of conflict and displacement they may be even more difficult to attain, but at all times an explicit attempt should be made to strive for the highest ethical standards.

Providers should see clients as partners in health care and should involve them in decision-making. Training should include communication skills and opportunities for staff to explore their own attitudes to providing reproductive health services to various groups (e.g. adolescents, unmarried women, commercial sex workers, women suffering from complications of unsafe abortion and men). Emphasis should be placed on the need for a positive non-judgmental attitude to all clients. A member of staff who is unwilling to provide a particular service must be willing to refer the client to someone else.

Organization of comprehensive care

Opportunities to provide a full range of services should not be missed. For example, maternal care is a unique opportunity to provide women with other elements of reproductive health care and to address issues such as nutrition and sexually transmitted diseases. Similarly, immunization of children provides an opportunity to offer maternal health care and family planning information and services. Look for opportunities to provide a more comprehensive service. Whenever possible, the full range of services should be offered by one health care provider. If this is not possible, the client should be referred to other providers on the same day and should not be expected to wait long periods to see each provider. In addition, links between different sectors should be fully exploited.



Integration within primary health care services

Reproductive health services should be integrated horizontally (in terms of components of care), vertically (in terms of levels of care) and over time (in terms of continuity and follow-up, refer to Section A, Chapter 3).

12.2 Human resources

The acceptability of the health worker to the client is crucial. Trustworthiness, confidentiality, kindness and a non-judgmental and non-coercive attitude are vital. Frequently, peer service providers may be the most trusted. However, this is not always the case; for example, adolescents may sometimes be more comfortable receiving treatment and advice from a trusted adult rather than from a peer.

Staff recruitment

In cultures where women may receive health care only from female service providers, it is essential to recruit female health workers, counsellors, translators, social service staff, protection officers etc. Similarly, having male service providers may be essential for male uptake of services. As a general rule, all programmes should aim for at least a 50:50 ratio of male and female staff (both agency staff and refugee/displaced staff).

Professional health staff

As well as appropriate professional qualifications, a strong staff commitment to reproductive health is one of the most important determinants of the success or failure of reproductive health services in a refugee or displacement setting.

Other attributes to look for are: experience of working in emergency situations, a commitment to community participation, gender awareness, knowledge of educational methodologies, and a commitment to teaching as well as to quality service provision.

It may be easier to recruit nurses with midwifery and community education skills from within the host country, if it is a developing country where almost all nurses are trained in these skills. Host country staff are also more likely to be willing to make a long-term commitment, which becomes more important as long-term programmes are planned. The competency level of all staff involved in providing reproductive health care services should never be assumed. It is important that structured supervisory programmes are planned to acknowledge high standards of performance and help staff identify and improve weak areas of performance. In some places it may be appropriate to develop mentorship programmes by having a more experienced practitioner work with and supervise a less experienced practitioner. All health care professionals should be trained in how to work with and supervise the community-based health care providers.

Community-based health workers

As far as possible, community-based health workers should be peers of the groups they will be working with. People who are already respected in the community should be chosen, with the community involved in the selection process. The community should be briefed on the kinds of personal qualities that are needed: trustworthiness, acceptability, skill in communication, and appropriate educational background.

Literacy or a minimum standard of education is often used as a requirement in recruiting community-based staff. In societies where fewer women than men are educated, this can prevent women from being employed. Training programmes and job descriptions can be adapted to the needs and capacities of non-literate health workers.

As well as traditional birth attendants (TBAs) and community health workers (CHWs), other categories of community-based health workers who have been trained and used in reproductive health programmes in refugee and displacement situations. These include

community health teachers (CHTs), community-based distributors (CBDs), AIDS community educators (ACEs), health information teams (HITs) and community counsellors. The decision whether to train one or two cadres of generic health workers, or a number of specialist groups, will depend on local needs and resources (Table 10).

A clear policy on the payment of health workers should be established from the outset, with agreement of all agencies.

Training

Training, continuing education and staff supervision are critical not only for high quality of care during the displacement, but also for long-term capacity-building among the refugee/ displaced community. As the situation stabilizes, attention needs to be turned to training of trainers and to training in management and supervisory skills. Training women in these skills contributes greatly to their empowerment. In insecure situations, when outsiders may be

withdrawn or evacuated at short notice, it is even more important to train community members in all skills needed to run reproductive health programmes.

	Advantages	Disadvantages
Generic health workers (TBAs and CHWs)	<ul style="list-style-type: none"> ➤ Families and communities get to know one or two health workers ➤ Easier to coordinate smaller numbers ➤ Less training input required 	<ul style="list-style-type: none"> ➤ Health workers may be spread too thinly and asked to meet too many needs ➤ Training may not provide them with the appropriate skills to meet the many needs ➤ TBAs may face a conflict of interest in providing family planning education if they receive income from assisting with deliveries
Specialist health workers (TBAs, HITs, CBDs, ACEs, community counsellors etc.)	<ul style="list-style-type: none"> ➤ More knowledgeable about specialist area ➤ Peer educators are more acceptable and effective ➤ Can be mobilized to carry out intensive IEC campaigns 	<ul style="list-style-type: none"> ➤ Donors may be reluctant to sustain funding for large numbers of health workers in the long term ➤ Families and communities may find themselves swamped with poorly coordinated and possibly contradictory information

Table 11 summarizes the reproductive health training needs of

Birth attendants

If properly trained and supervised, and fully supported by an emergency obstetric referral system, TBAs or community-based midwives can be central to successful reproductive health programmes. (The ratio of trained TBAs per head of population to aim for is 1 per 1500-2000 population.) As well as caring for pregnant women, they can also act as community educators on nutrition and childcare, HIV/STI/AIDS prevention and care and family planning and as community-based counsellors and reconciliators. However, what can be expected of TBAs will also depend on their traditional role within any given culture.

different groups in a refugee setting. Training methods and content will depend on the target audience, but all training should be skill-based, participatory and geared towards problem-solving methods. Methods will include self-learning, one-off workshops, seminars, study days and supervised practice, as well as classroom and practical training.

Not only health workers but also all relief agency staff need orientation to reproductive health and gender and human rights issues. In the case of international staff, this should form part of a pre-departure orientation package. However, gender orientation or reproductive health awareness training, such as that discussed



Table 11: Training requirements*

Relief workers	Including headquarters staff, UNHCR and NGO programme manager, protection officers
<ul style="list-style-type: none">➤ Managers should have a basic understanding of reproductive health issues and a comprehensive understanding of gender and human rights issues.➤ Protection officers in particular should have a comprehensive understanding of issues of violence and skills in communication and counselling.➤ The reproductive health coordinator should have management skills, including assessment, monitoring and evaluation, as well as a comprehensive understanding of reproductive health, gender and human rights.	
Host country representatives	Including health care personnel, police, information officers
<ul style="list-style-type: none">➤ Health care personnel from host countries should have skills in providing reproductive health care, communication and counselling, and a basic understanding of gender and human rights issues.➤ Police and information officers should have a comprehensive understanding of human rights issues, and a basic understanding of gender and reproductive health.	
Health care providers	Including physicians, nurses/midwives, front-line health workers, community health workers, TBAs
<ul style="list-style-type: none">➤ Health care providers at all levels must have skills in the provision of reproductive health to all groups, including adolescents, and in communication and counselling, according to locally and internationally established guidelines. They should have a comprehensive understanding of gender and human rights issues, and a basic understanding of assessment, monitoring and evaluation. They should also have training and supervisory skills as required.➤ Community-based health workers should have community mobilization, communication and counselling skills. They should be skilled in whatever service they are providing to the community.	
Social service providers	Including social workers, interviewers, counsellors, teachers
<ul style="list-style-type: none">➤ Social service providers should be skilled in communication and counselling, with a basic understanding of reproductive health and a comprehensive understanding of gender and human rights.	
Community members	Including leaders of women's and adolescent groups
<ul style="list-style-type: none">➤ Key community leaders should have a common understanding of reproductive health, gender and human rights, as well as basic skills in assessment, monitoring and evaluation.	

* Adapted from: *Proceedings of the Interagency Symposium on Reproductive Health in Refugee Situations, Geneva, 28-30 June 1995*, p. 48.

in Section B, Chapter 6, can be held at any time once the situation has stabilized. This could be included as part of the training of all refugee health or community workers.

Supervision

Supervision should be built into the overall plan of action and the plan for training. To be successful, it should be regular, constructive and facilitative. It should cover all aspects of the health worker's job description (i.e. knowledge, technical skills, communication and counselling skills, and administrative skills). It must include opportunities for supportive feedback to staff, and continuing education based on problems identified by the health care providers and/or supervisor.

12.3 Steps in managing a health worker training programme

Identify needs in training. Training in reproductive health needs can be looked at under the headings of:

- information needs;
- technical skills;
- organization and managerial skills,
- communication, education and counselling skills;
- administration skills;
- respect for client confidentiality and freedom of choice;
- community mobilization and leadership skills for community-based health workers.

Training needs should be based on an assessment of:

- current knowledge;
- existing attitudes;
- existing levels of competency;
- changes required in the organization and management of services;

- analysis of the tasks the health worker will be expected to perform.

(If results of client satisfaction surveys are available, these should be taken into account when identifying training needs.)

From this analysis it is possible to identify learning needs by comparing what health workers already know and what they are competent in, to what knowledge, attitudes and skills they will be required to provide for an effective reproductive health service.

The uptake of reproductive health services depends both on the level of client confidence in the health provider's technical skills and on the health provider's attitudes and communication skills. For this reason, strong emphasis must be given to training in communication skills as well as in technical skills.

Gender awareness, and the impact of gender on reproductive health (e.g. on reproductive health decision-making within families), should be part of training. If health service providers are from a different culture than that of the users of the health services, training should include awareness of cultural differences and how they can impact on reproductive health. (This is also necessary if service providers are of a different class or caste from service users.) Training should include an exploration of how gender roles and culture have changed as a result of conflict and displacement.

As well as identifying what the content of the training should be, other needs should be taken into account. For example, female health workers may not be able to attend training if the classes are held at the time when the water taps are open or food is distributed.

Seek funding, plan and organize resources

Funding should be sought both for initial training and for continuing training and supervision. Resources should include training materials and supplies. Training in reproductive health should be integrated with training in other aspects of primary health care.



Adapt and develop training materials

Whenever possible, existing curricula should be adapted and used, rather than writing new curricula. If the official training curricula of the host country or of the refugees' country of origin are used, it may be possible to arrange for health workers trained in the refugee/displacement setting to receive national recognition and registration.

Training materials are listed in Appendix X—Bibliography, and include technical guidelines on different aspects of reproductive health. A useful five-day training programme on communication skills is *Strengthening communication skills for women's health: a training guide* (see Bibliography for details).

Identify trainers

Trainers of health workers may be drawn from international, national or refugee/displaced staff. The attributes of a good trainer include:

- background training in relevant areas of reproductive health, and experience of work in resource-poor settings;
- familiarity with the knowledge, attitudes, beliefs and practices of the community, particularly with reference to reproductive health;
- experience in organizing training programmes;
- experience in using participative learning methodologies;
- supervisory and managerial skills;
- ability to innovate and adapt existing materials and strategies;
- ability to motivate and lead people.

Structure the training programme

Not everything can be taught at once. The learning experience should provide the correct medium for the knowledge, skills and attitudes to be learned. It is important to build on what

people already know and what they can already do. A seminar or workshop can provide basic knowledge and initiate the development of skills through role-plays, simulated practice and demonstrations. Training should be continued in the workplace through on-the-job competency-based training programmes. These programmes can be managed by clinical trainers or competent supervisors who assess individual performance against specified criteria in order to identify and improve weak areas of performance. This can be achieved through a structured supervisory programme that provides supervised

RWANDA/TANZANIA

"So pervasive and widespread is the societal pressure to reproduce that many service providers voiced the feeling that as well as coercive sex there will be coercive fertility. Interviews with service providers also exposed the fact that some would not respond positively to an unmarried woman's request to provide contraception, stating that "she should now deliver for Rwanda". This underlines the need to provide training, supported by supervision, in which the client's right to choose will be emphasized."

Source: Report on WHO mission to Tanzania (Ngara and Karagwe), GPA/FHE, 26 October-10 November 1994

MEXICO

"In the Yucatan peninsula of Mexico ... the newborn infant's umbilical cord used to be cut with a piece of fresh bamboo and singed with a burning candle by the "village midwife". As a result of a training programme, this practice was discouraged and replaced by cutting the cord with sterilized scissors. However, since midwives could not follow the sterilization procedures which they had learnt in the course under the conditions of their actual work, the number of cases of neonatal tetanus actually began to rise in the area, suggesting that the more "traditional" practice was in fact an appropriate and well-adapted one, and should not have been abandoned completely."

Social and cultural issues in human resources development for maternal health and safe motherhood. (Report of a working group meeting, WHO/MCH/MSM/91.4)

practice and on-the-job training. This type of training can be supported by a continuing education programme that offers periodic study days, weekly study sessions (scientific hours), case audits and reviews to provide inputs that develop further the knowledge and skills of the practitioners.

Monitor and evaluate the impact of training

Each training programme should be evaluated and the results of the evaluation used in planning future training. The evaluation should look not only at the gains in knowledge, skills and attitudes of the trainees, but also at the impact these have on the reproductive health of the clients or community. Evaluation to determine sustained levels of improved practice can only be achieved by developing a supervisory programme. Supervisors should never behave like inspectors. Supervisors must be taught how to be facilitators so that they work with staff to identify and solve problems.

Recruitment and training of translators

Good translators are vital to successful service provision where service providers or educators do not speak the language of the community. In an area as sensitive as reproductive health, both the translation skills and the attitudes of the translator are crucial. As with health workers, translators should be respected by the community they serve. Translators should be included in training programmes so that they are familiar with the subject matters they will be asked to translate. They must understand the need for confidentiality and for a non-judgmental attitude towards clients.

12.4 Service delivery

A comprehensive package of reproductive health services is described in Table 2. The components of reproductive health services

should be integrated and coordinated with each other, with other primary health care services, and with other sectors. "Vertical integration" of services is also important, linking family, community and community-based health workers with the health centre and with the referral service. Good communication between different levels of care and clearly understood protocols for referral are required.

Reproductive health services should also be concerned with women's and men's health throughout the life span, and not just concentrated on episodes of pregnancy, contraception or STIs.

Community-based services

As far as possible, reproductive health services should be provided at community level. However, for this to succeed, there needs to be an efficient referral system and adequate training, supervision and support of community-based health workers. This can be provided through frequent supervisory visits and meetings for feedback and continuing education. Community-based delivery of care is most successful where the community is actively involved and has a sense of ownership of services.

Clinic-based services

The *Mother-Baby Package* describes two types of health centre through which primary health care services are delivered in stable settings. In larger refugee settings there may be a

"Delivery of care at the lowest feasible level with arrangements for effective referral of complicated cases is generally the least expensive arrangement from a number of perspectives, including transportation, use of specialists and women's time."

Source: Complications of abortion: technical and managerial guidelines for prevention and treatment. WHO, Geneva, 1995



similar pattern of peripheral Type I health centres, a central Type II health centre and a referral centre either on or off the site (Table 12).

As a general rule, integrated family health clinics where all components of primary health care services, including reproductive health

the clinic provides the widest range of reproductive health services that resources allow. Clinics should be designed and constructed with private consulting areas.

Patient flow

Effective systems for managing the flow of patients through a facility ensure that, regardless of fluctuations in caseload, patients receive care in a logical sequence and without unnecessary delays. Managers can often improve the quality of care

Table 12: Type I and Type II health centres		
Type I	Dispensary Health post Health subcentre Primary health care unit	<ul style="list-style-type: none"> ➤ limited ambulatory and curative services ➤ community development ➤ no beds (possibly one maternity bed) ➤ staffed by auxiliary nurse/midwife ➤ population served <10,000
Type II	Health centre Primary health care centre	<ul style="list-style-type: none"> ➤ ambulatory and curative services ➤ health promotion, prevention and education ➤ support for subcentres ➤ maternity and observation beds ➤ outpatient operating room ➤ staffed by multidisciplinary team of professional and auxiliary health workers ➤ population served maximum 100,000

services, are provided in one facility are the most effective means of ensuring access to all. In some circumstances it may be necessary to segregate services for men and women because of cultural constraints. It may be possible to meet the need for segregation by designing family health clinics with separate entrances and waiting areas leading into a central consulting and treatment area.

In situations where many women have been raped, there may be a need for separate, confidential reproductive health services for women, perhaps at a safe place where women gather for practical and psychological support, education and income-generating activities.

In smaller settlements, there may be no more than a weekly mobile clinic. If this is the case, every effort should be made to ensure that

significantly by organizing existing resources more efficiently. Six critical questions for managers are:

- What activities must be carried out in a particular area, and in what order?
- Where and why does congestion occur?
- What is the patient waiting time and what is the patient contact time?
- Is there privacy during a consultation?
- How is care provided? Is it provided by one practitioner or by several practitioners performing individual tasks?
- How could space and personnel be modified to increase the efficiency of activities and better serve the patients?

Referral services

An efficient referral system is essential for the provision of emergency obstetric care. It is also necessary for family planning services not available on-site (e.g. insertion of IUDs and surgical implants) and for gynaecological referrals. The referral system usually has two tiers: from TBAs in the community to the health centre for review and first aid, and from the health centre to the nearest hospital with surgical facilities. The essential elements required to establish a referral service during the emergency phase are summarized in Section B, Chapter 7.

A functioning referral system in a refugee or displacement setting requires:

- TBA and community education on the recognition of danger signs during pregnancy, delivery and the postpartum period, and knowledge of when and how to refer;
- provision of obstetric first aid before referral;
- coordination between all organizations involved in providing reproductive health services (including those responsible for transport);
- good coordination between the health services in the camp or settlement and the local/host country referral centre;
- adequate transportation systems within the community and between levels of care, and clear agreement on responsibilities for transportation;
- agreed written protocols on clinical services at each level of care with specific indications for referral, and the channels and procedures for referral, clearly identified (i.e. who refers to whom and to where and what medical information to accompany patients?);
- a referral centre with the capacity to respond to the demand (this may involve support of local services through material resources, personnel, training etc.);
- regular meetings between managers of different agencies to review and evaluate the referral system.

Where there is insecurity in a camp or settlement or danger when travelling to an outside referral hospital, particularly at night, local solutions must be found in consultation with TBAs, community midwives, community leaders and local police. Such solutions may include:

- a security escort for midwives and doctors entering the camp;
- community protection for TBAs;
- community transport of patients to a safe site (provide bicycles, stretchers etc.);
- strengthening TBA training in emergency obstetric first aid.

12.5 Laboratory services

The laboratory tests that should be available as part of a comprehensive package are listed in Table 7, Section C, Chapter 9.

Laboratory services may be provided through:

- an existing local health service laboratory, which may need support to cope with increased demand;
- a temporary or mobile laboratory;
- a purpose-built laboratory;
- simple tests carried out at Type II health centres.

12.6 Psychosocial support services

Reproductive health and mental health are closely linked through HIV/AIDS counselling, support for breastfeeding mothers and particularly through support for victims of rape or other forms of gender-based or sexual violence. Refer to Section E, Gender-based and sexual violence during conflict and displacement.

Agencies with responsibility for reproductive health services should work closely with mental health services, psychosocial support services,



PASTORAL CARE: ZAMBIA

"The Chikankata concept of integrated AIDS management incorporates pastoral care alongside medical and nursing care, counselling and education. A person with HIV or AIDS may experience feelings of shame, guilt, helplessness, alienation, bitterness, depression, or fear in the face of imminent death. Pastoral care is an effective means of helping many people cope with these feelings by drawing on spiritual resources. In the case of Chikankata, the religious context is Christian, but the principles of pastoral care also apply to other religious faiths. The Chikankata AIDS team members define Christian pastoral care as "a commitment to expressing and interpreting God's love and resources through service and counsel in Christ's name".

Pastoral care may take various forms—praying together, reading from the Scriptures, or encouraging a spiritual perspective. Virtually all patients in the Chikankata catchment area accept the spiritual dimension of life as just as real as the material, and many profess themselves to be Christian. The sharing of religious—and specifically Christian—concepts is not seen as an intrusion into one's private life. On the contrary, it is both appreciated and expected, particularly of health workers from a mission hospital such as Chikankata.

When a patient dies, one or more members of the AIDS team provides pre-burial counselling to the family and attends the funeral if possible. Attending funerals demonstrates that the support and care do not end with the death of the patient, and that the team has an ongoing concern for the welfare of the family and the community. The funeral ceremony is also an opportunity for pastoral care.

All members of the Chikankata AIDS team are able to function in a pastoral role, but this need not be the case in all home care teams. It will usually be sufficient if at least one member of the team can play this role, providing the others—regardless of their religious beliefs—all recognize the validity of pastoral care in meeting the needs of the patient as a whole person. The members of the AIDS Department also provide one another with spiritual support, and this has been a major factor in enabling them to cope with the emotional stress arising from working in the field of AIDS."

*Source: Campbell IG,
Williams G and A.
AIDS management:
an integrated approach.
Strategies for hope, 3, 1990, p. 22*

social services etc. The WHO/UNHCR publication *Mental health of refugees* is a valuable tool for anyone working with refugee or displaced populations. It is intended for use by workers in refugee camps who may not have health training or, indeed, any professional training. It covers stress and relaxation, functional complaints, common mental disorders, helping refugee children, traditional medicine and traditional healers, alcohol and other drug problems, helping victims of torture or other violence, and helping victims of rape. (See the Bibliography for details and for further references on mental health.)

HIV/AIDS counselling

Resources for HIV testing should be devoted, first and foremost, to ensuring a safe blood supply. A voluntary HIV testing and counselling programme is of lower priority but should not be ruled out, if resources are available and care/support is available for positive HIV/AIDS patients.

HIV testing for diagnosis of HIV-related illness may be offered, but only if confidentiality, informed consent, pre-test and post-test counselling and confirmatory testing can be assured. If counselling and a confirmatory test are not available, diagnostic tests for blood transfusion should be anonymous and unlinked.

HIV/AIDS counselling has two main goals: to give psychosocial support to those whose lives have been affected by HIV, and to prevent HIV infection and its transmission to other people. These goals are achieved by:

- providing clients with information on HIV/AIDS (e.g. means of transmission, prevention and testing);
- helping the infected individual, family and friends to handle possible emotional reactions to HIV/AIDS (e.g. anger, fear, denial);
- discussing courses of action adapted to clients' needs and circumstances and encouraging change, when needed for the

prevention and control of infection (e.g. through protected or safer sex).

12.7 Information, education, communication (IEC)

IEC refers to a whole spectrum of activities that aim to inform, educate and communicate with the refugee/displaced community. Each IEC intervention will have a message, a medium, and a target audience. Some examples are:

- a one-to-one interaction (e.g. a health worker counselling a client on contraceptive method choice in a family planning clinic or a TBA giving a pregnant woman advice on hygiene and nutrition during a home visit);
- role-plays, songs or dramas on STI/HIV/AIDS prevention, targeted at a specific audience (e.g. unaccompanied minors);
- a one-day workshop with male and female community leaders to look at community approaches to preventing gender-based and sexual violence;
- classes and workshops on topics of interest to community members, including sexuality, relationships, reproductive health, gender issues etc. (an excellent resource for such workshops in an African setting is the *Stepping stones* manual and video; see Appendix X—Bibliography for details).

Community education campaigns may be more effective in raising levels of knowledge and awareness, while one-to-one activities such as client counselling and peer promotion may be more effective in bringing about behaviour change. In some situations, advocacy with political leaders will be necessary before community education can be undertaken.

IEC is particularly important for adolescents who, even when services exist, may not recognize problems, may not know they can be treated, or may not know where they can be

treated. The effectiveness of IEC and counselling in refugee settings depends on health workers' understanding of behaviours and attitudes that affect reproductive health, and on effective communication skills. It is vital to ensure that decision-makers within families and communities are targeted for education on reproductive health.

Appendix VII describes the basic steps involved in developing IEC messages and materials, and in pretesting and revising these materials.

Going beyond the basic needs assessment

The more detailed and accurate the information that is available on community beliefs and barriers to care, the better and more effective the IEC messages and materials will be. Basic questions to determine IEC needs and priorities are included in the needs assessment described in Appendix III, and IEC campaigns can be based on this information. However, it is strongly recommended that a staff member with expertise in this area be hired to conduct a more in-depth assessment and to plan and implement IEC related to reproductive health. This person should have a basic knowledge of reproductive health and experience in participatory methods of assessment (such as focus group discussions, in-depth interviews, body mapping etc.) and community education. Ideally, this person should be from the refugee/displaced community; if an outsider is brought in, he or she should have experience of working in other cultures.

IEC and a gender approach

IEC messages must do much more than simply provide factual information about the different aspects of reproductive health and availability of services. The inequities in power between men and women, adolescent girls and older men should also be addressed.



IEC needs to be firmly based on a gender approach that examines the relationships between men and women. (Gender is discussed in further detail in Sections A, B and E.)

Opportunities should be created for women and adolescents to explore realistic and safe ways to protect themselves and their reproductive health. In addition, where women or adolescent girls or boys are not the main decision-makers regarding their own reproductive health, those who are the decision-makers should be targeted. Decision-makers may be husbands or other male family members, or older female relatives. IEC activities targeted at decision-makers should focus not only on increasing knowledge, but also on bringing about changes in decision-making behaviour with regard to matters such as the use of condoms and other contraceptives.

"Women who do not participate in the decision whether to have sexual relations will have difficulty following a course of treatment for reproductive tract infections or using effectively contraceptive methods such as the diaphragm, spermicides, condoms, and natural family planning. AIDS prevention campaigns targeting women for condom use do not take into account that many women play little or no role in contraceptive decision-making. The popular perception of the woman who uses a condom is that she is either a prostitute or an unfaithful wife; the mere suggestion of using a condom can provoke a husband's violent reaction."

Source: Cox ES.

*Violence against women in Central America and its impact on reproductive health.
Paper presented at the Safe Motherhood Central America Conference, Guatemala, 27-31 January 1992*

12.8 Management of supplies

Detailed step-by-step guidance on the management of contraceptive logistics in refugee settings is given in *Contraceptive logistics guidelines for refugee settings* (see Appendix X—Bibliography for details). The tools and information contained in the guidelines can be adapted to the management of other (non-contraceptive) reproductive health medicines and supplies, and the guidelines are recommended for health programme managers and those responsible for logistics in refugee or displacement settings.

The basic steps for managing medicines and supplies (adapted from the guidelines) are:

- select medicines and supplies to be used;
- estimate quantities (ideally, estimates should be based on historical usage figures such as logistics data and service statistics; where these are not available or not reliable, population-based data can be used from a census or demographic survey);
- identify sources and procure medicines and supplies (Appendix XI gives addresses of selected suppliers);
- develop a logistics management information system to track stock on hand, rates of consumption, and losses and adjustments, through stock-keeping records, stock transaction records and consumption records;
- develop procedures to efficiently manage inventories (i.e. to decide how much stock should be ordered and issued, and when, and to maintain proper stock levels in order to avoid shortages and oversupply);
- develop procedures to ensure proper storage (use a first expiry/first out system in stores; ensure adequate space; use a dry, well lit, well ventilated storeroom out of direct sunlight; protect from water and fire; store cartons of condoms away from electric motors and fluorescent lights).

This chapter discusses the meaning and complexities of post-conflict situations.

13.1 What is meant by "post-conflict"?

The transition from conflict to peace is not always clear-cut. Although relative peace may have been established in some parts of a war-torn country, armed conflict may continue in other areas for a long time. The period of post-conflict transition is itself highly unstable, with the constant possibility of a return to open conflict. The authority of a new government is often weak, and it may be some time before the people of the country and international donors feel confidence in the permanence of peace. Figure 5 highlights some of the complexities of this process, and particularly the need to address underlying causes of conflict if a lasting peace is to be created.

Refugee, internally displaced and stayee populations face different challenges in the "post-conflict" era. Long-term outcomes for refugees include:

- return to the country of origin;
- settlement in the host country;
- settlement in a third country of asylum.

Internally displaced persons may:

- return to the area from which they were originally displaced;
- become integrated to a greater or lesser extent in the area to which they had fled.

Third country resettlement will not be an option for displaced persons.

Refugees or internally displaced persons returning to their country or area of origin will be reunited with people who stayed in their

homes throughout the conflict. The reintegration of returnee and stayee populations is one of many challenges faced in the post-conflict period.

Settlement in a third country of asylum is beyond the scope of these guidelines.

Systematic study of the needs of post-conflict societies, and of the positive or negative impact that different rehabilitation assistance has on them, is relatively new. The War-torn Societies Project has begun this process.

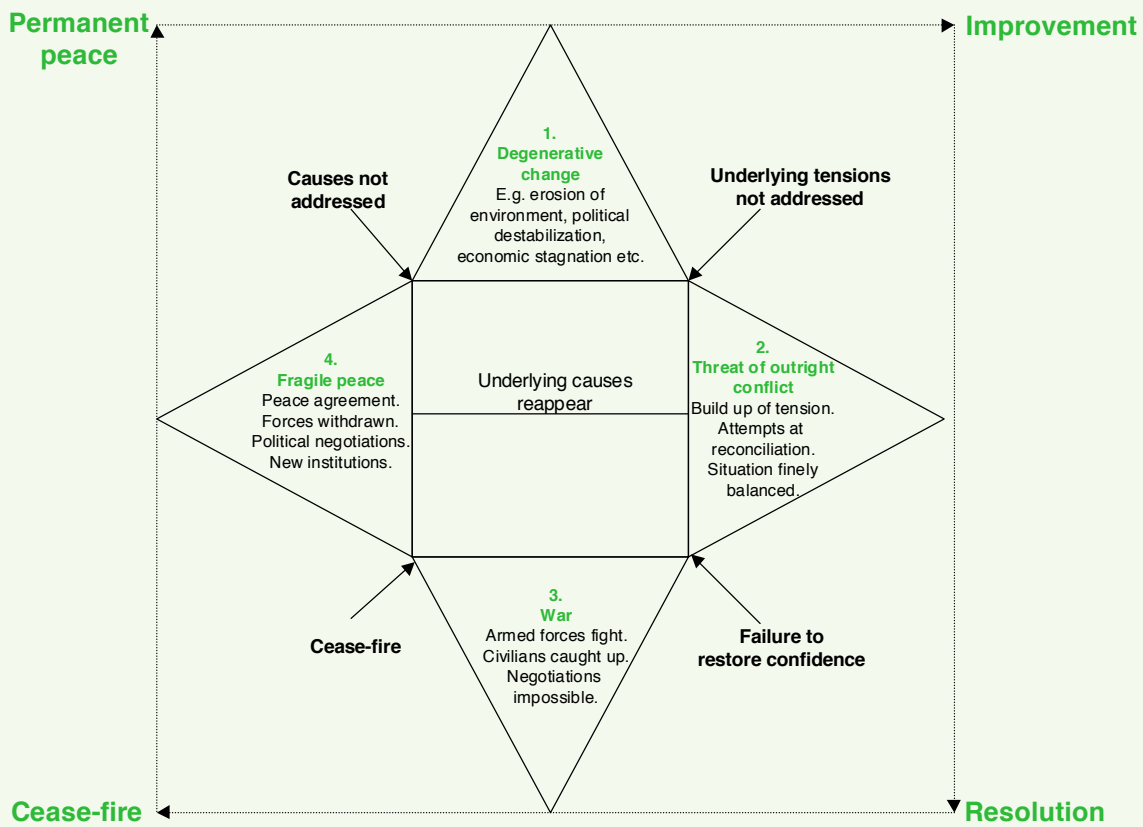
Documenting and sharing information on reproductive health needs in post-conflict settings is also rare, although anecdotal reports exist. However, Zwi, Macrae and others at the London School of Hygiene and Tropical Medicine have explored the issues relating to rehabilitation of the health sector in post-conflict settings in the *Conflict and health* series. This chapter draws on this series and a number of other sources to define key issues affecting the health sector in post-conflict settings, and the ways in which these may apply to or impact on reproductive health.

The aims of the War-torn Societies Project, jointly initiated by UNRISD, the United Nations Research Institute for Social Development and PSIS, the Programme for Strategic and International Security Studies, are to assist the international donor community, international organizations, NGOs and local authorities and organizations to understand and respond better to the complex challenges of post-conflict settings.

*Source: The challenge of peace.
Newsletter of the WSP,
UNRISD, 1996, 4:2*



Figure 5: Conflict as a process



This chapter describes the reproductive health issues to consider when refugee populations return during the post-conflict phase and reintegrate into their own country and/or community. If internally displaced populations return to their homes as part of an organized return, and if they can be reached by humanitarian assistance, the same issues will apply.

14.1 Return and reintegration

"We tend to treat 'the Ugandan refugees' or 'the Tigrayan refugees' or even simply 'refugees' as homogenous categories, as though all people so designated shared the same interests and the same objectives ... We need to learn more about the way refugee populations are internally differentiated and about how these differences affect preferences for and against the decision to return. The result will be a more untidy and complex picture, but it is only by understanding the choices, preferences and decision-making procedures of the refugees themselves that it will be possible to give substance to the much repeated objective of 'empowering' them."

Source: UNRISD. Refugees returning home. Addis Ababa, 15-17 September 1993, p. 16

The decision to return

Refugees may return to their country of origin as part of an organized voluntary repatriation programme. However, the traditional model of peace followed by negotiated and organized repatriations is more the exception than the rule. (Forced repatriation of refugees is illegal according to international law.) Refugees and internally displaced persons may choose to return spontaneously, either while the conflict continues or after it has abated, or they may decide to remain in the country/area of asylum. The reasons behind these choices will depend on many factors, including the relative degree of security in the home area, the amount of time between the original displacement and the time when a return is possible, and the availability of work and income-generating possibilities in the place of origin.

Voluntary repatriation is the preferred solution of the international community. However, the question is whether, and under what circumstances, the refugee sees it as the most desirable solution. There is a danger that plans for voluntary repatriation programmes, while appearing to be consultative, may not reflect the wishes and needs of refugees.

If consultation is only with traditional leaders among the refugees, women may be excluded from the decision-making process. This will have implications for women's access to resources, and their capacity to protect their reproductive health during and after the return. Likewise, special attention is needed to ensure that the views of unaccompanied adolescents and other potentially marginalized groups are heard.

In preparing for voluntary repatriation, the ways in which decisions are made within families and communities should be understood. Research into the motivations of refugees regarding repatriation should be disaggregated by sex and age. Mechanisms should be developed so that women can be informed about the issues relating to repatriation, and their concerns addressed.

MOZAMBIQUE/SOUTH AFRICA

"65% of households were economically supported by women. Among the refugees, however, culture and tradition are still rigidly male-oriented (so) that whether she feeds the family throughout the year, when it comes to key decision-making, the woman is absolutely powerless. She refers such matters to the man whose presence is sometimes made once a year."

Source: Dolan C. Maputo: the changing status of Mozambicans in South Africa and its impact on their repatriation to and reintegration in Mozambique. Draft report to the Norwegian Refugee Council, Jan. 1997



14.2 Protecting reproductive health during and after the return

During the return, and immediately afterwards when local health services may not be able to cope with a large influx of returnees, the minimum aim should be provide reproductive health services equivalent to Core Package described in Section B, Chapter 5. The service components that make up this package are intended to:

- prevent excess neonatal and maternal morbidity and mortality;
- prevent and manage response to gender-based and sexual violence;
- enforce universal precautions against HIV;
- make condoms freely available;
- ensure safe blood transfusions;
- meet existing family planning needs;
- provide menstrual protection.

In the return phase, these aims will be achieved by:

- identifying pregnant women and issuing them with clean delivery kits, iron supplements, and food supplements, as appropriate;
- providing returning TBAs and midwives with supplies and medicines;
- issuing hand-held clinical records to all returnees, if these are not already in use;
- assessing risks from gender-based and sexual violence during and after the return and instituting measures for protection;
- identifying vulnerable groups and individuals (including lone female heads of household, unaccompanied minors, the physically and mentally disabled and elderly, and severely traumatized individuals), and identifying the special needs of these groups during and after the return;

VIETNAM/THAILAND

"Women participate to a very limited degree in information meetings, video showings or discussions. Individual women and women's groups have expressed the need for more specific information for women regarding jobs, training, education, child care, education of children, daily life, cultural, political and economic conditions in Vietnam affecting women, and about projects for women returnees. However, little of this information has been made available, and what exists is difficult to access. The use of discussion groups for women, single mothers, non-refugees, and youths has been attempted in a few places, but is not a common practice."

*Source: Halvorsen K.
Refugee women and repatriation:
perspectives from Southeast Asia.
Refuge, 1995, 14(8)*

- ensuring that women have access to repatriation assistance, registration, identity papers etc.;
- supplying health service outlets with materials needed to implement universal precautions (soap, gloves, aprons, gowns, facilities for sterilization and a system for safe disposal of sharps) as well as IEC materials for health workers;
- ensuring that condoms are available prior to departure and establishing mechanisms for the supply and distribution of condoms both during and after the return;
- providing family planning methods to users for an extended period (e.g. 3 or 6 months);
- ensuring that women fitted with IUDs and implants will have access to follow-up on return (if not, counsel about changing to another method);
- with women in the community, identifying methods to meet the need for menstrual protection during and after the return.

In addition, there will be a need to:

- establish links and mechanisms for coordination with agencies providing assistance in the home country;
- provide health workers trained in reproductive health skills in the refugee camp with certification of training (in some circumstances, it may be possible to negotiate some formal recognition of this training with training bodies in the home country).

As far as possible, these measures should be applied to those refugees who intend to resettle spontaneously as well as to those returning in an organized repatriation.

14.3 Reintegration of returnees

Many refugees will return to their home areas having lost their land, their homes and their means of livelihood. In voluntary repatriation operations organized by UNHCR, returning refugees are usually provided with a basic package of rehabilitation assistance including foodstuffs (usually for a 3-6 month period), shelter materials, seeds, other agricultural items and a cash grant.

However, stayees and returning internally displaced persons will often have suffered as much, if not more than, the refugees. A community-based approach to rehabilitation assistance is preferable, rather than one that targets returning refugees. This means that vulnerable individuals, whether returnee or

stayee, can be identified for special attention as appropriate. A community-based approach has the advantage of reducing the vulnerability of entire communities. It also avoids the resentments that can develop when returnees receive special assistance.

Whether assistance is targeted at returnees or at communities, there is a need for continuing focus on the needs of women, unaccompanied adolescents and minority groups both in providing rehabilitation assistance and in monitoring the impact of assistance. Lone female heads of households, whether returnee or stayee, may face extreme difficulties. This will have serious consequences for their health, including their reproductive health, and for the health of their children.

14.4 Gender concerns

The following questions will help in determining whether or not gender concerns have been taken into account in the programme for repatriation:

- Have demographic data about the refugee population been produced and used for repatriation planning purposes?
- Does counselling and information about voluntary repatriation reach men and women equally, and who makes the decision to return?
- Are men or women or minority groups systematically neglected in information dissemination in the refugee camps and in reintegration assistance after the return?
- Is physical abuse by other refugees, government officials, pirates or bandits during and upon return a gender-specific problem?
- Does monitoring include investigating the needs and concerns of vulnerable groups such as female-headed households, elderly women, single young mothers, and severely traumatized women?
- Are the specific reintegration needs of women being addressed?

ZIMBABWE

"After its independence in April 1980, the country linked humanitarian assistance for refugees and displaced persons with development assistance to the areas where they returned, thus forging an integrated strategy towards returnee aid and development advocated only years later by international conferences."

Source: UNRISD. 30 years of research for social development. 1993, p. 40



This chapter discusses the reproductive health and relevant legal issues to consider when refugee populations settle in the host country.

15.1 Integration of services

Refugees who remain in the country of asylum may continue as long-term refugees in camp-like settings, or they may become integrated to a greater or lesser extent into the host community. In either situation, a time will come when it no longer makes sense, financially or politically, to continue providing health services to refugees through parallel structures.

Ideally, international organizations and NGOs should, from the outset, develop refugee reproductive health services with the long-term aim of full integration with host country health services. Unfortunately, this does not always happen. Although reproductive health services are seriously neglected in some refugee settings, in other cases services are provided to a standard far beyond what is available to host communities and through structures unrelated to host country health structures.

Obviously, this gives rise to difficulties when the time comes to integrate services or to hand them over to a local NGO. As well as facing changes in established ways of doing things, refugees will have raised expectations that can no longer be met. Problems may arise in relation to controversial components of reproductive health, such as condom distribution, family planning services and services for adolescents. These difficulties should be acknowledged at an early stage so that all possible ways of continuing comprehensive services can be explored.

"In refugee settings where the repatriation timeline is uncertain every effort should be made to initiate a handover at the earliest date possible. Ideally, the decision could be made a year in advance in order to allow ample time to:

- explain clearly to all interested parties the reasons for departure;
- have a clear timeline for departure which is communicated to all interested parties well in advance of departure so that expectations are set and met;
- identify or form a local NGO early on;
- assure that the new agency will support key components of programme, especially potentially controversial components included in reproductive health programmes;
- work out the details of the transfer with all expenses considered in the negotiations;
- overlap with the new NGO to provide programme orientation and technical assistance;
- apply for funding in conjunction with the new NGO in order to support continuation;
- develop leadership potential of staff members;
- prepare staff for changes in programme approach and management style."

*Source: Goodyear L.
Lessons learned: Côte d'Ivoire and
Ghana: Family planning and AIDS
program: training and evaluation and
transfer to a local NGO.
International Rescue Committee,
1996*



15.2 Hand-over of reproductive health services

The following recommendations were developed by an international NGO working with Liberian refugees in Ghana. The recommendations are based on lessons learned during the hand-over of reproductive health services to a local NGO.

15.3 Legal vulnerability of long-term refugees

Refugees who have chosen not to repatriate voluntarily may find themselves in a legal vacuum. They will no longer be protected by international refugee law, nor will they be fully protected as citizens of the host country. They may not be eligible for health care on an equal footing with citizens of the host country. Women may be vulnerable to gender-based violence from a hostile community or from police or government officials, without being protected by the laws of the country.

The solutions to these problems lie in international law and in the national politics of the host country. However, health programme managers should be aware that long-term refugees are a potentially marginalized group. Special efforts may need to be made to ascertain

the reproductive health needs of this group, as they may be reluctant to draw attention to themselves by expressing their needs. Policies on non-discrimination should be developed to guide health workers.

MOZAMBIQUE/SOUTH AFRICA

"The theme unifying all processes of local integration, whether social or economic, is lack of legal status. It has prevented settlement within the official land allocation system, it has prevented whole populations from being considered in local planning processes, allowed endless petty discrimination and scape-goating by locals without fear of reprisals, and it has permitted employers to exploit Mozambicans in a way which has divided them from local employees rather than integrating them into the workforce..."

While being in the homeland areas reduces the prospect of arrest and deportation, it is no guarantee of personal safety, even for those who have been able to obtain identity documents. As one respondent noted: 'The problem is that even if they are legal citizens in the sense that they have IDs, most Mozambicans still don't feel safe and fail to report various violations. The common ones are rape, robbery, and (verbal abuse when) going to the clinics.'"

*Source: Dolan C.
Maputo: the changing status of
Mozambicans in South Africa and its impact on
their
repatriation to and reintegration in
Mozambique
(Draft report to the Norwegian Refugee
Council, January 1997)*

This chapter discusses the implications of re-establishing or establishing reproductive health services in countries recovering from conflict or civil strife.

"In many Third World countries conflict has exacerbated and compounded the structural weaknesses inherent in health systems in the pre-conflict era. Countries recovering from conflict therefore face a dual challenge with regard to health development in the post-conflict period: to address both the general imbalances in the health system common to many Third World countries, and those particular social, political and health problems engendered and exacerbated by war."

*Source: Macrae et al.
A healthy peace?
Rehabilitation and development of the health
sector in a "post" conflict situation:
the case of Uganda.
London School of Hygiene and Tropical
Medicine, Feb. 1995, page ix*

16.1 Policy issues in post-conflict settings

The primary focus of this chapter is broad issues of policy rather than the day-to-day management of reproductive health services, the issues that are unique to post-conflict settings. This chapter may therefore be primarily of interest to senior managers and policy-makers. However, health programme managers working at local or district level should also be aware of these issues when planning reproductive health programmes, in order to set local planning within a broader policy framework and avoid the fragmentation of health services.

The strategies for conflict reduction, vulnerability reduction and emergency preparedness discussed in Sections A and B should also be reviewed in the post-conflict setting. The best time to implement measures for conflict prevention is in the immediate aftermath of a conflict, when the public desire for peace and the political will to act are at their peak. The strategies of using health as a "Bridge

to Peace" (described in Section B, Chapter 8) should be re-visited during the "Post-conflict" period.

The post-conflict setting poses serious constraints to meeting basic reproductive health needs. At the same time, new needs will have arisen as a result of the conflict. However, the post-conflict period can also present opportunities for reform and improvement, such as the development of a strong national policy on reproductive health in countries where reproductive health was previously neglected. The post-conflict transition period can present significant opportunities for improving women's status, which in turn will have a positive impact on reproductive health. Table 13 summarizes the reproductive health needs and challenges of the post-conflict setting.

16.2 Health policy in the post-conflict setting and after the return

In the aftermath of a conflict there may be no coherent national health policy. This can have serious consequences for the rehabilitation of the country and for the long-term development of the health sector (see box on Uganda). In the post-conflict setting, national policy-making structures (e.g. the civil service, government ministries, academic institutions) may be weak or absent. In addition, the authority of the government may not yet be fully recognized, and there may be a lack of accurate information on which to base health policies. The development and implementation of national policies may be impeded by continuing patterns of decentralized decision-making from the period of the conflict. NGOs and donor organizations may wish to continue working in their preferred programme niches, and may resist regulation by the new government.

There may have been a brain drain of policy-makers from government and academic institutions, while policy-makers who stayed in



Table 13: Reproductive health in the post-conflict setting: needs and challenges

Demographic changes

- Changes in the ratio of women to men, increased numbers of widows and increased numbers of unaccompanied minors, including street children.
- There may be a shift in the distribution of the population between urban and rural areas, with consequent social changes.

Gender relations

- There may be continuing marked changes in gender roles and expectations in the aftermath of conflict.
- Women may have taken part in the fighting. Their view of themselves, and how men view them, may have changed as a result. Women in general may have discovered new capacities within themselves as a result of the economic and social challenges posed by the conflict. They may have experienced new freedom of movement that they did not know before.
- Resistance movements that have come to power may have made a commitment to working towards equality for women during the years of the conflict.
- There may be renewed conservatism surrounding gender relations. Gender roles may have become entrenched as a result of the conflict and there may now be more rigid definitions of "masculine" and "feminine" behaviour.
- The new government may support a social or religious viewpoint that places legal limits on women's freedom of movement and freedom of choice.
- There may be differences in how gender relations have changed among returnee and stayee populations. Refugee camps can be socially artificial and static, whereas there may have been rapid changes in the home country during the conflict.

Safe motherhood

- Maternal and neonatal mortality may continue at high levels due to continuing disruption in access to emergency obstetric services and to food, clean water, fuel, sanitation and shelter.
- Clinics, hospitals, maternal and child health services, health programmes, the health infrastructure and health service staffing may continue to be disrupted or not accessible.
- Widespread poverty and unemployment may place the cost of health services, including maternal health services, beyond the reach of the majority of the population.
- Malnutrition, anaemia, chronic untreated diseases and a high prevalence of STIs may continue to affect maternal outcomes.

STI/HIV/AIDS

- New population movements (e.g. return of refugees, displaced and ex-combatants) may bring new risks for the spread of STIs and HIV/AIDS.
- The presence of international peacekeeping forces may contribute to the growth of a sex industry and the further spread of STI/HIV/AIDS.
- There may be increasing numbers of AIDS orphans and people with AIDS, placing heavy burdens on women as carers and on overstretched health and social services.

Sexual violence

- The long-term physical, emotional and social effects of gender-based and sexual violence and other forms of trauma will become apparent, and have profound impacts on community reconstruction.
- As well as the impact on the individual, family and community life, trauma victims may become repeat users of health services, presenting with chronic stress related diseases and psychosomatic disorders.
- The threat of gender-based sexual violence may continue as hostile communities come back into contact with each other and as demobilized soldiers and ex-combatants return to their home areas. Unaccompanied women will continue to be particularly vulnerable.
- Continuing social tensions may be accompanied by increased domestic violence within families.

Family planning

- Desired family size may have changed as a result of the conflict: couples may wish to replace lost children, or may wish to defer pregnancy until they feel secure that the conflict is truly over.
- In some circumstances, returnees' expectations of family planning services may have increased as a result of the services that were made available during displacement.

the country may have been cut off from international debate on health. This can lead to a tendency simply to try to recreate the health structures that existed prior to the conflict. This isolation may be particularly serious in the area of reproductive health, where there have been major changes in recent years. New developments have led to:

- a growing recognition of the burden of maternal mortality in developing countries; a rapid evolution in the understanding of STIs and AIDS, and in approaches to prevention; and a shift in focus from population control to the health of individual women, with an approach that empowers couples to make informed choices about individual family size and that recognizes the crucial importance of men in contraceptive decision-making;
- a move away from the fragmentation of reproductive health services (there is an emphasis on integration of reproductive health within primary health care structures, and on a holistic approach to reproductive health care);
- a growing recognition that solutions to reproductive health lie in social and political changes as much as in improvements in health care;
- a growing understanding of gender, and of the need to approach reproductive health from a gender perspective;
- an increased awareness of the impact of gender-based violence on women's health and on reproductive health.

16.3 Reproductive health policy challenges arising out of the conflict

If there has been widespread gender-based and sexual violence during the conflict, a coordinated national policy response will be needed. This should link reproductive health and mental health programmes, legal and

human rights responses, and community development and reconciliation programmes. Policies for the demobilization and integration of ex-combatants and for the integration of displaced populations should also explicitly address the threat of gender-based violence against women and girls.

Government policies on AIDS prevention will need to respond to changes in the distribution of the disease, and to changes in sexual behaviour among different groups (e.g. ex-combatants, adolescents, widows etc.) arising out of the social upheaval of conflict and displacement. The presence of international peacekeeping forces can have a profound impact on the spread of AIDS, as was seen in Cambodia.

Family planning policies may change to reflect the priorities and beliefs of the new

UGANDA

"Projects developed in the immediate post-conflict period were designed at a time when the health system and the wider political and economic system within which it functioned were in a state of total collapse. The poor status of the health system was seen to merit an urgent response. The projects formulated at this time were seen as emergency, first steps towards health development, and it was hoped that the initiatives implemented at this time—specifically physical rehabilitation, and the development of vertical programmes—would provide a platform on which a future comprehensive and integrated health system could be based.

There is now a widespread consensus that these efforts may in fact have had a distorting effect on the health system, and that attempts to address the crisis of health financing and institutional development will have to confront a triple inheritance—an inappropriate health system developed prior to and immediately after independence, the effects of war, and the effects of the rehabilitation efforts on the health system."

*Source: Macrae et al.
A healthy peace? Rehabilitation and
development of the health sector in
a "post" conflict situation:
the case of Uganda.
London School of Hygiene and Tropical
Medicine, Feb. 1995, p. 47*



CAMBODIA

"Numerous problems have arisen concerning the behaviour of United Nations troops and security personnel and their relations with the host population ... The influx of troops and other foreigners has contributed to an increase in prostitution. While this was to be expected, the scale of the phenomenon was not. Neither was the 10-fold increase in the incidence of HIV/AIDS infection in 1992. The growth of the "rest and recreation" industry has had an impact not only on women but also on children. There is some evidence to suggest that children are increasingly being used in the sex industry, partly to minimize the risk to clients of becoming infected with HIV or other diseases. The "attractions" of Phnom Penh, when combined with the decline in the education system and the needs of many families to mobilize all potential earners, have fuelled a growth in the numbers of street children.

Much stricter guidelines governing the recruitment, briefing and training of peace-keeping and professional personnel should be drawn up. Special attention should be given to the question of social relations with the host population. More thought should be given to the provision of on-base recreation facilities and to the possibility of testing peace-keeping forces for HIV/AIDS before entering the country as well as upon leaving."

Source: Workshop Report: The challenge of rebuilding wartorn societies and the social consequences of the peace process in Cambodia. Geneva, September 1993, p. 25

government. There may be a shift towards official acceptance and promotion of family planning, or a shift towards an active pro-natalist policy and a rejection of family planning. Changes in family planning policy will have implications for maternal mortality and for safe motherhood services. Ethnic groups which have lost power as a result of the conflict may view the promotion of family planning with suspicion.

Changed perceptions of gender roles arising out of the conflict may present an opportunity for policies that promote equality for women, and for inclusion of a gender perspective in all policies for national rehabilitation.

16.4 Creating a forum for policy formulation

"The role of donors in policy formulation in post-conflict situations cannot be under-emphasized. The high level of donor support for capital and recurrent health expenditures means that they have considerable leverage in determining what can and should be implemented. It might also be argued that they have a concomitant high level of responsibility for the successes and weaknesses of policy."

*Source: Macrae et al.
A healthy peace? Rehabilitation and development of the health sector in a "post" conflict situation: the case of Uganda.
London School of Hygiene and Tropical Medicine, Feb. 1995, p. 68*

There is an urgent need for donors, international organizations and NGOs to promote policy dialogue in post-conflict settings. One possibility would be to support a forum where health policy can be debated and formulated. Such a forum could draw upon representatives of the international aid community as well as on key national professional, political and community groups. WHO, through its national, regional and international offices is well placed to coordinate and facilitate such a forum.

The broader the range of community inputs to the debate on health policy, the more likely it is that policies will be appropriate and acceptable. Community-based health groups, women's organizations, other community-based political and social movements, local politicians and health professionals all have a part to play. Community structures that may have developed during the period of conflict should also be built upon.

Policy debate should be decentralized. Regional policies are needed to reflect the needs of regions, which have been differentially affected by the conflict. Appropriate responses to support and strengthen reproductive health will differ according to:

- the nature of the conflict from which the country is recovering;
- the degree of security in different regions of the country; the strength of reproductive health services before the conflict;
- the ways in which services and resources have been affected by the conflict;
- the reproductive health needs that have arisen as a result of the conflict.

16.5 Relief versus development approaches to post-conflict rehabilitation

While sustainable development and political stability may be the stated objectives of international rehabilitation assistance, this assistance is often delivered through relief-oriented agencies, or through the relief desks of relief and development agencies. Use of relief mechanisms allows for rapid disbursement of funds, but the thorough planning and consultation procedures needed for appropriate and sustainable development are frequently bypassed. Also, donor funds channelled through relief mechanisms may have to be used within a relatively short period of time (1-2 years). These factors can contribute to expensive but unsustainable

projects, without consideration for long-term recurrent costs.

In some post-conflict settings, relatively generous funds may be earmarked for reproductive health. While this is to be welcomed, the ways in which these funds are used should be carefully considered in order to result in sustained improvements and so that reproductive health develops as an integral part of primary health care.

Finding a balance between rapid, visible inputs and long-term sustainable measures

There is a need to find a balance between rapid visible inputs, such as rehabilitation of the physical infrastructure and rapid vertical programmes, and sustainable development of comprehensive and integrated health care.

High-profile inputs such as repair of clinics

and hospitals may bring social and psychological benefits to demoralized communities eager for visible evidence of peace. This can bring political rewards to a new government seeking legitimacy, but there is a danger that political needs may dictate health policy. Donors may also have a preference for projects with rapid visible results. However, unless funds have been secured to meet long-term recurrent costs (e.g. maintenance and repair, medicines, salaries), such inputs may be a waste of resources. Where fighting continues, rebuilding physical structures may attract violence, and the risks should be weighed against the advantages (see Section B, Chapter 8). It is crucial to

CAMBODIA

"Many of the problems and destabilizing effects associated with the peace process have to do with the conditions of urgency and scale surrounding the involvement of international agencies in Cambodia. **This sense of urgency has led to an excessive emphasis on short-term humanitarian relief aid and insufficient concern for essential forms of development assistance.** It also resulted in the hasty design and implementation of projects. As a result, action has often been taken without an adequate assessment of needs, priorities, resource availability and impacts. There has been a lack of real consultation with the Cambodian authorities to determine priority needs or to develop policy options for the country's further reconstruction and development. Many donors have chosen to follow their own development assistance agendas which do not necessarily coincide with either the country's rehabilitation priorities or the time frame of the transitional period."

Source: UNRISD. Rebuilding wartorn societies. 1993, p. 21



assess the potential long-term impact of rapid rehabilitation of the physical infrastructure on the future sustainability of the health system, and to assess the extent to which it constitutes a basis for integrated and comprehensive health care.

A sustainable and integrated policy for rehabilitation and development of the health sector would include measures that:

- encourage community participation;
- strengthen primary health care structures;
- integrate reproductive health within primary health care;
- rehabilitate and develop health information and management systems;
- train health workers in responding to post-conflict health needs;
- develop management and supervisory skills at local and district level.

"The key question is whether elements of (these two) approaches can be integrated into a phased approach which acknowledges the political, social and psychological value of rapidly restoring or creating the basic infrastructure for health service delivery, while planning for sustainability and encouraging community and district involvement in health. It is clear that there are not easy answers to this critical dilemma, which is perhaps the most unique feature of post-conflict situations. Resolving the dilemma will, however, require that it be acknowledged at an early stage of rehabilitation planning by all the different agencies—national and international, central and district."

Source: Macrae et al. A healthy peace? Rehabilitation and development of the health sector in a "post" conflict situation: the case of Uganda. London School of Hygiene and Tropical Medicine. Feb. 1995, p. 68

Such a policy would have a long-term positive impact on the capacity of the health services and communities to support reproductive health care services. However, it also has disadvantages: it can be costly and slow to produce results, and it may require a level of

government coordination that is not achievable in the post-conflict setting.

16.6 Information gathering in post-conflict settings

Planning and policy formulation in the post-conflict setting should be based on accurate information on needs and resources in communities and at regional and national levels. Urgent priority therefore needs to be given to re-establishing national and district health information systems. Coordination of information gathering activities between government and international agencies and local and international NGOs is vital for maximizing information and avoiding waste of resources (see Section B, Chapter 6 and Appendix II).

Many of the challenges to information gathering during armed conflict will persist into the post-conflict period, particularly in areas still affected by violence (see Section C, Chapter 10). However, the post-conflict setting can also provide an opportunity for making gender desegregation a routine component of all information gathering, and present opportunities for experimenting with innovative methods of rapid participatory assessment. For national policy formulation and for planning of individual programmes, information will need to be gathered on:

- the state of the physical infrastructure of the health services;
- the availability of health workers, including any volunteers or special cadres trained during the conflict;
- the coping mechanisms that exist within communities (both traditional mechanisms which have survived through the conflict, and individual and community responses which were developed in response to the conflict);
- reproductive health needs of communities, including needs arising out of the conflict;
- ways in which the reproductive health needs of different sectors of the community

(returnees, stayees, women, men, adolescents, urban, rural, different ethnic groups) have been differentially affected by the conflict;

- the gender-specific impact of rehabilitation programmes.

It is important to note that the primary step in any assessment is to search for and review existing sources of information. This will provide a basis for determining unmet information needs.

16.7 Coordination in post-conflict settings

The lack of coordination and the patterns of decentralized decision-making seen during the period of conflict may continue into the post-conflict period. The government's authority may not be fully established, and its capacity to coordinate the activities of donors, international organizations and the private sector may be weak. Even where there are clear government policies, outside bodies may resist being constrained by regulations.

"It is commonly assumed that there will be a community with which to work. But particularly in war and post-war situations this may not be the case ... Networks of social support, local decision-making, trade and credit will have been disrupted and will have adapted to difficult, possibly extreme, circumstances. The construction of relationships between people, the establishing of accountability and trust between neighbours, will take time. It is not simply a question of families being shifted back to their home areas."

Source: UNRISD. Rebuilding wartorn societies. 1993, p. 15

CAMBODIA

"Scores of fact-finding missions have entered the country. While they have absorbed much of the time of Cambodian officials and resource persons working in the country, they have rarely integrated Cambodians as team members. Neither have they generated much new knowledge, instead choosing to recycle information contained in a few reports or obtained from interviews with the same people. What knowledge has been acquired has often left the country. It is rarely disseminated within Cambodia, let alone translated into Khmer...."

There should be greater reliance on institutions and resources and, in the absence of donor community knowledge about local society and culture, more research to determine the strengths and limitations of existing institutions, what remains of traditional community or support structures, and what institutions are re-emerging which could contribute to social cohesion, psychological rehabilitation, and basic needs provisioning."

Source: UNRISD. Rebuilding wartorn societies. 1993, p. 26

Donors and international organizations may have their own preferred strategies and programmes, which may not necessarily correspond to the areas of greatest need. In the area of reproductive health, the lack of a coordinated policy and of government regulation can leave the way open for the development of fragmented and unintegrated programmes. This lack of coordination can waste resources and fragment programmes.

Priority should be given to developing mechanisms for coordination at national and district levels. Donors and aid agencies will need to collaborate with government and each other to build consensus and to establish coordinating mechanisms.

Donors can support a coordinated approach to rehabilitation of the health sector by asking recipients of funds to show how proposed activities will fit into local and national structures, and by making this a criterion for funding.

WHO will have a central role to play in coordinating the rehabilitation of the health sector, while at the same time strengthening national capacity. At the local level, NGOs and private health care providers should work with district health teams to:

- coordinate the planning and implementation of reproductive health programmes;
- coordinate reproductive health supporting activities in the spheres of education, social services, mental health programmes, and employment.



16.8 Community participation, community reconstruction

Some communities come through the experience of war with a strengthened sense of solidarity. Participatory structures may have evolved which can be developed further in the post-conflict setting. Changed attitudes to gender roles may create opportunities for women to participate in all levels of society. It is vital that these structures and opportunities are identified and built upon in rehabilitating and developing reproductive health services.

However, constraints to community participation in the post-conflict setting can arise due to the attitudes and strategies of international donors and aid agencies. In reproductive health, as in all other areas, capacity-building among nationals of the conflict-affected country must be given the highest priority. At national level, this applies to information gathering, policy-making, priority setting, coordination, etc. At district level, management capacity must be strengthened. At local level, strategies should be developed to empower health workers and communities. In countries and communities which have seen the loss through death or exile of health professionals, policy-makers and community leaders, this will require extensive training.

The demoralization of communities fractured by years of trauma and violence presents a second challenge to community participation in the post-conflict setting.

There are no easy answers to healing the individual and communal wounds of war. More research is needed into how resilient individuals and communities recover from the effects of massive trauma and violence, and how others can be assisted to do so.

Processes for bringing to justice the perpetrators of violence, and for recognizing the suffering of victims, are seen as an essential component in healing the wounds of war and in reconciling divided communities. Where it occurs, the complicity of health workers and medical staff in carrying out atrocities must be identified and dealt with, if trust in the health services is to be re-established.

In the post-conflict phase, ways should be found to meet reproductive health needs while also helping to consolidate peace and preventing slippage back into violence and humanitarian crisis. If a return to armed conflict is to be avoided, the underlying causes of tension should be identified and addressed. Equitable distribution of rehabilitation assistance can be used as a means of conflict reduction, as can a long-term commitment to equitable development.

Atrocities such as those perpetrated in Rwanda in 1994 can make talk of intercommunal reconciliation seem facile. Even in less savage wars, bitterness runs deep, and evidence on which to base policies is very limited. The difficulties involved in trying to bring the perpetrators of war crimes to justice can seem insurmountable. These are enormous problems, and yet, if the horrors are not to be repeated, solutions must be found.

This chapter describes the characteristics and special problems of gender-based and sexual violence during conflict and displacement.

17.1 Defining the problem

The term "gender-based and sexual violence" as used in these guidelines refers to all forms of gender-based violence against women, including sexual violence, and also to all forms of sexual violence against men and boys. During conflict and displacement, women and girls continue to be at far greater threat of gender-based and sexual violence than men, so the chapter focuses primarily on violence against women.

17.2 The forms of gender-based and sexual violence during conflict and displacement

During armed conflict and displacement, domestic violence may be exacerbated (see box). Gender-based and sexual violence can also take forms of a different nature and on a different scale from what occurred prior to the conflict. This can range from random acts of sexual assault by enemy troops, bandits or border guards, to rape as a deliberate act of war, explicitly ordered or tacitly condoned by military authorities. Some aspects of this violence are:

- Mass rape, rape camps, military sexual slavery, forced prostitution, forced "marriages" and forced pregnancies. Multiple rapes and gang rape may be common.
- Young girls and women who are alone are often at greatest risk.
- Sexual assaults are frequently associated with violent physical assault and many women die as a result.
- There may be a resurgence of female genital mutilation among refugees and displaced

DEFINITION OF VIOLENCE AGAINST WOMEN FROM THE DECLARATION ON THE ELIMINATION OF VIOLENCE AGAINST WOMEN

"For the purposes of this Declaration, the term 'violence against women' means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."

"Violence against women shall be understood to encompass, but not be limited to, the following:

- Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;
- Physical, sexual and psychological violence occurring within the general community, including rape, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;
- Physical, sexual and psychological violence perpetrated or condoned by the state, wherever it occurs."

Source: Declaration on the elimination of violence against women (Resolution no. A/RES/48/104). New York, United Nations, 23 February 1994

persons as a way of reinforcing cultural identity.

- Women may be forced to offer sex for survival, or in exchange for food, shelter or protection.

It must also be remembered that gender-based and sexual violence may be only one trauma among many. Other traumas include being tortured or mutilated, watching family or friends being tortured, mutilated, murdered or raped, being kidnapped or detained without trial, the "disappearance" of family members, random violence, bombing and shelling, and severe deprivation of food, water, shelter and



safety. However, the stigma and silence associated with rape and other forms of gender-based and sexual violence make them different from other forms of trauma.

RWANDA: GANG RAPE

"The next day, they killed all the men and the boys. I was left with my baby and the three girls. At the riverside, I was raped by a group of six Interahamwe one after another. I knew all of them. Some were killed by the RPF and the others are now in Gitarama prison. They said they were raping me to see if Tutsi women were like Hutu women. After they finished raping me, they threw me in the river to die along with my children. My children all drowned, but the river threw me back. I floated back to the riverside."

Source: Shattered lives: sexual violence during the Rwandan genocide and its aftermath. Human Rights Watch, 1996, p. 59

17.3 Why does gender-based and sexual violence increase during conflict and displacement?

The reasons for the increase in prevalence of gender-based and sexual violence during armed conflict, displacement and in the post-conflict phase may include:

- an underlying acceptance of violence against women in many societies (gender-based violence during armed conflict and during peacetime should be seen not as two separate issues but as a continuum);
- a general breakdown in law and order, with an increase in all forms of violence;
- the perception by perpetrators that they can get away with acts of gender-based and sexual violence, and that they will not be brought to justice;
- the polarization of gender roles during armed conflict with the development of an

ideal of masculinity that is macho and aggressive, and the idealization of women as bearers of the cultural identity (who, as such, come under attack by enemy forces);

- the perception of women's bodies as "territory" to be conquered (rape can act as a "dialogue" between male opponents where the woman as rape victim embodies the message that the more powerful opponent has conquered "human territory"); the use of rape, forced pregnancy and other forms of gender-based and sexual violence against both women and men, as a weapon of "ethnic cleansing" (i.e. as part of an attempt to destroy an ethnic group either physically or by demoralizing individuals and communities, undermining the sense of identity of individual women and destroying the social bonds within the group).

17.4 Who is most vulnerable?

In situations of conflict and displacement, all women and girls are at risk. However, certain groups are particularly vulnerable, namely:

- women and girls (and men and boys) from targeted ethnic groups, where there is an official (or unofficial) policy of using rape as a weapon of ethnic cleansing;
- women who are alone and lone female heads of household;
- the elderly and infirm, and the physically or mentally disabled;
- unaccompanied children, both girls and boys, and children in foster care arrangements (younger women and girls may be specifically selected for rape, being seen as less likely to be infected with HIV);
- women and men held in detention and detention-like situations, including concentration camps and rape camps.

17.5 Gender-based and sexual violence during the phases of conflict and displacement

Gender-based and sexual violence can occur during any of the phases of conflict and displacement.

- **During armed conflict**, it may be perpetrated by police, military or guerrilla forces, by prison officers in detention centres, and in concentration camps and rape camps. It may sometimes occur with the complicity of male leaders who are willing to barter women or girls for arms, ammunition or other benefits.
- **During flight**, all women, but particularly women who are alone, are at risk of attack from bandits, pirates and smugglers. They may also be at risk from border guards and members of security forces who demand sex in exchange for safe passage.
- They will face similar risks during the **return phase**, particularly if the return is spontaneous, or forced.
- **Refugees and internally displaced women** can come under attack **in the country or place of asylum**. Without the legal protection that refugees enjoy, internally displaced women are even more vulnerable to attack. This may come from members of the victim's own family, clan or tribe, from members of a different clan or tribe within the camp or settlement, or from members of the local population. Bandits may attack women, particularly if they have to walk far from their home area in search of firewood or water, or when using washing facilities or latrines in isolated parts of a camp. Attack may also come from police or security forces whose task is to protect camp residents. International or national staff may also be the perpetrators of gender-based and sexual violence, demanding sex in exchange for food, shelter, protection, determination of refugee status etc.

- In the **post-conflict phase**, gender-based and sexual violence may continue as refugees and internally displaced persons return to their areas of origin, and as hostile communities come back into contact with each other. Returnees may be targeted by the government for having fled; and sexual extortion may be used in exchange for documents, assistance etc. Women and girls may also be abused or exploited by members of international peacekeeping forces.

17.6 Men and boys as victims of sexual violence

While some legal and social networks, however rudimentary, may exist for women and girls who have been sexually attacked, there is rarely anything comparable for male victims. In some countries, the legally defined crime of rape may only apply to women. Like women, men may experience profound humiliation, and they may also experience a sense of confusion about their sexuality. In addition, in societies where

RAPE DURING CONFLICT AND DISPLACEMENT: THE SCALE OF THE PROBLEM

In Bosnia-Herzegovina, aside from the unreported cases, the number of raped women was estimated (1993) to be 20,000-50,000.

In 1971 the number of women raped in Bangladesh was estimated at 200,000.

According to cautious estimates, 110,000 women were raped in the Berlin area after World War II. Less conservative estimates cite the number as 900,000 raped and abused women.

In 1985, 39% of Vietnamese boat women between the ages of 11 and 40 were reported to have been abducted and/or raped at sea.

As well as these more violent forms of assault, women who are alone in conflict and displaced settings may find themselves forced into exploitative relationships in order to survive: one survey of refugees in Eastern and Central Sudan in 1983 found that 27% of single mothers who were heads of households had resorted to prostitution to earn a living.



men are discouraged from talking about their emotions, they may find it even more difficult than women to acknowledge what has happened to them. For these reasons, it is suspected that the reported cases of sexual violence against males are a fraction of the true number of cases.

There may be an underlying incidence of sexual violence against adult males, adolescents and young boys, which continues or escalates during conflict or displacement. In addition, rape of men and boys may occur during armed conflict as an act of domination by an opposing military group, and sexual violence against men and boys may occur in prison or detention. Adolescent boys may be at greatest risk in all of these circumstances. Sexual violence against males may include:

- rape;
- damage to the genitals from rape or electrocution during torture;
- castration;
- forced sexual acts between male prisoners.

The medical, legal and psychosocial responses to male victims of sexual violence are essentially the same as for female victims. They should, if possible, be seen by a doctor, protection officer, counsellor and interpreter of the same sex. Male staff should therefore receive training in responding to the needs of victims of sexual violence.

PHYSICAL AND PSYCHOLOGICAL TRAUMA IN MALE VICTIMS OF SEXUAL ASSAULT

Male victims of sexual assault are more likely to suffer significant physical trauma than female victims. Acute treatment of male patients should proceed in a manner that closely parallels female victims, including providing appropriate medical and preventive services based on the medical history and physical examination. Maintenance of an open, non-judgmental attitude is important as this will help to gain the confidence of the individual that has been attacked.

Source: Strategies for the treatment and prevention of sexual assault. American Medical Association, 1995, p. 23

This chapter describes the consequences of gender-based and sexual violence and the impact this has on the provision of health services.

18.1 Physical consequences

Women who have been subjected to violence may have broken bones, knife wounds, concussion, or any of the other signs of a violent assault. In addition, for women who have been sexually assaulted, the following points are relevant:

- Women who have been sexually assaulted may have mutilation or damage to the genitals, including bruising, lacerations, tearing of the perineum and damage to the bladder, rectum and surrounding pelvic structures. Untreated wounds may be infected.
- Damage to the genitals is most severe in girls under 15, and in girls and women who have previously been subjected to female genital mutilation. In addition, these women may be forcibly cut open. These girls and women are also at much higher risk of contracting an STI or HIV.
- Other injuries associated with the use of force during a sexual assault include bruising to the arms and chest, patches of hair missing from the back of the head and bruising of the forehead.
- Women who have been sexually assaulted are at high risk of contracting an STI or HIV/AIDS, developing pelvic inflammatory disease, and long-term infertility. The increased mobility and changing sexual behaviours associated with conflict and displacement create ideal conditions for spread of STIs and HIV/AIDS. Damage to the genitals increases the risk of transmission still further.
- There is a high risk of miscarriage of an existing pregnancy, or all the consequences of unsafe abortion, or pregnancy and delivery.

The most extreme physical consequence is death, which in some situations may be very common for women who are raped.

18.2 Unwanted pregnancy resulting from rape

- There may be a rise in the incidence of unsafe abortion, especially where abortion is illegal or unavailable.
- Women may not attend for antenatal care. After the baby is born, they may refuse to breastfeed and may not seek postnatal care.
- Children born of rape may be neglected, stigmatized, ostracized or abandoned. Infanticide may occur.

18.3 Psychological effects

The psychological impact of rape and other forms of violence vary according to the woman, her culture and the circumstances. During armed conflict, the psychological distress of victims can be greatly compounded by the breakdown of usual support systems and by the absence of a safe and supportive environment for healing.

- In the short term, there may be feelings of shock, a paralysing fear of injury or death, and a profound sense of loss of control over one's life.
- In the longer term, there may be profound feelings of shame, depression, anxiety and grief, characterized by persistent fears, avoidance of situations that trigger memories of the violation, difficulty in remembering events, intrusive thoughts of the abuse, decreased ability to respond to life in general and difficulty in re-establishing intimate relationships.
- Women may experience apathy, depression, silent withdrawal, hypochondria, lack of self-confidence and loss of sexual desire. They may have feelings of shame or guilt. (However, in one study of 35 women in



RAPE IN DIFFERENT CULTURES

Rape defiles the most sacred and personal part of one's body. Because most cultures place religious or cultural value on sexual purity or privacy, sexual abuse degrades the person in her own eyes, before her family and community, and in her relationship to her god or deity.

Rape can destroy the will of victims to live and change the way they fit into their culture.

Rape can also be a serious disgrace and traumatic experience for the whole family when the purity of the daughter, wife, sister or mother has implications for religious identity. For example, the Vietnamese cult of ancestors reveres purity, and in Islamic cultures the woman's purity represents loyalty to the family.

Source: Kane S.

Working with victims of organized violence from different cultures: a Red Cross and Red Crescent Guide. IFRCRC, Geneva, 1995

Uganda who had been raped, while all the women reported feelings of shame, only 10% said they had feelings of self-blame or guilt, and 90% felt very angry about what had happened to them.)

- Psychological distress can also manifest primarily in physical and gynaecological symptoms such as headaches and reports of vaginal discharge and pelvic pain.
- Psychosomatic symptoms associated with feeling dirty and infected following the rape may persist despite repeated physical treatment.
- Women who have been abused may act in ways that are self-destructive (e.g. through excessive use of drugs or alcohol).
- Psychological distress may in some cases be so severe that it precipitates thoughts, or even acts, of suicide, homicide or infanticide.
- Children of traumatized mothers may be neglected or abused themselves.

18.4 Social consequences

Conflict and displacement disrupt the social structures of communities. Widespread gender-based and sexual violence exacerbates this disruption still further by its profound negative impact on the "social health" of a community and on intrafamilial relationships. This breakdown of community and family support in turn exacerbates the psychological impact of violence.

- The formal structures (e.g. health, legal, religious and social structures) which people normally turn to for help in time of need may have been destroyed, or trust in them may have been destroyed because of their association with the perpetrators of abuse.
- In the case of genocide or extremely violent episodes of conflict, every social system may be implicated. All the old points of reference may be gone and the sense of being part of a community may be lost. People may no longer know who to trust or who to turn to for help.
- There is likely to be a legacy of bitterness towards the group from which the perpetrators came. This will have a long-term negative impact on reconciliation and community reconstruction.
- Social bonds are damaged if women who have been sexually abused isolate themselves or are isolated by their families and communities.
- Bonds within families can be irreparably damaged when children have seen their mothers being raped, or when a family member has been forced to watch or participate in atrocities against another member of the family.
- Women who have been sexually abused may avoid forming sexual relationships with men in the future, and children born of rape may be stigmatized or neglected by traumatized mothers.

18.5 Impact on health systems

Studies show that violence against women in families places a substantial burden on health care systems. Victims often present with vague somatic complaints that are difficult to diagnose and treat. During conflict and displacement, the needs of large numbers of victims of gender-based and sexual violence will place many more demands on already overstretched services. In addition, if cases of abuse are not correctly diagnosed and treated, unidentified victims can become repeat users of health services. This creates a burden on services that will last long into the post-conflict phase.

18.6 Impact on health service providers

Health workers can easily feel overwhelmed by the needs of victims of violence. They may have little or no training in health problems related to violence, and may feel helpless. If they do have the training and skills to respond to the needs, they may feel overwhelmed by the numbers of patients and the magnitude of their problems. In addition, staff may themselves have suffered or witnessed violence and may be re-traumatized by their contact with patients who are victims of violence. Adequate staff training, counselling and support are therefore essential.



This chapter describes the principles which should underlie the development of a response to gender-based and sexual violence.

19.1 A multisectoral response

Gender-based and sexual violence is not only a health issue. It requires an integrated response that weaves together medical, psychological, spiritual, social, economic, political and legal services. Not only is this approach more effective in promoting individual and community healing, it also avoids reducing trauma to a medical and psychological problem which would strip it of its social, cultural, political, and human rights context. A multisectoral response to the problem is described in Figure 6.

19.2 Developing a coordinated response

Whatever the setting (conflict, post-conflict, refugee or displaced), a system should be established to coordinate all activities relating to victims of violence. The health services can take a lead in this by:

- identifying existing organizations in the locality or district which can contribute towards the care and rehabilitation of victims of violence;
- establishing links between the health services and their social partners (e.g. social services, women's groups, teachers, police, legal groups, religious groups, mental health services, traditional healers, religious leaders, and human rights groups);
- in collaboration with other partners, carrying out an assessment to identify local needs and appropriate responses;
- based on this assessment, developing a multidisciplinary and intersectoral plan;
- establishing mechanisms for referral of victims between different sectors as

TANZANIA: DROP-IN CENTRES IN A REFUGEE SETTING: A COORDINATED RESPONSE

It became apparent from the needs assessment that a 24-hour support service for survivors needed to be established. A "drop-in" Centre was created in each of the four refugee camps. Each centre was located in the maternity wing of the medical complexes. Staff at the centres were identified from the group of women leaders in all the camps.

The centres are located in a safe and friendly environment within close reach of medical facilities and where women gather regularly. This helps survivors avoid being identified or stigmatized for seeking assistance and allows women to feel safe and assured of confidentiality. Because the drop-in centres offer a wide range of gynaecological and other health services in addition to addressing problems of gender-based and sexual violence, people cannot assume that every woman who comes there has been raped. The services at the centre include counselling, medical attention, emergency contraception, legal advice and protection.

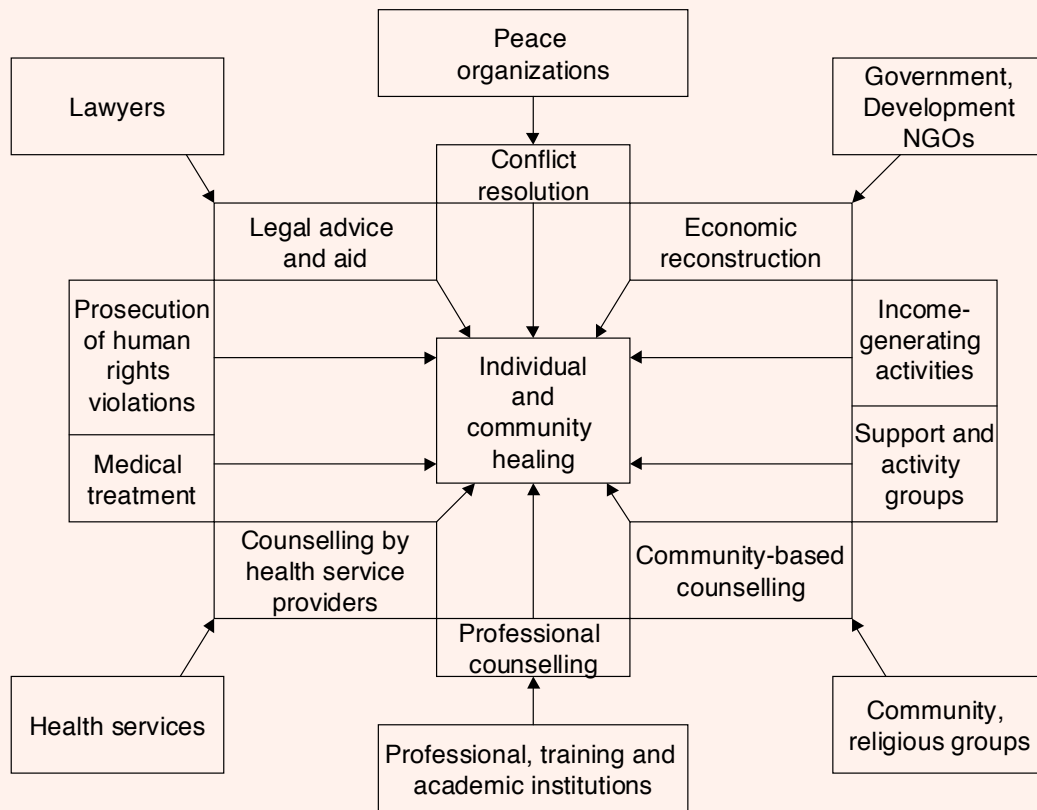
Additional social support is given via follow-up visits in the survivors' homes. The centres also offer a place of safety and rest for a woman who is being beaten by her husband. The staff offer legal and protective services and UNHCR protection officers work with the centres to assist with these procedures. Because the centres provide prompt legal guidance, women are able to prosecute their aggressors with proper documentation, such as police assault forms.

Additional needs of the survivor, such as home repairs or a new plot of land are provided by various humanitarian agencies. In cases of sexual assault, women are sometimes given clothing. Because many rape survivors prefer to change their clothing after being assaulted, the centre supplies clothing as a form of supportive therapy. No adoption facilities for children born of rape exist in the camps. When women give birth to a child conceived from sexual assault, the programme provides food, basic clothing and emotional support to mother and child. (This is a difficult issue and raises questions concerning the best way to support these children without stigmatizing them.)

*Source: Nduna S.
A safe space created by and for women.
IRC, Tanzania, March 1998*



Figure 6: A multisectoral approach to individual and community healing



appropriate (e.g. between the health sector and organizations which focus on economic assistance);

- sensitizing personnel in other sectors to the psychosocial needs of victims of violence, if necessary through training;
- advocating for the inclusion of psychosocial support and counselling in the activities of various sectors;
- establishing mechanisms for systematic evaluation of interventions and of coordination mechanisms.

19.3 Community reconstruction

Conflict-affected communities can be so traumatized that the bonds that hold a community together may cease to exist (see Section B). Outsiders working in such settings must be aware of the mistrust caused by the

conflict. Every proposed intervention should be considered in the light of how it would affect community reconstruction and empowerment. Priority should be given to developing leadership skills, particularly among women.

19.4 Building on traditional coping mechanisms

There is a need for caution when outsiders are involved in planning responses (and particularly the psychosocial response) to gender-based and sexual violence. Perceptions of mental health and ill-health vary greatly between cultures, and successful responses will vary greatly according to the traditional coping mechanisms of the community. It is essential that needs and appropriate responses be identified by women and men from within the affected community. This will ensure that programmes are

appropriate and sustainable, and will also help empower the community, thus contributing to improved mental health.

19.5 Assessment and planning

Assessment: special considerations

Section C, Chapter 10 provides a detailed summary of how to organize an assessment. Preliminary information on gender-based and sexual violence can be gathered through such an assessment. However, to identify more precisely the types and magnitude of different forms of violence within a community, as well as appropriate responses and available resources, an in-depth assessment is required. The form that this will take and the areas it will focus on will vary from one community and setting to another. The following points are suggested as broad guidelines. They should be adapted to meet local circumstances.

RWANDA: NATIONAL AND INTERNATIONAL NGO PARTNERSHIP

National NGOs have a good knowledge of the social, legal, economic and health situation of the national population. They are therefore able to assess needs and community resources for coping with the effects of violence, and to prepare appropriate projects and plans of action. But local NGOs face enormous financial constraints.

International NGOs generally have access to finance, but they know much less about the situation and the needs of the community where they operate. And yet they should be able to adapt the requirements of the institutions governing them to the need for greater flexibility and maintenance of quality of services when dealing with victims of violence, notwithstanding the "urgency" of the situation. To this end, partnership with national NGOs would increase the synergy of international know-how and national familiarity with the terrain.

WHO Workshop on the Management of Health Problems of Women Victims of Violence, 11-14 February 1997, Rwanda

Objectives

Objectives for an assessment of gender-based and sexual violence might include the following:

- to identify the extent of different types of violence which are occurring or have occurred within the community;
- to identify the health needs which arise as a result of these forms of violence;
- to identify groups which are especially vulnerable;
- to identify the individual and community strengths and resources that exist to prevent and to respond to violence;
- to identify intervention strategies for prevention and treatment based on these community strengths and resources.

Breadth of the assessment

An assessment that looks at a range of issues, rather than focusing on sexual violence alone may be more acceptable to the community and government, and may be more likely to receive support. In addition, women in refugee, conflict and displaced settings have identified a broad range of forms of violence and injuries, which are of concern to them. These can include all forms of conflict-related violence, domestic violence, land-mine injuries, and violence against children and elders. A broader survey will identify health needs arising from these forms of violence. However, care must be taken that only information, which can be analysed and used, is collected.

The decision whether or not to include men and adolescent boys in the survey depends on local circumstances. If preliminary information indicates a significant level of sexual violence against men and boys, they should be included, possibly using an adapted form of the questionnaire developed for interviewing women. It may also be useful to include men in the in-depth interviews or group discussions. This will gather information about male



perceptions and attitudes to gender-based and sexual violence against women, and how these relate to women's perceptions and attitudes.

Partnership

Because of the sensitivity of the subject matter, little will be achieved without the support and approval of government authorities and male and female community leaders. Women community leaders should be involved in initiating the assessment, and in its design, implementation and analysis. Health workers should also be involved from the outset in order to maximize their sense of ownership in the survey and its recommendations. Creating an atmosphere of trust in the interview team is crucial before victims of violence will be prepared to talk about their experiences.

Methodology

Information should be gathered through a combination of quantitative and qualitative methods which cover the same issues allowing for triangulation (see Section C, Chapter 10 and the Appendix IX—Glossary).

For example:

- Quantitative
 - a survey in which a randomly sampled group from the target population is interviewed using a structured questionnaire;
 - structured interviews with health workers;
 - review of health centre records.
- Qualitative
 - in-depth, semi-structured interviews of a randomly sampled group, or of key informants; and/or
 - group interviews/focus group discussions.

These and other information collection methods are summarized in Section C, Chapter 10, Appendix III and Appendix IV. Whichever study method is used, the issue of

confidentiality must be addressed. Respondents involved in the survey must feel confident that the answers they provide will be respected and held in confidence.

Designing a questionnaire

The questionnaire should begin with the least sensitive subjects, moving from general questions about health or social circumstances to questions about violence witnessed, and then to violence experienced. The questionnaire might cover:

- questions about health, reproductive health, social circumstances, experiences of conflict or displacement;
- questions to determine violence witnessed (against whom? by whom?);
- forms of violence experienced within a defined period (e.g. previous 6 months, or since displacement);
- questions to identify categories of perpetrators (stranger, relative, military, civilian);
- physical and psychological health consequences of violence experienced;
- attitude to violence experienced;
- questions to determine interviewee's experience of existing resources for the treatment of victims, with regard to availability, accessibility and acceptability;
- interventions identified by the interviewee to assist in prevention and treatment.

Ethical review

An ethical committee should review the assessment as it is being developed. The purpose of the ethical review is to ensure that no harm is done as a result of the assessment process. The committee could include a community leader, a women's group representative, the health programme manager, and individuals with expertise in counselling and in human rights. Ethical issues that should be considered include:

TANZANIA: ASSESSING THE PREVALENCE OF SEXUAL AND GENDER-BASED VIOLENCE IN A REFUGEE CAMP

Assessment methodology

The assessment methodology involved two distinct ways of assessing the prevalence of violence against women: in-depth interviews and a survey. A comparison of the results revealed commonalities and differences. These suggested what types of information could best be collected using one approach or the other. A key to success was the participation of the elected women's representatives in its design and implementation.

Out of a total of 3803 women aged 12-49, 400 (over 10% of the target population) were randomly selected and asked to participate in the survey. Using the registry of female's aged 12-49, every tenth woman was selected and assigned to one of the four interviewers. Three women left the camp and could not be contacted. Of the remaining 397, 58 (15%) women declined to participate. Common reasons given for not participating included "it did not happen to me", or the respondent felt she was too young or simply did not wish to speak. A total of 339 (85%) consented to participate in the survey.

The survey results were translated into English, frequencies conducted using Epi-info software, and analysed by programme staff. A meeting was held with women's representatives to discuss results. The women's representatives were excited and proud of their ability to implement the survey. They organized meetings with the women in the community to report preliminary results.

Assessment results

The finding that sexual violence affects a significant proportion of the population in the camp is supported by both data sources: 22% of women aged 12-49 voluntarily reported during in-depth interviews that they had experienced sexual violence since the conflict erupted in Burundi, and 27% of randomly surveyed females in the same age group reported having experienced the same. In addition to sexual violence involving vaginal penetration, the in-depth interviews also revealed cases of other forms of gender violence, including domestic abuse, sexual harassment, withholding of ration cards from estranged wives, and a wide variety of gynaecological concerns.

Source: Nduna S.

*A safe space created by and for women.
IRC, Tanzania, March 1998*

- the use of non-political, non-discriminatory language in questionnaires;
- informed consent of interviewees, based on information about the assessment and the ways in which the information will be used;
- ensuring that interviewees are not pressured to answer in particular ways to suit any political agenda;
- ensuring that confidentiality of interviewees is assured;
- ensuring that interviewers are aware of the risks of retraumatization, and that post-interview counselling is available for interviewees when necessary;
- providing interviewees with information on available services and support, including medical care, social services, legal aid, protection, women's centres etc.

Interviewer training and support

Adequate training and support for interviewers are essential. Interviewers face the risk of secondary traumatization as a result of their contacts with victims of violence. To avoid this, time should be set aside every day for interviewers to debrief. Counselling should also be made available to interviewers.

Planning

To design a programme to respond to the needs during the assessment, the steps described in Section C, Chapter 11 should be followed. The active participation of women and men from the community in all stages of the planning process will result in appropriate and effective interventions.



This chapter describes the consequences of gender-based and sexual violence and the impact this has on the provision of health services.

20.1 Community sensitization

Gender-based and sexual violence is a frequently hidden problem. Even when it is widespread during armed conflict or displacement, it may not be talked about within the affected community. Relief agency personnel may not be aware of the extent of the problem or of the victims' needs. Victims may feel that nothing can be done to protect them from these forms of violence, or to aid them in their recovery.

A programme of assistance to victims of violence is much more likely to be successful if it is accompanied by an IEC campaign aimed at sensitizing victims, communities and all personnel working with them (relief agency personnel, health workers, teachers, police, security officers etc.) to the existence of these forms of violence, and to the needs of victims.

This can be done through formal meetings, small group discussions, presentations at meetings on other issues, informal meetings and contacts with individuals. As members of the community, providers of health services can also encourage women victims of violence to make better use of the health and welfare services in the community. They can explain to women the importance of medical follow-up and tell them of the opportunity available for psychological and social support.

20.2 Supporting a community-based response

If one-to-one counselling is available, it is important that it be complemented by a community-based group approach to psychosocial recovery. There are a number of reasons for this:

- One-to-one counselling can be swamped by the needs of an entire community that has been traumatized.
- In addition, particularly in cultures that are less focused on the individual, the restoration of networks of family and community support through groups and community activities will be fundamental to healing. This can be especially important for rape victims who feel isolated by the silence that the stigma of rape imposes on them.
- Community-based responses and self-help groups will in themselves improve community cohesion and healing.

Identify and support traditional coping mechanisms

Within every community there are traditional methods of healing, and community members who play a role in helping, supporting, healing and reconciliation. These may be community leaders, religious leaders, traditional healers, traditional birth attendants, trained nurses or social workers, or simply older women or men who are respected by others and consulted in times of trouble. These people will have vital knowledge of traditional coping mechanisms and systems of support, and they should be identified and supported by outsiders. They may be suitable participants for a training programme in counselling skills. Religious and spiritual ceremonies may be particularly important in bringing a sense of healing to women who have been raped.

Self-help support and activity groups

Self-help groups should be actively supported with a safe space for meetings and with financial support. It may be appropriate to provide training to group members in counselling skills and group dynamics. These groups can be a channel for medical and legal services and for education on rape and other forms of gender-based violence.



Self-help groups may take the form of activity or support groups, but frequently the distinction between these groups is blurred. Members of a support group need both practical and emotional support. An activity group (such as an income-generating group or a sports group) may evolve into a group where members talk and share experiences.

Promoting and supporting self-help groups for women has multiple benefits. These groups:

- create a safe and confidential environment in which problems can be acknowledged and discussed;
- provide time for women to develop their own coping strategies without being pressured by outside influences;
- help women to recognize that other people with the same problem can be of help and that they, too, can help others;
- empower women and the community as a whole as they find solutions to their individual and communal problems, developing and strengthening their own coping strategies.

SUPPORT AND ACTIVITY GROUPS

Studies indicate that groups are one of the most successful approaches for survivors of violence. Activity and support groups provide members with an immediate community. Activity groups focus on specific activities, and support groups provide support to their members. Since it is unacceptable in many cultures to talk about one's feelings, activity groups are excellent ways to reduce isolation and encourage a sense of belonging.

*Source: Kane S.
Working with victims of organized violence
from different cultures.
IFRCRC, Geneva, 1995*

Outreach

The people who have been most traumatized are often the most isolated, and the ones least likely to join activity or support groups, or to talk with friends or neighbours. Outreach networks should be developed and supported. For example, traditional helpers can take the skills they have learned in counselling training, such as active listening and encouraging people to share and to talk about their experiences and express their feelings, to these people in their homes. They can also put isolated individuals in touch with services that offer practical support.

20.3 Adapting health service delivery to improve care

Health services are often ill prepared to respond to the needs of victims of gender-based and sexual violence. The following strategies will help to make services more responsive to the needs of victims:

Improve reception and privacy for patients

- **Improve reception by the receptionist, clerks, health workers and auxiliaries.** The first health service staff with whom patients come into contact must be made aware (through training) of health problems related to violence and of how all patients should be received. This care must apply to the reception of all patients coming to the health service since the staff will not know why the patient is attending the service.
- **Improve privacy for patients** during all consultations, so that those coming for general health reasons will feel encouraged to disclose private details.

- If possible, set aside a private room for counselling. If this is not possible, try to ensure that there is a private area that makes patients feel that they can have a confidential discussion.

Ensure quality of care in treatment of victims of violence

- Structure services so that they are available, accessible, and acceptable to all potential users, including adolescents, older women, widows and members of marginalized groups.
- Develop protocols for medical and psychological treatment of victims.
- Ensure that adequate medicines, supplies and equipment are available.
- Train, supervise and support staff to provide holistic and empathetic care. If possible, hire additional suitably qualified staff.
- Recognize limitations of the health facility and establish mechanisms for medical and psychological referral.
- Monitor and evaluate health services through regular appraisal, using feedback from clients and through regular supervision of health service providers.

Protect confidentiality

Creating safety and confidentiality for victims of rape and other forms of gender-based and sexual violence is of particular importance.

- Develop a coding system that protects confidentiality, particularly if information is being shared between different sectors.
- Ensure that information is shared only with the informed consent of the patient.
- Stress the importance of confidentiality during training of health workers, interpreters and others who come into contact with victims of violence.
- Prioritize care of victims of violence within programme budgets.

- Identify resources and funds to support treatment of victims.

Develop integrated services for treatment of victims of violence

- Offer treatment to victims of violence as one of the day-to-day services of the health centre.
- Ensure availability on the health care team of at least one staff member trained in counselling and in reproductive health.
- Develop links between the different components of health and reproductive health services, other health-supporting sectors and community-based services.
- Encourage case referral between sectors.
- Organize home visits when necessary for treatment and support.
- Establish links with, and support the development of, women's groups and safe spaces for women victims of violence.

20.4 Staff recruitment

If a significant problem of gender-based and sexual violence has been identified during the assessment, this information can be used as an advocacy tool to raise funds either to train existing staff or to hire extra staff. If possible, staff should be hired who have experience in responding to the physical and psychological needs of victims of violence. Such staff if they are not already experienced trainers, should be trained to train others who have not dealt with victims of violence. Other issues to consider in staff recruitment include the following:

- Every effort should be made to ensure that a health worker of the same sex could see both male and female patients.
- Ideally, health workers and patients should have a common language and culture.
- If the use of an interpreter cannot be avoided, interpreters of the same sex should be used.



RWANDA: RECOMMENDATIONS ON HOW TO REMOVE OBSTACLES TO TREATMENT OF VICTIMS OF VIOLENCE

OBSTACLES	HOW TO REMOVE THEM
<p>Sociocultural obstacles</p> <ul style="list-style-type: none"> ➤ Sexuality is a taboo subject, not to be discussed. Extreme modesty. ➤ Religious education forbidding information on sexuality. ➤ Resigned, fatalistic behaviour. 	<p>Lifting of sociocultural barriers</p> <ul style="list-style-type: none"> ➤ IEC for the victims, for the community, for health and welfare personnel. ➤ Establishment of reception centres for the treatment of adolescents. ➤ Counselling.
<p>Lack of information</p> <ul style="list-style-type: none"> ➤ "Don't know who to consult." ➤ Underestimation of the gravity of the repercussions of violence. ➤ Lack of knowledge of problems. 	<p>Improvement of information</p> <ul style="list-style-type: none"> ➤ Strengthening channels for IEC. ➤ IEC campaign to raise awareness of the problems of victims of violence. ➤ Attitude change through counselling.
<p>Lack of funding</p> <ul style="list-style-type: none"> ➤ Inability to pay for treatment, especially if the health services are private. 	<p>Development and/or acquisition of resources</p> <ul style="list-style-type: none"> ➤ Public services must ensure that treatment of victims of violence is free of charge.
<p>Inadequate facilities</p> <ul style="list-style-type: none"> ➤ Inadequate or inappropriate premises, lack of equipment and supply. 	<p>Rehabilitation of health facilities</p> <ul style="list-style-type: none"> ➤ Reorganization of existing health services to include treatment of victims of violence. ➤ Improve the reception of victims of violence.
<p>Inadequate staffing</p> <ul style="list-style-type: none"> ➤ Shortage of health workers, or staff not qualified to cater for victims of violence. 	<p>Increase the quantity and quality of health workers</p> <ul style="list-style-type: none"> ➤ Retraining of existing staff. ➤ Increasing the number of health workers. ➤ Enhancing the health and social work professions.
<p>Psychological trauma in victims</p> <ul style="list-style-type: none"> ➤ The impact of violence varies according to the different personalities and temperaments of individuals. ➤ Distrust resulting from trauma. 	<p>Self-help for the victims</p> <ul style="list-style-type: none"> ➤ Organization (with no stigma attached) of victims in associations or groups. ➤ Promotion of income-generating activities. ➤ Counselling for self-help.
<p>Obstacles in the community</p> <ul style="list-style-type: none"> ➤ Defence or maintenance of social taboos and interdictions. ➤ Rumours on the inadequacy of the medical services. ➤ Lack of community appreciation of health problems related to violence. 	<p>Community participation</p> <ul style="list-style-type: none"> ➤ Support for existing associations. ➤ General IEC on trauma arising from violence. ➤ Counselling at community level.

- Medical practitioners from the victim's own community or from the host country, rather than international doctors, should conduct examinations and write medical reports. They will be in a better position to give evidence in later legal proceedings, if they occur.
- members of community associations;
- opinion makers and community leaders;
- the media.

20.5 Training

The general goal of training is to provide all those working with victims of violence with the knowledge, skills and attitudes required to respond to medical and psychosocial needs. To be effective, ongoing training, supervision and support must back up one-off training of health workers (see Section C, Chapter 12). To maximize impact, training should be in three stages: training of trainers; training of health workers by the new trainers; and community-based training, by the trained health workers, for those working in the informal health sector.

Because trainees from within a community will have had their own experiences of violence and may have suffered psychological and physical trauma, time should be set aside throughout the training for trainees to talk about their own experiences of violence.

Target groups for training

Not only health workers, but also all who may become involved in assisting victims of violence should receive appropriate training. These groups will include:

- medical and paramedical staff (physicians, nurses and midwives);
- social service personnel, social workers;
- health workers from the informal health and social sector (community health workers, traditional practitioners and traditional birth attendants);
- staff of the Ministry of Health and allied ministries;
- staff of NGOs and relief agencies;
- teachers, police, lawyers, the judiciary;

Components of training for health workers

The curriculum for health worker training will depend on local needs and on previous levels of knowledge. The following are suggested as subjects to be covered in a training programme developed for health professionals:

- understanding gender-based and sexual violence and its physical, psychological and social consequences;
- creating a safe and supportive environment that facilitates disclosure by the patient;
- confidentiality;
- history-taking;
- acute management of victims of sexual assault;
- understanding the risk of retraumatization, and how to minimize this;
- counselling of victims of violence;
- when and how to refer;
- support available to the victim of violence (self-help groups, economic and legal aid etc.);
- human rights aspects of gender-based and sexual violence.

20.6 Creating a safe and supportive environment to facilitate disclosure

The problem of non-disclosure

Victims of rape, sexual assault or domestic violence may not attend health services at all, because:

- these are taboo subjects that arouse feelings of shame;



RWANDA: SKILLS DEVELOPMENT FOR HEALTH PROFESSIONALS

A project on the reproductive health needs of women victims of violence in Rwanda was initiated jointly by the Ministry of Family, Gender and Social Affairs, the Ministry of Health and WHO. A seminar was organized to identify the needs of the project partners. The 4-day orientation workshop brought together 36 health professionals and social workers to discuss key issues in providing quality health services to survivors of violence. The following needs were identified during the workshop:

- The need for training at various levels for parties involved in the project, in order to better understand violence and its health consequences for individuals, families and communities.
- The need for skills development for health professionals in order to meet the health needs of survivors of violence.
- Training in counselling techniques and the role of the counsellor.
- Sensitization of the general public and of community organizations on violence and its consequences and on ways to alleviate the suffering of victims.

Arising out of the workshop, a training-of-trainers course was conducted in January 1998. Health professionals and their social partners who had been involved in providing care to victims of violence received a 10-day course in education and training techniques for counselling. During the training, increased knowledge about the medical and psychological sequelae of violence, and training in how to identify cases of post-traumatic stress disorder, were provided by Rwandan psychologists. Seminar participants also conducted training exercises so that the principles of adult training could be mastered. From the training workshop, the following elements for developing, training and implementing counselling services were identified:

- The need for good inter-personnel communication skills.
- Understanding post-traumatic stress disorder as a non-medical issue.
- The importance of treating victims with care, confidentiality and ethical consideration.
- The importance of providing health care in an environment which is conducive to the disclosure of violence-related injuries and to counselling.
- Providing both medical treatment and psychosocial support.
- Ensuring that medical problems attached to the causes for seeking health care are identified and treated.
- Ensuring the active contribution of the client and her/his family and community in the treatment protocol.

WHO Workshop on the Management of Health Problems of Women Victims of Violence, 11-14 February 1997, Rwanda

- they fear reprisal from perpetrators if it is known that they have sought care;
- appropriate health services do not exist;
- services that exist are inaccessible, unacceptable or too expensive;
- they do not know of the existence of services.

If victims do attend health services, they may present with wounds or fractures, with psychosomatic disorders, or may seek treatment because of a fear of pregnancy or of having contracted an STI, without disclosing that they have been raped or sexually assaulted. Or they may have obvious signs of violence, which the health workers ignore, because they do not know how to manage the situation. Years may pass without the patient disclosing what has happened to her, yet she may repeatedly present with psychosomatic problems that do not respond to treatment. If the underlying problems can be correctly diagnosed and treated, not only will the patient's distress be alleviated but also a continuous drain on scarce health service resources will diminish.

Facilitating disclosure

An environment must be created so that victims feel free to disclose what has happened to them. Sensitizing the community to increase awareness of the medical and psychosocial services that are available will encourage victims of violence to seek help, as will word-of-mouth reports of empathetic and effective treatment of victims of violence. Once a patient comes to the health centre, the health worker should create a climate of trust, and take the history in a way that will encourage the patient to disclose gender-based or sexual violence.

Creating a relationship of trust

A relationship of trust must first be established between the health worker and the patient. Sympathetic and non-judgmental attitudes are essential. Rape or other forms of violence, which are considered shameful or taboo, will only be referred to when the person

UGANDA: KEEPING THE SECRET FOR YEARS

"A 23-year-old woman was raped by several soldiers. While relatives and neighbours almost certainly knew that her ordeal had happened, before talking to members of our team she had never before discussed what happened or its consequences for her with anyone else. The rape had taken place approximately four years prior to our interviews with her. She had become convinced that she had developed a foul-smelling vaginal discharge. She had attended many medical clinics for this and had received several courses of different antibiotics. Members of our team took swabs and no infection was identified. However, it was difficult to reassure her, and she was convinced that she had been rendered infertile by the rape and its aftermath. She had not sought marriage because of this."

Source: Bracken et al. Psychological responses to war and atrocity: the limitations of current concepts, Social Science and Medicine, 1995, 40(8):1073-1082

providing treatment has won the woman's confidence.

Training should give health workers the opportunity to practice working with victims of violence through role-play. There should also be opportunities for health workers to explore their own attitudes to sexual violence. They should be encouraged to examine honestly their willingness to facilitate disclosure, and the reasons why they may be reluctant to do so.

In one study it was found that health care workers identified only one battered woman in 35, even though battered women proved quite willing to admit abuse when questioned in private. Among the reasons for this reluctance may be a fear of being overwhelmed by the needs of patients, and this should be addressed through strategies for staff support. It is important that health workers feel they have enough time to talk with the patient, and health

services should be organized to provide the time and privacy such a discussion will require.

Interpreters should be included in training on the emotional needs of victims of violence, on the attitudes to adopt when dealing with these patients, and especially on the need for confidentiality.

History-taking to facilitate disclosure

Health workers should receive training in how to take a history in a way that will encourage a patient to disclose experience of gender-based or sexual violence.

- Questions about sexual and reproductive health should form a routine part of history taking. This allows the patient to discuss problems in this area.
- History taking should also routinely include questions about current or past stresses,

COMMON PHYSICAL INJURIES ASSOCIATED WITH SEXUAL ASSAULT

- Trauma to the genitals.
- Abrasions and bruises on the upper limbs, head and neck.
- Forcible signs of restraint—rope burns on wrists or ankles, mouth injuries sustained during gagging.
- Petechiae of the face and conjunctiva, secondary to choking.
- Broken teeth, swollen jaw or cheekbone, eye injuries from being punched or slapped in the face.
- Muscle soreness or stiffness in the shoulder, neck, knee, hip or back from restraint in postures that allow sexual penetration.

Strategies for the treatment and prevention of sexual assault. American Medical Association, 1995

In more severe assaults, which may be more common during violent conflict, associated injuries will be much more severe, including broken limbs, mutilation, hacking of limbs etc.



PSYCHOLOGICAL AND PSYCHOSOMATIC PROBLEMS ASSOCIATED WITH GENDER-BASED AND SEXUAL VIOLENCE

- Symptoms of depression or anxiety, panic attacks, phobias, obsessive thinking or compulsive behaviours.
- Autonomic hyper-reactivity; gastrointestinal symptoms, eating disorders, headaches, sleep complaints, nightmares, chronic fatigue.
- Thoughts or acts of suicide, homicide or infanticide.
- Decreased ability to respond to life generally; difficulty re-establishing intimate relationships; lack of desire for sexual relationships, sexual dysfunction in an ongoing relationship; compulsive sexual behaviours.
- Aggression towards self and others, self-injury, self-neglect, alcohol or drug abuse; neglect or abuse of children.
- Persistent unexplainable symptoms; chronic pain; recurring illnesses or symptoms without obvious medical cause; presentation of new symptoms as soon as existing problems are diagnosed and treated; poor compliance with medical treatment.
- Persistent physical and gynaecological symptoms such as headaches and reports of vaginal discharge and pelvic pain. Psychosomatic symptoms associated with feeling dirty and infected, which may persist despite repeated physical treatment.
- Marked anxiety about procedures that are invasive or that cause the patient to feel helpless.

traumas or violence experienced. The health worker should ask the patient directly, but in a culturally sensitive manner whether there is any stress or problem she wishes to talk about. Because patients may not discuss this subject until they have come to trust the health worker, the health worker should be prepared to repeat enquiries about trauma, even if early enquiries produced a negative response.

- Health workers must learn the different type of approaches and questions they can use to be able to repeat enquiries about trauma without upsetting the patient.
- Health workers need to be aware of the physical injuries commonly associated with a recent sexual assault. This may alert them

to the possibility of an assault that the patient has not yet disclosed.

- Health workers should be alert to the psychological and psychosomatic problems with which victims of gender-based or sexual violence may present. (However, they should also be aware that many of these symptoms might also be seen in victims of other kinds of traumatic experience.)

20.7 Treatment

Once a patient reveals a history of sexual assault, she should receive appropriate, effective and empathetic medical and psychological care. Table 14 summarizes the medical and psychological care of patients who have experienced different forms of violence. In all cases, the patient should be an active participant in her own treatment, so that she can begin to reclaim a sense of control over her life.

Acute management of victims of sexual assault

The steps involved in acute management of victims of sexual assault are summarized below. Requirements for evidence gathering and documentation of rape/sexual assault will vary from one jurisdiction to another, so doctors and other health professionals should be aware of local requirements. Whenever possible, the examining doctor should be female. If this is not possible, the victim should be told that a male doctor would examine her, and a woman should chaperone her throughout.

- First rule out respiratory distress, physical shock, internal bleeding or haemorrhage.
- Create a safe environment that is quiet, private and protected. Empathy, support and gentleness are very important. Speak quietly and move slowly at all times, and do not leave the patient alone. Obtain the patient's informed consent for any procedures that are necessary.
- Help the patient to recover a sense of control over her environment by informing

her in advance of what is happening, when it is starting, how long it might go on, and when it is almost over. Ask the patient to signal when to begin any procedure and tell her she may request that the procedure be stopped if she is uncomfortable or in pain.

- Obtain a general medical history before making direct inquiries about the assault. A gradual transition can then be made to disclosure of details about the attack.
- In inquiring about the sexual assault, questions should be asked in a way that allows for brief answers. In addition to making answering potentially embarrassing questions easier, a simple question format results in a concise medical record. This precision reduces inconsistencies between medical and legal records, thereby averting challenges to the victim's credibility if charges are pressed.
- Assure the patient that she may stop the questioning and continue it when ready by signalling.
- A physical examination has the dual purpose of assessing the patient's health status and collecting forensic evidence that may be used to prove when and where the patient was assaulted and who committed the assault. While it is not the health worker's role to prove that a crime has occurred, the

Table 14: Medical and psychological care of victims of violence

Problem	Medical treatment	Psychosocial care
Recent rape/sexual assault (within 72 hours)	Acute management of sexual assault. Follow local protocol for gathering evidence	Acute: create safe, non-threatening environment Post-acute: counselling, group support
History of rape/sexual assault in the past	Check for STIs, treat. Rule out physical causes for suspected psychosomatic presentations	Counselling, group support
Ongoing domestic violence	Treat physical injuries. Rule out physical causes for suspected psychosomatic presentations	Counselling, group support
Other forms of violence	Treat physical injuries. Rule out physical causes for suspected psychosomatic presentations	Acute: create safe, non-threatening environment Post-acute: counselling, group support
Psychological trauma related to violence witnessed	Rule out physical causes for suspected psychosomatic presentations	Counselling, group support

All cases: refer to police, legal aid, social assistance, women's refuge etc. as appropriate to the case and as desired by the patient

medical record can lend crucial support to the prosecution of perpetrators.

- The least invasive procedures should be performed first.
- Injuries and medical treatment that may serve as legal evidence of the patient's condition should be documented. Specimens and laboratory samples should be collected in a way that will not obstruct the patient's option to pursue criminal charges.
- Counselling about STIs should be provided. Prophylaxis should be provided if local incidence is known to be high.
- HIV testing should occur only in the context of adequate counselling, and provisions for follow-up testing and receiving results should be established. (Baseline HIV testing in the immediate aftermath of the assault can only rule out or diagnose pre-existing infection.)
- Pregnancy testing may be indicated to rule out pre-existing pregnancy. Counselling



AVOIDING RETRAUMATIZATION

Be culturally sensitive

History-taking

Well-meant but detailed discussion of the assault may further traumatize the patient. Furthermore, sexual assault disrupts cognitive perceptions, rendering memory of events incomplete or inaccurate. Extensive probing can also create a discrepancy between a patient's statement in the medical record and subsequent statements for legal purposes. These statements can lower the credibility of testimony if charges are pursued against the perpetrator.

It is wrong to suppose that if the patient is encouraged to verbalize events and "work the attack through", she will feel better and calmer. Sexual assault is a circumstance of such magnitude that it does not respond during the acute phase to emotional release or catharsis.

Medical procedures

Because many medical procedures involve touch, are invasive, or are performed by authority figures in positions of control, health workers must be sensitive to the risk of re-traumatizing vulnerable patients during examinations and testing. All procedures (even routine ones) should be explained carefully and patiently in advance, and the patient should be invited to offer ideas about how to make the procedure less problematic. This may include changing the rate or duration of the procedure or having other staff, friends, or family members present.

Pelvic, rectal, oropharyngeal and breast examinations may be especially difficult when sexual abuse has been part of the victimization. Talking patients through the steps, allowing the patient additional control (e.g. stopping or restarting the examination as needed), maintaining eye contact, allowing the patient to see more (e.g. use of a mirror in pelvic exams), or having the patient assist (i.e. putting his/her hand over the health worker's hand to guide the exam) may be useful techniques in increasing the patient's comfort.

Hospital care

Hospital care may be particularly intimidating, and the involvement of so many caregivers can be daunting. Keeping the treatment team to a minimum, consistent nursing, introductions of all new team members, and careful explanations in advance of all anticipated events (even transport, starting intravenous lines, blood draws etc.) can be most helpful.

Medical situations that may cause re-experience of trauma

- Genital, breast, rectal, oral examination.
- General anaesthesia, muscle paralysis.
- Insertion of catheters, needles.
- Confinement, seclusion, immobilization, endoscopic procedures.
- Labour.
- Inadequate privacy arrangements.
- Loud procedures (e.g. breaking bones).
- Open discord between care staff members.
- Practitioner resembles the patient's abuser in some way.

Source: Mental health effects of family violence: diagnostic and treatment guidelines. American Medical Association, 1995, and Strategies for the treatment and prevention of sexual assault. American Medical Association, 1995

about emergency contraception should be provided.

20.8 Avoiding retraumatization

All health workers should be aware that patients can be retraumatized as a result of a physical examination, or by the sense of powerlessness they may experience in a medical situation, or by recounting their story to a health worker or to other people such as journalists. The following box describes some of the steps that can be taken to avoid retraumatization.

20.9 Counselling

Many cultures encourage people to try to forget frightening things that have happened to them but studies indicate that the majority of victims who are able to talk about their traumatic experiences in a safe and supportive environment eventually reduce their fears and anxiety regarding such experiences. (In some cultures, people may be more comfortable expressing themselves through drama, songs, storytelling or art rather than talking directly about their experience, but the basic principle of encouraging them to express their feelings remains the same.) Both one-to-one counselling and self-help groups provide opportunities for victims of violence to talk through what has happened.

Counselling is based on listening and talking with the patient in a non-directive, non-threatening and non-judgmental manner. This kind of support encourages the client to regain control over her life and places her at the centre of the counselling process. The main roles and functions of the counsellor working with victims of violence are:

- to support the client who has suffered physical, psychological or social trauma;
- to establish a climate that allows the client to feel accepted so that she can drop her defences and speak freely;

- to help the client to analyse her own situation and the resources that are available to her, so that she can find her own solutions to remedy the physical, psychological and social consequences of the violence;
- to support the client in putting these solutions into practice.

RWANDA: THE LIMITATIONS OF A MEDICAL RESPONSE

"It has been two years since the war, but these patients are very difficult to cure. Initially, they come in with infections, vaginal infections, and urinary tract problems—problems that are sexually transmitted. You cure the direct illness, but psychologically they are not healed. They continue to come back complaining of cramps or pains but there is nothing physically wrong with them. These women are profoundly marked psychologically. Medically, they are healed, but they continue to be sick. And there are no services that specifically deal with the problems these women have. There are some groups for widows and the like, but there are no groups to help women who have gone through this (rape)."

Source: Shattered lives: sexual violence during the Rwandan genocide and its aftermath. Human Rights Watch, 1996, p. 73

PSYCHOSOCIAL SUPPORT IN CONTINUING EMERGENCIES

"It is generally suggested that psychosocial support services be provided after victims have reached safety. This is based on the belief that most people cannot begin to heal and recover until they feel safe from further violence. It is clear, however, that some survivors will suffer if they are denied help until they are in a safe and secure environment. Specific approaches and strategies can be provided to victims to help them even when they are struggling to survive. Helping people to solve problems involving basic issues of shelter, food, transportation and in some cases protection is often the most important help anyone can provide until they reach safety. Social support gives victims the message that "someone cares", which can give them hope and encourage their desire to survive."

Working with victims of organized violence from different cultures. IFRCRC, Geneva, 1995



Table 15: Sources of stress for health personnel caring for victims of violence, and how they might be alleviated

Feelings of inadequacy	Lack of self-confidence in ability to cope with needs of victims
<ul style="list-style-type: none"> ➤ Provide initial and ongoing training in treatment of victims of violence. ➤ Provide supportive supervision by competent staff. ➤ Establish system for referral of cases to more qualified staff. 	
Feelings of helplessness	Feeling outraged at the human rights abuses perpetrated against patients, but feeling powerless to do anything about it
<ul style="list-style-type: none"> ➤ Establish channels within the organization for formal or informal reporting of human rights abuses. ➤ Provide staff with clear guidance on what they can do, and feedback on actions taken (see Chapter 21). 	
Personal problems coming to the surface	Staff reminded of their own problems by the story of the client
<ul style="list-style-type: none"> ➤ Staff to meet regularly with a support team or with a "buddy" for personal and professional support. ➤ Make professional counselling available to staff. 	
Burnout	Commitment is overwhelmed by the scale of the problem, too many cases to be handled at once
<ul style="list-style-type: none"> ➤ Ensure that responsibilities are shared by training a number of staff, and by encouraging teamwork. ➤ Encourage staff to recognize their own limits. ➤ Give regular and frequent vacations (R&R) and ensure that these are taken. ➤ Send staff on refresher courses, study trips, and seminars. 	
Secondary trauma	Prolonged contact with victims of violence traumatizes staff in the long term
<ul style="list-style-type: none"> ➤ Ensure that responsibilities are shared by training a number of staff, and by encouraging teamwork. ➤ Encourage staff to recognize their own limits. ➤ Give regular and frequent vacations (R&R) and ensure that these are taken. ➤ Send staff on refresher courses, study trips, and seminars. 	
Strong emotional reaction to a particular patient	E.g. someone who has harmed the staff member or his or her family, or someone the staff member identifies with a group that has harmed them; or a patient develops a strong negative emotional reaction to a particular member of staff
<ul style="list-style-type: none"> ➤ Referral of the cases to other colleagues or to other health centres. ➤ Support for staff members to cope with their own responses. 	

Training

Both health professionals and community-based health workers should have training to develop their counselling skills. Those who work with community groups should receive training to develop group facilitation skills. Training of both groups should include recognition and referral of psychiatric problems. Community counsellors should be familiar with the medical and psychiatric referral service. Psychotropic drugs from the WHO Essential Drugs list should be available at referral level.

20.10 Support for staff working with victims of violence

Given the physical and psychological suffering of victims of violence, the providers of health services can in their turn suffer distress when they are providing treatment. Whether in the public or the private sector, the formal or the informal, in health services or in NGOs or associations, the same types of distress can occur. In addition, some health workers may themselves have suffered or witnessed acts of violence and may be retraumatized by hearing of the experiences of patients. These additional stresses from caring for victims of violence will come on top of the stresses associated with working in any emergency setting.

It is therefore imperative that all health workers (local, national and international) receive adequate support to enable them to

continue to do their work. To fail to provide this kind of support is to risk staff burnout and traumatization. This support should take the form of:

- adequate training and supervision to respond to the needs of victims of violence;
- creating a culture of mutual support among staff;
- strong back up and support for field staff.

Table 15 summarizes some of the different stresses that those who work with victims of violence may experience, and management responses that can help to alleviate these stresses.

20.11 Evaluation

Evaluation of interventions to meet the needs of victims of gender-based and sexual violence should be participatory in nature in order to build on the process of assessment, planning and implementation. Two key elements will be:

- inclusion of women and community leaders from the target community in designing the evaluation;
- reliance primarily on feedback from the target population (victims of gender-based and sexual violence) as to the effectiveness of interventions (rather than relying primarily on record review, interviews with service providers etc.).

Evaluation is looked at in more detail in Section C (The Stabilization Phase).



Appendix I:

Human rights: resource materials

Database on human rights training

Electronic resource centre for human rights training. Possibility to receive documents over email. Very complete.

<http://erc.hrea.org>

Manuals for training of medical personnel http://erc.hrea.org/Library/medical_personnel.html

Manuals on women and human rights

<http://erc.hrea.org/Library/women.html>

useful websites on health and human rights

American Association on the Advancement of Science (AAAS)

Science and Human Rights Programme. Includes AAAS Human Rights Action Network, Directory of Human Rights Resources on the Internet, and E-Thesaurus on Economic, Social and Cultural Rights.

<http://shr.aaas.org/program/index.htm>

The François Xavier Bagnoud Center for Health and Human Rights at the Harvard School of Public Health

<http://www.hri.ca/partners/fxbcenter/>

UNAIDS

Joint United Nations Programme on HIV/AIDS

<http://www.unaids.org>

The World Health Organization

<http://www.who.int/>

Printed training manuals on human rights

"Local Action Global Change: Learning about the Human Rights of Women and Girls"
Julie Mertus with Nancy Flowers and Mallika Dutt.

UNIFEM Center for Women's Global Leadership, 1999

ISBN 0-912917-01-6

Exists in English, Spanish, French, and translated locally into Albanian, Arabic, Russian, Serbo-Croat and Ukrainian. It is permitted to reproduce this manual into other languages.

More information from Julie Mertus

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Fax: (1) 419 772 1875

Email: suitcase@igc.apc.org

"Training Manual on Ethical and Human Rights Standards for Health Care Professionals"
Commonwealth Medical Association Trust (Commat)

BMA House

Tavistock Square

London WC1H 9JP

United Kingdom

Fax: (44) 171 383 6195

Email: com_med_assn@compuserve.com

Website: <http://www.cma.co.za>



Reading on health and human rights

"Health and Human Rights: A Reader"
Editors: J. Mann, S. Gruskin, M. Grodin, G. Annas.
Routledge, 1999.
ISBN/ISSN: 0-415-92101-5,
ISBN/ISSN: 0-415-92102-3 (paperback)

Reading on human rights of women

"Human Rights of Women: National and International Perspectives"
edited by Rebecca Cook
University of Pennsylvania Press, Philadelphia
1994
ISBN 0-8122-3261-5
ISBN 0-8122-1538-9 (paperback)

"Women and Human Rights"
prepared by Katarina Tomasevski
Zed Books Ltd, 1993
ISBN 1 85649 119 6
ISBN 1 85649 120 X (paperback)

Reading on women's health and human rights

"Human Rights in Relation to Women's Health: The Promotion and Protection of Women's Health through International Human Rights Law"
World Health Organization, 1993
WHO/DGH/93.1

Reference guide on UN human rights

"United Nations Reference Guide in the Field of Human Rights"
United Nations, New York, 1993
ST/HR/6

Web-resources on human rights treaties, globally and regionally

UN Human Rights Machinery Overview and Calendar

<http://www.unhchr.ch/map.htm>
UN Human Rights Instruments
<http://www.unhchr.ch/html/intlinst.htm>
International Red Cross Committee, a basic introduction to International Humanitarian Law
<http://www.icrc.org/eng/ihl>
UN Human Rights Treaty Bodies (i.e. country reports and committee recommendations)
<http://www.unhchr.ch/tbs/doc.nsf>

African region

Organization of African Unity
<http://www.oau-oua.org>
The African Charter on Human and Peoples' Rights (Organization of African Unity)
http://www.oau-oua.org/oau_info/rights.htm

The Americas

Organization of American States, and the American Convention on Human Rights
<http://www.oas.org/>
Search for:

- American Convention on Human Rights "Pact of San Jose, Costa Rica"
- Human Rights in the Area of Economic, Social and Cultural Rights "Protocol of San Salvador"

Inter American Court of Human Rights
http://www.nu.or.cr/ci/home_ing.htm
(English)
<http://www.nu.or.cr/ci/> (Spanish)
Jurisprudence of the Inter American Court of Human Rights
<http://www.nu.or.cr/ci/Jurisprudencia/Juris.htm>

Europe

The European Council
<http://www.coe.fr/>
The complete text of the European Convention on Human Rights, its protocols, the European Social Charter and more
<http://www.coe.fr/eng/legaltxt/e-dh.htm>

Health workers may be more likely than others to see the evidence of human rights violations because of the nature of their work and their special status within communities. Individually, and as representatives of their organizations, health workers may face the dilemma of how to reconcile their privileged position of observing violations with the dangers of becoming too visible through reporting or advocating against these violations. Individually initiated responses may endanger the health worker's personal security as well as the security of the victims and their families or communities. Accusations of human rights violations by organizations may result in a humanitarian organization being denied access to the population they serve. In order to safely and effectively respond to human rights violations, individual health workers and their organizations must coordinate their response strategy with refugees themselves, especially women. Together, preventative measures and appropriate protective, medical, psychosocial and legal responses to violations can be established.

21.1 An organizational responsibility

Organizations can best respond to human rights violations if they are trained and organized to do so. Responding to human rights violations in either a refugee or displaced setting requires institutional protocols on which all health workers are trained. Given the role humanitarian organizations and individual field staff play in such settings, it becomes critical to establish the process for documenting violations to ensure the safety and confidentiality of staff and survivors.

In the absence of organizational guidance individual health workers can be faced with a dilemma: if they speak out against human rights violations, the safety of staff may be threatened, and the organization may be denied access to the population. If they do not speak out, they may be seen as implicitly condoning violations. It is imperative that international, national and nongovernmental organizations develop a clear

position on human rights and on how they expect field staff to respond to violations which they witness. In developing an organizational response, the security of staff and of the victims of violations must be paramount.

Strategies and training programmes should suit local circumstances and the structures and mandates of the organization. They should be formulated before an emergency arises. They should be developed in coordination with a human rights professional working within the organization, or by a human rights agency working in an advisory capacity. For each specific situation, they should be reviewed and revised in coordination with local women's groups or representatives from the refugee population to ensure that refugee perspectives and concerns are taken into account. All guidelines and protocols must be introduced to staff with proper training and reference materials.

Human rights must be the basis of the organizational response. The rights of women in refugee or displaced settings include the right to be free from sexual violence and coercion. This should be enforced through national, regional and international laws such as the Geneva Conventions of 1949, and CEDAW, among others. Advocacy with governments, insurgents and international bodies to bring about the cessation of human rights violations should form part of an organization's human rights response. In addition, knowledge of human rights and humanitarian law can be used in negotiations with warring parties (e.g. in negotiating protection for health services and health workers).

The way in which humanitarian assistance is delivered can create a culture that fosters human rights. In particular, participatory methods empower individuals and communities by enabling women and men to retain control of their lives. Also, in balancing the threat of losing access to a population with the need to respond to violations, it should be remembered that access to health care is itself a fundamental human right. For more information on specific



human rights laws that address violence against women, see Appendix I.

21.2 Establishing a network for reporting human rights violations

Channels for reporting suspected violations should be established in coordination with humanitarian organizations and human rights organizations. Documentation of violations must be done only with proper training and if the information gathered will actually be used. Gathering information which is not used can increase the sense of helplessness and frustration on the part of field staff. How the information is used will depend on the mandate of the particular organization and should be included into the organization guidelines or protocol on responding to sexual violence for health workers.

21.3 Training health workers to respond to human rights violations

Key to the success of any organizational protocol is appropriate training for all staff. To ensure understanding, sensitivity to the issues, and appropriate responses by staff, a pre-departure basic training should be given addressing the following four areas:

Instruments governing human rights and humanitarian law

- Staff should have a basic knowledge of the instruments which protect human rights during armed conflict and displacement, and which protect against violence, including gender-based and sexual violence.
- Staff should understand international humanitarian law concerning the conduct of war and concerning protection of humanitarian assistance, of health workers and of health services. (International

humanitarian law relates to the protection of civilian populations during wartime.)

Monitoring indicators for evidence of widespread violations

- Health workers should be aware of the indirect evidence of human rights violations which they may see in the course of their work. For example, they may see a dramatic increase in the incidence of STIs among women from a particular population, combined with physical injuries and mutilations. Such evidence should alert them to the possibility that rape is widespread.
- Health workers may also receive direct reports of human rights violations, including acts of rape and other forms of gender-based and sexual violence.

Channels for reporting suspected violations

- Health workers should receive clear guidance on what to do if they become aware of or suspect human rights violations.
- They should be made aware of the United Nations bodies and NGOs working in the area which have an institutional mandate to monitor and protect human rights.

FORMER YUGOSLAVIA

- In light of evidence of rape perpetrated on a massive scale, the UN Commission on Human Rights passed a resolution placing rape, for the first time, clearly within the framework of war crimes and called for an international tribunal to prosecute these crimes.
- In the tribunal, individual officers could be held accountable at several levels: those who committed rape, those who ordered it, and those in authority who failed to prevent it.

*Source: Swiss and Giller.
Rape as a crime of war, a medical perspective.
JAMA, 1993, 270(5)*

- They should be made aware of the formal and informal channels for reporting which exist within the organization for which they work and with organizations with a human rights mandate. These channels should be detailed in the organizational protocol or guidelines.

Documentation of individual cases

- Health staff working with humanitarian organizations during emergencies will not usually be involved in the documenting of individual cases of human rights violations for the purposes of prosecution. However, their training should cover how to collect clinical evidence in a way that will allow it to be used at a later date for prosecution of violations, if so desired by the victim. This will include guidance on what information and evidence to gather, how to document the information and how to protect confidentiality.

For more information on training, see Appendix I.

21.4 Legal avenues for prosecuting human rights violations

While health workers do not need to have detailed information on the legal avenues that may be pursued, it is helpful to have a brief overview. Cases may be pursued through:

- a criminal prosecution through the national courts, usually with the assistance of non-governmental advocacy groups or women's health groups;
- other national remedies, such as a national ombudsman, human rights commission or truth commission;
- prosecution within another national jurisdiction, particularly if the violation occurred while temporarily displaced in another country or territory;

HUMAN RIGHTS VIOLATIONS: WHY ACT?

- Human rights violations must be documented, reported and prosecuted both for reasons of justice and to act as a deterrent to future acts. If those who perpetrate these violations believe that their acts will go unpunished, there is no reason for them to stop.
- In the past, rape has sometimes been considered an inevitable aspect of war. Now that mass rape has been formally recognized as a crime of war, it is vital that the message is clear: acts of gender-based and sexual violence during war are violations of human rights and will be prosecuted as such.
- High profile monitoring of human rights violations can also play a role in conflict reduction, if it succeeds in minimizing the atrocities which can trigger an escalation of violence. Reporting on human rights violations is also important for field staff themselves, in order to prevent these acts coming to be seen as normal, and to avoid a sense of impotent burnout. To protect the humanity of victims and of witnesses alike, there must be no silent witnesses.
- Perhaps most importantly of all, if health workers and others perceive rape as a human rights violation and convey this attitude, they can reaffirm a woman's humanity, make clear the criminality of the act, and decrease any sense of self-blame she may feel. Telling her story as an act of testimony against her attackers can become a political act and a way of reclaiming power. This remains true even if there is no opportunity for prosecution, or if the woman herself does not wish to prosecute.

- an international tribunal such as those set up for war crimes committed in the former Yugoslavia and Rwanda;
- permanent United Nations human rights mechanisms such as the UN.





Appendix II:

Breastfeeding in emergency situations

Guiding principles for feeding infants and young children during emergencies

All infants born into populations affected by emergencies should be fed only breast milk from birth to 4-6 months of age.

Every effort should be made to create and sustain an atmosphere which encourages frequent breastfeeding, for all children under 2 years of age.

- In areas of high HIV prevalence, breastfeeding should be promoted, supported and protected among mothers who are HIV-negative or of unknown HIV status. Women who are HIV-positive or of unknown HIV status should be counselled on different feeding options and supported in their choice.
- The joint WHO, UNICEF and UNAIDS policy guidelines regarding HIV and Infant Feeding offer several different feeding options for consideration by HIV-positive mothers which may or may not prove viable in populations affected by emergencies:
 - replacement feeding with commercial formula or home prepared formula;
 - breastfeeding exclusively and stopping early;
 - use of heat treated expressed breast-milk;
 - wet nursing.
- If possible, a way should be found to breastfeed infants whose mothers are absent or incapacitated.

The quantity, distribution and use of breast-milk substitutes at emergency sites should be strictly controlled.

- Breast-milk substitutes should be fed by cup and spoon.

- Breast-milk substitutes should be available only for infants who do not have access to breast milk and for infants of mothers who are HIV positive and choose not to breastfeed.
- Those using breast-milk substitutes should be adequately informed and equipped to ensure safe and appropriate preparation and feeding.
- The use of infant-feeding bottles and artificial teats should be actively discouraged.

To sustain growth and good health, older infants and young children need foods that are both easy to eat and digest and nutritionally complement breast milk.

Caregivers need uninterrupted access to ingredients to prepare and feed nutrient-dense foods to older infants and young children.

- Adequate feeding of infants and young children cannot be assured if basic household food and economic needs are unmet.
- Blended foods, especially if they are fortified with essential nutrients, are useful for feeding older infants and young children. However, their provision should not reduce efforts to promote the use of local foods and other donated commodities in preparing suitable complementary foods for older infants and young children.
- The preparation of complementary foods and their feeding to older infants and young children should be done frequently and safely in a clean environment.

Because the number of caregivers is reduced during emergencies and the capacity of those who remain is diminished by physical and



mental stress, it is essential to strengthen care-giving capacity for promoting good infant and child feeding practices.

To encourage adequate intake of breast milk and complementary foods, the health and vigour of children, including newborns, should be protected so that they are able to suckle frequently and maintain their appetite.

The search for malnourished children should be active and constant so that their condition can be identified before it becomes severe. The underlying causes of malnutrition should be investigated and corrected.

- Therapeutic feeding is required to rehabilitate severely malnourished children.

To minimize the negative impact of emergencies on feeding practices, interventions should begin immediately during an emergency's acute phase; they should focus on alleviating pressures on caregivers and channelling scarce resources for the benefit of infants and young children.

Emergencies, by definition, are periods marked by frequent and rapid change. Promoting optimal feeding for infants and young children in such circumstances requires a flexible approach based on continual careful monitoring.

HIV and infant feeding: a policy statement developed collaboratively by UNAIDS, WHO and UNICEF, 1998

Introduction

The number of infants born with HIV infection is growing every day. The AIDS pandemic represents a tragic setback in the progress made on child welfare and survival. Given the vital importance of breast milk and breastfeeding for child health, the increasing prevalence of HIV infection around the world, and the evidence of a risk of HIV transmission through breastfeeding, it is now crucial that policies be developed on HIV infection and

infant feeding. The following statement provides policy-makers with a number of key elements for the formulation of such policies.

The human rights perspective

All women and men, irrespective of their HIV status, have the right to determine the course of their reproductive life and health, and to have access to information and services that allow them to protect their own and their family's health. Where the welfare of children is concerned, decisions should be made that are in keeping with children's best interests. These principles are derived from international human rights instruments, including the Universal Declaration of Human Rights (1948), the Convention on the Elimination of All Forms of Discrimination against Women (1979), and the Convention on the Rights of the Child (1989), and they are consistent with the Cairo Declaration (1994) and the Beijing Platform for Action (1995).

Preventing HIV infection in women

The vast majority of HIV-infected children have been infected through their mothers, most of whom have been infected through unprotected heterosexual intercourse. High priority therefore, now and in the long term, should be given to policies and programmes aimed at reducing women's vulnerability to HIV infection—especially their social and economic vulnerability—through improving their status in society. Immediate practical measures should include ensuring access to information about HIV/AIDS and its prevention, promotion of safer sex including the use of condoms, and adequate treatment of sexually transmitted diseases which significantly increase the risk of HIV transmission.

The health of mothers and children

Overall, breastfeeding provides substantial benefits to both children and mothers. It significantly improves child survival by protecting against diarrhoeal diseases, pneumonia and other potentially fatal infections, while it enhances quality of life

through its nutritional and psychosocial benefits. In contrast, artificial feeding increases risks to child health and contributes to child mortality. Breastfeeding contributes to maternal health in various ways, including prolonging the interval between births and helping to protect against ovarian and breast cancers.

However, there is evidence that HIV can be transmitted through breastfeeding. Various studies conducted to date indicate that between one-quarter and one-third of infants born worldwide to women infected with HIV become infected with the virus themselves. While in most cases transmission occurs during late pregnancy and delivery, preliminary studies indicate that more than one-third of these infected infants are infected through breastfeeding. These studies suggest an average risk for HIV transmission through breastfeeding of one in seven children born to, and breastfed by, a woman infected with HIV. Additional data are needed to identify precisely the timing of transmission through breastfeeding (in order to provide mothers infected with HIV with better information about the risks and benefits of early weaning), to quantify the risk attributable to breastfeeding, and to determine the associated risk factors. Studies are also needed to assess other interventions for reducing mother-to-child transmission of HIV infection.

Elements for establishing a policy on HIV and infant feeding

1. Supporting breastfeeding

As a general principle, in all populations, irrespective of HIV infection rates, breastfeeding

should continue to be protected, promoted and supported.

2. Improving access to HIV counselling and testing

Access to voluntary and confidential HIV counselling and testing should be facilitated for women and men of reproductive age. It is important to offer a supportive environment that encourages individuals to be informed and counselled about their HIV status rather than one that discourages them out of fear of discrimination or stigmatization.

As part of the counselling process, women and men of reproductive age should be informed of the implications of their HIV status for the health and welfare of their children. Counselling for women who are aware of their HIV status should include the best available information on the benefits of breastfeeding, and on the risk of HIV transmission through breastfeeding, and on the risks and possible advantages associated with other methods of infant feeding.

3. Ensuring informed choice

Because both parents have a responsibility for the health and welfare of their children, and because the infant feeding method chosen has health and financial implications for the entire family, mothers and fathers should be encouraged to reach a decision together on this matter. However, it is mothers who are in the best position to decide whether to breastfeed, particularly when they alone may know their HIV status and may wish to exercise their right to keep that information confidential. It is therefore important that women be empowered

WHO, UNICEF, UNAIDS Statement on the Current Status of WHO/ UNICEF/UNAIDS Policy Guidelines, 1999

A recently early report that HIV is less likely to be transmitted through exclusive breastfeeding does not warrant a change in existing WHO/UNICEF/UNAIDS policy. The current guidelines emphasize the need for counselling so that mothers can make a fully informed decision. In addition, it indicates the options available and states that for HIV-positive mothers who choose to breastfeed, the safest option is to breastfeed exclusively to minimize the risk of other childhood infections. A technique should be used that minimizes risk of mastitis and nipple damage. Stopping breastfeeding when the infant is 3-6 months old is an option which can avoid late postnatal transmission, reduce health hazards because of older age of the infant and reduce social difficulties associated with a mother not breastfeeding.



to make fully informed decisions about infant feeding, and that they be suitably supported in carrying out these decisions. This should include efforts to promote a hygienic environment, essentially clean water and sanitation, that will minimize health risks when a breast-milk substitute is used.

When children born to women infected with HIV can be ensured uninterrupted access to nutritionally adequate breast-milk substitutes that are safely prepared and fed to them, they are at less risk of illness and death if they are not breast-fed. However, when these conditions are not fulfilled, in particular in an environment

where infectious diseases and malnutrition are the primary causes of death during infancy, artificial feeding substantially increases children's risk of illness and death.

4. Preventing commercial pressures for artificial feeding

Manufacturers and distributors of products which fall within the scope of the International Code of Marketing of Breast-milk Substitutes (1981) should be reminded of their responsibilities under the Code and continue to take the necessary action to ensure that their conduct at every level conforms to the principles and aim of the Code.

Appendix III:

Needs assessment in stable settings: information categories

The following list is an overview of the categories of information to be gathered as part of a needs assessment in a stable refugee or displaced setting (it may also be of use in stable, non-refugee post-conflict settings). It should be used in conjunction with the Information Pyramid described in Appendix IV, and with the detailed assessment framework described in Section C. The list is not an assessment questionnaire; its function is to guide the assessor towards areas which need to be explored when planning an assessment.

i) Community composition

- What is the composition of the population (total, women, those of reproductive age, adolescents, unaccompanied women and minors and different ethnic groups)?

ii) Community organization and structures

- What are the physical and social relationships between the host and displaced community?
- How is the community organized? (What are the social, political, formal and informal networks within the community, among women, among men, among adolescents, and among different ethnic groups? How does information pass within the community?)

iii) Community relationships, gender relationships

- Who are the formal and informal leaders and opinion formers? (Among different groups of women, men, and adolescents, are women accustomed to assuming leadership roles?) What are the patterns of authority and guidance among adolescents, respected elders, peers?

- What are the divisions and conflicts within the community? What mechanisms exist for conflict resolution?
- What are the traditional gender roles of men and women? (What are the patterns of access to and control of resources? What are the patterns of decision-making within relationships? How have these changed as a result of displacement?)
- What are the norms relating to rites of passage into adulthood and to adolescent sexuality? How have these changed as a result of the displacement?

iv) Community capacity

- What are the human resources and capacities for self-help within the community, among women, among men and among adolescents (health workers, traditional healers, educators, formal and informal leaders, counsellors etc.)?
- What are the community's traditional practical and psychological coping mechanisms (at individual, family and community level)?
- Has the community developed a dependency on outside solutions?
- What community structures exist for protection from sexual violence and for the punishment of perpetrators of violence?
- Are there particular social problems within the community that could have a direct negative impact on reproductive health (e.g. alcoholism, generally high levels of violence, prostitution etc.)?
- What outside resources are available to assist the refugee/displaced community (national and international staff, women's groups, human rights groups etc.)?



v) **Physical environment**

- Does the physical environment offer safety and security from violence/sexual violence? (Are women and girls safe from attack in their homes, when moving about within the camp or settlement by day or by night, and when going out of the camp for water, fuel or, agriculture? Are particular groups of women/girls/boys at risk?)
- Does the physical layout of the camp encourage supportive communities? Is accommodation arranged in traditional groupings?

vi) **Socioeconomic environment**

- Are camp administration structures gender sensitive?
- Do women have equal access to and control of resources (employment, education, income generation, agricultural resources, documentation, general access and control of resources)?
- What issues need to be considered to develop a religious and culturally sensitive reproductive health programme?

vii) **Disease and disability**

- What is the prevalence of reproductive health related mortality and morbidity as reported through the health information system?
- What reproductive health needs are identified by key informants representing different groups within the community?
- What reproductive health related beliefs and practices are reported?
- What information is available on the reproductive health of the displaced community from their country or area of origin (incidences of disease, previous exposure to services, results of surveys, previous health education, IEC materials)?

viii) **Attitudes to reproductive health**

- What are the attitudes of women/men/adolescents from different ethnic groups to

different aspects of reproductive health (e.g. safe motherhood, family planning, sexual violence, rape victims, children born of rape, emergency contraception, unwanted pregnancies, STI/HIV/AIDS)?

- What are the attitudes of formal and informal leaders within the different communities to these issues?
- What are the attitudes to adolescent sexuality and to adolescents using reproductive health services? What are the attitudes of health workers to providing services to adolescents? How do adolescents perceive their own reproductive health needs?
- What are the attitudes of the religious leaders to reproductive health issues? How is the community influenced by their attitudes?

ix) **Reproductive health services**

- Which elements of the comprehensive reproductive health services outlined in Section B are lacking? Are all the other elements of primary health care also in place?
- How are existing services being provided? (By which agencies? Are they integrated with each other and with other elements of primary health care? Is the emphasis on community-based services? Are services being provided in line with host country norms and standards?)
- What is the uptake of existing services? What level of satisfaction with services do key informants report? What physical and cultural barriers to care exist? Are the services affordable, accessible and confidential?
- Are services accessible to all groups of women, men and adolescents? Are they accessible to different ethnic groups? Is each of these groups aware of available services? What is the uptake of services?
- What are the attitudes of health workers to the different elements of reproductive

health? What are the training needs of health workers from the community and of national and international staff?

- Has a referral system been established to local health services? Is it running smoothly? How are/how can the local community and the local health services be best supported (e.g. with personnel, supplies, health worker training, other)?
- How can agencies working with the displaced community and with the host community best support each other and coordinate health and reproductive health services?
- Has a smoothly running logistics system been established, with supplies meeting demand? Are there adequate storage facilities for medicines and supplies? Are stores cool, shaded, well ventilated?

- Have sources of donations of vaccines, condoms, contraceptives been identified? Do donations meet acceptable standards?

x) **Health policy/funding**

- What are the policies of the host country relating to reproductive health?
- What are the official policies of agencies working with the population? What are the levels of unofficial support?
- What funds are available or might become available to support reproductive health programmes? What are donors' attitudes towards different components of reproductive health? Are donors available who would be willing to fund reproductive health programmes exclusively?
- What are donors' requirements with regard to presentation of proposals and budgets, monitoring and reporting?



Appendix IV:

using an information pyramid for information gathering and analysis

The information pyramid provides a checklist for asking questions and a framework for analysis. It forms the basis of an approach for obtaining and analysing data that will enable planners to have useful, although not exhaustive, information with which to identify and seek solutions to the health problems of people living in a defined geographical area.

Information pyramids have three characteristics:

- They are based on needs identified by the community.
- They are built on information gathered from documents, from a dialogue between planners and community members, and from the observations of planners in the community.
- They are constructed in the recognition that communities often experience comparatively rapid change and therefore, the pyramids reflect the situation only at a given time. The information in a pyramid changes as information is gathered at various points in time.

An example of an information pyramid for assessing community needs with a view to planning interventions for health improvements is shown in Figure 7 and described below.

The pyramid is built on a foundation of information about community composition, organization and capacities to act. Health planners and managers need to know about the community with which they are working and need to discover the strengths and weaknesses of community leadership, organizations and structures.

The next level of the pyramid describes the sociological factors that influence health, including the physical environment,

socioeconomic conditions, disease and disability. This information is needed to investigate the potential for and barriers to community improvements. Data on the physical environment are used to determine the environmental causes of disease and disability. Data on social aspects focus on traditional beliefs and values that facilitate or impede behavioural changes. An analysis of economic aspects highlights income sources, earning potential and the economic opportunities of various community groups.

The third level concerns data on the existence, coverage, accessibility and acceptability of services, including health services, environmental services such as water and waste disposal, and social services such as education and assistance for the disabled.

The top of the pyramid, the final level, for which some general knowledge is required, concerns national, regional and local policies about health improvements for low-income areas. Information on these policies, particularly health policies, will indicate whether the political leadership is committed to primary health care. With strong government support at both the top and local levels, health improvements for the urban and rural poor will have the potential to proceed more rapidly, and without major political barriers.

When planners undertake Rapid Participatory Appraisal to plan for health improvements, they collect blocks of information relating to these four general levels and so build up the pyramid. Its shape reminds them that success depends on building a planning process that rests on a strong community information base, and that the amount of information needed about each area is relative to its position on the pyramid. It is the



quality of the information, not the quantity, that is most crucial.

Using the information pyramid

An opportunity pyramid provides the framework, in picture form, for the collection and analysis of data. To reinforce this visual method of presenting data, rapid assessment teams use paper of three different colours (in constructing the pyramid), for example, blue paper for information from interviews, green paper for information from observations, and yellow paper for information from documents. Scrap paper can be used (A4 size cut into three or four equal parts). In deciding what information is to be collected, team members use felt pens to write down key words on the blank paper (e.g. "water sources", "main income", "main diseases"), the colour of which indicates where such information can be obtained. For this example, "water sources" is written on a green paper; "income sources" is written on blue paper; "major diseases" is

written on yellow paper. These papers are then placed in the block of the pyramid that defines the category to which each idea belongs. When this exercise is complete, a checklist of information is created.

When analysing the information obtained from the fieldwork, the same process is used. Key words are written upon paper, the colour of which corresponds to the source of the information, then placed in the block on the pyramid corresponding to the general category to which the information belongs.

Used in this fashion, the pyramid:

- allows teams to see, in picture form, whether there is any imbalance in the information that is due to be or has been collected;
- provides categories both for collection and for analysis of information;
- enables teams to see whether information has come from more than one source (triangulation) and has thus been cross-checked.

Figure 7: Blocks for an information pyramid



Adapted from: Annett HB, Rifkin SB. *Guidelines for rapid participatory appraisal to assess community health needs: a focus on health improvements for low-income urban and rural areas*. Geneva, World Health Organization, 1995 (WHO/SHS/DHS/95.8).



Appendix V:

Emergency contraception

Extracted from the WHO document *Emergency contraception* (WHO/FRH/FPP/98.19) and updated from *Emergency contraceptive pills: contraceptive technology update series* (North Carolina, Family Health International, 1998) and Randomised controlled trial of levonorgestrel versus the Yuzpe regimen of combined oral contraceptives for emergency contraception. *Lancet*, 1998, 352:428-433 (World Health Organization, Task Force on Postovulatory Methods of Fertility Regulation, Special Programme of Research Development and Research Training in Human Reproduction).

Emergency contraceptive pills (ECPs)

ECPs are hormonal methods that can be used to prevent pregnancy following unprotected sexual intercourse. They are sometimes referred to as "morning after" or "postcoital" pills. These names do not convey the correct timing and use since emergency contraceptive pills can be used up to three days after unprotected intercourse. In addition, the term does not convey the important message that emergency contraceptive pills should not be used regularly because they are intended for "emergency" use only.

Three emergency contraceptive pill regimens

- 1) One of the best-studied progestin-only regimes consists of a single pill containing 0.75mg of levonorgestrel. The pill should be taken within 72 hours of unprotected intercourse, followed by the same dose 12 hours later.

- In countries where pills containing 0.75mg of levonorgestrel are not available, women can use other progestin-only pill formulations for emergency contraception. In these formulations each pill only contains a small amount of progestin, generally 0.0375mg of levonorgestrel. Hence a woman would need to take 20 pills and repeat the dose in 12 hours. This provides the same hormonal dose as taking the tablets containing 0.75 mg of levonorgestrel.
- 2) Low-dose pills containing 30 µg ethinylestradiol and 150 µg levonorgestrel (or 300 µg dl-norgestrel):
 - Four pills should be taken as the first dose as soon as convenient, but no later than 72 hours after unprotected intercourse. These should be followed by another four pills 12 hours later.
 - 3) The standard regimen (the Yuzpe method) consists of the "combined" oral pills containing 50 µg ethinylestradiol and 250 µg levonorgestrel (or 500 µg dl-norgestrel):
 - Two pills should be taken as the first dose as soon as convenient, but no later than 72 hours after unprotected intercourse. These should be followed by two other pills 12 hours later.

Mode of action

Emergency contraceptive pills may inhibit or delay ovulation. They may prevent implantation by altering the endometrium. They may also prevent fertilization or transport of sperm or ova. Emergency contraceptive pills do not interrupt pregnancy and are therefore not a form of abortion.



Efficacy

The World Health Organization has conducted a large study on the effectiveness of emergency contraceptive pills. The study showed that combined pills prevented about 57% of expected pregnancies under typical use and 76% under correct use. Progestin-only pills prevented 85% under typical use and 89% under correct use. The study indicated that the correct dosage of progestin-only pills is more effective and produces fewer side-effects than the use of combined pills.

Side-effects and their management

Nausea:

Occurs in about 50% of women.

Management: Taking the pills with food or at bedtime may help reduce nausea. Routine prophylactic use is not recommended in settings where resources are limited.

Vomiting:

Occurs in about 20% of women.

Management: If vomiting occurs within two hours of taking emergency contraceptive pills, the dose should be repeated. In cases of severe vomiting, the repeat dose of the pills may be administered vaginally.

Irregular uterine bleeding:

The majority of women will have their menstrual period on time or slightly early.

Management: If there is a delay in menstruation of more than one week, a pregnancy test should be performed.

Other side-effects of emergency contraceptive pills include:

- breast tenderness,
- headache,
- dizziness and
- fatigue.

Eligibility criteria

The sole contraindication for the use of emergency contraceptive pills is pregnancy. Emergency contraceptive pills should not be given to a woman who has a confirmed pregnancy primarily because they will not be effective. However, experts believe there is no harm to a pregnant woman or fetus if emergency contraceptive pills are inadvertently used during early pregnancy.

Counselling

As with any contraceptive method, emergency contraceptive pills should be provided in a manner that is respectful of the client and responsive to her needs for information and care. During counselling, providers should reassure all clients, regardless of age and marital status.

Appendix VI:

Outline for a project proposal (whenever possible, use the project proposal format of the funding agency to which the project will be submitted)

- Title of the project
- Summary (no more than one page): giving brief description of the aims and objectives, programme beneficiaries, the co-operating agencies and their responsibilities, the proposed activities, the timescale, the total cost of the project and the funds requested from the donor to whom the proposal is being submitted
- Organizational background, track record in reproductive health
- Statement of problem/need, supported by data from the needs assessment. The reasons why the need exists, the seriousness of the problem, the target population and the expected impact this project will have
- The aims and objectives of the project: what you hope to achieve, giving reasons why each of the objectives has been selected
- Strategy/workplan: this need not be as detailed as the plan of action, but should indicate the key activities/interventions which will be undertaken to achieve the objectives and who will have responsibility for each
- Timetable showing sequence and duration of activities
- Analysis of factors influencing achievement of objectives including assumptions and constraints, potential obstacles
- Management of the project: management and support structures, coordination, lines of responsibility and communication, key personnel
- Monitoring and evaluation strategies, explaining how data will be collected and key indicators
- Resources and budget: needs for money, personnel, facilities, equipment and supplies, description of fund management
- Budget and budget justification
- If possible use a logical framework or operational framework to summarize activities



Appendix VII:

Steps in developing and pretesting IEC materials

Steps in developing Information, Education and Communication (IEC) messages and materials

- Gather all available reproductive health-related IEC materials from both the host country and the country of origin.
- Identify and prioritize the community's IEC needs.
- Define specific target audiences (e.g. women of reproductive age, unaccompanied minors, commercial sex workers, traditional healers), their specific IEC needs and specific objectives of the IEC campaign.
- In collaboration with key informants from targeted groups, develop short, accurate, relevant messages geared to the audience in question.
- Ensure that services are available as promised: people must be able to act on the advice that is contained within the IEC messages and materials.
- Decide on the most appropriate media to disseminate the message (e.g. printed materials, posters, flipcharts, radio, video shops, megaphone announcements, role plays, songs, drama, home visits, group talks, ongoing classes, one-off workshops, community gatherings).
- Decide on the most appropriate people to convey the message (e.g. peer educators, TBAs, schoolteachers, informal leaders and opinion formers, religious leaders).
- Adapt existing materials or design new materials as necessary. Where new materials need to be developed on site, this will involve hiring artists and setting up a small studio.
- Pretest and revise materials (see below).
- Conduct IEC campaign.
- Evaluate effectiveness of campaign through follow-up focus group discussions, interviews and surveys and through observed changes in behaviour (e.g. increased STI clinic attendance).

Summary of pretesting and revision

Pretesting messages with members of the target group identifies what changes need to be made to ensure that people understand and like them. A pretest examines what the message says (the information given) and how the message is received. The main methods of pretesting are:

- Individual interviews: Participants are shown the materials or messages one at a time and asked a series of questions. This technique is especially good for pretesting illustrated materials for people who cannot read, and also for mass media messages.
- Focus group discussions: A group of people is asked to review the printed material, video, film, song or play. This method is most appropriate for messages conveyed through channels that are meant to be used with a group, like flipcharts and theatre plays.

Pretesting should follow these principles:

- The site and time of day should be convenient to the participants.
- The people doing the pretesting should be carefully trained to:
 - be supportive of the people responding, encouraging them to speak freely without interruption;
 - ask specific questions about the words, the pictures and the message;



- ask for suggestions on how to improve the message or picture.
- The pictures and text of printed materials should be tested separately to see if people can understand one without the other.
- Pretesting should continue until about 90% of the participants:
 - see what they are supposed to in the pictures;
 - understand what they are supposed to in the text;
 - like the pictures and the text;
 - do not have any changes to suggest.

Appendix VIII:

Cost categories for health service planning

Costs are usually divided into capital (nonrecurring) and revenue (recurring) costs. Some of the typical categories of capital and recurring costs for health services in refugee/displaced settings are listed below.

Capital or nonrecurring costs

- Premises (purchased/constructed) (office, clinics, classrooms, maternity units, women's house etc.)
- Initial personnel training and orientation (of both community and agency staff)
- Equipment and non-expendable supplies (e.g. furnishings, instruments, linen, also photocopiers, computers etc.)
- Equipment and other supports to local health services
- Vehicles for general and emergency transportation
- Textbooks, teaching materials
- Development of forms and information materials
- Community mobilization activities (promotional materials and events)
- Surveys and special studies

Recurring costs

- Premises (leased/rented)
- In-service training
- Salaries and benefits
- Incentives, food for work etc.
- Pharmaceutical and expendable clinical and laboratory supplies
- Support services (cleaning, laundry, secretarial etc.)
- Payments to referral services
- Ongoing support to local health services
- Supervision, monitoring and evaluation
- Information, education, communication materials and activities
- Reprinting of forms and information materials
- Maintenance and taxes for physical plant
- Maintenance and fuel for vehicles
- Utilities (water, electricity)
- Communications (telephone, telex, radio)
- Office supplies



Appendix IX: Glossary

Abortion: The termination of pregnancy from whatever cause before the fetus is capable of extrauterine life.

Abortion death: The death of a woman from any cause occurring within 42 days after spontaneous abortion or initiation of induced abortion. If the death occurred after 42 days, the fatal complication must have begun within this interval.

Anaemia: A reduction in the number of red blood cells or in the amount of haemoglobin present in them. Anaemia can be caused by excessive blood loss, or by not eating enough foods rich in iron and folic acid. Some diseases can also cause anaemia by destroying the red blood cells.

Anaemia in pregnancy: Anaemia in pregnancy is defined as a haemoglobin concentration of less than 110 g/l. Degree of anaemia—classified as moderate (70-109 g/l), severe (40-69 g/l) and very severe (<40 g/l). Corresponding haematocrit (PCV) values are 24-37%, 13-23% and <13% respectively.

Antepartum haemorrhage: Bleeding from the genital tract occurring after the 20th week of pregnancy but before delivery of the baby.

Assessment: The process of identifying and understanding a problem and planning a series of actions to deal with it. There are usually a number of different stages in the process, but the end result is always to have a clear and realistic plan of activities designed to achieve a set of clear aims and objectives.

Case: A person in the population or study group identified as having a disease or health problem of interest.

Case-fatality rate: The probability of death among diagnosed cases of a specific health problem:

$$\frac{\text{number of persons dying of a specific problem during a specified period}}{\text{total number of persons with the problem during the specified period}}$$

Cause-specific death rate: A mortality rate indicating the number of deaths attributable to a specific health problem or disease in a given population in a given time period (usually expressed per 100,000 population per year).

Clean delivery: A delivery that follows three basic principles of cleanliness (clean hands, clean surface, clean cutting of the cord).

Contraceptive prevalence rate (CPR): The percentage of women of reproductive age who are using (or whose partner is using) a contraceptive method at a given point in time.

Crude birth rate (CBR): The number of live births in a given period per 1000 people in the same period. Usually expressed per year.



Crude death rate: The number of deaths from all causes per 1000 population in a given year or per 10,000 per day in an emergency situation.

Deliveries attended by skilled health personnel: Percentage of deliveries attended by skilled health personnel irrespective of outcome.

- **Skilled health personnel or skilled attendant:** Doctors (specialist/non-specialist) and/or persons with midwifery skills who can diagnose and manage obstetrical complications as well as normal deliveries.
- **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, to conduct deliveries alone, to provide lifesaving obstetric care, and to care for the newborn and the infant.

Disaggregate: Analyse data according to different groupings to show differences between certain groups (by gender, age, ethnic group etc.) and therefore to reflect the true variations within the sample.

Eclampsia: A condition peculiar to pregnancy or a newly delivered woman, characterized by fits followed by more or less prolonged coma. The woman usually has hypertension and proteinuria. The fits may occur in the antepartum, intrapartum and postpartum periods.

Essential obstetric care: The minimal health care interventions needed to manage complications of pregnancy and delivery.

Evaluation: An assessment at one point in time that concentrates specifically on whether the objectives of a piece of work have been achieved and what impact has been made.

Fertility rate: The number of live births per 1000 women of childbearing age, usually taken as 15-44 years, in a given year.

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 separation, the fetus does not breathe or show any other evidence of life.

First-in/First-out (FIFO): A method of managing supplies in a storage facility to ensure that stock with the earliest expiry date that has been stored for the longer period is issued before stock which has been stored at a later date and has a later expiry date.

Focus group discussions: A small group of people (6-12) with specialist knowledge or interest in a particular topic are invited to discuss specific topics in detail. A facilitator is chosen to keep the discussion on or around the original topic, and to stop individuals dominating the discussion. It can bring together people who have a particular problem, those who cannot speak up at large meetings (such as women or minority groups), or those who are peripherally involved in a community, such as nomadic herders.

Hypertensive disorders of pregnancy: A diagnosis of hypertension in a pregnant woman is made when the diastolic blood pressure is 90 mmHg or greater. A differentiation should be made between pregnancy-induced hypertension (which occurs without a previous history of hypertension) and that associated with pre-existing hypertension.

Incidence rate: The rate at which people without a health problem develop the problem during a specific time, i.e. the number of new cases developing in a population over a period of time.

In-depth interviews: Semi-structured interviews with no formal questionnaire but with a checklist of topics to be covered. They are useful both for gathering detailed information about a community from key informants and also for discussing subjects which are too complex or too sensitive to be discussed in a group.

KABP survey: Survey of knowledge, attitudes, beliefs and practice through structured face-to-face interviews (or self-administered questionnaires) with a representative sample of the target population. Provides quantifiable data on what people know, believe, want and do.

Live birth: Complete expulsion or extraction from its mother of a baby, irrespective of the duration of the pregnancy, which after such separation breathes or shows any 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.

Logistics: The science of forecasting, procuring, storing, transporting and distributing supplies.

Low birth weight: Birth weight less than 2500 g.

Maternal mortality: A maternal death is the death of a woman while pregnant or within 42 days of termination of the pregnancy, irrespective of the duration and the site of pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

Maternal mortality rate: The maternal mortality rate is 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 period.

Monitoring: The systematic and continuous collecting and analysing of information about the progress of a piece of work over time.

Neonatal death: A death of a liveborn infant during the period which commences at birth and ends 28 completed days after birth. It 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.

Neonatal mortality rate: Number of deaths among live births during the first 28 completed days of life per 1000 live births.

Neonatal period: The neonatal period commences at birth and ends 28 completed days after birth.



Objectives: Specific, time-bound and measurable goals for particular aspects of a piece of work which contribute to achieving the longer-term aims.

Obstructed labour: A labour in which progress is arrested by mechanical factors and delivery is impossible without operative intervention.

Perinatal mortality: The perinatal period commences at 22 completed weeks of gestation (154 days) when birth weight is normally at least 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 1000 total births (live births plus fetal deaths) during the same time period.

Postpartum haemorrhage: The loss of 500 ml or more of blood from the genital tract after delivery of the baby. In anaemic mothers, a lower level of blood loss should be the cut-off point for starting therapeutic action.

Pre-eclampsia: A condition peculiar to pregnancy manifested by hypertension, oedema and/or proteinuria.

Pre-term: Less than 37 completed weeks of gestation.

Prevalence rate (PR): A measure of the total number of people (old and new cases) in a population who have a health problem at a specified point in time (usually used for chronic conditions like AIDS).

Prolonged labour: Active labour with regular uterine contractions for more than 12 hours.

Prolonged rupture of the membranes (regardless of labour status): Rupture of the membranes for more than 12 hours.

Puerperal sepsis: Infection of the genital tract occurring at any time between the onset of rupture of membranes or labour and the 42-day postpartum period in which, apart from fever, one or more of the following are present: pelvic pain, abnormal vaginal discharge (e.g. presence of pus), abnormal smell/foul odour of discharge, delay in the rate of reduction of size of uterus.

Qualitative assessment methods such as in-depth interviews, observation and focus group discussions provide detailed information about behaviour and beliefs, and about the spectrum of beliefs in the community, but do not provide information on the incidence of these behaviours and beliefs.

Quantitative assessment methods such as probability sampling surveys, KABP surveys, routine surveillance and record review provide answers to the questions *who, what, when, where, how much, how many, how often*. They can give statistically accurate information about an entire community, but little information on the reasons why people behave as they do.

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.

Ratio: A measure of the frequency of one group of events relative to the frequency of a different group of events (e.g. the number of abortions per 1000 live births—abortion ratio).

Safe/attraumatic delivery: A safe delivery is one where the birth attendant monitors progress to avoid prolonged, obstructed labour or other complications which can lead to haemorrhage, infection and shock in the mother and birth asphyxia and brain damage in the infant.

Spontaneous abortion or miscarriage: A fetal death in early pregnancy. At what gestational age a miscarriage becomes a stillbirth for reporting purposes depends on the policy of the country.

Stillbirth: A fetal death late in pregnancy. At what gestational age a miscarriage becomes a stillbirth for reporting purposes depends on the policy of the country.

Surveillance: A dynamic process in which data on the occurrence and distribution of health or disease in a population are collected, collated, analysed, and disseminated.

Traditional birth attendant (TBA): A trained or untrained birth attendant who traditionally assists women at community level.

Trained TBA: A TBA or a family TBA who has received a short course of training through the modern health care sector to upgrade her skills.

Unsafe abortion: A procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking minimal medical standards or both.



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Appendix XI:

Selected supplies and equipment catalogues and procurement services

- UNICEF Copenhagen Warehouse: Standard stock items catalogue. UNICEF Plads, Freeport, DK-2100 Copenhagen 0, Denmark. Fax: (45) 31 26 94 21
- WHO supplies and equipment list—basic standard items. WHO, CH-1211 Geneva 27, Switzerland. Fax: (41) 22 791 4187
- Inter-Agency Procurement Services Office (IAPSO), UNDP. IAPSO, Gittervej 20, Freeport, P.O. Box 2530, DL-2100 Copenhagen 0, Denmark. Fax: (45) 35 27 37 99
- Medecins Sans Frontières Logistique: Logistics catalogue and medical catalogue. MSF Logistique, 14 avenue de l'Argonne, F-33700 Merignac, France. Fax: (33) 5 56 13 73 74
- UNFPA, 220 East 42nd Street, New York, NY 10017, USA. Fax: (1) 212 297 4915



