REPRODUCTIVE HEALTH CARE

Description

This chapter reviews the contribution of reproductive health care to the overall quality of life. It focuses on the priority reproductive health needs of displaced populations and describes a logical approach to establishing reproductive health services.

Learning Objectives

- To characterise the leading causes of reproductive health morbidity and mortality in humanitarian emergencies.
- To design reproductive health projects that address the needs of displaced women and adolescents.
- To describe how to introduce the Minimum Initial Services Package (MISP) and more long-term reproductive health care for displaced populations.
- To describe how to monitor and evaluate a reproductive health program in emergency situations.

Key Competencies

- To understand the leading causes of reproductive health morbidity and mortality among displaced populations.
- To assess reproductive health needs and plan the most appropriate reproductive health services.
- To recognise the challenges of implementing reproductive health programs for displaced populations.
- To define the most useful indicators for monitoring and evaluating reproductive health programs.

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OVERVIEW OF REPRODUCTIVE HEALTH ISSUES IN EMERGENCIES

> *"Reproductive health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so."*
>
> — Program of Action
> International Conference on Population and Development
> Cairo, September 1994

Reproductive health care in emergencies is not a luxury, but a necessity that saves lives and reduces illness. Until very recently, it has been a neglected area of relief work, despite the fact that poor reproductive health becomes a significant cause of death and disease in camp settings once emergency health needs have been met. The United Nations High Commissioner for Refugees (UNHCR) recognises the importance of reproductive health by stating, "While food, water, and shelter remain a priority, reproductive health care is among the crucial elements that give refugees basic human welfare and dignity that is their right."

Reproductive health care for displaced populations involves four technical areas:

- Safe Motherhood (antenatal care, delivery care, and postpartum care)
- Prevention and Care of Sexually Transmitted Diseases (STDs) and HIV/AIDS
- Family Planning
- Protection from and response to sexual and gender violence — This covers how to manage the consequences of sexual and gender-based violence including provision for emergency post-coital contraception.

Below is a list of terms and definitions that are commonly used in the area of reproductive health care:

Table 11-1: Terms and Definitions

AIDS (Acquired Immunodeficiency Syndrome)	A disease defined by a set of signs and symptoms characterised by the body's compromised immune response; caused by HIV and transmitted through body fluids (e.g., semen, blood).
Anaemia	A reduction in the quantity of red blood cells per unit volume blood to below normal units.
Birth Spacing	Deliberate use of fertility control to extend the period between births. May be achieved through natural, barrier, hormonal, or intrauterine methods.
Contraceptive Prevalence Rate (CPR)	CPR = A x D, where A = acceptor rate/year and D = average "life expectancy" or duration of contraceptive use.
Crude Birth Rate (CBR)	Number of births in a population during a year (or other limited time frame) divided by the total midyear population (or midpoint of the time frame selected).
Ectopic Pregnancy	A pregnancy whereby the embryo implants outside the uterus, usually in the fallopian tube.
Emergency Contraception	Post-coital mechanisms to inhibit ovulation and implantation.
Female Genital Mutilation (FGM) **(aka female circumcision)**	The removal of all or part of the female external genitalia for cultural or any other non-medical purposes.
Gender-based Violence	Violence that is directed specifically against a woman because she is a woman, or which affects women disproportionately.[1]
Haemorrhage	Severe (often difficult to control) bleeding from within the body.
Human Immunodeficiency Virus (HIV)	The virus that causes AIDS; it causes a defect in the body's immune system by invading and then multiplying within white blood cells.

Hypertension	Abnormally high blood pressure.
Maternal Mortality	The death of a woman while pregnant or within 42 days of termination of pregnancy (be it birth, abortion, or miscarriage) due to complications from the pregnancy, delivery, or management of either, or due to existing medical conditions that were aggravated by the pregnancy or delivery.[2]
Maternal Mortality Rate	The number of maternal deaths per 100,000 women of reproductive age.
Maternal Mortality Ratio	The number of maternal deaths per 100,000 births.
Midwife	A skilled birth attendant who has received sufficient training to diagnose and manage complications during childbirth, as well as assist normal deliveries. Generally midwives are able to handle basic obstetric problems but will refer more serious complications to a physician.
Minimum Initial Services Package (MISP)	A package of materials and services which should be immediately put in place during the acute phase of an emergency, as recommended in the Inter-Agency Field Manual on Reproductive Health in Refugee Situations by UNHCR and UNFPA. It includes: 1) Prevention of and response to sexual and gender-based violence (including provision for emergency post-coital contraception) 2) Enforcement of respect for universal sterile precautions against HIV/AIDS 3) Guaranteeing the availability of free condoms 4) Provision for safe delivery kits 5) Planning for comprehensive reproductive health services that are integrated into primary health care (PHC) as soon as possible 6) Human and material resources needed for implementing the MISP
Oral Contraception	Various hormonally-based medications (using estrogen and/or progestin) which a woman can take orally, on a daily basis, to prevent pregnancy. The hormone doses impact on the reproductive hormonal system to inhibit ovulation and other reproductive functions temporarily (effective only for as long as the medication is taken).
Perinatal Death	A foetal death of 28 weeks or more, and infant deaths under seven days of age.
Rape	Sexual intercourse with another person (male or female) without his/her consent. Statutory rape is the rape of a minor who is below the legal age for engaging in sexual intercourse.
Sexual Violence	Covers all forms of sexual threat, assault, interference, and exploitation including statutory rape and molestation without physical harm or penetration.
Safe Motherhood	Programs that are designed to minimise the health risks of pregnancy and childbirth to the mother (and infant). These programs include antenatal care, delivery care, and postnatal care.
Septic Abortion	Abortion performed under unsanitary conditions leading to infection (common in countries where abortion is not legal and a leading cause of maternal death).
Sexually Transmitted Diseases (STDs)	Any disease that is communicated primarily or exclusively through intimate sexual contact; can cause infertility through miscarriage, prenatal deaths, and damage to male and female reproductive systems.
Syndromic Management of Disease	Diagnosis and treatment of illness based on a health care provider's thorough analysis of signs and symptoms presented by the patient.
Total Fertility Rate	Number of live births born to 1,000 women of reproductive age (per year).
Traditional Birth Attendant (TBA)	A community-based birth attendant who, with limited formal training, provides basic prenatal, delivery, and postnatal care. Although not trained to manage complications of pregnancy and childbirth, (s)he provides important referral services for problem cases.
Unmet Need for Contraception	A measure based on the number of women of reproductive age and in a sexual union who report that they want to postpone or avoid childbearing and also report that they and their partner are not using contraception.
Women of Reproductive Age	Women between the ages of 15-44 or 15-49 (depending on the childbearing trends of the population in question), for the purposes of demographic statistics; often used as the denominator in reproductive health demographic measures.

In 1997 the number of refugees and internally displaced persons (IDPs)[3] world-wide approached 50 million — the majority being women and children.[4] Women bear the greatest burden of reproductive ill health, as well as a disproportionate amount of the hardship that affects families in emergency settings. It is critical that a lack of comprehensive reproductive health services does not add to the suffering of women in emergencies. Lack of quality reproductive health services can lead to the following:

- high mortality rates among women and children
- an increase in the spread of sexually transmitted diseases (STDs) and HIV/AIDS
- an increase in unsafe abortions
- an increase in morbidity related to high fertility rates and poor birth spacing.

Key Facts

There are some key facts to recognise when considering the importance of women's reproductive health and the magnitude of challenges that currently face public health professionals all over the world:

- An average of 80% of refugees are women and children.[5]
- Approximately 25% of refugees are women of reproductive age.[6]
- Reproductive ill-health accounts for one-third of the total burden of disease suffered by women in developing countries.[7]
- 120-150 million women who want to limit or space their pregnancies still do not have the means to do so effectively.[8]

Health Risks of Pregnancy and Childbirth

> *"Whatever a woman's choice in terms of the number and timing of her children, childbirth must no longer carry with it the risk of death or disability for her and her new-born which it has held for far too long."*
>
> — World Health Organisation, Safe Motherhood Progress Report 1993-1995

Pregnancy and childbirth are recognised health risks for women in developing countries. In general, it is estimated that 15 million women a year suffer long-term, chronic illness and disability because they do not receive the care they need during their pregnancy. These risks are magnified for women living in emergency settings, where the majority give birth in temporary shelters under conditions that are hazardous for themselves and their children. Their physical health is often seriously depleted as a result of the trauma and deprivation associated with their flight. The poor nutrition and stressful living conditions in camp settings only compound this problem. As a result, the region with the largest numbers of displaced populations has the highest maternal mortality rate.

Key Facts

- Over 585,000 women die every year (an average of 1,600 per day) as a result of causes related to pregnancy or childbirth—almost all in developing countries.[9]
- Between 25-33% of all deaths of women of reproductive age in the developing world are the result of pregnancy or childbirth.[10] It is the leading cause of death and disability for women between the ages of 15 and 49 in the developing world.
- Unsafe abortion is a leading cause of maternal mortality world-wide, accounting for 70,000 deaths every year. Millions more suffer long-term health problems such as chronic infection, pain, and infertility.

- Another 15 million women in developing countries suffer acute complications that can lead to lifelong pain, illness, and infertility.[11] For the refugee population within the post-emergency phase, pregnancy and child-delivery complications are the leading cause of mortality and morbidity among women.[12]
- 50% of all perinatal deaths are due primarily to inadequate maternal care during pregnancy and delivery.[13]

Risk Factors for Maternal Morbidity and Mortality

Underlying risk factors for maternal deaths and illness are particularly severe in emergency situations. These include:

- Inadequate pre-natal care which is necessary for the early detection of complications
- Under-nourishment
- Undesired pregnancies and induced septic abortion due to sexual violence and interruption of family planning services
- Insufficient staff and resources for hygienic non-emergency deliveries
- Inadequate referral systems and/or transportation for obstetric emergencies

Obstetric Emergencies

Women exposed to one or more of the above risk factors often find themselves in an obstetric emergency situation. If no provision is made for emergency obstetric care they may suffer great pain, bleeding, and infection often leading to infertility and sometimes death. Long-term consequences include premature delivery, chronic pelvic pain, and increased likelihood of ectopic pregnancy and spontaneous abortion.

The table below defines the leading obstetric emergencies that can kill a woman within a short time.

Table 11-2: Leading Causes of Maternal Mortality and Morbidity

Five Leading Causes of Maternal Mortality and Morbidity
• **Haemorrhage** – may occur during pregnancy or delivery due to prolonged labour; trauma and/or rupture of the uterus or other parts of the reproductive tract; ectopic pregnancy; abnormal development and/or rupture of the placenta; abnormal bleeding associated with anaemia or coagulation disorders.
• **Sepsis** – infection can arise after delivery, miscarriage or unsafe abortion when tissues remain in the uterus or if non-sterile procedures or instruments are used (e.g., frequent vaginal exams without gloves). Pre-existing STDs and prolonged rupture of the amniotic membrane before delivery increase the risk of sepsis.
• **Eclampsia** – can occur in the latter stage of pregnancy or after delivery. It is characterised by uncontrolled fits, oedema, and/or elevated blood pressure during delivery and can lead to rupture of the liver, kidney failure, or heart failure and cerebral haemorrhage.
• **Unsafe Abortion** – can lead to haemorrhage due to puncture of organs or an abnormal placenta, infection from unsanitary instruments and inappropriate procedures, or complications from an incomplete abortion.
• **Obstructed Labour** – can be due to small pelvis (because of physical immaturity or stunted growth), distorted pelvis, cervix or vagina (latter from FGM); irregular position of foetus prior to and during delivery.

The following table describes a common problem in developing countries — a lack of essential health services to prevent, detect, and manage high-risk pregnancies and births.

Figure 11-1: Example of Lack of Health Services for High-Risk Obstetric Care

Need for Emergency Obstetric Care
In 1997, when members of the Reproductive Health for Refugees Consortium visited Somali refugee camps in eastern Ethiopia, the need for emergency obstetric care was clear. 90 percent of births took place in traditional tukuls, in poor conditions. Most refugee women were unaware of risk signs during their pregnancies and were therefore not referred in good time to the hospital in Jijiga. The hospital is at least one hour's drive away from the camps. In addition, ambulance services are controlled not by medical staff but by camp administrators and are not available 24 hours a day. Because of this lack of ambulances or alternative transport, it is often impossible to hospitalise cases of obstetric emergency.

Initiatives to improve the general health of refugee populations must seek to do the following:

- reduce the numbers of high risk and unwanted pregnancies
- reduce the number of obstetric complications
- reduce the number of women dying from obstetric complications

Without the above interventions, many refugee women and their new-borns will die needlessly. In refugee settings, a woman is often the main provider for her family. If she dies, her family is left without her care, support and protection, and the risk of mortality among her children increases. Therefore, the consequences of inaction affect the entire refugee community and exacerbate the difficulties and instabilities of refugee life.

Sexually Transmitted Diseases and HIV/AIDS

> *"Reproductive health eludes many of the world's people because of such factors as: inadequate levels of knowledge about human sexuality and inappropriate or poor-quality reproductive health information and services; the prevalence of high-risk sexual behaviour; discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives."*
>
> — Program of Action
> International Conference on Population and Development
> Cairo, September 1994

Sexually transmitted diseases (STDs) including HIV/AIDS spread fastest where there is poverty, powerlessness, and social instability. These conditions are characteristic of life in refugee settings. As a consequence, there is an increasing incidence of STDs and HIV among displaced populations.[14]

Key Facts

- STDs cause the second highest burden of disease for women aged 15-44 in developing countries, after maternal mortality and morbidity.
- Biological and social factors make women and girls more vulnerable to AIDS than men, especially in adolescence and youth, when in many places HIV infection in young women has been found to be 3-5 times higher than among boys.[15]
- In Africa, women's peak infection rates occur at earlier ages than men's. This helps explain why there are an estimated 12 women living with HIV for every 10 men in this region.[16]
- In Africa, AIDS now kills ten times more people a year than war.[17]

Risk Factors for STDs and HIV

There are a number of other factors associated with populations in emergency situations that may contribute to this serious health problem[18]:

- At every stage of flight, displaced women and girls are vulnerable to rape and sexual abuse. This reality often continues within the camp setting as well.
- Sexual violence against displaced men and boys, particularly prisoners and captives, is also known to occur.
- As traditional sources of support and families structures are interrupted and/or destroyed by conflict and displacement, cultural or familial controls of behaviour may become loose.
- Displaced people deprived of their normal sources of income may be forced to exchange sex for money or basic survival needs. Their risk of getting STDs/HIV may increase if the disease prevalence is higher in host populations. On the other hand, host populations with low STDs/HIV prevalence may be at increased risk of these infections if the disease prevalence in displaced populations is high.
- Unaccompanied minors are usually more likely to become sexually active at an earlier age than they would under normal circumstances.
- Greater social acceptance of high-risk male sexual behaviour can expose both men and their partners to infection while social norms limit women's access to information about sexual matters.
- The risk of HIV transmission through contaminated blood can be higher in emergency settings, especially in situations of war and civil strife, as more transfusions may be required and the infrastructure for screening is often lacking.
- Rural dwellers typically have lower rates of STDs/HIV and a lower risk of acquiring infections. They are also less aware about means of prevention. Forced migration to areas of high population density increases their exposure to people from different backgrounds and hence an increased risk of infection.

The impact of STDs and HIV/AIDS is not just physical: it can also affect the emotional and economic well being of the refugee community. People living with HIV/AIDS and their families may experience social rejection and isolation, increasing the psychological traumas that often accompany refugee life. STDs and HIV/AIDS also leave families vulnerable to poverty and economic dependence, since young adults in their productive working years are most at risk of infection.

Sexually Transmitted Diseases (STDs)

STDs are infections caused by various micro-organisms that are transmitted mainly by intimate sexual contact through fluids produced in the human reproductive tract. The signs and symptoms of common STDs are summarised in the next table.

Table 11-3: Symptoms of STDs

Disease	Signs and Symptoms
Gonorrhoea	Common STD caused by a bacteria, characterised by a pus-like discharge from urethra or cervix, and painful urination in both men and women. Can lead to infertility in both sexes.
Chlamydia	Caused by a micro-organism which can produce inflammation of the vagina/cervix or urethra; can also lead to pelvic inflammatory disease (PID) in the female. Characterised by a thin mucous discharge in men, and cervical discharge in women (can be yellow or green in colour).
Syphilis	Caused by a spirochete which produces a genital ulcer in the early stages (usually painless), and a more general non-itchy skin rash in a secondary stage. If not treated, can also affect the heart and brain in late stages.
Chancroid	This is the most common cause of genital ulcer disease in many parts of the developing world; involves painful, soft sores on the genitals which discharge pus; sometimes causes enlarged lymph nodes in the groin.
Tricomomiasis	Caused by a parasite that produces effects ranging from no symptoms to irritation, itching, odour, vaginal discharge, and/or frequent urination in women. While males rarely display symptoms, they may develop inflammation of the urethra and/or skin lesions on the penis.
Genital Herpes	Caused by a virus producing multiple, shallow ulcers anywhere on the genitalia; lesions usually heal and recur in cycles. Viral shedding can occur during latent periods. There is no known cure.
Human Papilloma Virus (HPV)	A common virus causing small, painless primary lesions in the area of infection, usually referred to as genital warts. Research indicates a probable link between HPV exposure and later development of cervical cancer.

Although much attention has been given to HIV/AIDS, it should be emphasised that STDs pose a serious public health threat. Their presence greatly increases the risk of HIV transmission, which in turn increases the risk of active tuberculosis. Women with STDs may suffer chronic pain, infertility, reproductive tract cancer, and complications during pregnancy and childbirth. Their children too may be adversely affected with increased risk of morbidity and mortality.

HIV/AIDS

As stated earlier, displaced persons may be at a higher risk of HIV infection than at any other time in their lives. There are four main routes of acquiring HIV infection.

- Sexual intercourse
- Mother-to-child
- Blood transfusion
- Contaminated instruments, needles and gloves

Many people are not aware that they have contracted HIV until the illness has progressed to full-blown AIDS. The actual signs and symptoms of AIDS vary considerably among patients. However, the common theme is that as the virus destroys the body's immune system, a number of infections and cancers may develop. These infections and cancers ultimately lead to the death of an HIV-infected person. Some of the illnesses associated with HIV/AIDS include tuberculosis, certain skin cancers (e.g., kaposi sarcoma on the skin), certain forms of meningitis (e.g., crypto-coccal meningitis), and pneumonia (pneumocystis carinii pneumonia).

Although there is no fully effective cure for HIV/AIDS at this time, there are many ways in which relief workers can work with local populations to prevent the spread of both STDs and HIV/AIDS in the emergency setting, as described later in this chapter.

Unplanned and Untimely Pregnancies

> *"All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so."*
>
> — Program of Action
> International Conference on Population and Development
> Cairo, September 1994

Key Facts

- World-wide, some 350 million couples lack access to safe, effective, and affordable family planning services.[19]
- Family planning can prevent 25-30 percent of all maternal deaths.[20]
- Spacing births at least three years apart can decrease infant mortality by around 20 percent.[21]

More than 120 million women say they want to space or limit their families, but currently do not have accessible, affordable, or appropriate means to do so. This problem is most evident in emergency settings where a high number of women are struggling with unwanted, unplanned, and poorly spaced pregnancies, which can be hazardous to them and their children. Given the choice, many displaced women would prefer not to become pregnant and face the difficulties of childbearing in a camp setting. However, many do not have this choice since contraceptive services are often unavailable. Even where services do exist, many women are often unaware of the benefits of contraception. Some may be constrained from using contraception due to cultural mores or political pressure to rebuild the population. Unwanted pregnancies, and the attendant increase in unsafe abortions are also by-products of a breakdown in social order which allows rape and prostitution to flourish.

Family planning plays a crucial role in helping women remain healthy by preventing unwanted or untimely pregnancies. Increasing access to safe, effective contraception saves the lives of women and children. Many contraceptives have added health benefits. For example, the pill can protect against certain cancers, while the condom provides protection against HIV/AIDS and other sexually transmitted diseases. The best guarantee of infant survival is to ensure the survival of the mother. Hence, family planning and birth spacing increase the chance that children will grow up healthy. Family planning also has positive long-term benefits for the entire refugee community. Smaller families allow women and couples to care for their children more effectively, manage scarce resources for health, education, food and housing, and undertake a greater range of income-generating activities.

Sexual and Gender-Based Violence

> *"Migrants and displaced persons in many parts of the world have limited access to reproductive health care and may face specific serious threats to their reproductive health and rights. Services must be sensitive particularly to the needs of individual women and adolescents and responsive to their often powerless situation, with particular attention to those who are victims of sexual violence."*
>
> — Program of Action
> International Conference on Population and Development
> Cairo, September 1994

Sexual violence covers all forms of sexual threat, assault, interference and exploitation, including statutory rape and molestation without physical harm or penetration. Gender violence is violence that is directed specifically against a woman because she is a woman or which affects women disproportionately. Sexual and

gender-based violence includes a wide range of abuses, with rape being perhaps the most obvious form. Other abuses include attempted rape, assaults, domestic violence, incest, involuntary prostitution, torture, insertion of objects into genital openings, and female genital mutilation.[22]

Note: *Although those most at risk are typically women and girls (especially if unaccompanied), sexual violence against men and boys also occurs.*

Key Facts

- The World Bank estimates that trauma resulting from sexual and gender-based violence accounts for 5% of the total burden of disease, among women of reproductive age in developing countries.
- Between 16-52% of all women have been assaulted by an intimate male partner.[23]
- In more than 60 percent of all rape cases, the victim knows the perpetrator.[24]
- Over 130 million women in the world today are estimated to have undergone female genital mutilation (FGM). An additional 2 million young women undergo FGM every year.[25]
- Studies have shown that between 36-62% of all sexual assault victims are aged 15 and under.[26]

Sexual and gender-based violence (abbreviated as "sgbv") is a tragically common problem for refugee populations, producing serious physical and psychological consequences for its victims. It is endemic in conflict situations, where rape and other forms of violent sexual assault are increasingly used as weapons of war. Mass rape of populations is used to dominate, control, and inflict psychological impairment. It may also be used as a method of torture during interrogation. In the former Yugoslavia, rape was deliberately employed to demoralise men and women held in captivity. In Rwanda, and other countries where the ethnicity of the child is determined by the father's ethnicity, rape has been used to alter the ethnic composition of the population. All human beings want to escape such degradation. Sadly for women and girls (and even men) in emergency situations, the environment is full of sexual violence inflicted by guards, soldiers, and others in a position of military/political/economic authority, as well as by fellow displaced persons.

The consequences of sexual and gender-based violence are often long lasting and severe, and include the following:

- **Physical consequences** which may include HIV and STD infection, unintended pregnancy, unsafe abortion, menstrual disorders, trauma to the reproductive tract, and miscarriage if already pregnant.
- **Psychological effects** may be considerable, such as post-traumatic stress disorder and depression.
- **Social consequences**: Women who have suffered such violence are sometimes stigmatised and/or rejected by the community.

FGM (Female Genital Mutilation)

An additional area of concern is the harmful traditional practice of female genital mutilation (FGM), which is a cross-cultural and cross-religious ritual performed by communities in Africa and Asia, including the Middle East. Over 130 million women world-wide have undergone this ritual. Displaced communities may revive this practice by embracing traditions more fervently in an attempt to reassert their cultural identity in their new environment. From a public health perspective, it is important to assess how FGM is performed and the extent to which it is practised within a displaced population in order to define the magnitude and nature of the problem.

There are three forms of FGM practised around the world, namely:

- “Sunna” — excision of the prepuce and/or tip of the clitoris
- Clitoridectomy – excision of the entire clitoris (prepuce and glands) and the labia minora
- Infibulation — joining of the remaining sides of the vulva after excision of the clitoris and all the labia

Reasons for FGM include family honour, cleanliness, insurance of virginity and faithfulness to the husband, protection against spells, etc. Local midwives usually perform the operation without anaesthesia and under unsanitary conditions. Depending on the extent of the operation, consequences of FGM may range from infections, serious damage, heavy bleeding, and urinary retention to psychosexual and obstetrical complications and even death.

PLANNING EMERGENCY REPRODUCTIVE HEALTH PROGRAMS

Emergency reproductive health care is necessary for the physical, mental, and social well-being of displaced populations. It should be delivered in a timely manner, integrated into primary health care (PHC), and co-ordinated with other sectors and institutions. Because reproductive health care is concerned about highly personal aspects of life, program planning must involve the affected community in order to be sensitive to their religious and cultural values.

Assessment

A reproductive health needs assessment should first be carried out in order to identify the type and extent of reproductive health services needed by displaced populations. This assessment should be led by staff with reproductive health care experience and should involve members of the displaced community. However, this approach may be challenging due to the sensitivity of reproductive health issues.

A basic assessment exercise should provide the following baseline information:

Table 11-4: *Reproductive Health Assessment Checklist*

HEALTH FACTORS

Demographic Profile and Health Status

- Total population
- Number of women of reproductive age
- Number of children 0-15 years
- Number of children 0-5 years
- Number of female headed households
- Crude birth rate
- Maternal mortality rate
- Maternal mortality ratio
- Total fertility rate
- Estimated number of pregnant women**

Available Service and Resources

- Extent and condition of existing health facilities
- Staffing and coverage (i.e., availability of staff)
  (Note: includes both formal staff and informal, such as TBAs)
- Service statistics (i.e., which services are used; the extent to which facilities function at full capacity, etc.)
- Inventories of equipment, drugs, and commodities

SOCIAL FACTORS

Community Knowledge, Attitudes, and Practices

Understanding cultural norms and the effect of dislocation on relevant practices including:

- Rites of passage
  - Marriage
  - Age of first sexual activity
  - Circumcision
- Status of women and children
- Family planning, including child spacing
- Extent of unwanted pregnancies
- Antenatal health care practices
- Child delivery practices and postnatal care
- Knowledge of AIDS and STDs
- Opinions about camp security
- Extent of sexual violence

Note:

1) Special attention should be paid to differences across ethnic groups residing at the camp, should there be more than one group present.
2) It is very important to learn and use the local words for key reproductive health terms and concepts.

**See appendix for details on making this estimate.

Note: *Survey instruments for collecting the above data are available through the Reproductive Health for Refugees Consortium in its document, "Refugee Reproductive Health Needs Assessment Field Tools."*[27]

Once staff have collected and analysed the information, results should be summarised in a formal report. This report should be distributed to all concerned parties (e.g., relevant host country ministries, international agencies, and donors). Summary findings should highlight the following information:

- Affected Population — a reproductive health profile, including the leading causes of reproductive health related mortality and morbidity, and the population's knowledge, attitudes, and practices
- Hierarchy of needs
- Local Capacities — the capacity of existing health facilities, services, and human resources within the camp to deliver reproductive health services to the affected population
- External resources necessary to address current and potential reproductive health problems
- Recommendations — the details for any further investigation and/or program implementation

Setting Priorities

Based on the assessment and feedback received from concerned parties, including representatives of the displaced population, the reproductive health program planners must prioritise the identified problems through a systematic approach. Using the guidelines discussed in the Management chapter, the team should organise the discussion around the following principles:

- List the problems observed through the assessment exercise.
- Ask planners to consider each problem in terms of its prevalence, seriousness, feasibility of control, and community acceptance. Each criteria should be scored from 1-4 (1 being the lowest and 4 being the highest) as shown below.
- Use additive and/or multiplicative scores to identify the problem areas that planners have ranked highest. See the following example of an additive scoring system:

Table 11-5: Worksheet for Preference Ranking of Problems in Reproductive Health

Health Problems	Prevalence	Seriousness	Feasibility of Control	Community Acceptance	Additive Scores	Multiplicative Score
1. Poor lighting at night	4	3	2	4	13	96
2. Few skilled staff	2	4	2	2	10	32
3. No medicines for STDs	1	1	4	3	9	12
4. Malnutrition in pregnant women	4	1	3	3	11	36
5. High rate of unsafe abortion	3	4	2	1	10	24
6. Unmet need for contraception	3	4	1	3	11	36

Note: *Although both additive and multiplicative scoring systems indicate that "poor lighting at night" is ranked as the highest priority, and "no medicines for STDs" as the lowest, the multiplicative scores show a greater relative difference among the other categories. For example, health problems #2 and #5 both score 10 on the additive score, but are different (32, and 24 respectively) on the multiplicative score. In this way, the multiplicative scoring system can be more sensitive to differences in ranking.*

Setting Goals and Objectives

Goals and objectives for a reproductive health program should be defined according to the assessment findings. They will be useful for directing relief managers during the implementation process as well as for evaluating the effectiveness and impact of a program. It is important to define goals and objectives for both the acute emergency and post-emergency phases. Even though the reproductive health program is established during the post-emergency phase, some minimal reproductive health services should be initiated to address emergency reproductive health problems that arise during the acute emergency phase. Goals are general statements about the desired end-point of the program. Objectives are more specific statements about how to reach the set goals. The following table defines goals and objectives for implementing reproductive health measures during the emergency and post-emergency phase:

Table 11-6: Sample Goals and Objectives for Reproductive Health Programs in Emergency Settings

Emergency	Post-Emergency
Goals: • Co-ordinate and implement the MISP • Prevent and manage the consequences of sexual violence • Reduce HIV transmission • Prevent excess neo-natal and maternal morbidity and mortality • Plan for provision of comprehensive reproductive health services **Objectives:** • Design and locate camp sites that enhance physical security • Provide a medical response to survivors of sexual violence, including contraception, as appropriate • Enforce respect for universal precautions against HIV/AIDS • Guarantee the availability of free condoms by procuring sufficient quantities of condoms and developing an effective free distribution system • Promote clean home deliveries by providing clean delivery kits for use by mothers or birth attendants • Facilitate clean deliveries at health facilities by providing midwife delivery kits • Organise a 24-hour referral system for obstetric emergencies • Identify suitable sites for future delivery of comprehensive reproductive health services • Identify qualified and experienced staff to co-ordinate reproductive health activities	**Goals:** • Reduce levels of maternal mortality and morbidity in the population • Reduce the levels of unmet need for contraception • Improve adolescent knowledge, attitudes, and practices concerning the transmission of sexually transmitted illnesses • Increase women's security within the camp and surrounding areas **Objectives:** • Improve medical staff skills at the referral clinic level within six months • Ensure local clinic is well equipped with materials and equipment to handle obstetric emergencies by the end of the third month • Provide training for TBAs in safe motherhood topics every three months • Develop comprehensive ante- and postnatal care programs by the end of the sixth month • Procure sufficient and appropriate contraceptives for post emergency needs within three months • Implement public awareness campaign on the benefits and availability of family planning services by the end of four months • Conduct STD/HIV/AIDS adolescent peer counselling training sessions by the end of six months • Organise community security patrols to improve the safety of women at night within three months • Conduct sexual and gender-based violence awareness training for vulnerable groups once a month • Organise camp-wide public awareness campaigns on the rights of women and children and the prevention of sexual violence beginning by the end of the fourth month • Conduct regular assessments on the equity of relief material distributions, beginning by the end of the third month

Note: *The goals listed under the emergency section of this table are based on the* **Minimum Initial Services Package (MISP)** *in the* Inter-agency Field Manual on Reproductive Health in Refugee Situations *by UNHCR and UNFPA. The post-emergency goals and objectives are examples by the authors.*

Objectives should be based on realistic targets (refer to management section). Examples of **objectives** in a reproductive health program that focuses on reducing maternal mortality are defined below. Please note that these are examples only and should not be considered as standard guidelines:

- To distribute 40 safe delivery kits to TBAs by the end of the first month. (Output Indicator)
- To train, within the first three months, 15 refugee health workers in physical assessment and follow-up of pregnant women within their respective camp centres to ensure timely and appropriate referral to outside clinic services as necessary. (Process Indicator)
- To reduce by 50% the number of maternal deaths occurring within the first year of operation. (Impact Indicator)

Detailed Plan of Action

A detailed plan of action helps managers define exactly how the goals and objectives will be achieved by specifying *what* are the activities, *how* they will be done, *when* and *by whom.* It can be used to co-ordinate reproductive health activities with other existing health services and ensure that staff, especially physicians, can be involved when necessary. An example of a detailed action plan for a safe motherhood project is shown below.

Table 11-7: Sample Plan of Action for a Safe Motherhood Project

Goal	Services	Strategy	Activities	Who Will Deliver	How and When
Decrease Maternal Mortality	1. Antenatal care	Improve recognition and response to high risk mothers at community level	a. Train outreach workers (TBAs and CHWs)	Nurse/midwives	One week training for 15 outreach workers within 3 months
			b. Conduct IEC campaigns on necessity of ANC visits	TBAs and CHWs, Nurse/midwives Community organisers	Weekly public broadcast, Monthly women's groups Daily home visits
	2. Emergency obstetric services	Increase skills and resources at the referra hospital	a. Train midwives and doctors	Local obstetrician & Senior nurse/midwives	National level EOC training within 3 months
			b. Regular supply of EOC drugs and materials	Logistics staff	Order & procure locally every month

Project activities should be based on specific indicators. For each service, define the principal **inputs**, **processes**, and **outcomes** (mainly output and effect since impact is difficult to measure). When evaluating the program activities, these indicators should be used as measures of progress towards the overall goal(s) of the intervention. A sample worksheet showing different indicators for the safe motherhood activities is shown below:

Table 11-8: Sample Worksheet of Indicators for a Safe Motherhood Project

GOAL	OBJECTIVE	INPUT	PROCESS	OUTPUT	EFFECT	IMPACT
Decrease maternal mortality	Provide Safe Motherhood training for TBAs every 3 months	TBAs, Training material, Trainers	Training, Skills testing	Percent of TBAs trained	Early detection & referral of high risk mothers Competence in carrying out normal deliveries	Safer home deliveries Reduced maternal mortality
	Improve EOC skills in medical staff at the referral hospital within six months	Medical staff, Training materials, Trainers	Training, Skills testing	Percent of medical staff trained	Compliance to standard EOC procedures	Efficient management of obstetric emergencies Reduced maternal mortality
	Equip referral hospital to provide EOC within 3 months	Medical & surgical drugs/supplies Transport	Procurement and delivery	Stock of EOC supplies & equipment	Better care for mothers with obstetric complications	Provider and patient satisfaction in EOC Reduced maternal mortality

Considering Constraints and Changes

Most reproductive health programs face constraints that are difficult to overcome, particularly in emergency settings. Unfortunately, some constraints can be critical and can cause well-planned programs to fail. The following factors may prevent the success of reproductive health programs:

- Cultural taboos about discussing human sexuality.
- Inappropriate or poor quality reproductive health information and services.
- The prevalence of high-risk sexual behaviour.
- Discriminatory social practices.
- Negative attitudes towards girls and women.
- Limited power women and girls have over their sexual reproductive lives.
- Reproductive health care is not considered a priority as people are focussing only on their immediate survival needs.

While designing the program, it is important to consult the community representatives in order to identify possible constraints and determine how to overcome them. Programs should also prepare for possible future changes, such as major population movements, sudden changes in political and/or economic conditions, declining community participation, etc. This will make the program flexible to respond to necessary changes in the relief environment. None of these assumptions should be so crucial as to jeopardise the project activities altogether, should they prove to be incorrect.

Identifying Resources

Identifying resources for reproductive health projects in the acute emergency phase may be difficult. Humanitarian ethics dictate that relief assistance should first address the immediate survival needs of a displaced population, which includes provision of water, food, shelter, and medical care to control disease outbreaks. Once the emergency situation is stable, it is inevitable that concern of displaced populations will shift to reproductive health care. Relief agencies must be prepared for this shift and should convince donors during the emergency phase so that resources are available when needed. Generally, resources for reproductive health programs fall into two broad categories: *human resources* and *material resources.*

Human Resources

A successful reproductive health program requires adequate and well-trained staff. Most of the human resources should be members of the displaced population because they understand the cultural norms for reproductive health care. The community representatives can help identify individuals who can be trained to carry out the required activities. Integrating reproductive health projects within the existing primary health care programs will build support from all health care providers.

Table 11-9: Human Resource Needs of Various Health Care Programs

Project	Human Resource Needs
Safe Motherhood	Refugee health workers; traditional birth attendants; nurse/midwives; physicians (for emergency obstetric care)
Family Planning	Refugee health workers; clinical officer; possibly physicians
STD/HIV/AIDS Prevention and Treatment	Refugee health workers; nurses; clinical officer; pharmacist; physician
Prevention and Response to Sexual and Gender-based Violence	Organisation and leadership trainers; refugee community representatives; counsellors; security patrols

Once the program planners have defined the level of skills and competence required by staff members who will carry out the reproductive health activities, they should develop job descriptions. Even though not everyone in the team may be new, a job description and proper job orientation can help all concerned parties understand the new responsibilities and duties of each member of the reproductive health team. Reproductive health training should be provided at the beginning to ensure all team members carry out their duties efficiently and effectively. Staff supervision and ongoing support is important to increase motivation for delivering quality services, particularly for members who are not formally paid for their work. (For more details on supervision and motivation, refer to the *Human Resource Management* chapter.)

Material Resources

The material resources needed to implement a reproductive health program will depend not only on the type of project, but also the population size and the prevalence of reproductive health problems. Ideally, reproductive health projects should rely mainly on local resources, in order to deal with the possibility of declining donor support. Initially, however, external support may be required to procure the start up material resources. The following table lists the key material resources to be considered for different projects.

Note: S*tandard reproductive health reference rates may be used for estimating resources. See attached references in the Appendix.*

Table 11-10: Materials Needs for Various Health Care Programs

Project	Key Material Resources
Safe Motherhood	• For maternity ward in clinic: drugs, dressings, fluids, surgical instruments, sterilisation equipment, extra beds, blankets, etc. • For home deliveries: TBA kits; UNICEF midwife kits; transportation for referral of complicated cases • For pregnant and breast-feeding women: additional food rations and nutritional supplements
Family Planning	• For potential clients: medical examination material; contraceptive prophylactics; storage containers and/or facilities, instructional charts, calendars, scales, etc.
STD/HIV/AIDS Prevention and Treatment	• For curative care: medicines for STD treatment and HIV-related illness, examination gloves and protective clothing, containers for the disposal of needles and other hazardous waste, disinfectants; etc. • For preventive care: condoms, IEC materials (posters, charts) • For blood transfusion: sphygmomanometer, ball, artery forceps, blood bags, transfusion sets, IV catheters, blood lancets, testing kits/reagents, multi-well plates, test-tubes, pipettes, syringes, needles, gloves, weighing scales
Prevention and Response to Sexual Violence	• For security: lighting equipment, shelter material, basic supplies • For economic empowerment: income-generation activities • For crisis response: emergency contraception, medication

Note: *In addition to the above, staff should be equipped with standard guidelines for case management and basic stationary for record keeping, inventory, and training purposes.*

The following guidelines (based on the Inter-agency field manual on Reproductive Health in Refugee Settings) may help in estimating quantities of supplies needed.

Table 11-11: Guidelines on Estimating Resource Quantity Requirements

Resource	Quantity
Referral facility for EOC	• One for every 150,000 to 200,000 people, having a functioning operating theatre, with enough trained staff to perform emergency caesarean sections • Blood bank with guidelines for safe blood transfusions
Safe delivery kits/ UNICEF midwife kits	• Quantity based on a calculation of the crude birth rate (CBR) of the population. Example: If a population has a CBR of 3%, and there are 2,000-3,000 people, 5-8 births per month can be expected. • Note also that one TBA can care for 2,000-3,000 women, with a CBR of 3% (about 60-90 deliveries per year).
Condoms	• From the total population, the percentage of sexually active male population can be estimated at roughly 20%; multiply this by the percentage of males actually using condoms (based on assessment information); multiply that total by 12 (estimating use of 12 condoms per month per male); add to this figure 20% for wastage

The Minimum Initial Service Package (MISP)

A Minimum Initial Service Package has been developed by various international agencies to address the immediate reproductive health needs of displaced populations during the acute emergency phase.

While the MISP outlines priority strategies and activities, the UNFPA Reproductive Health Kit for Emergency Situations provides the actual material resources needed for implementing MISP. The UNFPA has organised 13 self-contained Reproductive Health Kits that are standardised with WHO's New Emergency Health Kits. The following table summarises the contents of each kit:

Table 11-12: Contents of UNFPA Reproductive Health Kit for Emergency Situations

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

Note: *The New Emergency Health Kit contains emergency contraceptives, materials for universal precautions and midwifery kits.*

These kits can also be ordered from UNFPA (New York, Geneva, or country office) or through any other UN agency to meet the reproductive health needs of different emergency phases:

- Acute phase — order Subkits 0-3 for MISP
- Post-emergency — order Subkits 4-12 for comprehensive reproductive health care

IMPLEMENTING EMERGENCY REPRODUCTIVE HEALTH PROGRAMS

Implementing emergency reproductive health care entails much more than the skeleton maternal and child health (MCH) services currently provided to most displaced populations. An emergency reproductive health program is culturally appropriate and sensitive to the different needs of men and women, and of different age groups. It must be accessible and available to single women, widows, older women, men, and adolescents. The following sections provide guidance on specific program implementation options that field workers should consider within each of the reproductive health technical areas.

Safe Motherhood

Safe Motherhood is a comprehensive program that can effectively save lives of women and children in emergency situations. It seeks to ensure that women receive appropriate attention throughout their pregnancy and childbirth. It includes pre- and post-natal care including care of the baby and breast-feeding support, as well as delivery care and referral of women with obstetric complications, including unsafe abortion. It also provides access to family planning services and reproductive health education.

Antenatal Care

Regular antenatal care is a crucial factor in ensuring the health of both the mother and child throughout pregnancy. It is during antenatal care that health care workers can check important health indicators and look for any possible complications and/or risk factors. It is a fundamental component of safe motherhood. Appropriate antenatal care includes the following[28]:

- risk screening
- detecting and managing complications
- observing and recording clinical signs such as height, blood pressure, oedema, detecting anaemia, uterine growth, foetal heart rate, and presentation
- maintaining maternal nutrition
- promoting health
- using preventive medications such as iron folate, tetanus toxoid immunisations, anti-malarials, and antihelminthics

Delivery Care

If facilities for delivery care are not available on site, referral systems need to be established and strengthened to ensure 24-hour access to emergency facilities. Delivery care interventions include[29]:

- Providing skilled assistance
- Clean and safe delivery
- Recognising, managing, and detecting complications early
- 24-hour referral and transportation to emergency obstetric facilities

Emergency Obstetric Care

Emergency obstetric care requires many resources:

- adequate supplies of drugs and equipment
- safe blood for transfusion
- trained staff (for identifying emergency obstetrical conditions, counselling high risk mothers and making appropriate referrals)
- means of transportation for referral of obstetric emergencies

In settings where women's access to medical advice and services is restricted, strong information, education and communication (IEC) and health education campaigns are needed that target all women of reproductive age and the wider community. The following table outlines activities for improving the outcome of women facing obstetric emergencies.

Table 11-13: EOC Activities for Improving Outcome of Obstetric Emergencies

Obstetric Problem	EOC Activities	
	Acute Emergency Phase	**Post-Emergency Phase**
Infection	• Provide TBA Safe Delivery Kits and training for TBAs in prevention, identification and referral of mothers with infection. • Provide UNICEF Midwife Kits to ensure clean and safe deliveries at health facilities. .	• Facilitate and promote the sterilisation of medical equipment, obstetric care hygiene, and use of antibiotics at the clinic level. • Ante-natal health education for women of reproductive age including the concept of safe delivery.
Haemorrhage	• Ensure pregnant women receive adequate nutrition (and preventive medication if necessary) to prevent anaemia. • Establish a referral system for obstetric emergencies (see "Obstetric Emergency" below).	• Train TBAs to encourage immediate breast-feeding after delivery to prevent haemorrhage. • Train TBAs to identify haemorrhage and properly determine when advanced assistance is necessary. • Train midwives and/or other available medical staff in the following procedures: handling basic complications, stabilising a patient, and correctly determining when referral is necessary.
Eclampsia	• Establish obstetric emergency referral system (see "Obstetric Emergency" below).	• Train TBAs to identify the signs of pre-eclampsia and eclampsia during delivery and properly determine when advanced assistance is necessary. • Train midwives and/or other available medical staff to handle basic symptoms, stabilise the patient, and properly determine when advanced assistance is necessary.
Obstructed Labour/ **Obstetric Emergency**	• Establish adequate facilities within the camp and/or establish links with outside facilities for emergencies (support facilities through staff training; equipment; and transportation as necessary).	• Train TBAs to identify at-risk mothers and the signs of obstructed labour and other obstetric emergencies and determine when advanced assistance is necessary. • Train midwives and/or other available medical staff to handle common obstetric emergencies and stabilise patients before referral.
Unsafe Abortion	• Ensure the availability of emergency post-coital contraception (i.e., combined oral contraceptive and/or copper IUD which must be inserted by a trained professional). • Establish adequate facilities within the camp and/or establish links with outside facilities for emergencies (support facilities through staff training; equipment; and transportation as necessary).	• Train refugee health workers, TBAs, etc. to recognise the symptoms of unsafe abortion. • Train midwives and/or other available medical staff in the treatment of basic physical consequences of unsafe abortion and techniques of stabilisation before referral. • Provide adequate family planning services, including information and education programs. • Undertake related program activities to minimise sexual and gender-based violence.

Postnatal Care

Sometimes, women develop complications of pregnancy and childbirth that are not immediately evident after the birth of the child. Postnatal care ensures that the health status of the mother and child are monitored long enough to detect such problems. This is particularly important in emergency situations where women may be alone and/or the head of household. Postnatal care includes the following:

- Recognition, early detection, and management of complications in new mothers
- Promotion and support for breast-feeding within the first hour of birth
- Attention to the health of the new-born
- Information and services for family planning

Health Education

Maternal mortality can be reduced by early recognition of high-risk pregnancies and timely interventions in cases of risk. Most women are not aware of the causes of maternal death or the danger signs indicating an obstetric complication. A program of maternal health IEC (Information, Education, and Communication) activities should be developed to help the community identify complications early and take appropriate action when required.

Preventing and Caring for Sexually Transmitted Diseases (STDs) and HIV/AIDS

Services related to STD/HIV prevention should not be considered a luxury. It is crucial from both a public health and human rights perspective that activities to promote the prevention, treatment, and management of STDs should be incorporated into relief and development work. Although there currently exists no known fully effective cure for HIV/AIDS, there are many ways in which relief workers can work with displaced people to create programs that can limit the spread of HIV in an emergency setting.

Field workers should be aware of the highly sensitive nature of this area of reproductive health. Confidentiality must be maintained in all cases and interventions should consider the local culture and situation. The active involvement of refugee representatives during the planning of interventions is particularly important. The following case study shows how an international organisation was able to successfully work around the complicated issues of HIV prevention in an emergency.

Figure 11-2: Case Study Illustrating HIV Prevention

Case Study

The civil war in Rwanda created a refugee crisis of unprecedented proportions; the Great Lakes region is now home to over 2 million refugees [30].

The Reproductive Health Minimum Initial Service Package (MISP) was the centrepiece of an interagency initiative in the Great Lakes region to ensure reproductive health care — including prevention of sexually transmitted diseases — is incorporated as a central component of relief operations. The two key objectives of the package are as follows:

- to guarantee the availability of free condoms
- to promote universal precautions against HIV/AIDS

In the Ngara camps in Tanzania, CARE found Rwandan refugees unmotivated to use condoms for STD prevention because of a desire to have more children to replace those lost in the genocide. In response, the staff developed a more effective strategy by highlighting the importance of protecting fertility through STD treatment to reduce the risk of HIV transmission.

Although prevention and management of STDs and HIV/AIDS in emergencies have generally proven very difficult, the following approach can be considered:

Immediate Emergency Phase [31]:

- Providing basic STD/HIV information to remind the displaced people about the risk of disease transmission in the emergency situation and where to get condoms and medical treatment.
- Obtaining condoms and establishing ways to distribute them for free.
- Establishing universal precautions and ensuring adequate supplies and equipment to prevent the spread of HIV infection between health workers and the displaced populations.
- Performing safe blood transfusion, if necessary.
- Identifying a responsible party to plan and co-ordinate the STD/HIV/AIDS program in the post-emergency phase.

  Note: *Emergency health care should include the basic treatment of STDs and common infectious illnesses arising from AIDS, as cases are presented during this phase.*[32]

Post-Emergency Phase:

- Collect data on STD/HIV/AIDS incidence where possible based on standard clinical definitions However, mass HIV screening should not be done.
- Establish the program for care of patients with STD and HIV/AIDS, through the following:
  - training of staff in the syndromic approach to STD diagnosis and management
  - voluntary and strictly confidential HIV screening
  - comprehensive care for persons with AIDS
  - IEC (information, education, and communication) campaigns for preventing the spread of STD/HIV/AIDS
- Establish procedures to screen blood donations for HIV and build compliance to the universal precautions against HIV/AIDS.
- Continue distributing free condoms through effective mechanisms.

Management of STDs

Health workers must be trained to carry out STD prevention and care, as follows:

- Promote and provide condoms, which are effective in preventing STD transmission when properly used.
- Educate and counsel specific target groups in the community about safe sex practices, early recognition of STDs symptoms, and the importance of early treatment.
- Diagnose and provide effective treatment for STDs, based on observed syndromes.
- Promote patient compliance for completing the course of STD treatment.
- Trace partners of patients with STDs and encourage them to get treated.
- Monitor the incidence of STDs in the community.

Because laboratory testing is not always possible in emergency settings, a syndromic approach to STD treatment and prevention should be adopted. Technical details about the treatment of specific STDs can be obtained in standard medical textbooks. The success of STD care in a population depends on consistent availability of drugs.

Special arrangements may be made to ensure women and young people have access to STD treatment. If left untreated, STDs can lead to serious consequences including sterility (gonorrhoea), serious debilitation and complications in foetal development (syphilis). Scientific evidence shows that frequent STD infections also facilitate the transmission of HIV, more specifically through the presence of open sores in the genital area. Effective prevention and management of STDs can therefore serve the dual purpose of reducing and preventing the transmission of HIV infection, although it is by no means a sufficient HIV prevention measure in and of itself.

Safe Blood Transfusions

Blood transfusion may be necessary for women with major complications of delivery, e.g., antepartum haemorrhage, uterine rupture, postpartum haemorrhage, etc. Because the risk of getting HIV through blood transfusions is almost 100%, clear guidelines should be developed for emergency situations where regular services may have broken down. Guidelines for reducing the risk of HIV infection from blood transfusion may include the following:

- Strict criteria for blood transfusion — Give blood only to save life and when there is no other option (e.g., blood substitutes are not available or adequate).
- Recruitment of donors — Collect blood from donors who are identified as the least likely to be HIV-infected. These are more likely to be found among voluntary than paid donors.
- To ensure blood is safe for transfusion, first test it with reliable HIV as well as hepatitis B assays, and then store it under suitable conditions.
- When it is absolutely necessary, staff should follow standard procedures for transfusing blood.
- Safe disposal of potentially dangerous waste products, e.g., unsafe blood, used blood bags, needles and syringes.

Note: *Technical details on blood testing, transfusion procedures and use of blood substitutes can be obtained from references suggested at the end of this chapter.*

HIV-Positive Mothers and Infant Feeding

Breastfeeding should be promoted and supported, even in a population known to have a high prevalence of HIV. However, HIV-positive mothers and pregnant women should be informed about the high risk (7-22%) of HIV transmission to their children both during pregnancy and through breastfeeding. To date, the only known method of reducing this risk is anti-retroviral treatment, which is very expensive. While HIV research is expanding quickly, it is currently not practical to provide these treatments within the context of most emergencies. Therefore, displaced women who are HIV-positive should be given other options, such as infant formula, home-prepared formula, or expressing and heat treating their own breast milk. If infant formulas are introduced, program managers must be able to guarantee the access and use of clean water (plus equipment and fuel for heating). Sufficient supplies should be procured to last each mother/child six months, and products should meet with international quality and marketing standards.[33] For more details about infant feeding, see the *Food and Nutrition* chapter.

(For more details about HIV/AIDS, see the *Control of Communicable Diseases* chapter.)

Family Planning

Effective family planning programs can assure couples of the internationally accepted right to reproductive health. This includes the material and educational means to achieve physical well-being and to limit or space children as desired. Access to family planning services can therefore help reduce maternal mortality and morbidity in camp settings by allowing women to limit and space their children effectively and prevent undesired pregnancy (which may lead to septic abortions).

The reproductive health team in charge of implementing a family planning project should take into account the family planning environment that existed within the host country prior to flight (i.e., coverage and common types of family planning methods and outreach approaches used) as well as the cultural norms concerning family planning[34]. The team should be trained to carry out family planning counselling and administer materials in a culturally appropriate manner. During the acute emergency phase, promoting and freely distributing condoms is necessary to prevent STDs and HIV transmission and unwanted pregnancies. In the post-emergency phase, family planning programs should be established to provide individuals and couples with effective counselling, a choice of contraceptive mechanisms, adequate follow-up, and general information, education, and communication campaigns.

The success of a family planning project depends on the availability of family planning materials. Standard guidelines for obtaining and distributing contraceptives should be consulted (refer to the Resource List at the end of this chapter). Family planning programs may only be considered as effective when the **contraceptive prevalence rates** (calculated as: acceptor rate/year x average duration of contraceptive use) are high. Because continuation is so important, field workers must ensure quality information and education services, organising distribution mechanisms, for various methods (such that if one method proves inappropriate for a woman or couple, another method is available), and proper follow-up by well-trained staff.

Important Family Planning Issues

Family planning within the emergency setting provides field workers with some special challenges. It is essential to ensure that all women treated for unsafe abortion are informed and educated and have access to family planning prior to discharge. The following important issues need to be considered:

Integration

Family planning services are best placed within the regular health system available in the camp. Such integration can reduce the potential stigmatisation of individuals, particularly unaccompanied women and adolescents, who may need the services most. Family planning education, which is a critical part of any successful intervention within this area, can be integrated into a number of other indirectly related interventions with excellent results. Field workers should look outside their own program areas for information, education, and communication opportunities. As always, cultural norms and traditions within this context must be respected.[35]

Health Education

Health education is a critical component of any successful family planning program, as described in the following:

Figure 11-3: Case Study Illustrating the Necessity of Health Education

Case Study

In the early 1990s the International Rescue Committee (IRC) established a reproductive health project to serve refugees in the Côte d'Ivoire. Crucially, this initiative was launched in response to requests from the refugee community itself. The IRC field staff have worked closely with the refugees at all stages to ensure that services were accessible and culturally appropriate. As a result, the project has been highly successful in promoting alternatives to traditional methods of preventing pregnancy or spacing births.

Pictorial aids, simple counting methods, and other techniques are used to make family planning and HIV prevention classes interesting and understandable for both men and women. Contraceptives are readily available through IRC health workers, while condoms are also on sale through local grocery stores and other retail outlets.

Contraceptive Methods

While it is the needs assessment exercise that should guide field workers in selecting the type of contraceptive methods to be introduced to the emergency situation, special considerations may be important as described in the table below.

Table 11-14: Special Considerations for Family Planning

Family Planning Method	Special Considerations in the Emergency Situation
Condoms	Distribution of condoms is the most straightforward method of family planning for displaced populations. It is appropriate for all phases of the emergency. Failure rates, however, can be high due to inadequate and/or improper use. Displaced women may find themselves in a particularly low status position and at great pains to negotiate condom use with their partners. Education and information are crucial for effective use of condoms and should be started as soon as possible during the post-emergency phase.
Injectable Progestogen	Injections are usually administered every 3 months. While this method has very low failure rates (1-6%), it is problematic in the emergency setting and should be avoided. Injectables require stable populations, whereby women can regularly access health services and can continue with the same method when they return home or to another country of asylum. Good record keeping and follow-up are crucial.
IUD	Using IUDs in emergency situations depends on the availability of supplies, health technicians who are skilled in insertion, and access to follow-up services. IUDs are suitable where a displaced population is familiar with the method and is likely to have access to similar services upon return to country of origin and/or asylum. Follow-up is particularly critical for IUDs, which may require refitting and/or removal should complications arise.
Oral Contraceptives	This method, which also affords low failure rates, may be considered for relatively stable populations in the post-emergency phase. The critical factor is continuity. Regular supply must be organised for continued availability of pills; good follow-up service is necessary to prevent program drop-out; and the population itself must be sufficiently stable to allow women regular access to family planning care while at the camp and later.
Implants (Norplant)	The implant method is usually effective for about 5 years, but can only be used if proper follow-up and its removal on demand is assured in the countries of origin or final destination. Generally, emergency situations do not allow for these requirements.
Breastfeeding	Breastfeeding is an effective contraceptive method if a woman is exclusively breast feeding her infant on demand (no other food is being given to the baby), she is not menstruating, and her infant is less than six months old. If any one of these three criteria is not met, then an additional method of contraception is advised[36].
Sterilisation	Although it is the most effective means of contraception, this permanent method requires minor surgical operation. It is inappropriate during the emergency phase, and for many refugee settings, as it requires skilled medical staff and other surgical necessities. However, a local referral hospital may be available to provide these services.

Emergency Contraception

Emergency post-coital contraception may be particularly appropriate for displaced populations with high levels of sexual violence. There are two methods of post-coital contraception that are effective: the combined oral contraceptive (also known as the morning-after-pill), and the copper IUD. It should be understood from the outset that neither method causes abortion. Instead both inhibit ovulation and the development of the uterus lining, which is necessary for implantation and growth of a fertilised egg. In this way, the reproductive system is made temporarily unsuitable for conception.

Note: *Emergency contraception should not be used as a long-term family planning method.*

Emergency contraception must be made available from the initial phase of the emergency program, as an intervention for the physical consequences of rape. Field staff should be trained to recognise victims of sexual violence and encourage them to pursue medical attention in order to offer them the option of emergency contraception. (For further details see the section on sexual and gender-based violence).

Special Needs of Adolescents

Adolescence is a challenging time for young people in non-emergency situations. In emergencies, where adolescents may be lacking one or both parents and traditional societal structures have been damaged, the transition to adulthood can be even more stressful. It is especially important that field workers consider the special needs of adolescents for family planning when designing reproductive health programs. While the specific details will vary somewhat across cultures, the following points can guide concerned staff:[37]

- Proper design of education programs, which incorporate the views and feedback from the adolescents themselves; peer education programs have often been found to be useful.
- Many young people are easily reached through schools. Therefore, reproductive health education and counselling for adolescents should be integrated with other education and health promotion programs in order to reach as many adolescents as possible and avoid stigmatisation of those seeking specific assistance.
- There is need to supplement the traditional sources of information about reproduction, sexuality, and family education.
- Reproductive health information, education, and communication (IEC) efforts should focus not only on reproduction, but also on prevention of STD/HIV disease transmission and building life skills to enable youth to manage situations of risks to STD/HIV infections, unwanted pregnancies, and abortion.
- Adolescents should be made aware of the dangers of sexual violence and know how to seek help in an emergency.
- It is important to understand and be sensitive to the refugee population's concerns about adolescents having access to reproductive health services. Confidentiality is crucial and certain emergency situations may demand for it even more.

Preventing and Responding to Sexual and Gender-Based Violence

Addressing sexual and gender-based violence is essential to ensure the health and well being of displaced women (and even younger females and males). It requires a change of attitudes among relief workers and the community at all levels. Although it is very difficult to obtain accurate statistics on the number and frequency of sexual and gender-based violence incidents, even within an enclosed camp setting, field staff should assume that it occurs regularly. To ensure successful implementation, field staff should also be prepared to deal with the issue on a number of fronts and consult with various people, including:

- Staff from the United Nations and other concerned NGOs
- Host authorities in the health sector and legal system (police, military)
- Representatives of the affected communities (community leaders, teachers, religious leaders, and other members)
- Women at risk who should be encouraged to participate

The UNHCR has established guidelines for the prevention of, and response to sexual violence against refugee women,[38] which are discussed below. The Women's Commission for Refugee Women and Children has produced a synopsis of these guidelines, which are available upon request.[39] The following areas are addressed:

Camp Security

- General security should be improved within the camp and surrounding area, including security patrols (which may be community-based) and maintaining sufficient lighting at night.
- Safe access to water sources, latrines, washing facilities, fire wood collection points and other areas frequented by women and adolescents should be available at all times. It is important to elicit feedback from particularly vulnerable groups when designing the camp layout and evaluating at regular intervals.
- Provision of additional materials and advice about the security of dwellings may be necessary. For example, refugee dwellings may be better protected against outside raiders if surrounded by thorny branches or other materials. Field staff may also consider the need to provide special accommodation with locked facilities for unaccompanied woman and girls, and lone female heads of household.

Distribution of Food and Other Survival Materials

- Displaced persons who are most vulnerable to abuse and violence (such as female heads of household, unaccompanied women and adolescents) can be placed in even more vulnerable positions if relief assistance is not distributed fairly. All attempts must be made to prevent such situations. Needs of vulnerable groups should be addressed following an assessment and, if necessary, revisions made in the existing distribution mechanisms.

Monitoring

- Because of the very personal nature of sexual and gender-based violence, field staff may find it difficult to monitor the prevalence and incidence of events. However, one of the most effective ways to support this process is through the facilitation of women's groups and associations which may serve as a channel for women to report attacks. Women's health clinics may be able to offer a "safe" environment for reporting attacks, though field staff should ensure both that actual services are provided at such facilities and that the confidentiality of any victim can be maintained.
- Field staff should also learn to recognise possible "signs and symptoms" of violence, for example:
  - physical signs of STD infections, injuries
  - social isolation of women or young girls who have been attacked
  - psychological signs of trauma (e.g. reports of pains, nightmares, loss of appetite, headaches, sadness, fear, confusion, loss of memory, attention problems, isolation and talk of suicide)
- Field staff who suspect that an incident of sexual violence has occurred should approach the situation very carefully, offering the victim the chance to report the attack to a social worker, health worker, community services officer or protection officer, of the same gender, in complete confidentiality. The victim should never be pressured to report or discuss the incident to anyone, including field staff.
- Field staff should regularly document each incident and monitor the prevalence and incidence of events (to be kept secure and confidential). Then should also consider the points below in crisis response.

Crisis Response

Relief workers should be trained to recognise victims of sexual violence and to respond to victims in the following manner:

- Documenting and reporting of rape and/or other sexual abuse through a confidential system
- Clinically managing the physical consequences of sexual and/or domestic violence, including counselling on and offering emergency post-coital contraception
- Recognising the psychosocial needs of victims of sexual violence and referring them to *community-based* counselling and support services
- Establish post-crisis services to reintegrate victims back into the community, according to the cultural norms of the community.

Figure 11-4: Community-Based Response to Sexual Violence Against Women[40]

During the Rwanda refugee situation in Ngara in 1994, sexual violence reportedly became a serious problem as the refugee population started settling down. Through discussions with all parties, the idea of **Crisis Intervention Teams (CITS)** was developed. All teams were made up of refugees and supported by community service NGOs. Teams were trained by staff from UNICEF, CARE and UNHCR who had experience in working with victims of sexual abuse. Training information was drawn heavily from the UNHCR manual – *Sexual Violence Against Refugees: Guidelines on Prevention and Response*.

CITS members were expected to:

- Provide psychosocial counselling and support to the victims and their families
- Mediate between the victims' and perpetrators' families if necessary
- Make contact with community groups with a view of helping victims reintegrate into society by getting involved in community activities like income generation schemes, cultural or educational programs or women, youth or religious groups
- Raise awareness in the community of the problem of sexual violence, how it could be prevented, and what to do when it occurred

Note: *Unfortunately, the above-mentioned community-based response program did not last long enough to produce materials that could be used elsewhere because of the sudden return of refugees to Rwanda.*

Emergency Post-Coital Contraception

As noted in the section on Family Planning, emergency post-coital contraception should be introduced during the acute emergency phase, as part of the reproductive health program's MISP to assist women who have been victims of sexual violence. Trained health professionals should maintain a regular supply of the combined oral contraceptive, or the cooper IUD and offer them to all suspected victims of sexual violence.

Confidentiality

It is critical that field staff ensure strict confidentiality about any specific incidents of sexual or gender-based violence. The possible consequences of inadequate confidentiality about these issues include the stigmatisation of victims, violent revenge against those committing the violent acts, and the reluctance of other victims to seek assistance. In addition to maintaining the anonymity of any victim's identity and security of any written information about him/her and the incident, field staff should ensure that counselling and other activities are carried out in a manner that will not immediately identify individuals as victims of sexual violence. This also includes medical examination and/or any legal proceedings that may result from the incident.

Information/Education and Other Preventive Programming

- Information and education for all community members about the basic rights for all groups to protection from physical abuse and sexual violence.
- Information and communication programs advising vulnerable groups about the risks and prevention of sexual violence and domestic violence and how to obtain emergency reproductive health care.
- Programs to combat male frustration and boredom (which can increase the incidence of sexual violence).
- Programs to address alcoholism and other forms of substance abuse, which can impair the judgement of both the perpetrators and victims of sexual and gender-based violence.
- Programs supporting women's activities, such as income generation and literacy training, which may promote women's self-sufficiency and empowerment.
- In instances where communities hosting displaced populations may perceive negative consequences of the displaced population, extending external assistance to the host communities (such as improving local schools, airstrips, or other facilities) can help "keep the peace" between host and displaced populations.

Security for Detainees and Imprisoned Persons

Sometimes, displaced persons may be detained and/or arrested by local authorities for various reasons. Field staff should ensure that these individuals are afforded the same medical care and protection from sexual violence (which is common under such conditions the world over), to every extent possible.

Controlling Female Genital Mutilation (FGM)

Control of FGM involves exposing the irrationality of the practice to the concerned community, as well as providing medical care for complications. However, this should be approached with caution because of the following factors:

- Proof of virginity may be an economic asset — dowry of a girl is higher if she is proven to be a virgin when she is married.
- Not all forms of FGM can be easily condemned — some religious circles may favour the sunna type.
- The economic survival of midwives and sometimes health workers may depend on performing the operation.

Considering the above factors, there are a number of activities that can raise the awareness of both the displaced populations and heath workers serving them, about the health effects of FGM. These include the following[41]:

- Campaigns (including the use of videos where possible, as well as drama and other cultural activities) to emphasise the harmful health consequences of FGM practices:
  - increased individual risk of blood-borne infections such as HIV
  - the formation of rigid scar tissue around the vaginal opening which often leads to delays in the second stage of labour placing both mother and child at risk
  - difficulties in using certain contraceptive methods such as the IUD
  - difficulty in diagnosing STDs
- Discussions between health workers and members of the displaced population to enable health workers to understand the prevalence and nature of any FGM practices.

- Education of target populations (both men and women), such as religious leaders, traditional leaders (chiefs, elders, and political leaders), teachers, TBAs and other health workers, as well as the general displaced population about the harmful health consequences of FGM. It is particularly important to educate young girls about these issues.
- Integration of FGM issues into campaigns and workshops covering related reproductive health issues such as STDs, HIV/AIDS, safe motherhood, etc.
- Supporting other income generating activities for those who earn money through harmful practices (often village women, TBAs, or male barbers). Traditional practitioners must be helped to find other ways to secure the respect of their community.
- Promoting other "rite of passage" activities, which encourage the "coming of age" for young women without the use of FGM.
- Promoting female education in general. The incidence of harmful traditional practices, such as female genital mutilation and early childhood marriage, decreases as literacy increases.

MONITORING AND EVALUATING REPRODUCTIVE HEALTH PROGRAMS

The progress of relief operations must be regularly reported to donors and other stakeholders. This is best achieved through project monitoring and evaluation. To maximise the use of limited resources, reproductive health activities should be monitored and evaluated with other primary health care services. It is important to consult the displaced community and share with them any results from monitoring and evaluating reproductive health activities.

Monitoring

Regular monitoring is necessary for reviewing the progress of each reproductive health activity in reaching the set objectives, as well as in detecting reproductive health problems. Only two or three indicators should be selected for each activity, which are based on the goals and objectives of the reproductive health program. Various tools e.g., clinic registers, forms, internal reports, etc. may be used for monitoring as well as for program management (especially supervision and decision-making).

The following table gives examples of indicators and sources of information that may be used to monitor reproductive health activities.

Table 11-15: Indicators for Monitoring Reproductive Health Projects

Project	Activity	Indicator	Source of Information
Safe Motherhood	Antenatal care	• Number of ANC consultations in last 3 months (antenatal care coverage) • Percent of pregnant women given micro-nutrient supplements (specify supplements and reason) • Percent of high risk pregnancies detected • Percent of pregnant women screened and testing positive for syphilis (RPR test)	Program Manager's records, Clinic records, Outreach worker's records, Exit survey, KAP survey
	Delivery Care	• Coverage of home deliveries • Percent of deliveries with complications (home, health facility) • Percent of new-borns with low birth weight (below 2.5 kg.) where recorded	Program Manager's records, Clinic records, Outreach worker's records
	EOC	• Coverage of complications • Percent of deliveries through caesarean section • Incidence of maternal deaths (home, health facility) • Perinatal mortality (incidence per 1,000 live births per year)	Program Manager's records, Clinic records, Outreach worker's records, KAP survey
	Postnatal Care	• Percent of women visiting post-natal care services (within 6 weeks of birth) • Neonatal mortality (incidence per 1,000 live births per year)	Clinic records, Outreach worker's records, KAP survey
STDs and HIV/AIDS	Universal Precautions against HIV/AIDS	• Number of communications about universal precautions (group talks, lectures, posters, etc.) per month • Percentage of staff complying to universal precautions • Number of stock-outs of essential materials for universal precautions in last month	Program Manager's records, Clinic records, Logistics records
	Condom distribution	• Number of condoms distributed and mechanism per month • Percent of population with access to condoms • Percent of population reporting condom use during most recent sexual intercourse	Outreach worker's records, Clinic records, KAP survey
	IEC on HIV prevention	• Number of IEC communications conducted (group talks, home visits, media messages, films) per month • Percent of population aware about the three main methods of HIV transmission • Proportion of adults reporting one or no sexual partner over the last three months	Outreach worker's records KAP survey
	Safe blood transfusion	• Percentage of blood tested for HIV before transfusion • Prevalence of HIV positive in donor blood	Clinic records
	STD management	• Number of cases diagnosed with STDs in last month • Number of cases treated for STDs (by age, sex, syndrome) per month	Patient records Exit survey

-continued

Project	Activity	Indicator	Source of Information
Family Planning	Availability of contraceptives	• Number of contraceptives distributed or administered • Number of contraceptive stock-outs in last month	Clinic records, Logistics records
	Client recruitment and follow-up	• Number of new acceptors in last three months, per method • Number of family planning visits in last month • Family planning drop-out rate, by method • Contraceptive prevalence rate*	Clinic records Outreach worker's records
	IEC campaign on family planning	• Number of communications (group talks, home visits, media messages, posters, etc.) per month • Percent of population reporting knowledge of at least 3 contraceptive methods	Clinic records Outreach workers records, Program manager's records, KAP survey
Sexual and Gender-based Violence	Monitoring	• Number of reported cases of sexual and gender-based violence per month (incidence per 10,000 population) • Level of insecurity around settlement	Clinic records, Outreach worker's records, Focus group discussions
	IEC campaigns	• Percent of population aware about how to prevent incidents and assist victims	
	Crisis Response	• Percentage of victims of sexual violence who received medical care within 3 days	Clinic records

*(CPR = A x D, where A = acceptor rate/year and D = average "life expectancy" or duration of contraceptive use)

Evaluating

Evaluation of a reproductive health program can serve a number of purposes. First, it provides important lessons to the concerned program managers about designing future activities and corrective measures where necessary. The information can also help donors to determine the impact of their investment. The evaluation process and results should be shared with all project participants, the partners, and beneficiaries for whom the program has been designed.

Evaluation information, particularly in the field of refugee reproductive health, can be used by other organisations faced with similar problems around the world. It is only recently that significant focus has been placed on the reproductive health needs of refugees. To date, there is limited documentation on fertility, sexual violence, the incidence of HIV/AIDs, and maternal deaths in refugee situations. It is therefore vital that both successful and failed programs are evaluated and the information shared with other organisations and concerned parties, to the extent possible.

Pre-defined goals, objectives, and indicators of a project should serve as the basis for an evaluation. In terms of the practical aspects of evaluation, emergency workers must consider the following questions in designing the evaluation exercise and required tools:

- Who needs and will use the information (i.e., what is the purpose of the evaluation)? Answering this question will help to determine whether the evaluation should be *internal*, *external*, and/or *participatory*.
- How will the information be used? To adjust on-going activities (process-oriented) or future activities (outcome-oriented)?
- What kind of information is needed? Quantitative, qualitative, or both?

The table below outlines some sample question for various reproductive health issues that need to be evaluated:

Table 11-16: Sample Questions for Various Reproductive Health Issues

Issues	Sample Questions
Breadth of Services	• What reproductive health services are in place (MISP, Safe Motherhood, etc.)? • What other reproductive health services are operating within the reach of the displaced community? • What resources could be accessed at the national level for technical assistance, supplies and support? • Are the present services adequate for the health needs of special groups (unmarried women, men, adolescents, disabled, etc.)?
Access	• Are the services within walking distance? Is transport available for those women who are unable to walk to the clinic? • Is the walking route safe and if necessary patrolled with security? • Does the clinic operate during hours that do not conflict with women's obligations to their family or community? • Can women get to services privately (without their families or peers' awareness)? • Are outreach efforts made to accommodate those women who do not come to the clinic and those who need follow-up?
Usage	• Are services used as expected? • Do women readily seek treatment at the clinic? • Are men supportive of women pursuing or participating in delivering the services? • Do men and adolescents feel comfortable using these services? • What factors prevent them from using the existing services? • Is protection necessary and/or available for women who actively promote reproductive health care in the community?
Resources	• Are there sufficient resources (human, material) to deliver the reproductive health services? • Are sufficient resources (staff, management, equipment, supplies) available in the host country to support the reproductive health program? • Are the available resources used to maximise program coverage and efficiency?
Service Integration	• Are reproductive health services closely integrated with general health services? • Are referral systems in place between services? • Are findings from reproductive health surveillance shared with other sectors (e.g., nutrition, protection)? • Do staff and management in other relief sectors support the reproductive health services?
Quality of Care	• Are reproductive health care guidelines available and promoted? • Are the staff sufficiently trained? • Are sterile equipment and procedures consistently followed? • Are IEC materials available and appropriate for the target audience?
Empowerment of Women	• Is health education and training of displaced women a major component of the staff's work? • Are displaced women involved in management decisions related to health, sanitation and service delivery? • Are women consulted about whether reproductive health services are beneficial?

(Further details about doing program evaluations are discussed in the *Management* chapter.)

APPENDIX A

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

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

APPENDIX B: REPRODUCTIVE HEALTH REFERENCE RATES AND RATIOS

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

Abortions

10-15%	of all pregnancies may spontaneously abort before 20 weeks gestation
90%	of these spontaneous abortions will occur during the first 3 months
15-20%	of all spontaneous abortions that occur require medical interventions

Hypertensive Disorder of Pregnancy (HDP) or Pre-eclampsia

5-20%	of all pregnancies will develop HDP
5-25%	of all primigravida pregnancies will develop HDP

Labour and Delivery Complications

15%	of all pregnancies will require some type of intervention at delivery
3-7%	of all pregnancies will require a Caesarean section
10-15%	of all women will have some degree of cephalo-pelvic disproportion (higher in poorer socio-economic populations)
10%	of deliveries will involve a primary postpartum haemorrhage (occurring 24 hours or more after delivery)
0.1-0.4%	of deliveries will result in uterine rupture
0.25-2.4%	of all deliveries will result in some type of birth trauma to the baby
1.5%	of all births will have a congenital malformation (does not include cardiac malformations diagnosed later in neonatal period)
31%	of these malformations will result in death

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[3] Please note: The term "refugee" officially describes a person who has crossed an international border, while an "internally displaced person" (IDP) has had to leave her home but has remained in her own country. For the purposes of this chapter, "refugee" is used to refer to both groups.

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