

Inter-agency Working Group (IAWG) on Reproductive Health in Crises



Tenth Annual Meeting

8-10 October 2007
Kenya Red Cross Society
Nairobi, Kenya



IAWG Tenth Annual Meeting

Table of Contents

Executive Summary	4
1. Background and Objectives	4
Background.....	4
Objectives of the Tenth Annual Meeting.....	5
2. Opening and Welcome.....	5
3. Panel Discussion.....	5
Session 1: Where Have We Come From and Where Are We Now?	5
1. Introduction.....	5
2. History and Update of IAWG	5
3. Update the Asia Pacific IAWG Regional Network: SPRINT	6
Session 2.1: Review of Global Initiatives.....	6
1. Global IBP Network	6
2. Overview of Global MISP Activities.....	6
3. Partnership for Reproductive Health in Emergencies Training	7
Question and Answers	7
Session 2.2: Review of Global Initiatives.....	7
1. Update on the Revision of Reproductive Health in Refugee Situations: An Inter-agency Field Manual.....	7
2. Fuel and Firewood Initiative	7
3. Humanitarian Reform: Implications for Reproductive Health	8
4. RAISE Initiative and Training Center.....	8
Question and Answers	9
Session 3.1: Regional Initiatives.....	9
1. Uganda and Chad: Sexual and Reproductive Health among IDPs and Refugees.....	9
2. Horn of Africa: Providing Fistula Services in Conflict Settings.....	9
3. Lessons Learned in Reaching Transactional Sex Workers	9
4. Reproductive Health in North-western Tanzania: Emergency Obstetric Care.....	10
Questions and Answers	10
Session 3.2: Regional Initiatives.....	10
1. East, Central and Southern Africa: Gender-based Violence (GBV) Task Force	10
2. West Africa: Operational Barriers to Obtaining Family Planning in Conflict-affected Countries	11
3. Cote d'Ivoire: HIV Prevention in Emergency Settings: Peacekeepers and the Disarmament, Demobilization and Reintegration (DDR) Process.....	11
Questions and Answers	11
Session 4.1: Technical Updates, Special Topics and Emerging Reproductive Health Issues.....	12
1. Comprehensive HIV Programming for Refugee/Mobile Populations: The Turkana District Experience.....	12
2. Female Condom: A Powerful Tool for Protection.....	12
3. Rapid Diagnostic Tests for Syphilis.....	12
Question and Answers	13
Session 4: Technical Updates, Special Topics and Emerging Reproductive Health Issues.....	14
1. Cervical Cancer	14
2. Health Information System (HIS): Reproductive Health Data for Decision Making	14
3. Misoprostol for Post-partum Hemorrhage	14
Questions and Answers	15
4. Technical Working Group Discussions	16
1. MISP Working Group.....	16
2. Advocacy Working Group	17
3. Data and Research Working Group	18
4. Regional Working Group	18
5. Safe Motherhood Working Group.....	18
6. Family Planning Working Group.....	19
7. HIV/AIDS/STIs Working Group.....	20
8. Gender-based Violence Working Group.....	20

9. Adolescent Working Group.....	21
5. Final Plenary Session and Adoption of IAWG Call to Action	23
Annex I: Strategy Paper and Terms of Reference	24
Annex II: IAWG Call to Action	36
Annex III: Meeting Agenda.....	37
Annex IV: List of Participants	40
Annex V: Technical Working Groups	43
Annex VI: Agency Updates on Reproductive Health in Crises Efforts.....	44

Executive Summary

The Inter-agency Working Group (IAWG) on Reproductive Health in Crises held its tenth annual meeting in Nairobi, Kenya, at the Kenya Red Cross Society from 8-10 October 2007. Participants reviewed progress made towards promoting access to quality reproductive health care for displaced populations, discussed key policy and programmatic issues, developed work plans for 2007-2008, and discussed strategies to collectively begin a regional IAWG for the Africa region. Technical updates and emerging topics that were addressed included HIV/AIDS programming in humanitarian contexts, the female condom, rapid diagnostic tests for syphilis, cervical cancer, health information systems for data collection, and Misoprostol for post-partum hemorrhage. During the afternoon session of the second day, participants divided into nine thematic working groups to share information on efforts in the area, identify gaps, and propose and prioritize solutions. These working groups included the Minimum Initial Service Package (MISP) for reproductive health, advocacy, data and research, safe motherhood, family planning, sexually transmitted infections (STIs) including HIV/AIDS, gender-based violence, adolescent reproductive health, and a group to develop a strategy for a regional IAWG in Africa.

With support from AusAID, the meeting brought together a wide range of individuals dedicated to improving reproductive health care for people affected by conflict and natural disasters. Over 100 representatives from 43 agencies were present at the meeting, the largest in size since the establishment of IAWG in 1995. At the concluding session, an IAWG Call to Action was adopted by participants to call upon the Inter-agency Standing Committee (IASC) Global Health Cluster members and the World Health Organization (WHO) to renew their commitment to comprehensive reproductive health in crises and for the Health Cluster to include comprehensive reproductive health as a specific core component of humanitarian response. The IAWG reaffirmed its commitment to enhancing the reproductive health of crisis-affected women, men and young people, and to ensuring that such persons are active participants and advocates in the decisions that affect their reproductive health.

1. Background and Objectives

Background

Formerly the Inter-agency Working Group (IAWG) on Reproductive Health in *Refugee Situations*, the IAWG on Reproductive Health in Crises was formed in 1995 to promote access to quality reproductive health care for refugee women and others affected by armed conflict. It was originally comprised of over 30 groups, including UN agencies, universities, governmental and nongovernmental organizations, and was led by the United Nations High Commissioner for Refugees (UNHCR), the World Health Organization (WHO) and the United Nations Population Fund (UNFPA).

The IAWG developed the [Reproductive Health in Refugee Situations: An Inter-agency Field Manual](#), which outlined the minimum and comprehensive reproductive health services that must be provided in all disaster settings, developed kits for rapid deployment to aid workers, and recognized the need for continued advocacy, funding and technical assistance for reproductive health programs in refugee situations.

Since its formation, the IAWG has met annually (with the exception of 2005) to exchange information, identify challenges, gain from the experience of others, build partnerships and collectively work towards the institutionalization of reproductive health care for refugees and internally displaced persons. In 2004, the IAWG conducted a [ten-year global evaluation](#) of reproductive health in conflict-affected settings to identify gaps and constraints so that UN agencies, governments and nongovernmental agencies can better target resources and interventions.

The IAWG is currently advocating for the institutionalization of reproductive health in crises by supporting regional IAWG networks in the Asia-Pacific and sub-Saharan Africa. Membership in IAWG is open to representatives of UN, nongovernmental, research and donor agencies interested in the advancement of the reproductive health of women, men and youth in emergency situations.

Objectives of the Tenth Annual Meeting

With support from AusAID, the tenth IAWG meeting was held in Nairobi, Kenya from 8-10 October 2007, at the Kenya Red Cross Society. The objectives for this meeting were to:

- Review progress towards achieving the programmatic goals and future steps outlined in the Terms of Reference for Year 2004 and beyond, and the next steps outlined in the 2006 IAWG meeting held in Sydney.
- Share information, identify key areas of common work, plan next steps and areas of coordination and collaboration for 2007-2008.
- Establish a regional IAWG forum for Africa which will serve to share information and lessons learned across projects in the region and enable synergistic partnerships to minimize duplication of efforts and to fill gaps.

Over 100 participants attended the meeting, representing 43 agencies, organizations and institutions. (The agenda for the meeting and the list of participants are included in Annex III: Meeting Agenda and Annex IV: List of Participants).

2. Opening and Welcome

The meeting was opened by Mr. Gullet, Representative of the Kenya Red Cross Society. Mr. Gullet discussed partnerships and how they bring together complimentary strengths, allow for more holistic approaches, and create durable relationships. He noted that leadership and a shared vision, participation of local players, transparent and effective management, investment in learning and development, and a review of the partnership process were all needed in maintaining successful collaboration. Mr. Gullet also mentioned the Kenya Red Cross's work in reproductive health, including community interventions to reduce maternal and neonatal morbidity and mortality, prevention and response to gender-based violence (GBV), and equipping communities with the knowledge and skills needed to reduce HIV transmission.

Ms. Fartun Abdi Ahmed, a representative of the Somali refugee community in Kenya, spoke about her experiences as a refugee in Nairobi. She noted the importance of reproductive health services for displaced persons.

Dr Amira, Senior Deputy Director of the Kenyan Ministry of Health, Division of Emergencies and Disaster Preparedness, spoke about the reproductive health needs of women. He welcomed the participants from all over the world and stressed the importance and value that meeting people's reproductive health needs had on the family. He also mentioned the need to balance pessimism and optimism in our work, and advised that team work and collaboration were key to success.

3. Panel Discussion

Session 1: Where Have We Come From and Where Are We Now?

The first through second sessions were moderated by Dr. Jonathan Ndzi from the United Nations Population Fund (UNFPA) Senegal.

1. Introduction

Ms. Jennifer Miquel, Regional Emergency Coordinator of UNFPA-Nairobi, outlined the purpose of the meeting: to discuss key policy and programmatic issues including technical updates, develop work plans for 2007/8, and agree upon a strategy to collectively begin a regional IAWG for the Africa region.

2. History and Update of IAWG

Ms. Susan Purdin, Senior Technical Advisor for Reproductive Health of the International Rescue Committee in New York, briefed participants on reproductive health and the history of reproductive health care in crisis situations. Ms. Purdin mentioned that refugees' right to reproductive health care was first recognized at the International Conference on Population and Development (ICPD) in Cairo in 1994, when reproductive health was defined as:

RH is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, in all matters relating to the reproductive systems and its functions and processes. RH 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. (ICPD Programme of Action, 1994)

The IAWG was born out of the ICPD as a working group that would follow up on the outcomes of a 1995 Symposium on Reproductive Health in Refugee Situations, to collectively determine how to implement comprehensive reproductive health services for refugees. The IAWG also developed the [Inter-agency Field Manual on Reproductive Health in Refugee Settings](#) (IAFM) that articulates the Minimum Initial Service Package (MISP) for reproductive health, which is a set of priority reproductive health activities for implementation at the beginning of every new emergency. The MISP is now a Sphere standard, and numerous other guidelines have been subsequently developed by the international community on HIV/AIDS, GBV in humanitarian settings. In 2004, the IAWG conducted a global evaluation of reproductive health services for displaced populations. Findings showed that services were generally favorable for refugees in stable settings but were lacking for the internally displaced. The findings were presented at the 2004 IAWG meeting, and working groups were established to address the specific gaps. In 2006, the IAWG meeting was held in Sydney, Australia, where an IAWG regional network for the Asia-Pacific was initiated. Ms. Purdin closed the presentation by noting what the 2007 meeting hoped to accomplish for IAWG.

3. Update the Asia Pacific IAWG Regional Network: SPRINT

Dr. Anna Whelan from the University of New South Wales and Dr. Nguyen-Toan Tran from the International Planned Parenthood Federation's East and South East Asia and Oceania Region (IPPF-ESEAOR) updated participants on the developments on the Asia-Pacific IAWG regional network that was established at the 2006 IAWG meeting. With funding from AusAID, the SPRINT (Sexual and Reproductive Health Programme in Crisis and Post-Crisis Situations in East South-East Asia Pacific) Initiative emerged with the goal of increasing access to reproductive health information and services for populations living in crisis and post-crisis situations in East South-East Asia and the Pacific. The objectives of the three-year initiative are to: 1) increase the regional capacity of key stakeholders; 2) strengthen the coordination of sexual and reproductive health (SRH) response in crisis situations; 3) raise awareness on SRH in crises at national and regional levels; 4) respond to SRH needs in crises in a timely fashion; and 5) enhance access to SRH information and services for populations living in protracted post-crisis situations. Expected outcomes of the project include increased regional capacity to respond to crises; coordinated emergency and post-emergency response to reproductive health issues; the integration of reproductive health into regional and national emergency response agendas; and enhanced access to reproductive health information and services among crisis-affected populations. SPRINT is unique in that it is the first regional initiative to address reproductive health issues on a country by country basis; in addition, the initiative attempts to bridge the gap between immediate relief and development through a grassroots presence and early intervention.

Session 2.1: Review of Global Initiatives

1. Global IBP Network

Ms. Megan O'Brien from Johns Hopkins University's Center for Communication Programs presented on the IBP Knowledge Gateway. The IBP Initiative was founded in 1999 by the WHO and 12 partner organizations to bring improvements to reproductive health through developing mechanisms to enhance networking and collaboration and to support the scaling-up of evidence-based guidelines and good practices. The IBP Knowledge Gateway is a dynamic electronic communication tool that provides users with an online "space" in which they can create their own communities or participate in pre-existing ones. Presently, there are approximately 4,500 members registered in the Knowledge Gateway that participate in over 50 health-related communities. The IAWG has a unique community, and its purpose is to exchange information, identify challenges, gain from the experience of others, build partnerships, and collectively work towards the institutionalization of reproductive health care for refugees and the internally displaced. The Knowledge Gateway enables email and online discussion, and hence, it is a useful communication tool to connect IAWG members. Ms. O'Brien encouraged everyone to register online at <http://my.ibpinitiative.org/public/iawg>.

2. Overview of Global MISP Activities

Ms. Sandra Krause and Ms. Sarah Chynoweth, both from the Women's Commission for Refugee Women and Children's Reproductive Health Program, presented on the MISP for reproductive health. The MISP is a set of priority interventions to be implemented at the early days of a new emergency.

The five core components of the MISP are to: 1) identify an organization and/or individual to coordinate the implementation of the MISP; 2) prevent sexual violence and provide appropriate assistance to survivors; 3) reduce the transmission of HIV; 4) prevent excess maternal and neonatal mortality and morbidity; and 5) plan for the provision of comprehensive RH services. The MISP has been promoted through IAWG's MISP Working Group, academic partnerships (see next presentation) and other training initiatives. In 2006, the Women's Commission published a [distance learning module](#) to assist practitioners and other key stakeholders to effectively implement the MISP. The module is currently available in English and French, and is being translated in to Arabic, Bahasa Indonesian, Portuguese, Russian and Spanish. The online module also offers a post-test whereby successful completion of the test enables test-takers to be certified in the MISP module and receive a certificate. The post-test verified 3.5 continuing education credits for US nurses. Ms. Krause and Ms. Chynoweth revealed the number of IAWG meeting participants that had completed the MISP module, and announced that those that completed it by the end of the meeting and recommended five other people who also passed the test by the end of the year would be eligible to enter a draw to win a red I-Pod.

3. Partnership for Reproductive Health in Emergencies Training

Dr. Wilma Doedens, Technical Advisor for UNFPA's Humanitarian Response Unit, discussed IAWG's reproductive health in emergencies training, which was developed to establish partnerships between IAWG and formal training institutions to ensure that training on reproductive health in emergencies is initiated for humanitarian staff on a regular and sustainable basis. Members of the steering committee include UNFPA, the Reproductive Health Response in Conflict (RHRC) Consortium, Ghent University, Columbia University, Kenyatta University, among other organizations. An initial brainstorming meeting took place in September 2006 in Geneva to discuss the nature of the collaboration, and a meeting to review the MISP curriculum was held in May 2007. Strategies discussed for the initiative include offering institutional and mobile trainings, certifying participants after trainings, developing a database of trainees, and offering scholarships for participation. In order to realize some of these, next steps to this initiative include developing trainer materials, translating existing training resources into additional languages, piloting a coordinator's training, and instituting a centralized training of trainers (ToT) for master trainers and a decentralized ToT for a regional cadre of qualified workers.

Question and Answers

One participant suggested that media should be involved in the MISP module, since the French module is not interactive at this time. The participant offered to work with a female journalist group in Cote d'Ivoire to make it more Francophone- and user-friendly. Another MISP-related question pertained to whether or not primary health care was a part of the MISP. It was clarified that while planning for comprehensive reproductive health services is one of the core components, only the minimum essential reproductive health priorities are included in the activities.

Session 2.2: Review of Global Initiatives

1. Update on the Revision of Reproductive Health in Refugee Situations: An Inter-agency Field Manual

Dr. Lisa Thomas, Maternal Neonatal Consultant for the Women's Commission for Refugee Women and Children, discussed the revision process of the 1999 [Inter-agency Field Manual on Reproductive Health in Refugee Situations](#) (IAFM). In order to update the existing content, members of IAWG have begun a parallel process to develop a [corrigendum](#) of essential corrections and to revise each chapter of the manual. The corrigendum is now available in English and French, and the revised IAFM is expected to be launched in early 2009. The IAFM includes the MISP and outlines comprehensive reproductive health in crisis situations.

2. Fuel and Firewood Initiative

Ms. Erin Patrick, Fuel and Firewood Consultant for the Women's Commission for Refugee Women and Children, discussed the Women's Commission's fuel and firewood initiative, which aims to address the multi-sectoral issue of fuel in humanitarian settings. The first phase of the project investigated methods for reducing vulnerability to GBV during firewood collection and assessed protection strategies, alternative fuels and fuel technologies in humanitarian settings. Field research was conducted in Darfur and Nepal, culminating in the [Beyond Firewood](#) reports. The main findings of the research highlighted the need for a multi-sectoral approach and for coordination among sectors

and agencies in the field and at headquarters level. The second phase of the initiative involved the establishment of a two-part mechanism for developing a coordinated global response: the Inter-Agency Standing Committee Task Force on Safe Access to Firewood and alternative Energy in Humanitarian Settings (IASC Task Force SAFE), which will run through May 2008; and the longer-term International Network on Household Energy in Humanitarian Settings. The objectives of the former are to determine what aspects of a multi-sectoral fuel strategy must be put in place at specific phases of response, to ensure that all actors are aware of and implementing their specific responsibilities per sector, and to disseminate information and best practices. The International Network is an informal, field-based network of NGOs, research institutes and other relevant “non-traditional” humanitarian actors that will monitor the implementation of the Task Force’s guidance and ensure the continued relevance and sustainability of tools, resources and information. The Network will maintain a website that will serve as a central repository and “go-to” place for new fuel technologies. A third component of the second phase has been field work in Darfur and eastern Chad to promote the expansion of effective fuel-related initiatives, including protection strategies. The overall goals of the fuel and firewood initiative are to ensure that cooking fuel is seen as a central, multi-sectoral humanitarian issue and that effective fuel strategies are implemented from the earliest phase of a new emergency so that displaced women and girls have safe, effective and sustainable alternatives to unsafe firewood collection.

3. Humanitarian Reform: Implications for Reproductive Health

Ms. Pamela Delargy, Chief of UNFPA’s Humanitarian Response Unit, discussed the UN humanitarian reform and the implications for reproductive health. In light of the changing nature of crises, increased global awareness, and better humanitarian response overall, a humanitarian reform process has been launched based on predictability, accountability and equity. In terms of predictability, the cluster approach has been designed to address the gaps in humanitarian response by designating specific agencies to take responsibility for different sectors in internally displaced settings. The aim of the approach is to set high standards of predictability, accountability and partnerships in all sectors or areas of activity, and to be more strategic in terms of response and the prioritization of available resources. Ms. Delargy explained the role of the cluster lead in working at the global and field levels, in addition to some of the challenges and opportunities of the approach for reproductive health and the work of IAWG. She also noted the reforms that were being undertaken to strengthen the humanitarian coordination system, in addition to humanitarian financing. The Central Emergency Response Fund (CERF) is one tool to ensure timely, adequate and flexible funding for UN agencies and their implementing partners. The funds target core life-saving activities, and within health, it funds areas such as coordination, medical care and psychosocial support to GBV survivors and interventions that reduce maternal and neonatal risk including the provision of Inter-agency Reproductive Health Kits. The CERF, however, does not fund areas such as capacity building and training, unless that is related to direct implementation of emergency response. Ms. Delargy, in addition, noted the partnerships between UN and non-UN actors, including the Global Humanitarian Platform, which is a forum of NGOs, the Red Cross and Red Crescent Movement, UN and other international organizations that aim to enhance the effectiveness of humanitarian action. The Inter-agency Standing Committee (IASC) Country Teams are also now required to exist in all countries with a Humanitarian Coordinator; these developments provide opportunities to include reproductive health and gender issues into cluster standards and coordination mechanisms. Ms. Delargy also noted that based on local decision-making, CERF funding has proved to be more reproductive health-friendly and gender-friendly than the Consolidated Appeals Process (CAP) funding mechanism. She concluded by further mentioning that the standby arrangements of the IASC’s Gender Capacity Stand-by Project (GenCap) and other mechanisms can also allow for additional specialized staffing for implementation of reproductive health-related activities.

4. RAISE Initiative and Training Center

Dr. Fred Akonde from Marie Stopes Kenya and Dr. Therese McGinn of Columbia University presented on the Reproductive Health, Access, Information and Services in Emergencies (RAISE) Initiative’s training center in Eastleigh Nairobi. The objective of the clinical training center is to train providers in comprehensive reproductive health care skills in order to improve the provision of reproductive health care among displaced populations. The training center has been established within the existing Marie Stopes Kenya Eastleigh Maternity Home in Nairobi, and RAISE is currently developing training modules on family planning (temporary and permanent), emergency obstetric care, HIV/AIDS/STIs,

medical response to GBV and post-abortion care, all of which will be field-tested. The training center will also provide on-going medical technical assistance and follow-up to trainees in the field.

In addition, the presenters informed participants on the upcoming RAISE/Reproductive Health Response in Conflict (RHRC) Consortium's research conference scheduled for 18-20 June 2008 in Kampala's Speke Conference Centre. Participants were encouraged to submit abstracts on reproductive health in crises-related issues and to access more information from www.raiseinitiative.org.

Question and Answers

The fuel and firewood presentation prompted clarification on income generation activities, to which Ms. Patrick responded given that activities like sewing, bread making, and so on do not always generate enough income to offset the money forfeited by giving up fuel collection. Ms. Patrick also encouraged relevant organizations to join the International Network since participation was being solicited from a wide range of actors. Regarding the RAISE training center, there was a question on how the trainees worked with the community, and how they were monitored. Dr. Akonde noted that community interaction is a component of the family planning curriculum for instance, and that trainee monitoring and follow-up is embedded in the training center's monitoring and evaluation plan.

Session 3.1: Regional Initiatives

The third session was moderated by Ms. Nicole Fulton, Regional Reproductive Health Officer for East and Horn of Africa for UNHCR.

1. Uganda and Chad: Sexual and Reproductive Health among IDPs and Refugees

Mr. Ada Pouye, Emergency Response Advisor for the International Planned Parenthood Federation's (IPPF) Africa Region in Kenya presented on two studies conducted in Gulu and eastern Chad between September 2004 and February 2005. The study examined the reproductive health situation in order to determine appropriate reproductive health interventions and to develop advocacy strategies to better provide services to the displaced populations. Findings showed that the MISIP was not fully integrated into health interventions, there was an overall lack of qualified persons to care for survivors of sexual violence, and STI treatment was unavailable at the regional hospital. Further, there was a general lack of consideration for young people's reproductive health needs. In addition to the lessons learned such as the impact of insecurity on health, Mr. Pouye spoke about the developments following the study, in addition to the piloting of two projects in Chad and in Guinea-Conakry and the development of a joint IPPF-UNFPA regional reproductive health initiative for populations affected by conflict in the Great Lakes region.

2. Horn of Africa: Providing Fistula Services in Conflict Settings

Dr. Biruk Amare from Addis Ababa Fistula Hospital in Ethiopia presented on caring for obstetric fistula among displaced populations in the Horn of Africa. In addition to the difficulties of providing fistula services in resource-poor settings, Dr. Biruk noted the additional challenges prevalent in crisis settings, including the higher incidence of traumatic fistula, lack of supplies and human resources, and the impact of insecurity on continued care. Dr. Biruk explained the components of fistula care, including the medical, psychosocial, social and rehabilitative aspects, and the services offered by the Addis Ababa Fistula Hospital that include patient outreach and center-based training.

3. Lessons Learned in Reaching Transactional Sex Workers

Professor Elizabeth Ngugi, Director of the University of Nairobi's Centre for HIV Prevention and Research discussed the lessons learned in addressing the needs of transactional sex workers in camp settings. According to Professor Ngugi, unless sex workers are reached by targeted interventions, condom use has been found to be low in the camps in Kenya. Transactional sex is highly stigmatized, and as a result, access to condoms can be a challenge. Clients allegedly come from within the displaced community and the host communities. Professor Ngugi closed her presentation by noting that interventions for sex workers should address cross-cutting issues such as gender, human rights and economic alternatives.

4. Reproductive Health in North-western Tanzania: Emergency Obstetric Care

Mr. Herman Tirwosha and Ms. Nadine Cornier, both from UNHCR, presented on interventions for emergency obstetric care (EmOC) in the refugee camps of north-western Tanzania. Data from the camps showed that the maternal mortality ratio and neonatal mortality rates have fallen from 2004 to 2007, while the percent of skilled attendance at birth has increased within the same time period. Such positive developments have been a result of an increase in the availability of skilled persons providing basic EmOC; the creation of strong referral systems for comprehensive EmOC; improved community-based initiatives and participation; strong collaboration, coordination and information-sharing among stakeholders; among numerous other factors. Yet challenges remain, including the issue of high staff turnover; low acceptance of family planning in the communities; insufficient post-abortion management including lack of manual vacuum aspirators; and significant early marriage and pregnancies among the populations. In terms of the way forward, the presenters mentioned that UNHCR will continue building the capacity of midwives and community health workers, and improve family planning rates through identifying and training family planning promoters among the community, in addition to undertaking other planned activities.

Questions and Answers

One of the questions to Mr. Pouye's presentation pertained to efforts to address the reproductive health needs of young people in the settings. Mr. Pouye responded by noting that there are no specific services for young people, and as a result, they have to go to the regular health services. A comment from the audience on young people noted the issue of denial, and that in some societies, the argument that reproductive health services is "culturally inappropriate" is raised.

To Dr. Tafesse, a participant asked for clarification difference between vesico-vaginal/recto-vaginal fistula and traumatic fistula, whereby he explained the anatomical classifications and causes of fistula. Dr. Tafesse noted that traumatic fistula often results in vesico-vaginal and recto-vaginal fistula, and while the success rate of closing the wound is 97 percent, the chance of improving incontinence is 70 percent. Another participant asked whether the Addis Ababa Fistula Hospital had standby agreements with organizations that can be deployed to work in district hospitals that serve displaced populations. While the Hospital does not have formal arrangements, organizations have provided logistics for the Hospital's teams to be dispatched. Staff have worked in Loki Choki through the sponsorship of the International Committee of the Red Cross (ICRC), in addition to training local doctors in the DRC. The Hospital focuses on improving the capacity of local health centers through using a team-based approach.

A representative from Ipas asked Professor Ngugi whether she had information regarding clients who are humanitarian actors, since Ipas found that where this was the case, factors such as alcohol use and power were present. Professor Ngugi answered that while she had not conducted specific research on the clientele, she noted that they represented all professions, including religious institutions; hence, it was everybody's problem. Dr. Tafesse also noted that the sex trade is problematic in Kakuma camp where HIV prevalence is higher in the host community.

A comment to the EmOC presentation was that it would be good to add the case fatality rate to program indicators. Another participant expressed sadness over the lack of MVA equipment, since many had been provided by various organizations. To a question regarding retention of health workers, the response provided was the issue of money. Without incentives, it is difficult to keep health workers, resulting in high staff turnover.

Session 3.2: Regional Initiatives

1. East, Central and Southern Africa: Gender-based Violence (GBV) Task Force

Ms. Jennifer Miquel from UNFPA presented on the Regional GBV Task Force, which is an open forum of UN agencies and international and national organizations committed to addressing GBV in the East, Central, and Southern Africa region (ECSAR). The GBV Task Force was established in 2005 from the recognition over the lack of attention to and coordination of GBV activities in the Great Lakes Region and the Horn of Africa. The primary goal of the Task Force is to improve capacity to address GBV in the region by sharing and managing information, harmonizing activities, mobilizing resources, facilitating advocacy, and identifying technical and other forms of assistance at the international,

regional, national and local levels. The Task Force is part of the Inter-agency Working Group on Disaster Preparedness for Central and East Africa, and the Regional Humanitarian Partnership Team. The Steering Committee is comprised of the UN Children's Fund (UNICEF), the UN Development Fund for Women (UNIFEM), UNFPA, United States Agency for International Development (USAID), UN Office for the Coordination of Humanitarian Affairs (OCHA) and UNHCR, and meets every three months. Key activities for 2007 include the development of a regional framework for joint programming on GBV and HIV and the drafting of a strategy document on reducing sexual exploitation and abuse in humanitarian settings, among numerous other coordinated activities. More information, including a calendar of events, is available from www.humanitarianinfor.org/iawg-nairobi.

2. West Africa: Operational Barriers to Obtaining Family Planning in Conflict-affected Countries

Ms. Theresa Shaver from the White Ribbon Alliance presented on operational barriers to accessing family planning before, during and after the conflict in Sierra Leone. As part of USAID's Health Policy Initiative Task Order 1—a five-year global project that focusing on policy development and implementation for reproductive health and HIV/AIDS—the White Ribbon Alliance partnered with the World Conference of Religions for Peace and the Center for Development and Population Activities to conduct research in Sierra Leone to 1) explore refugee and IDP family planning needs before, during and after conflict; 2) determine the root causes of the barriers to quality accessible services; 3) build capacity of local groups to analyze operational barriers to services; and 4) devise policy actions and recommendations for overcoming barriers that are applicable both in-country and in other conflict-affected areas. The study methodology included focus group discussions, a mapping technique known as "Journey of a Woman," key informant interviews, and an application of a policy score. Some findings from the focus group discussions included limited knowledge, access and use of family planning in Sierra Leone and Liberia before the conflict; greater access to family planning for refugees in camps than IDPs; and a growth in demand for family planning among women post-conflict. Interviews with key informants also revealed numerous issues including stock-outs of commodities, lack of youth-friendly services, and limited knowledge and misconceptions about family planning among clients. Recommendations of stakeholders covered the need for a clear and comprehensive strategy to implement Sierra Leone's National Reproductive Health Policy; the need to improve contraceptive availability through building on the country's Contraceptive Security Strategy; the need for training and rebuilding health facilities; and other priorities. Lastly, recommendations for the international community consisted of advocating for the inclusion of family planning in repatriation plans with a focus on adequately supplying commodities; including family planning in the initial package of services provided to refugees; and developing a collaborative approach to importing commodities during conflict.

3. Cote d'Ivoire: HIV Prevention in Emergency Settings: Peacekeepers and the Disarmament, Demobilization and Reintegration (DDR) Process

Mr. Idrissa Kone from UNFPA Cote d'Ivoire presented on UNFPA's HIV prevention efforts for peacekeepers within the disarmament, demobilization and reintegration (DDR) process. As part of UNFPA's interventions in emergencies, the organization also works to minimize HIV transmission among peacekeepers during all phases of an emergency. Mr. Kone briefly described examples of UNFPA's work, and mentioned the lesson learned from the interventions. These included humanitarian actors not perceiving reproductive health and HIV as humanitarian issues; that engaging in prevention efforts among peacekeepers and at the outset of the DDR process can help reduce the rate of new infections; peacekeeping missions can contribute positively to HIV response through offering security, logistics and access to clinical services; and since the DDR process is influenced by the political climate, there are delays and additional challenges to instituting an HIV intervention.

Questions and Answers

One of the questions posed to the presentation on operational barriers to obtaining family planning was whether or the research examined unsafe abortion and its impact on demand for safe abortion. Ms. Shaver replied that the research only addressed family planning; to which the participant noted that this was a gap that needed to be evaluated. Another question pertained to bridging the relief to development worlds and if Ms. Shaver could comment on the dynamics of the different organizational cultures involved in the policy arena. Ms. Shaver noted that there were two levels but both

headquarters and field staff wanted to come together, and that they were proud of the process to advocate for a broad reproductive health policy.

Regarding the presentation on HIV and security, a participant asked whether raped women in Cote d'Ivoire had access to post-exposure prophylaxis (PEP) to minimize the possibility of HIV transmission. The response was such that all agencies promote kits that include emergency contraception (EC), PEP and STI prevention drugs. Another question pertained to condom interventions, to which the response was that there is a focal point for HIV that is responsible for counseling and condom promotion. A question on legal recourse for peacekeepers engaged in prostituting minors prompted major discussion from the audience, especially in terms of ensuring UN system-wide accountability. Participants noted that mechanisms have been established through the UN Secretary General, in addition to codes of conduct that are being enforced throughout the international community. The UN Department of Peacekeeping is also working to address the issue of impunity, so that peacekeepers can be prosecuted under national laws.

Session 4.1: Technical Updates, Special Topics and Emerging Reproductive Health Issues

The chairperson for this session was Dr. Fred Akonde of Marie Stopes Kenya.

1. Comprehensive HIV Programming for Refugee/Mobile Populations: The Turkana District Experience

Dr. Dan Koros of the International Rescue Committee (IRC) presented on IRC's comprehensive HIV/AIDS program among the refugees and pastoralist communities of the Turkana District in Kenya. Taking into account the unique features of the community and target populations, IRC's program goal was to increase the capacity of the health system, communities and partners to prevent HIV transmission, and to provide high quality care and support services to people infected with HIV/AIDS in the Turkana District. Areas of intervention included prevention (including prevention of mother-to-child transmission - PMTCT), counseling and testing, comprehensive care including the provision of antiretro-viral drugs (ARVs), and home-based care. IRC takes a holistic approach through working with local partners and the Ministry of Health, and relies on evidence-based approaches through regular assessments, Knowledge Attitudes and Practice (KAP) surveys and Participatory Rural Appraisals (PRAs). IRC has unique strategies for prevention, counseling and testing, PMTCT and comprehensive clinical care that have yielded concrete results in terms of lowering HIV prevalence among ante-natal care clients, decreasing STI rates, and increasing the number of persons enrolled on anti-retroviral therapy in Kakuma Camp. Hence, the IRC example shows that it is possible to implement a comprehensive HIV/AIDS program among mobile and conflict-affected populations through basing interventions on evidence-based approaches and partnering closely with local organizations.

2. Female Condom: A Powerful Tool for Protection

Ms. Annie Thairu from PATH Kenya presented on recent developments regarding the female condom. In addition to research that has shown the impact of female condoms on the levels of protected sex, Ms. Thairu noted the cost-effective nature of this barrier method, especially when included as part of a comprehensive prevention strategy. Female condoms are much less expensive than anti-retroviral therapy (ART) and they can be combined with ART for efficient and effective prevention and treatment. Challenges to increasing their access and use include user-dependency, negative perceptions from policymakers and providers; perceived obstacles to genital touching, and perceived costs. Numerous organizations are developing and testing various products as introduced by Ms. Thairu, but in order to enhance access and use there is a need for more advocacy at local, national and international levels; more public- and private-sector involvement in their development; a scaling-up of promotion and the monitoring and evaluating of impact; and enhanced research for improved programming and education.

3. Rapid Diagnostic Tests for Syphilis

Dr. Jonathan Ndzi of UNFPA presented on the rapid diagnostic tests for syphilis. There are two types of laboratory diagnosis for syphilis: the non-treponemal and treponemal tests, with the former being non-specific and the latter specific. The non-treponemal test is simple, less expensive, and can distinguish between active and non-active infections, but requires electricity, refrigeration and trained personnel. There is also a need for serum and the risk of false positives and false negatives with

excess antibodies exist. On the other hand, the treponemal test is simple, uses whole blood/serum/plasma and can be transported at less than 30 degrees Celsius. The advantages of rapid diagnostic tests are that they are suited for limited resource environments in that trained technical staff, refrigeration and electricity are not needed. The tests are highly specific and sensitive; in addition, they yield immediate results. There are disadvantages, however, including the tests not being able to distinguish between new and treated infections.

Question and Answers

Dr. Koros's presentation generated much discussion, as did the other presenters. One participant asked how IRC targets children aged 9 to 12 on HIV prevention, particularly around the issue of condoms. Dr. Koros responded by stating that IRC takes the approach of targeting parents, guardians or primary care givers so that they receive training on effectively communicating about sexuality to their children. A follow-up question asked whether a formal assessment had been undertaken to determine when it was culturally appropriate to initiate discussions on sex with children, and although the answer was in the negative, Dr. Koros noted that there is follow-up with parents to see how they are faring with their children. Another question pertained to PMTCT and IRC's recommendations for infant feeding practices. As part of the counseling process for PMTCT, women are provided with two options: exclusive breastfeeding for up to six months, or formula feeding for up to six months. After six months, the baby is weaned and provided with formula and normal foods. The participant also asked whether IRC had programs to address the issue of HIV/AIDS and malnutrition, to which Dr. Koros replied that malnutrition is addressed as part of the comprehensive package. Another person asked for more information on IRC's home-level VCT. IRC's home-based VCT was piloted in the Karamoja region of Uganda where outreach groups first met with leaders of the communal living groups. Once the leaders approved, IRC was able to access the populations to offer both group counseling, and then VCT at the home-level. The last stream of questions pertained to how IRC follows-up with ARV treatment for mobile populations. Dr. Koros responded by noting that IRC has hired and trained community health workers from the mobile communities so that they can follow-up with those that need ARVs. The issue he noted, however, is that many of the AIDS patients are too weak to move with the group. Follow-up rates are still low, but IRC is addressing this and is planning to conduct an evaluation. Another participant who asked how IRC tracks ARV clients in general, to which Dr. Koros replied that the Ministry of Health has developed an electronic system where appointment schedules are entered. The palliative care manager has access to the list, and if someone does not come for his/her scheduled appointment, there is active follow-up. For refugees, IRC has developed conditions for repatriation whereby ARV clients are strongly encouraged to remain until their destination has ARV treatment available.

The female condom presentation also solicited numerous questions. One participant asked why female condom 1 (FC1) was being phased out and asked for clarification on the differences between the FC1 and FC2. Ms. Thairu noted that as some users found FC1 difficult to use, FC2 has been modified for easier insertion, similar to a tampon. A related question noted the issue of noise associated with the female condom, to which Ms. Thairu responded by mentioning that the next generation of condoms will address issues of sensitivity, accessibility, user-friendliness and insertion, so that discomfort does not outweigh the benefits of the condom. A different question pertained to cost and rates of use and why female condoms appeared to be lacking in crisis settings. Ms. Thairu answered that both cost and user rates were problematic, but another significant challenge in crisis settings was convincing policy makers on women's need and right to have control over their bodies. This prompted a participant to contribute that female condoms are available in reproductive health kits, and that service providers are partly responsible for not ensuring their supply. Another participant agreed with this and commented on the potential of the female condom. The participant stated that FC2 is cheaper than FC1 and studies from Zimbabwe have shown that both women and men enjoy the female condom since it stimulated their genitals; hence, cost will decrease with demand, as shown by Brazil's example. Another participant asked how Ms. Thairu felt about the female condom and the future of microbicides vis-à-vis their role as an HIV inhibitor and contraceptive. The response was that female condoms can be seen as a precursor to microbicides since current studies on microbicides have not rendered complete success. This prompted a comment from the audience that a range of contraceptive options needs to be made available, not simply one.

For the presentation on rapid syphilis tests, a participant asked about syphilis screening during antenatal care. A participant from UNFPA commented that UNFPA is working closely with WHO to develop recommendations for rapid syphilis testing during antenatal care so as to be able to treat women in their first trimester.

Session 4: Technical Updates, Special Topics and Emerging Reproductive Health Issues

1. Cervical Cancer

Dr. Mike Chirenje from the Department of Obstetrics and Gynecology, University of Zimbabwe, presented on cervical cancer prevention. Dr. Chirenje mentioned that cervical cancer now disproportionately affects low resource countries, especially since screening is limited for many. Zimbabwe has had a cancer registry since 1963, but in 2002, cervical cancer ranked the highest among all cancers to women (25.9 percent), followed by Kaposi sarcoma (16.1 percent) and breast cancer (10.2 percent). Hence, one in ever five women diagnosed to have cancer had cervical cancer. Dr. Chirenje also spoke on the epidemiology and treatment of cervical cancer, also noting classic symptoms and the social implications for women experiencing such cancer. Furthermore, he spoke about studies that examined the effectiveness of HPV vaccines for the prevention of cervical cancer, including the 2006 Harper et al. study published in the *Lancet* that tested human papillomavirus (HPV) types 16 and 18, which causes 70 percent of cervical cancer cases. He also noted other preventive options, such as the Pap smear.

2. Health Information System (HIS): Reproductive Health Data for Decision Making

Ms. Nadine Cornier from UNHCR presented on monitoring and evaluation in crisis settings. UNHCR developed a standardized Health Information System (HIS) for use by the organization and its partners to improve the design, implementation, monitoring and evaluation of health interventions in refugee settings. The guiding principles include standardizing data collection and reporting; operationalizing and prioritizing support to front-line staff; being flexible to meet country needs; emphasizing communication and information use; and building consensus around minimum health indicators and standards at the international and country levels. The HIS encompasses ten technical sections and also promotes the use of various existing tools such as tally sheets, registers and guidelines. Ms. Cornier shared visual examples of the tools and data collected. She also presented an example of population-based data collection. The Centers for Disease Control and Prevention (CDC) recently released the [*Reproductive Health Assessment \(RHA\) Toolkit for Conflict-Affected Women*](#), which provides step by step instructions on how to conduct a quantitative assessment of reproductive health needs, barriers, and help-seeking behaviors. The RHA Toolkit contains sampling instructions, training manual for the entire survey team, questionnaire, pre-programmed data entry program and pre-programmed data analysis.

3. Misoprostol for Post-partum Hemorrhage

Dr. Lisa Thomas from the Women's Commission for Refugee Women and Children and Dr. Ribka Amsalu from Save the Children US presented on the use of Misoprostol for post-partum hemorrhage (PPH), which is the cause of 25 percent of maternal death worldwide. Dr. Thomas noted that Misoprostol is a heat stable, inexpensive drug used for abortion, incomplete abortion, induction of labor and the prevention and treatment of PPH. Oxytocin is the drug of choice in hospital settings for the active management of third-stage labor (AMTSL), but skilled care is required to administer it. There is growing evidence that oral Misoprostol is effective in preventing PPH in resource-poor communities, including a study published in the *Lancet* which found that 600 micrograms of Misoprostol administered within five minutes of cord clamping/cutting resulted in less blood loss and fewer blood transfusions. WHO recommendations for the prevention of PPH states that "in the absence of AMTSL, a uterotonic drug (Oxytocin or Misoprostol) should be offered by a health worker trained in its use for prevention of PPH." Health workers include auxiliary nurse-midwives, community midwives, village midwives and health visitors. In light of emerging evidence, the International Federation of Gynecology and Obstetrics (FIGO) and the International Confederation of Midwives (ICM) are calling upon national regulatory agencies and policy makers to approve the indication of Misoprostol specifically for the use in PPH prevention and treatment. Registration would provide a license to market the product for the specific indication, and would also legalize drug import and sales. Misoprostol for the particular use is currently registered in Nigeria, India, Nepal and Bangladesh, while registrations are underway in Indonesia, Egypt, Ethiopia, Tanzania and Zambia. As next steps,

community-based PPH prevention has been suggested, although prevention of misuse and investments in training and supervision must be addressed. In addition, Dr. Thomas noted that PPH prevention as an indication for use of Misoprostol should be placed on WHO's essential medicines list, and more research needs to be conducted on optimal dosages and routes.

Dr. Amsalu briefly described the joint program between Afghanistan's Ministry of Public Health and the ACCESS Initiative that aimed to 1) show that community-base distribution of 600 micrograms of Misoprostol and its subsequent use immediately after home delivery was safe, acceptable, feasible and programmatically effective; and 2) ensure that Misoprostol was not misused. Dr. Amsalu described the steps that were taken to establish the PPH prevention program and the challenges that were overcome in achieving coverage of remote and hard to access areas. Results of the study showed that the intervention reduced perceived PPH, as rates were considerably lower for those in the intervention area than in the comparison area. The study also found that the intervention was feasible, as three days of training followed by periodic supervision of the community health workers (CHW) by the community health supervisors (CHS) prevented misuse and maintained quality. Moreover, the intervention enabled pregnant women who were not in contact with the health care system to be reached by the CHW.

Questions and Answers

Questions for Dr. Chirenje included the effects of HIV on cervical cancer. Dr. Chirenje responded by stating that the operable stages are between the first and second of the four-stage disease. HIV complicates this because of bulky tumors, but since treatment is surgical and such surgery is often unavailable in many parts of Africa, many women who have the means are forced to move to other countries for treatment. A second question pertained to the HPV vaccine and whether that was recommended for all girls and boys at age 12. Dr. Chirenje commented that while many of the vaccines are protective against genital warts, they are currently not affordable for many African countries. Girls aged 9 and 12 are the best age group to vaccinate since many are in school, but talks have not yet expanded to the boy child. A third question was related to the issue that many women are not aware of cervical cancer, Pap smears, or associated issues. Dr. Chirenje answered by noting that a 2001 situation analysis of seven African countries found that less than 5 percent of women visiting primary health care facilities had been screened in Sub-Saharan Africa. Lastly, someone pointed out the particular shame and stigma associated with cervical cancer due to the fact that a significant proportion of women with such cancer are older and ashamed to seek care.

A question for Ms. Cornier was how data are used at the local level, to which she noted that at the camp/clinic level, health workers are trained to collect information in their unit area. They are then trained to calculate the indicators, which can be measured against thresholds to determine outbreaks of disease. The data and collection efforts have also provided opportunities for discussion, as providers have been able to compare results and discuss.

Regarding the presentation on Misoprostol, one participant noted that the IJGO (International Journal of Gynecology and Obstetrics) supplement will be issued at the end of 2007 for recommendations on dosage, and so on, for the multiple uses of Misoprostol. Another comment was the perceived challenge of getting the commitment of governments with regulations on abortion to approve the use of Misoprostol. Dr. Thomas commented that numerous countries with such regulations are in fact registering Misoprostol, and that the most dangerous misuse is not for abortion but for the induction of labor; hence, obstetricians and gynecologists may be the most likely to misuse misoprostol. While 25 micrograms is the recommended dosage for induction of labor at term, misuse can lead to fetal demise and maternal death; thus, significant training and monitoring are necessary. Furthermore, a question asked for the comparison of Misoprostol with Ergometrin, another drug used for PPH prevention and treatment. Dr. Thomas responded by noting that Ergometrin cannot be used among women with hypertension and studies have shown it to be inferior to Oxytocin. While some trials have shown that Oxytocin is more effective than Misoprostol for the active management of third stage labor, issues of availability and storage exist, which is why there is a call to enhance the use of Misoprostol specifically for PPH prevention.

Questions for Dr. Amsalu included whether or not Misoprostol was registered in Afghanistan and the training process for Misoprostol use there. Dr. Amsalu remarked that although Misoprostol is included

in Afghanistan's policy, it has not yet been registered for the specific use of PPH prevention. In terms of training, Dr. Amsalu noted the existence of a maternal and newborn health technical advisory group. While the actual training was two days, it was part of a larger training.

4. Technical Working Group Discussions

In the fifth session, participants divided into nine thematic working groups to share information on progress in the area, identify gaps, and propose and prioritize solutions. The instructions presented were as follows:

1. The facilitator should designate note-taker(s) and presenter(s) for the working group discussion. Each working group will have ten minutes to present on the morning of the third day. Please ensure that notes and presentations are typed for the presentation and the meeting minutes.
2. The objectives of the Thematic Working Group discussion are:
 - ♦ To review the relevant sections of the IAWG Terms of Reference (ToR) to identify gaps, solutions and priority actions; update the ToR; and set the agenda for further collaboration for the thematic area in 2007/8.
 - ♦ To determine modes of communication for the Thematic Working Group for further discussion after IAWG.
3. Cross-cutting issues to be considered include:
 - ♦ Internally displaced persons (IDPs)/Internally Stuck Persons (ISPs)
 - ♦ Quality and access to care in insecure/unstable environments
 - ♦ Community participation and capacity-building
4. For the Francophone Regional Strategy and Anglophone Regional Strategy Working Groups, other topics to discuss include:
 - ♦ Group formation process
 - ♦ Regional objectives
 - ♦ Activities for 2007/2008
 - ♦ Funding
 - ♦ Other issues as identified by the group to launch a regional IAWG.

The following section summarizes each of the working group discussions; final priorities have been summarized in the Terms of Reference in Annex I: Strategy Paper and Terms of Reference.

1. MISP Working Group

Participants: Yaya Sidi Sackor, ARC Rwanda; Judith Barasa, ARC Sudan; Katie Anfinson, ARC Headquarters; Sarah Chynoweth, Women's Commission for Refugee Women and Children

The MISP working group is comprised of the Women's Commission (coordinating agency), ARC, MSI, Save the Children, IPPF, UNSW, UNFPA and UNHCR. At the meeting, ARC and Women's Commission participated in the development of the objectives and activities of the working group. These activities were divided between long-term and short-term goals.

Short-term activities

Participants identified a number of activities that can be undertaken in the following year. As a criterion to join IAWG, members could be required to complete the MISP Module. The Women's Commission will follow up to see if it is possible for the request to be automatically generated as new members register for the IAWG IBP site. Each IAWG member will be encouraged to incorporate the MISP Module into their orientation package for new staff. In order to facilitate this, the MISP Working Group members can draft a generic email that agencies can forward to their HR regarding the integration of the MISP Module into their orientation packet. The regional IAWG group, of which ARC is a member, could establish a regional MISP committee that meets bi-annually to share resources, discuss challenges and good practices regarding MISP implementation, and collaborate on different initiatives. ARC also suggested developing a short film with interviews with humanitarian actors who support the MISP and can explain its significance from a field perspective.

The Women's Commission is currently advocating to systematize the MISP in humanitarian response by:

- ♦ achieving a commitment from humanitarian organizations to institutionalize implementation of the MISP in their health sector emergency response;
- ♦ certifying UN and INGO humanitarian aid workers, donors and others in the MISP;
- ♦ integrating the new MISP Module into humanitarian emergency courses; and
- ♦ advocating for the successful completion MISP Module by donors, humanitarian professionals and others.

MISP Working Group members will send information on additional complex emergency courses to the Women's Commission for follow up.

Long-term activities

The WG members also identified a number of long-term activities that the WG and/or IAWG could undertake. IAWG member agencies could designate an informal, internal MISP focal point for technical assistance and internal advocacy. This would not be a formal position, but someone identified as the agency's MISP point person. Another suggestion was to advocate for agencies to have their health staff certified in MISP (including country directors, health coordinators, skilled service providers and attendants, HQ program staff). The informal, internal RH focal point in each agency would be responsible for overseeing that appropriate staff are certified. Advocacy can be undertaken to encourage implementing agencies to institutionalize a position for an RH person on their emergency response team. Again, overseeing this process would be the responsibility of agencies' internal RH focal point. IAWG could also encourage lead agencies in health to ensure that at least one key staff person is trained in IAWG Training Partnership. The internal RH focal point could coordinate this process.

Higher level advocacy with UN agencies was also discussed. Implementing agencies could encourage UNFPA country offices to take the RH coordination lead in all emergencies and that they have RH/MISP coordinator in place. ARC Rwanda will approach UNFPA Rwanda office. UNFPA and UNHCR IAWG members could also advocate for RH to be incorporated into initial medical screenings and for UNFPA to link their RH coordinator and with UNHCR's medical coordinator. Finally, each MISP Working Group member agency could bring up the need for an RH coordinator at country level health cluster meeting.

2. Advocacy Working Group

Participants: Sandra Krause, Women's Commission for Refugee Women and Children; Claire Richardson, Marie Stopes Australia; Jane Singleton, ARHA; Jean Claude Mugunga, Rwanda Village Concept Project; Marlou den Hollander, MSI-UK.

Participants discussed whether IAWG should and could conduct advocacy, as thus far, IAWG has mainly been a platform for information-sharing, networking and production of advocacy materials. The group then discussed the different types of advocacy for IAWG, including the political, funding and implementation options. It also discussed the question of structure and whether or not IAWG would need a more formal structure, in addition to what it meant to be a participant/member of IAWG.

The group agreed that in its current format, IAWG could play a useful role in identifying gaps and priority areas that required an increased advocacy focus. Annual meetings could be used to identify three priority areas for advocacy, for example, that IAWG members could act upon in the following year. Issues identified by the group included:

- ♦ New reproductive health technologies in the emergency settings;
- ♦ Funding for local capacity building;
- ♦ Female condoms;
- ♦ The need for qualified reproductive health staff on the ground;
- ♦ Capacity/human resources within emergency response particularly in areas that are hard to reach, in addition to assisting local organizations with coordination and leadership on reproductive health service provision; and
- ♦ Community based initiatives such as Misoprostol distribution and care for survivors of sexual violence.

In light of the above, the ToR was discussed and specific recommendations for 2007-2008 were developed, as finalized in the annexed ToR. A new item on internal IAWG communication was added, so that IAWG members can share advocacy challenges and successes, and identify gaps and issues for collective action.

3. Data and Research Working Group

Participants: Judy Austin, RAISE Initiative; Charles Zandoh, Kintampo Health Research Centre, MOH, Ghana; Tam Feters, Ipas; Sarah Ashraf, Save the Children; Katie Mitchell, IRC; Maqsooda Kasi, IRC; Dayal Debnath, ARC; Stacy De Jesus, CDC; Kerry Thompson, CDC; Mabel Nakakande, Child Health and Development Centre, Makerere University; Transform Consult, Uganda; Therese McGinn, RAISE Initiative

The Data and Research Group adjusted the ToR so that objectives read: Identify and periodically update a prioritized list of refugee reproductive health questions; encourage research efforts in pursuit of prioritized questions; and disseminate information about refugee reproductive health-related studies.

Participants also undertook a brainstorming exercise whereby a list of studies known to either be underway or have been completed was generated. The list for 2007 included baseline surveys, mortality surveys and facility assessments conducted by many of the organizations represented in the working group.

The group also discussed overarching themes and concluded that the priority for 2007-2008 is operations research, including policy implications, and not epidemiologic studies. In terms of research ideas, a variety of topics were suggested. The complete list of research questions can be found with the ToR.

4. Regional Working Group

Participants: Jonathan Ndzi, UNFPA; Ada Pouye IPPF Africa Region; Amadou Sagnon, IRC DRC; Dueme Patrick Safi, Infogroup International, DRC; Mbunzama Mpongo Poupon, Infogroup International, DRC; Nguyen-Toan Tran, IPPF ESEAOR; Yao Bi Bakayoko Zeguella, CFMS/SR Cote d'Ivoire; Sarah Onyango, PPFA Kenya; Fred Akonde, Marie Stopes Kenya; Jennifer Miquel, UNFPA Nairobi; Nicole Fulton, UNHCR Nairobi; Susan Igras, CARE.

The Anglophone and Francophone groups merged to create one group for this discussion. Both groups agreed on the need for a regional IAWG; one for Anglophone and one for francophone Africa. The group agreed that the target should be all of those in crisis situations.

The objectives discussed included improving coordination and avoiding duplication; sharing experiences; building partnership and bringing in other organizations working in humanitarian settings to provide MISP/Comprehensive RH; advocating for higher prioritization of RH in organizations; and building capacity. Outcomes expected from these efforts are more reproductive health coordinators in humanitarian organizations and improved capacities of organizations and relevant ministries in responding to the reproductive health needs in emergencies.

Specific activities of the groups were also discussed (see relevant section of the ToR), in addition to some challenges. These included the regional divisions of Anglophone, Francophone and Lusophone Africa; donor interest and focus; coordination challenges as a result of numerous key players at the local level; and staff capacities to drive momentum forward.

5. Safe Motherhood Working Group

Participants: Lisa Thomas, Women's Commission; Hamali Omer, CARE; Nadine Cornier, UNHCR; Khan Ibrahim Abdelhai, UNFPA; Melaku Maru, UNHCR; Bill Powell, IPAS; Biruk Tafesse, Addis

Ababa Fistula Hospital; Saidkasim Sakhupov, UNFPA; Ribka Amsalu, Save the Children; Rogaia Abulegasim Abdelrahim, UNFPA.

In addition to reviewing and determining priorities in the ToR, participants identified gaps in maternal and newborn care. These gaps included a lack of capacity at the peripheral level, poor access to 24/7 EmOC services, a poor level of awareness and commitment to EmOC, the need for high *quality* coverage in high coverage services such as antenatal care, the lack of skilled birth attendants, poor documentation of best practices and communications, low demand for services by the community, a lack of information on the magnitude of fistula, and the fact that comprehensive reproductive health (CRH) is not a core area of the Health Cluster.

The working group also received updates on last year's ToR: Published and unpublished reports showed that the Columbia University's Averting Maternal Death and Disability (AMDD) program was a catalytic project for agencies to build their capacity and raise more resources for EmOC programming and that agencies in the project implemented EmOC programs, delivered services, and developed training modules. Examples within IAWG include IRC, Save the Children, and ARC who received resources for implementation, service delivery and capacity building.

The working group accepted the IAWG Call to Action, but suggested rephrasing the wording to make it more CRH specific. The group also recommended opportunities for advocacy, by IAWG such as using the achievement of the Millennium Development Goals (MDGs) (specifically MDG 5 on maternal mortality and MDG 4 on neonatal mortality)—as an advocacy tool for countries in conflict. The Sphere standards are another advocacy point—to establish basic EmOC in peripheral health units (the current minimum standard is one peripheral unit per 10,000 people).

6. Family Planning Working Group

Participants: Nathalie Kapp, WHO; Jennifer Nantale, ARC Rwanda; Khanlar Hajiev, Relief International Sudan; Megan O'Brien, Johns Hopkins University Center for Communications Program; Theresa Shaver, White Ribbon Alliance; Udaya Thomas, JHPIEGO.

Discussions culminated in the table below that outlines activities for 2007-2008 for the family planning working group.

Gaps/Needs	Activity to be taken	Responsible Person	Support needed from	Deadline
1. Need for standard basic FP update	<ol style="list-style-type: none"> Complete FP 101 course and take final exam for certification RAISE participants to ensure that other providers in site take and certify on FP 101 course RAISE representatives presenting at 2008 IAWG meeting on status 	<ol style="list-style-type: none"> RAISE trained participants All providers RAISE representatives 	1. RAISE, program managers, IAWG	Aug, 15, 2008
2. IAWG members having taken FP101 course	IAWG to have computer set up for the 2008 meeting so that meeting participants have access to course	IAWG Steering Committee	RHRC Consortium, IAWG, donors of next meeting	Oct 2008
3. Need for latest FP job aids	FP Wall chart and <i>Family Planning : A Global Handbook for Providers</i> to be provided to all FP programs in country sites	Meg O'Brien, agencies	Info Project, agencies	Jan 15, 2008
4. Knowledge sharing on working with communities	<ol style="list-style-type: none"> IBP site set up FP IAWG group to share references and resources on the IBP site Record downloads as a way of tracking use of the references and resources 	<ol style="list-style-type: none"> Meg O'Brien IAWG FP members IAWG members 	Info Project, IAWG	Feb 28, 2008

5. Revisions of MISIP	Follow-up with status of possible revisions	Theresa Shaver	IAWG FP members, MISIP members	March 15, 2008
-----------------------	---	----------------	--------------------------------	----------------

7. HIV/AIDS/STIs Working Group

Participants: Fartun Abdi Ahmed, GTZ, refugee representative; Otom Celestine, Futures Group; Herman Tirwosha, UNHCR; Namubiru Lydia Mugalu, Mbogo Health Care and Maternity Center; Dan Koros, IRC; Mary Otieno, UNFPA; Wilma Doedens, UNFPA.

The status of activities in the ToR was discussed, with challenges raised and recommendations made for 2007-2008. Regarding the compilation of a standardized package of training materials, while participants recognized that many resources existed, they noted that such a package was yet to be developed. Challenges raised included how training is conducted, who can conduct the train, and where to obtain funding for transportation and materials. Recommendations consisted of compiling a comprehensive list of training materials and supporting documents; IAWG agencies incorporating training on STI/HIV/AIDS in their work plan and budget; and developing a set of two-day refresher trainings for in-service training.

As for the Inter-agency Standing Committee (IASC) Guidelines on HIV/AIDS in Emergencies, the ongoing involvement of IAWG members was noted, and participants recommended continued advocacy for the inclusion of reproductive health in the revised guidelines. As a result of the need to base community programs and information, education and communication (IEC) messages on local culture and beliefs to be able to better involve the community to improve quality and access and address stigma; activities recommended included developing guidelines on designing community programs to address stigma.

To improve access to information and services for young people, some challenges identified included parents potentially acting as the main barrier to the establishment of youth centers or the inclusion of reproductive health in school curricula. The need for parent-focused interventions, such as “peer parents” was also discussed. In terms of activities for the upcoming year, the group suggested developing culturally appropriate media showing parents explaining their concerns and their approval of access to reproductive health information and services for their children.

Other topics discussed included developing programmatic guidance for humanitarian settings on the use of rapid diagnostic tests for syphilis screening in antenatal care, blood transfusions and STI services; and cervical cancer screening/prevention, family planning, STI and postnatal care services.

Following discussions, it was decided that Namubiru Lydia Mugalu and Fartun Abdu will develop a proposal to submit for funding.

8. Gender-based Violence Working Group

Participants: Bouchta Mourabit, UNFPA Somalia; Lauren Bienkowski, ARC Uganda; Florah Bukania, GTZ; John Mbugua, UNHCR Nairobi; Lilian Manyonga, AMREF Kenya; John Mbugua, UNHCR Nairobi; Catherine Ayuko, JHPIEGO-JHU Kenya; Odete Cossa, IPPF Kenya; Deman Mahamoud, IMC Kenya; Istarlin Sheikh, UNFPA; Odimgbe Deborah Ify, Pro-Health International, Nigeria; Yaya Sidi Sackor ARC Rwanda.

Participants shared experiences from Somalia, Rwanda and Uganda regarding lack of coordination among UN agencies, NGOs and local actors as well as poor-quality, unreliable and/or unavailable services. They also identified a clear need for effective trainings and follow-up for security and legal sectors as survivors continue to encounter inappropriate, delayed services. They also agreed on the need for improved communication and coordination among organizations implementing GBV interventions at field, country, regional and global levels. Another point raised in the discussion included medical treatment continuing to be unavailable for survivors of sexual violence despite clear

protocol. In addition, GBV programs are often unsustainable due to a failure to gain community input and build local capacity.

The group identified gaps in the current ToR, including: 1) the lack of awareness/understanding among GBV actors/key stakeholders regarding GBV guiding principles and guidelines for GBV interventions; and 2) the need for sexual exploitation and abuse (SEA) codes of conduct examined and reinforced in all organizations implementing GBV interventions. In this regard, participants noted that trainings for staff and stakeholders should encompass SEA and codes of conduct, and SEA focal points should ensure that SEA policies/codes of conduct are followed and monitored. In addition, the group recognized the need 3) for regional support for effective training tools/facilitation towards security personnel (police, soldiers) and legal advocates; 4) to encourage national GBV focal points within security and legal sectors to participate in GBV Task Force/working group meetings; and 5) for advocacy with regional bodies to place more emphasis on GBV-related issues.

As a result of the above discussion, the group determined priority actions for 2007-2008, which are also noted in the ToR:

- ♦ Capacity-building in the form of training of trainers for GBV Coordinators at the regional level.
- ♦ User-friendly information sheet from UNFPA on how to access/obtain Post-Exposure Prophylaxis (PEP) in emergencies, on-going conflict and post-conflict settings.
- ♦ Ensure roll-out of and adherence to the IASC GBV Guidelines by the Regional GBV Task Force with input from in-country RH Coordinators/GBV Focal Points.
- ♦ Advocate for the availability of high-quality mental health services.
- ♦ Practical, user-friendly guides to best practices for organizations specifically working to prevent and respond to GBV to supplement the IASC GBV guidelines.
 - Consistent M&E tools developed
 - Situation Analysis to be encouraged before GBV programs are implemented in order to ensure community participation, ownership, and sustainability
 - Establishing community-based GBV Working Groups and community safety action groups
- ♦ Continue examining and advocating for improved legal support and/or redress for survivors of GBV, including advocacy on legislation reform through national conferences and other means.
- ♦ “Best Practices” Intranet Exchange via regional discussion boards and information exchange.
- ♦ Increased awareness among donors regarding realistic timelines of programming to ensure that sustainable, community-driven, and survivor-centered GBV interventions are implemented.
- ♦ Link to International Labor Organization or other groups to decrease vulnerability to sexual exploitation among community members.

9. Adolescent Working Group

Participants: Faisal Ishag Abdallah Adam, CARE Sudan; Leah Elliot, ARC Rwanda; Atholl Kleinhans, Perinatal HIV Research Unit, South Africa; Pamela Onduso, Pathfinder International Kenya; Susan Purdin, IRC New York; Zaitoon Qazi, WHO Geneva; Mihoko Tanabe, Women’s Commission for Refugee Women and Children, New York; Meredith Walsh, Adolescent Reproductive Health Network, Thai-Burma Border.

Participants discussed the goals and activities listed in the IAWG Terms of Reference (ToR) to identify gaps, solutions and priority actions.

1 Advocacy on adolescent RH programming

A key issue that was identified was the need for a strong policy environment among donors and in all countries conducive to adolescent RH programming. While HIV/AIDS has forced policy makers to address the issues of young people, children aged 5-18 have generally fallen through the cracks in terms of health care due to their perceived sexual inactivity. Kenya’s adolescent RH policy was developed through civil society partnering with research institutions, and the sharing of operations research with policy makers and the public to facilitate policy development; following a model from South Africa. In crisis settings where additional risks prevail for adolescents (early sexual debut, sexual violence, etc.), there is a need to examine the implications of such risks on the provision of

services. Policies must explicitly encompass displaced populations, as they will otherwise remain a neglected group.

2 Dissemination of guidelines and tools

A number of resources were recommended for adolescent RH programming, including those of the [World Health Organization](#), [Advocates for Youth](#), and Family Health International's [Youth InfoNet](#). The [Reproductive Health Response in Conflict \(RHRC\) Consortium](#)'s website also lists numerous guidelines and tools on adolescent RH programming, many of which are specific to crisis settings, such as [Work with Young Refugees to Ensure Their Reproductive Health and Well-being: It's Their Right and Our Duty](#) (UNHCR, Women's Commission, 2002, on behalf of IAWG). A CD-Rom of resources on adolescent RH programming in crises is expected to become available in the coming year and the tools will be uploaded to the IAWG website.

3 Supporting the documentation and dissemination of youth involvement research studies and lessons learned

Among the participants, a number are engaging in adolescent RH-related research. In South Africa, the CDC risk reduction model is being modified for adolescent voluntary counseling and testing (VCT). In Thailand, NGOs adapted the Gender Equitable Men (GEM) scale into a Gender Equitable Sex (GES) scale and have completed the survey among migrant populations along the Thai-Burma border. The analysis will be available next year, although there is a need to make the data from the various organizations comparable. The Women's Commission's out-of-school youth program conducted a participatory research study in Northern Uganda to examine young people's perspectives to the existing conflict. The study was a follow-up to a similar participatory research project that the Women's Commission conducted in 2001, and also fed into the ten year strategic review of the Graça Machel study on the Impact of Armed Conflict on Children. UNFPA has also recently published, "Will you Listen: Young Voices from Conflict Zones," which was written by adolescents.

Research priorities identified included 1) examining the characteristics that determine and influence adolescent transitions from childhood to adulthood in both non-conflict and conflict settings, so as to be able to identify ways to support a healthy transition in communities affected by crises. Other issues noted were: 2) influences leading to positive deviance and 3) the effects of conflict and/or displacement on the construct of masculinities vis-à-vis the changing expectations of men and women in crisis settings.

4 Networking with other youth-serving organizations/groups and sharing contacts with members

The networking model has proven effective along the Thai-Burma border. Communities have found coordinating and sharing curricula successful, although sustainability is an issue since continued funding has been hard to obtain. While other participants noted the limited existence of functioning networks in their respective countries, it was agreed that adolescent RH issues should be placed on the agenda in health coordination meetings and RH meetings in emergencies.

5 Adolescent RH programming in crisis settings

Some elements of successful adolescent RH programming were identified, including:

- ♦ The need to reach adolescents with education and prevention strategies at an early age, before their sexual debut.
- ♦ Capturing the most at risk between ten and 19 years of age, and tailoring curricula for in-school and out-of-school youth.
- ♦ The importance of addressing gender roles for women in terms of empowerment and men in terms of making responsible RH choices.
- ♦ The importance of involving adolescents throughout the needs assessment, design, implementation and monitoring and evaluation of a project.
- ♦ Assuring meaningful community involvement, including parental, teacher and male involvement, and building on existing community organizations and resources.
- ♦ Promoting the multi-purpose youth centers that offer recreation, vocational training, and health services, among other services.
- ♦ Taking a comprehensive approach to RH through integrating services (such as HIV, GBV, etc.) and involving communities as a whole.

- Behavior Change Communication through consistent messaging and multiple channels of communication (radio, TV, drama, music, etc., such as the film, “Yellow Card”) vetted by youth.

5. Final Plenary Session and Adoption of IAWG Call to Action

Following the technical working group presentations that outlined each group’s priorities and action points for the coming year, participants endorsed the IAWG Call to Action, which called upon WHO and the Health Cluster to renew their commitment to comprehensive reproductive health in crisis settings. The IAWG Steering Committee noted that it will take the Call to Action to key persons at WHO and the Health Cluster, and will report back to IAWG members.

The meeting closed with a few remaining comments, including a discussion on family planning and menstrual hygiene. Regarding the former, a participant asked whether long-term family planning methods will be added to reproductive health kits. A participant from UNFPA noted that short-term methods are currently included in the emergency context, but there will be a review of the MISIP in early 2008 where longer-term methods can be discussed. Another participant also noted the lack of skilled providers that can administer some of the long-term methods, to which a response was the need for advocacy for provider training, at least for protracted settings.

As to the latter discussion on menstrual hygiene, a participant suggested that it would be interesting to examine available technologies in this area. Another participant noted the significance of the issue, as access to sanitary supplies impacts girls’ school attendance. It was announced that with funding from UNFPA, the Women’s Commission will be undertaking a study to research and develop menstrual hygiene standards in crisis situations, with a final report to be released in the upcoming year.

As a final comment, a participant asked how action points of the working groups were to be shared. The Steering Committee will follow-up with the meeting and the Call to Action while working groups are expected to begin acting upon their priorities. The Steering Committee will continue to operate in its informal style, and will prepare for the next annual meeting which is expected to take place in the Middle East or North Africa, in order to launch a new regional IAWG in the region.

Annex I: Strategy Paper and Terms of Reference

Inter-agency Working Group (IAWG) on Reproductive Health in Crisis Settings *Strategy Paper & Terms of Reference* October 2007

In a world where most people have less-than-optimal access to quality reproductive health services, refugees, internally displaced persons and others affected by conflict and disaster live in extraordinary circumstances that increase risks and further impede access to care.

In 1994, the Women's Commission for Refugee Women and Children published a seminal report documenting the lack of reproductive health services for refugees, *Refugee Women and Reproductive Health Care: Reassessing Priorities*. The International Conference on Population and Development, held in Cairo in 1994, recognized the special reproductive health needs of displaced populations, including both refugees and the internally displaced¹. Following the Cairo meeting the *Inter-Agency Working Group (IAWG) on Reproductive Health in Refugee Settings*² was formed for the purpose of promoting access to quality reproductive health care for refugee women and others affected by armed conflict. The IAWG was originally composed of over 30 groups, including UN agencies, universities, and governmental and nongovernmental organizations, and was led by the United Nations High Commissioner for Refugees (UNHCR), the World Health Organization (WHO) and the United Nations Population Fund (UNFPA).

The IAWG finalized the first guidelines for reproductive health care in refugee settings entitled, *Reproductive Health in Refugee Situations: An Inter-agency Field Manual (RHR Manual)* in 1999 following extensive field testing by people assisting refugees. The *RHR Manual* outlines the minimum reproductive health services that must be provided in all crisis settings and the components (safe motherhood, gender-based violence, sexually transmitted infections, including HIV/AIDS, and family planning) of comprehensive reproductive health that must be planned for and instituted as soon as possible after the onset of the crisis. The *RHR Manual* also addresses how to meet the reproductive health needs of young people and provides guidance on program implementation and monitoring and evaluation. In order to assist aid workers in setting up the minimum reproductive health services in a crisis, the IAWG also designed prepackaged kits of RH supplies for rapid deployment. The IAWG is committed to maintaining standards of care for reproductive health in crisis settings by updating and revising the *RHR Manual* and by contributing technical expertise on RH in other standards guiding humanitarian practice such as the Sphere Project.

Since its formation, the IAWG has met annually (with the exception of 2005) to exchange information, identify challenges, gain from the experience of others, build partnerships and collectively work toward the institutionalization of reproductive health care for refugees and internally displaced persons. The IAWG aims to ensure that reproductive health for women, men and young people is mainstreamed into emergency preparedness and response and throughout the transition from emergency response to development.

In 2004, the IAWG conducted a ten-year global evaluation of reproductive health in conflict-affected settings to identify gaps and constraints so that UN agencies, governments and nongovernmental agencies can better target resources and interventions. Findings showed that services were more favorable for refugees in stable settings but were generally not available at the onset of new emergencies and were severely lacking for internally displaced populations. Some newer technical areas, such as prevention of gender-based violence and HIV/AIDS services, were found to be weak, and critical gaps remain within safe motherhood, particularly emergency obstetric care, as well as family planning and management of sexually transmitted infection programs. In addition, other areas of need include increasing male involvement in sexual and reproductive health programming and reaching young people with comprehensive reproductive health services.

¹ A refugee is a person who, owing to a well-founded fear, has fled across an international border. Internally displaced persons (IDP) are people who have had to flee their homes and seek refuge in a "safer" part of their own country.

² The name was later changed to *Inter-agency Working Group on Reproductive Health in Crises* to better reflect the group's purpose in addressing the RH needs of all crisis-affected populations.

To address these gaps in reproductive health for crisis-affected populations, the IAWG members are committed to:

- promoting the sexual and reproductive rights of affected populations at all levels;
- promulgating supportive policies and new funding sources for the Minimum Initial Services Package (MISP) of Reproductive Health and comprehensive reproductive health for women, men and young people in emergencies;
- advocating to governments, bilateral donors, nongovernmental organizations and others to prioritize reproductive health in emergencies; and
- supporting the identification of research needs and dissemination of findings.

To achieve its objectives, the IAWG supports a holistic approach to reproductive health as defined in the Program of Action of the International Conference on Population and Development³ and embraces the principles of accountability to displaced populations, coordination, confidentiality, local participation and empowerment. Providing comprehensive, high quality reproductive health services requires a multi-sectoral integrated approach. Protection, health, nutrition, education and community service personnel all have a part to play in planning and delivering reproductive health services. The IAWG also strives to achieve complementarities with existing inter-agency bodies and initiatives such as the Inter-Agency Standing Committee and the UN Cluster Approach.

The IAWG works to increase the number of competent reproductive health service providers and coordinators working in crisis settings with a particular focus on national and other local staff. The IAWG is currently developing a set of core training materials for RH in emergencies, which covers the components of the MISP, and a sustainable system, rooted in regional centers, to train RH coordinators, clinicians working in the field and humanitarian coordinators at the policy level.

Currently, the IAWG is made up of approximately 195 member representatives of government and nongovernmental organizations, UN agencies and universities. While member organizations are working independently to improve reproductive health services in crisis, membership in the IAWG provides an opportunity to reach a common understanding of gaps and current issues, identify and engage in collaborative initiatives and receive technical and collegial support. Membership in the IAWG is open to all interested participants and its current members are committed to active outreach to identify new members. The IAWG also plans to establish a more formal administrative structure that may include a steering committee with representation from UN agencies, NGOs, academics and others. In addition, the IAWG is working to support the development of new regional IAWG networks in the Asia-Pacific region and in sub-Saharan Africa to increase linkages in the regions for information sharing, coordination and enhanced collaboration. To support coordination and collaboration and prevent the duplication of efforts, the IAWG documents gaps and needs in reproductive health for populations in crises and any known plans to address them in a terms of reference that is updated during each annual meeting.

In summary, the IAWG envisions a world in which crisis-affected women, men and young people's rights to reproductive health are upheld through access to voluntary, confidential and good quality reproductive health services at the onset of every new emergency as well as comprehensive reproductive health services as the crisis stabilizes, and that such persons are active participants and advocates in the decisions that affect their reproductive health.

³ "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."

Terms of Reference

October 2007

The IAWG Terms of Reference (ToR) is a tool for IAWG members to collectively identify annual progress, identify gaps and propose solutions to ensure women, men and young people in crisis situations have access to the MISIP in the early days and weeks of new emergencies and comprehensive reproductive health services as the situation stabilizes. While the full membership of the IAWG itself is not tasked with undertaking specific activities to address the gaps it is expected that IAWG member organizations, either individually or in partnership with others, will voluntarily commit to undertaking them. Thus, the ToR serves as a collective guiding post for its members to identify and prioritize gaps, progress and appropriate solutions.

IAWG Working Groups (WG) as per current agenda:

1. Advocacy
2. Data & Research
3. Regional Strategy
4. MISIP
5. Best practices & quality of care (Safe Motherhood, Family Planning, STI/HIV, GBV, Adolescent RH)

1. General Operating Issues and Advocacy (Advocacy WG Update)

- 1.1. Establish a formal system of communication: Implementing Best Practices (IBP) Knowledge Gateway for IAWG
Status: Achieved (The IBP network has been established by WHO and Women's Commission 2007)
- 1.2. All IAWG members to register on the IBP network at <http://my.ibpinitiative.org/iawg>
Status: 119 of 195 members registered (as of October 2007)
2007/8 Recommendations: All members ensure they are registered, and promote the IAWG forum among colleagues and peers
- 1.3. Establish a formal administrative structure for IAWG Steering committee with UN, NGO and other representation)
Status: Currently informal – decision taken for the informal steering Committee comprised of equal representation among participating agencies to hold bi-/monthly teleconferences with meeting minutes distributed to IAWG participant's through the IAWG Knowledge Gateway
2007/8 Recommendations: Organization(s) should convene IAWG on a rotational basis for a minimum of two years. Emphasize the benefits of both organizational membership (political leverage) and individual participation (reach larger constituency) in IAWG.
- 1.4. Establish administrative structure for Regional IAWG branches
Status: Defer to Regional IAWG branches
2007/8 Recommendation: Utilize Knowledge Gateway as link to Regional IAWG branches.
- 1.5. Form a Coordination and Outreach Committee to:
Status: The advocacy WG agreed to review the points under 1.5 and will actively undertake outreach over the next 12 months.
 - 1.5.1 Identify new members of IAWG and continue to sponsor participants to the annual meeting;
Status: 2007/8 Recommendation
 - 1.5.2 Identify challenges and solutions for strengthening and expanding coordination and collaboration with other inter-agency initiatives;
Status: 2007/8 Recommendation

- 1.5.3 Build new partnerships and improve existing partnerships with universities, UN agencies and local and international NGOs to share experiences and knowledge;
Status: 2007/8 Recommendation
- 1.5.4 Look beyond the traditional actors in SRH to related sectors/organizations such as general refugee lobby groups and the International Peace Research Institute;
Status: 2007/8 Recommendation
- 1.5.5 Introduce UN Office for the Coordination of Humanitarian Affairs (OCHA) and the World Food Program (WFP) to the IAWG and advocate for RH for IDPs in the Consolidated Appeals Process (CAP).
Status: Initiated- Women's Commission has been doing this informally and is willing to take the lead.

- 1.6 Liaison on advocacy issues and initiatives within IAWG and other SRH agencies
Status: 2007/8 Recommendations: IAWG take a role in identifying gaps and priority areas that require an advocacy focus. Annual meetings used to identify three priority areas for advocacy. This year, the following issues were identified:
 - 1.6.1 Integrate new technologies in RH in emergencies context
Status: An RH technologies consultation to introduce new technologies in relief settings is being planned with PATH. A concept paper has been developed, and following a scheduled conference call, a face-to-face consultation will be held at PATH.
 - 1.6.2 Identify funding for local capacity building
Status: 2007/8 Recommendation
 - 1.6.3 Female condoms
Status: 2007/8 Recommendation
 - 1.6.4 Invest in local SRH human resource capacity and assist local organizations with coordination and leadership on SRH service provision in crisis settings
Status: 2007/8 Recommendation
 - 1.6.5 Advocate for inclusion of the MISP in the IASC cluster approach, and especially in the global health cluster
Status: UNFPA, Women's Commission and IRC are currently working on this issue. UNFPA and other IAWG members have been part of the successful advocacy towards the CERF (central emergency response fund) secretariat to include the MISP as a life-saving activity.
 - 1.6.6 Develop a marketing strategy aimed at increasing the use of existing guidelines for RH services in conflict-affected settings; e.g., Inter-agency Field Manual
Status: Is there an agency with the marketing capacity to take on this task?

2. RH Research (Data and Research WG Update)

- 2.1 Identify and periodically update a prioritized list of RHR research questions
Status: 2007/8 Recommendation (see list of research questions at the end of the ToR)

- 2.2 Encourage research efforts in pursuit of a prioritized list of questions
Status: Ongoing

- 2.3 Disseminate information about RHR studies, reports and publications
Status: Columbia University continues to distribute Weekly Literature Review (members can sign up at litreview@raiseinitiative.org)

3. RH Health Information System (HIS) (No working group formed in 2007)

- 3.1 Promote the collection of a minimum set of RH indicators from all refugee settings
Status: In process (UNHCR established a new HIS; CDC published a Reproductive Health Assessment Toolkit for Conflict-Affected Women, May 2007)

- 3.2 Repeat desk study done in 1998 analyzing RH indicators from all/pilot refugee sites
Status: Ongoing

- 3.3 Develop/pilot user-friendly menu-driven software to facilitate selecting indicators, collecting and analyzing RH data in refugees settings
Status: Unknown
- 3.4 IASC Gender-based Violence Information Management Project
Status: Phase two of a global effort to develop a data information system on reported cases of GBV undertaken by IRC, UNHCR and UNFPA

4. Youth Programming (Best Practices and Quality of Care WG Update)

- 4.1 Advocate for quality adolescent RH programming
Status: The Women's Commission provides small grants to two networks of ten local organizations addressing RH for young people on the Thai-Burma border. UNFPA has completed a seven-country adolescent IDP project in Burundi, Colombia, DRC, Liberia, Palestine, Rwanda and Sierra Leone, of which the final report will be released soon.
2007/8 Recommendations: An identified focus is the need for a strong policy environment that will be conducive to quality adolescent RH programming. In addition, adolescent RH issues should be placed on the agenda of health coordination and RH meetings in emergencies.
- 4.2 Disseminate guidelines and tools such as the Youth Rights & Duties document and others developed by WHO, Advocates for Youth, or consolidated on FHI's *Youth InfoNet* and the RHRC Consortium website
Status: Ongoing; an annotated bibliography and CD-Rom of adolescent RH in crises-related resources is expected to become available in the coming year, and the tools will be uploaded to the IAWG website.
- 4.3 Support the documentation and dissemination of youth involvement research studies and lessons learned
Status: New recommendation. Research priorities for IAWG include: 1) examining the characteristics that determine and influence adolescent transitions from childhood to adulthood in both non-conflict and conflict settings, so as to be able to identify ways to support a healthy transition in communities affected by crises; 2) influences leading to positive deviance, and 3) the effects of conflict and/or displacement on the construct of masculinities vis-à-vis the changing expectations of men and women in crisis settings.
- 4.4 Networking with other youth-serving organizations/groups and sharing contacts with members
Status: Women's Commission has recently (2007) initiated an "out-of-school youth" project
- 4.5 Compile what is being done regarding programming for adolescents in refugee situations, building on the mapping exercise carried out by WHO in 1998
Status: WHO/ADH is currently working on this issue
- 4.6 A user-friendly document that articulates the argument for a multi-sectoral participatory approach in adolescent RH programming
Status: With funding from UNHCR, the Women's Commission published and distributed the document *Work with Young Refugees to Ensure Their Reproductive Health and Well-being: It's Their Right and Our Duty* on behalf of IAWG in January-April 2002.

5. Minimum Initial Services Package (MISP) (MISP WG Update)

- 5.1 All IAWG members to complete the MISP distance learning module
Status: All IAWG members registered for annual meeting Oct 07 reminded; encouraged to take Module through iPod lottery; additional advocacy in 2008.
- 5.2 Advocate to bilateral donors to support the MISP in emergency preparedness, early response and early recovery
Status: Ongoing

- 5.3 Continue to support the placement of RH Coordinators in Emergency Situations, and review and evaluate the impact of these coordinators in combination with the RH Kit review
Status: UNFPA (through funding from Colombia University) is placing regional emergency RH coordinators in Africa
- 5.4 Develop a database on available RH consultants within member organizations/agencies as part of UNFPA training programs
Status: UNHCR has established an RH consultant database; Columbia University also created an RH consultant database for RHRC members. UNFPA works closely with the Norwegian Refugee Council to have a roster of stand-by personnel (RH coordinators, GBV advisers, logistics advisers, HIV/AIDS coordinators) from these agencies to be seconded to UNFPA CO's in conflict/post-conflict situations. A similar agreement is being established with the Danish Refugee Council.
- 5.5 Identify a core set of training materials to support clinical training of RH coordinators and clinicians working in the field as well as humanitarian coordinators at the policy level
Status: Ongoing. Academic partnership established in 2007. Curriculum materials reviewed May 2007.
- 5.6 Achieve a commitment from humanitarian organizations to institutionalize the MISP in their health sector emergency preparedness and response
Status: Women's Commission addressing (Save the Children committed)
- 5.7 Certify as many humanitarian actors, policy makers and donors as possible in the MISP distance learning module
Status: Women's Commission is addressing; UNFPA and UNHCR are advocating to their country offices to undertake the MISP training.
- 5.8 Integrate the MISP Module into humanitarian emergency courses
Status: UNSW, Women's Commission
- 5.9 Improve the MISP response in real time with UNFPA and UNHCR fielding RH coordinators in new emergencies and the MISP working group to teleconference to share information with the onset of any new emergency
Status: Unknown
- 5.10 Advocate for RH to be incorporated into initial medical screenings. Suggest to UNFPA to link their RH coordinator with UNHCR's medical coordinator
Status: 2007/8 Recommendation
- 5.11 Each IAWG member encouraged to incorporate MISP Module into their orientation package for new staff
Status: 2007/8 Recommendation
- 5.12 Develop short film on interviews with humanitarian actors who used to not support the MISP and now are supportive of it
Status: 2007/8 Recommendation
- 5.13 Encourage IAWG member agencies to advocate internally to have their health staff certified in the MISP (CD, health coordinators, skilled service providers and attendants, HQ program staff)
Status: 2007/8 Recommendation

6. HIV/AIDS/STIs (Best Practices and Quality of Care WG Update)

- 6.1 Compile a comprehensive list of training materials and supporting documents

Status: 2007/8 Recommendation

- 6.2 IAWG agencies must put training on STI/HIV/AIDS in their work plan and budget
Status: 2007/8 Recommendation
- 6.3 Develop a set of two-day refresher trainings for in-service training
Status: 2007/8 Recommendation
- 6.4 Inter-agency Standing Committee (IASC) Guidelines on HIV/AIDS in Emergencies (advocate inclusion of RH)
Status: Ongoing with involvement of ARC, IRC, UNFPA and Women's Commission
2007/8 Recommendation continue advocacy for inclusion of RH
- 6.5 Better involve community to improve quality and access and address stigma
- o Develop guide on designing community programs to address stigma: outline research methodologies, good practices, examples of messages, lessons learned, etc. (IRC/UNFPA/UNHCR)
 - o Increase use of "Positive Lives" exhibition & community discussion guide (UNFPA/UNHCR/IAWG members)
- Status: 2007/8 Recommendations**
- 6.6 Improve access to information and services for young people
- o Develop culturally appropriate film/video/DVD (like UNHCR's "love in a time of AIDS") showing parents explaining their concerns and why they approved of access to RH information and services for their children. (GTZ/refugee representative/Mbogo HC /UNHCR /UNFPA/...)
- Status: 2007/8 Recommendation**
- 6.7 Develop programmatic guidance for humanitarian settings on:
- o Use of rapid Diagnostic tests for syphilis screening in antenatal care, blood transfusion and STI services (WHO/UNFPA/IRC)
 - o Cervical cancer screening/prevention, FP, STI and postnatal care services (UNFPA/SCF/JHPIEGO/Dr Mike/WHO)
- Status: 2007/8 Recommendation**

7. Maternal and Newborn Care (Best Practices and Quality of Care WG Update)

- 7.1 RHRC Consortium EmOC pilot project funded and supported by Columbia University AMDD project implemented in 12 conflict-affected settings in nine countries from 2000-2005
Status: Completed
- 7.2 Women's Commission on behalf of RHRC Consortium published *Field-friendly Guide to Integrate Emergency Obstetric Care in Humanitarian Programs*
Status: Completed
- 7.3 Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative established by Columbia University Mailman School of Public Health and Marie Stopes International. RAISE works to improve maternal and newborn care by advocating for policies and resources that respond to the unmet maternal health needs of populations in humanitarian emergencies, as well as assisting its partners in service delivery through the provision of training and technical support.
Status: Ongoing
- 7.4 UNHCR and Save the Children publish and present case stories on successful implementation of basic EmOC in health units at the peripheral level. Document and share feasibility and effectiveness as an example that it can be done.
Status: 2007/8 Recommendation

- 7.5 UNHCR compile and publish best practices and lessons learned from basic EmOC services at the peripheral level (globally)
Status: 2007/8 Recommendation
- 7.6 Change commitment from “coverage” to “quality” in services such as ANC. Define quality and provide checklists for supervisors. Link with increasing demand for services at the community level.
Status: 2007/8 Recommendation
- 7.7 UNFPA (Somalia) build commitment to EmOC and CRH at the senior and middle management levels by awareness raising and simple communication tools
Status: 2007/8 Recommendation
- 7.8 IAWG establish CRH as a separate priority/core area in MSF and Health Cluster priority lists and in all public health in emergency trainings
Status: 2007/8 Recommendation
- 7.9 Save the Children develop and share practical operational tools for Essential Newborn Care
Status: 2007/8 Recommendation
- 7.10 Explore the possibility of virtual consultancy, especially in insecure areas where referral is not possible
Status: 2007/8 Recommendation
- 7.11 Conduct a survey to better understand the magnitude of fistula among crisis-affected communities
Status: 2007/8 Recommendation
- 7.12 UNHCR, Save the Children pilot Misoprostol for prevention of post-partum hemorrhage
Status: 2007/8 Recommendation
- 7.13 IPAS address gaps in PAC data and service provision including:
 - o Lack/no availability of indicators/monitoring tools for PAC services
 - o MVA not part of IAEHK 2006 (Interagency Emergency Health Kit)
 - o Restrictions on level of qualification of providers for MVA is a barrier – nurses can provide MVA, but are often not allowed to do so
 - o Inclusion of PAC and EmOC in in-service training (UNFPA Somalia, South Sudan)**Status: 2007/8 Recommendation**
- 7.14 IAWG include postpartum sepsis and postpartum depression in the *Inter-agency Field Manual*
Status: 2007/8 Recommendation

8. Gender-based Violence (Best Practices and Quality of Care WG Update)

- 8.1 Capacity-building in the form of TOT for GBV Coordinators at a regional level
Status: 2007/8 Recommendation
- 8.2 User-friendly info sheet from UNFPA for how to access/obtain PEP in emergencies, on-going conflict, and post-conflict settings
Status: 2007/8 Recommendation
- 8.3 Ensure roll-out of and adherence to IASC GBV Guidelines by Regional GBV Task Force with input from in-country RH Coordinators/GBV Focal Points
Status: 2007/8 Recommendation
- 8.4 Advocate availability of high-quality mental health services
Status: 2007/8 Recommendation

- 8.5 Practical, user-friendly guides to best practices for organizations specifically working to prevent and respond to GBV to supplement IASC GBV guidelines
- o Consistent M&E tools developed
 - o Situation Analysis to be encouraged before GBV programs are implemented in order to ensure community participation, ownership, and sustainability
 - o Establishing community-based GBV Working Groups and community safety action group
- Status: 2007/8 Recommendation**
- 8.6 Continue examining and advocating improved legal support and/or redress for survivors of GBV (including advocacy on legislation reform through national conferences and other means)
- Status: 2007/8 Recommendation**
- 8.7 “Best Practices” Intranet Exchange via regional discussion boards and information exchange
- Status: 2007/8 Recommendation**
- 8.8 Increased awareness among donors regarding realistic timeline of programming to ensure sustainable, community-driven, and survivor-centered GBV interventions are implemented (organizations must have the capacity to implement best practices quickly)
- Status: 2007/8 Recommendation**
- 8.9 Link to ILO or other MED/IGA groups to decrease vulnerability to sexual exploitation among community members
- Status: 2007/8 Recommendation**
- 8.10 SEA codes of conduct examined and reinforced in all organizations implementing GBV interventions:
- o Ensure trainings for staff and stakeholders on SEA and codes of conduct
 - o SEA focal points to ensure SEA policies/codes of conduct are followed and monitored
- Status: 2007/8 Recommendation**

9. Family Planning (Best Practices and Quality of Care WG Update)

9.1 Technical Excellence

- 9.1.1 Reproductive Health Access, Information, and Services in Emergencies (RAISE) Initiative established by Columbia University Mailman School of Public Health and Marie Stopes International. RAISE works to promote family planning by advocating for policies and resources that respond to the unmet family planning needs of populations in humanitarian emergencies, as well as assists its partners in service delivery through the provision of training and technical support.
- Status: Ongoing**
- 9.1.2 One provider from each refugee camp or IDP setting take the Global Health FP101 course, starting with the first group of RAISE participants to champion and then monitor that all of their co-workers have taken the FP101 course.
- Status: 2007/8 Recommendation**
- 9.1.3 Providers to utilize the Family Planning Wall chart and models (when feasible) in their FP counseling.
- Status: 2007/8 Recommendation**
- 9.1.4 (Cross-cutting) Providers need technical updates on family Planning-HIV care and integration for future program planning.
- Status: Idea for future integration of HIV in family planning counseling**

9.2 Advocacy

- 9.2.1 Family Planning Advocacy Tool
- Status: Women’s Commission plans to develop as a component of the RAISE project**

9.2.2 In the next MISP document review in 2008, contraceptives are availed as a part of the essential package when men and women register.
Status: 2007/8 Recommendation

9.2.3 (Cross-cutting) Providers to give six month re-supply upon repatriation.
Status: 2007/8 Recommendation

9.2.4 In IDP settings, once a woman has accepted a family planning method from a provider, we support that providers train CHWs to re-supply family planning methods and education to neighboring communities.
Status: This support should be reflected in the field manual revision

9.3 Community Outreach

9.3.1 Make available references on working with communities (e.g. pictorial IEC)
Status: IAWG family planning group to share references on IBP Gateway

10. Logistics (Best Practices and Quality of Care WG Update)

10.1 Conduct evaluation of logistics/commodity needs issues in refugee settings. Also, determine how NGOs can integrate RH logistics/commodity planning with other logistics/commodity planning in emergency settings.
Status: 2007/8 Recommendations

10.2 Re-establish Commodity/Logistics Committee, which will include: JSI, UNFPA, and WHO. Request/recommend membership of USAID, MDM, CARE (implementing agency), UNFPA Global Commodity Security, World Bank and WHO/EDM
Status: Not implemented

10.3 Deployment of a logistics person in large operations to the field to facilitate the distribution of RH kits
Status: Unknown – Using companies to distribute kits in the field, but logistics person has not been discussed – should be a UNFPA responsibility.

10.4 Using systematic reviews, a small group including representatives of WHO, UNHCR, MSF, UNFPA and UNICEF will meet biannually and suggest changes in the content of the RH Kits
Status: Done in November 2005 by UNFPA. Suggested changes shared with IAWG in April 2007. In 2001, female condoms were added to kit #1, and small changes were made to other kits. In 2003, PEP was added to kit 3B. Translation and printing of the 2007 manuals in progress and will be made available by UNFPA in the near future.

10.5 Establish a working group to look at kit positioning and evaluate the distribution of the kit
Status: Will be done as part of the next kit review late 2007/early 2008

10.6 Identify the specific areas for capacity building. Recognized needs include existing RH kits; in-country distribution; ordering: what, how much, transition from “push” to “pull” RH kit; components (consumption based). Provide two places for field staff working in conflict settings for JSI (DELIVER) training on supply chain management.
Status: Not implemented, (but needed badly, according to Wilma Doedens)

10.7 All members to review activities and revise logistic component, share related program plans and link to the development of IAWG activities. For example:

- JSI regional training (West and East Africa) on RH Logistics. Project specific HIV prevention activities through training in logistics in Southern Sudan
- DELIVER: Standardized Measure for ensuring health commodity availability in refugee settings
- WHO review of essential RH drugs for countries
- Review of WHO new emergency health kits
- UNFPA (HRU) technical review of the RH kits

Status: Unknown

11. Training (Best Practices and Quality of Care WG Update)

- 11.1 Provide clinical training and follow-up, both in the field and at the Marie Stopes International's comprehensive SRH centre in Nairobi, Kenya, to improve the quality of care as part of the RAISE initiative.
Status: Clinical centre operational and trainings ongoing. Currently, trainings are for RAISE-related partners and over time, this resource might be more available to the field more broadly.
- 11.2 Develop an inventory/list of training materials
Status: (Save the Children US to initiate and follow-up with IAWG meeting working group). IAWG-Academic Partnership reviewed list of training materials to create a standard set of modules for MISP.
- 11.3 Create a matrix framework of training needs and target audiences
Status: New recommendation

12. Regional Strategy Working Group

- 12.1 Meeting before the end of the year called by UNHCR, UNFPA, IPPF, OCHA and WHO inviting humanitarian organization including those working on RH
- First step of sharing information (who does what where) to gain a better understanding of RH activities in the region (and gaps)
 - Decision on how to organize the group
 - One meeting in Nairobi before end of 2007, one in West Africa
- Status: 2007/8 Recommendation**
- 12.2 Information sharing
Status: 2007/8 Recommendation
- 12.3 Advocacy on the MISP
- Inclusion of MISP/Comprehensive RH training in existing trainings; e.g. Sphere training
 - Advocate local governments (relevant ministries) to include MISP/RH in preparedness and contingency plans
- Status: 2007/8 Recommendation**
- 12.4 Identify additional training needs
- 12.5 Identify regional resources; i.e., AMREF and RAISE training centers
- 12.6 Funding
- Approach AusAID who are funding HIV in emergencies programs in East Africa
 - Could RAISE fundraise for IAWG during their fundraising for RAISE conference?
- Status: 2007/8 Recommendation**
- 12.7 Investigate potential to launch of regional IAWG during RAISE conference in Uganda in June 2008
Status: 2007/8 Recommendation
- 12.8 Liaison and advocacy with the AU, donors, African parliamentarian networks, journalist network, IC/GLR, GLIA, ECOWAS, SADEC, etc.
Status: 2007/8 Recommendation

Research Questions

IAWG Annual Meeting
Nairobi 8-10 October 2007

Key areas of research identified by Research Working Group:

WG participants brainstormed current research needs. The overarching themes were as follows:

- Priority is operations research, including policy implications
- Priority is not epidemiologic studies

Note: We did not discuss clinical questions

Specific suggestions generated by the Data and Research WG are listed below.

Operations research ideas

- Understand factors influencing low utilization of EmOC/other RH services; alter services and measure changes in use
- Measure increases in use with linked child immunization and FP services
- Does level of community involvement influence FP use and other RH behavior?
- Reduce risk associated with transactional sex through, for example, pilot/ demonstration project on how to increase female condom use
- Measure abortion complications over time as services are improved (preferably as multi-site study)
- Test application of GBV screening questions to identify and refer those affected; measure change
- How does measured and perceived quality of care affect use of services? How can quality be maintained?
- Use existing data and routine statistics
 - e.g., measure cases of abortion complications as proportion of all gynecological (or obstetric) admissions

OR/Policy:

- How can organizations promote best practices and evidence-based practices?

Policy:

- What are costs to organization / donor of improving service delivery? What are costs to clients; how strong a barrier to care?

Descriptive:

- Understand discrepancy between reported and actual FGC status (e.g., West Darfur)

Other topics

- Male RH
- Adolescents
- Prevalence of obstetric / traumatic fistula (note large Ethiopian study on fistula)
- How alcohol, traditional practices, other lifestyle behaviors affect use of health care

Additional areas of research identified by other Working Groups

Operations Research:

- Test virtual (distance) clinical consultancy in insecure areas
- Effect of GBV services on long-term psychosocial health of survivors

Clinical/OR:

- Can mid-level health providers perform MVA (or other procedures) in conflict settings?
- Track the effect of clinical training on subsequent provider performance
- Pilot Misoprostol for PPH

Descriptive:

- Study methods used to handle menstruation globally (Women's Commission, funder identified)
- Examine adolescent development in conflict settings

Annex II: IAWG Call to Action

The Inter-agency Working Group (IAWG) on Reproductive Health in Crises calls upon Inter-Agency Standing Committee (IASC) Global Health Cluster members and the World Health Organization (WHO) as the lead agency to renew their commitment to promote access to quality reproductive health care in crisis situations, including natural disasters and armed conflict. Displaced and crisis-affected populations often lack access to comprehensive reproductive health care. Yet their lives and health are most threatened by the factors that accompany forced displacement – exposure to violence, acute poverty and lack of protection and health care.

The 1994 International Conference on Population and Development (ICPD) Programme of Action, endorsed by 179 countries, calls for political support for comprehensive reproductive health combined with solid funding for these programs, critical for protecting the lives of millions of crisis-affected persons around the world. Now more than ever, UN leadership is needed to recommit resources to ensure the timely provision of this lifesaving care.

Following the ICPD, the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises⁴ was formed to ensure access to quality reproductive health care for refugee women and others affected by armed conflict. The 1999 *Inter-agency Field Manual on Reproductive Health in Refugee Situations* (IAFM) set the standard for the provision of reproductive health services in crises and was signed by over 30 government and nongovernmental organizations, UN agencies, and universities. The IAWG continues to grow and today the IAFM is widely utilized in humanitarian settings. The provision of the Minimum Initial Service Package (MISP) of reproductive health services is a Sphere Standard.⁵

Steadfast leadership at all levels is needed to meet the demand for adequate human and financial resources so that lifesaving reproductive health services are available to those who need them most. Therefore:

- **IAWG calls upon WHO, the lead agency in the Global Health Cluster, to demonstrate its commitment by including comprehensive reproductive health — as defined by the ICPD and outlined in the IAFM — in its humanitarian program work plan and budget.**
- **IAWG also calls upon the Global Health Cluster to include comprehensive reproductive health as a specific core component of humanitarian response.**



⁴ IAWG was formerly known as the *Inter-agency Working Group on Reproductive Health in Refugee Settings*.

⁵ *Humanitarian Charter and Minimum Standards in Disaster Response* of the Sphere Project.

Annex III: Meeting Agenda

Many thanks to AusAID for their generous support of this conference.

DAY ONE

8:30 - 8:50 Registration

Chairperson: Jonathan Ndzi, UNFPA Senegal

9.00 - 9:15

Welcome

- Dr. Amira, Senior Deputy Director of the Ministry of Health, Division of Emergencies and Disaster Preparedness
- Mr. Gullet, Representative of the Kenyan Red Cross
- Fartun Abdi Ahmed, Representative of the refugee community in Kenya

9:15 - 10:00

Session 1: Where have we come from and where are we now?

- Introduction – Jennifer Miquel, UNFPA
- History and Update of IAWG – Susan Purdin, IRC
- Update on Asia Pacific Regional Network – Anna Whelan, University of New South Wales and Tran Nguyen Toan, IPPF

Questions and Discussion

10:00 - 10:45

Session 2: Review of global initiatives

- The IBP Knowledge Gateway: Connecting IAWG Members – Megan O'Brian, John Hopkins University
- Overview of Global MISP Activities – Sandra Krause and Sarah Chynoweth, Women's Commission for Refugee Women and Children
- Partnership for Reproductive Health in Emergencies Training – Wilma Doedens, UNFPA

Questions and Discussion

10:45 - 11:15

Coffee and tea break

11:15 - 12:30

Session 2 continued and discussion

- Inter-agency Field Manual Technical Updates – Lisa Thomas, Women's Commission
- Fuel and Firewood Initiative – Erin Patrick, Women's Commission
- Humanitarian Reform: Implications for Reproductive Health – Pamela Delargy, UNFPA
- RAISE Initiative and Training Centre – Therese McGinn, Columbia University and Fred Akonde, Marie Stopes

Questions and Discussion

12.30 - 14.00

Lunch – Refugee performance

Chairperson:

Nicole Fulton, UNHCR Kenya

14.00 - 15:30

Session 3: Regional initiatives

- Uganda and Chad – *SRH among IDPs and refugees* – Ada Pouye, IPPF
- Horn of Africa – *Obstetric Fistula amongst IDP/Refugee populations* – Biruk Tafesse Amare, Addis Ababa Fistula Hospital

- Transactional Sex, Lessons Learned – Elizabeth Ngugi, University of Nairobi

Questions and Discussion

15:30 - 16.00

Coffee and tea

16:00 - 17:30

Session 3 continued

- East, Central and Southern Africa – Regional *GBV Task Force* – Jennifer Miquel, UNFPA
- West Africa – *Operational Barriers Obtaining Family Planning in Conflict Affected Countries* – Theresa Shaver, Constella Futures
- Cote d'Ivoire, Sierra Leone – *HIV and Security* – Idrissa Kone, UNFPA Cote d'Ivoire
- Reproductive Health in North-western Tanzania: *Emergency Obstetric Care*, Herman Tirwosha and Nadine Cornier, UNHCR

17:30

Discussion/input opportunity from participants/wrap up of day

18:00- 18:30

Additional Presentations

19:30

Optional dinner at Carnivore Restaurant in Nairobi

DAY TWO

Chairperson:

Fred Akonde, Marie Stopes

09:00 - 09:15

Recap of day one

09.15 - 10:30

Session 4: Technical updates, special topics & emerging RH issues

- Comprehensive HIV Programming for Refugee/Mobile Populations: The Turkana District Experience – Dan Koros, IRC
- Female Condom: A Powerful Tool for Protection – Annie Thairu, PATH
- Rapid Diagnostic Tests for Syphilis – Jonathan Ndzi, UNFPA, WHO

Questions and Discussion

10:30 - 11.00

Coffee and break

11.00 - 12:30

Session 4: Technical Updates, special topics & emerging RH issues continued

- Cervical Cancer Prevention Strategies – Mike Chirenje, University of Zimbabwe
- Health Information System (HIS): Reproductive Health for Decision Making – Nadine Cornier, UNHCR
- Misoprostol for Post-Partum Haemorrhage – Lisa Thomas, Women's Commission
- Best Practices in Maternal and Newborn Health Prevention of Postpartum Haemorrhage at Homebirth in Afghanistan, Ribka Amsalu, Save the Children US

Questions and Discussion

12:30 - 13:30

Lunch

Chairperson:

Mike Chirenje, University of Zimbabwe

- 13:30 - 15:00 **Session 5: Thematic working groups (10): to develop work plans for 2007/8 including establishment of a regional IAWG network**
1. MISP – Sarah Chynoweth, Women’s Commission
 2. Advocacy – Sandra Krause, Women’s Commission
 3. Data & Research – Judy Austin, Columbia University
 4. Regional Strategy (Francophone) – Jonathan Ndzi, UNFPA Senegal
 5. Regional Strategy (Anglophone) – Sarah Onyango, PPFA
- Best practices & quality of care:*
6. Safe motherhood – Nadine Cornier, UNHCR
 7. Family planning – Nathalie Kapp, WHO
 8. STI/HIV – Wilma Doedens, UNFPA
 9. GBV – Jennifer Miguel, UNFPA
 10. Adolescent RH – Susan Purdin, IRC
- 15:00 - 15:30 *Coffee and break***
- 15:30 - 17:00 **Working groups continued (1hr 30 min)**
- 17.00 - 17:15 Wrap up of day
- 17:30 Aussie cocktail hour! Hosted by AusAID.

DAY THREE

Chairperson: Susan Purdin, IRC

- 09:00 - 09.10 Recap of Day Two
- 09:10 - 09:15 Female condom demonstration
- 09:15 - 09:30 IAWG Call to Action
- 09:30 - 10:30 Report back from groups to plenary
- 10:30 - 11:00 *Coffee/Group Photo***
- 11:00 - 11:45 Report back continued
- 11:45 - 12:15 Conclusions and recommendations for action and way forward
- 12:15 - 12:30 Closing remarks
- 12:30 - 13:30 *Working lunch for IAFM***
- 13:30 - 17:00 Special session on the review of the IAFM (closed meeting)

Associated training events 11-12 October

- CDC Reproductive Health Assessment Toolkit Training
- Constella Futures Reproductive Health Advocacy Training Workshop

Annex IV: List of Participants

Name	Organization	E-mail Address
Biruk Tafesse Amare	Addis Ababa Fistula Hospital, Ethiopia	biruktafesse@yahoo.com
Meredith Walsh	Adolescent Reproductive Health Network, Mae Sot, Thailand	meredithmwash@yahoo.com
Lillian Nafula Manyonge	African Medical and Research Foundation (AMREF) Bungoma, Kenya	bdmi@amrefke.org
Robina Biteyi	African Medical and Research Foundation (AMREF), Kenya	robinab@amrefke.org
Weston Khisa	African Medical and Research Foundation (AMREF), Kenya	westonk@amrefke.org
Katie Anfinson	American Refugee Committee (ARC), Minneapolis	KateA@archq.org
Jennifer Nantale	American Refugee Committee (ARC), Rwanda	byumba@arc.org.rw
Leah Elliot	American Refugee Committee (ARC), Rwanda	hiv@arc.org.rw
Sidiki Kanneh	American Refugee Committee (ARC), Rwanda	skanneh02@yahoo.com
Yaya Sidi Sackor	American Refugee Committee (ARC), Rwanda	nyabiheke@arc.org.rw
Dayal Debnath	American Refugee Committee (ARC), Sudan	dayalc@arc-sudan.org
Judith Barasa Ramoya	American Refugee Committee (ARC), Sudan	judithb@arc-sudan.org
Lauren Bienkowski	American Refugee Committee (ARC), Uganda	lauren.bienkowski@arc.co.ug
Lucy Kirimi	Australian Agency for International Development (AusAID), Kenya	Lucy.Kirimi@ausaid.gov.au
Jane Singleton	Australian Reproductive Health Alliance (ARHA)	jane@arha.org.au
Buzigi Edward	Be-Alive Uganda	buzigie@yahoo.com
Faisal Ishag Abdallah Adam	CARE Sudan	faisal@sdn.care.org
Hanadi Omer Mohammed	CARE Sudan	Hanadi@sdn.care.org
Susan Igras	CARE, Washington, D.C.	igras@care.org
Yao Bi Bakayoko Zeguella	Cellule des Femmes de Media contre le Sida et pour la Promotion de la Sante Reproductive en C'ote d'Ivoire (CFMS/SR-CI)	zeguelag@yahoo.fr
Kerry Ann Thomson	Centers for Disease Control and Prevention (CDC)	kthomson@cdc.gov
Stacy De Jesus	Centers for Disease Control and Prevention (CDC)	sdejesus@cdc.gov
Florah Bukania	Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ)	
Bosede Funmi Akinbolusere	Development Initiative for Community Enhancement, Nigeria	bfakinbolusere@yahoo.com
Carina Hickling	DSW, Uganda	c.e.hickling@gmail.com
Selestine Akoth Otom	Independent Consultant, Kenya	oselestine@yahoo.com
Dueme Patrick Safi	INFOGROUP International, DRC	dueme_patrick@yahoo.fr
Mbunzama Mpongo Poupon	INFOGROUP International, DRC	mbunzama_mpongo@yahoo.fr
Demam Mahamoud	International Medical Corps, Kenya	dmahamoud@imcworldwide.org
Amadou Sagnon	International Rescue Committee (IRC), DRC	Reproductivehealthadvisor@drcongo.theirc.org
Dan K. Koros	International Rescue Committee (IRC), Kenya	Dan.Koros@kenya.theirc.org

Name	Organization	E-mail Address
Susan Purdin	International Rescue Committee (IRC), New York	susan.purdin@theirc.org
Maqsooda Kasi	International Rescue Committee (IRC), Sudan	maqsooda.Kasi@theirc.org
Katy Mitchell	International Rescue Committee (IRC), Uganda	katy.mitchell@theirc.org
Bill Powell	Ipas	powellb@ipas.org
Tamara Fetters	Ipas	fetterst@ipas.org
Mary W. Kairu	Ipas Africa Alliance	mkairu@ipas.or.ke
Ada Pouye	IPPF Africa Region, Kenya	pouyea@ippfaro.org
Odete Moises Cossa	IPPF Africa Regional Office, Kenya	odetecossa@ippfaro.org
Nguyen-Toan Tran	IPPF ESEAOR, Malaysia	nttran@ippfeseaor.org
A. Udaya Thomas	JHPIEGO, Maryland	uthomas@jhpiego.net
Catherine Ayuko	JHPIEGO-Johns Hopkins University, Kenya	cayuko@jhpiego.net
Megan O'Brien	Johns Hopkins University Center for Communication Programs, Maryland	mlobrien@jhuccp.org
Jimmy Arikwanga	Karimojong Community Child Welfare Initiatives (KACOICI), Uganda	kacoci2006@yahoo.co.uk
Enos Omondi Ochieng	KEMRI-CMR, Kenya	eomondi@kemri-ucsf.org
Mr. Gullet	Kenya Red Cross	
Charles Zandoh	Kintampo Health Research Centre, Ghana	charles.zandoh@ghana-khrc.org
Mabel Nakakande	Makerere University Medical School/Transform Consult, Uganda	brmabel2002@yahoo.com
Claire Richardson	Marie Stopes International (MSI) Australia	claire.richardson@mariestopes.org.au
Marlou den Hollander	Marie Stopes International (MSI) UK	marlou.denhollander@mariestopes.org.uk
Fred Akonde	Marie Stopes Kenya	oyombe2002@yahoo.com
Namubiru Lydia Mugalu	Mbogo Health Care and Maternity, Uganda	mbogohcm@yahoo.com
Dr. Amira	Ministry of Health Kenya, Division of Emergencies and Disaster Preparedness	
Annie Thairu	PATH, Kenya	athairu@path.org
Pamela Onduso	Pathfinder International Kenya	ponduso@aphianairobicentral.org
Atholl Kleinhans	Perinatal HIV Research Unit, South Africa	kleinhans@hivsa.com
Sarah Onyango	Planned Parenthood Federation of America International (PPFA), Kenya	sarah.onyango@ppfa.or.ke
Odimbe Deborah Ify	Pro-Health International, Nigeria	debraodimbe@yahoo.com
Fartun Abdi	Refugee Community Representative/GTZ	fartaakudun@yahoo.com
Khanlar Hajiev	Relief International, Sudan	khanlar@ri.org
Judy Austin	Reproductive Health Access, Information and Services in Emergencies, New York	ja2026@columbia.edu
Therese McGinn	Reproductive Health Access, Information and Services in Emergencies, New York	tjm22@columbia.edu
Jean Claude Mugunga	Rwanda Village Concept Project, Rwanda	jcmugunga@gmail.com
Ribka Amsalu Tessera	Save the Children USA	ramsalu@savechildren.org
Sarah Ashraf	Save the Children USA, Sudan	sahiraf@savechildren.org.sd
Nadine Cornier	UN High Commissioner for Refugees (UNHCR), Geneva	cornier@unhcr.org
Carol Sparks	UN High Commissioner for Refugees (UNHCR), Nairobi	sparksc@unhcr.org
Chris Haskew	UN High Commissioner for Refugees (UNHCR), Nairobi	haskewc@unhcr.org

Name	Organization	E-mail Address
John Mbugua	UN High Commissioner for Refugees (UNHCR), Nairobi	mbuguaj@unhcr.org
Nicole Fulton	UN High Commissioner for Refugees (UNHCR), Nairobi	fulton@unhcr.org
Herman B. Tirwosha	UN High Commissioner for Refugees (UNHCR), Tanzania	tirwosha@unhcr.org
Melaku Maru	UN High Commissioner for Refugees (UNHCR), Ethiopia	maru@unhcr.org
Birgitt Hotz	UN Population Fund (UNFPA)	hotz@unfpa.org
Ilham Abdelhai	UN Population Fund (UNFPA)	abdelhai@unfpa.org
Istarlin Abdullahi Sheikh Ali	UN Population Fund (UNFPA)	istarlinsheikh@yahoo.com
Jonathan Ndzi	UN Population Fund (UNFPA)	ndzjonathan2003@gmail.com
Jeannette Zouiten	UN Population Fund (UNFPA), Geneva	jeannette.zouiten@undp.org
Wilma Doedens	UN Population Fund (UNFPA), Geneva	doedens@unfpa.org
Saidkasim Sakhipov	UN Population Fund (UNFPA), Hargiesa Sub-Office	sakhipov@unfpa.org
Jennifer Miquel	UN Population Fund (UNFPA), Nairobi	miquel@unfpa.org
Henia Dakkak	UN Population Fund (UNFPA), New York	dakkak@unfpa.org
Idrissa Kone	UN Population Fund (UNFPA), New York	ikone@unfpa.org
Mary Otieno	UN Population Fund (UNFPA), New York	motieno@unfpa.org
Pamela DeLargy	UN Population Fund (UNFPA), New York	delargy@unfpa.org
Bouchta Mourabit	UN Population Fund (UNFPA), Somalia	mourabit@unfpa.org
Masood Ali Shaikh	UN Population Fund (UNFPA), Somalia	shaikh@unfpa.org
Rogaia Abuelgasim Abdelrahim	UN Population Fund (UNFPA), Somalia	abuelgasim@unfpa.org
Elizabeth Ngugi	University of Nairobi	Engugi@csrtkenya.org
Anna Whelan	University of New South Wales	a.whelan@unsw.edu.au
Zvavahera Mike Chirenje	University of Zimbabwe-UCSF	chirenje@uz-ucsf.co.zw
Ritu Singh	US Agency for International Development	RiSingh@usaid.gov
Godfrey Mungazi	Vision and Hope Foundation, Zimbabwe	sirgoddy@yahoo.com
Nakigudde Faith	Wentz Medical Center, Uganda	feithk@yahoo.co.uk
Theresa Shaver	White Ribbon Alliance for Safe Motherhood, Washington, D.C.	tshaver@whiteribbonalliance.org
Erin Patrick	Women's Commission for Refugee Women and Children, New York	erinp@womenscommission.org
Lisa Thomas	Women's Commission for Refugee Women and Children, New York	lthomas@itiwebmail.com
Mihoko Tanabe	Women's Commission for Refugee Women and Children, New York	mihokot@womenscommission.org
Sandra Krause	Women's Commission for Refugee Women and Children, New York	sandra@womenscommission.org
Sarah Chynoweth	Women's Commission for Refugee Women and Children, New York	sarahch@womenscommission.org
Nathalie Kapp	World Health Organization (WHO), Geneva	kappn@who.int
Zaitoon Qazi	World Health Organization (WHO), Geneva	qaziz@who.int
Fe D. Garcia	World Vision Inc., Washington	fgarcia@worldvision.org
Mesfin Teklu	World Vision International, Kenya	mesfin_teklu@wvi.org

Annex V: Technical Working Groups

1. MISP

Sarah Chynoweth
Judith Barasa Ramoya
Katie Anfinson
Sidiki Kanneh

2. Advocacy

Sandra Krause
Claire Richardson
Jane Singleton
Jean Claude Mugunga
Marlou den Hollander

3. Data and Research

Judy Austin
Therese McGinn
Charles Zandoh
Dayal Debnath
Katy Mitchell
Kerry Thompson
Mabel Nakakande
Maqsooda Kasi
Masood Ali Shaikh
Sarah Ashrat
Stacy de Jesus
Tamara Fetters

4. Regional Strategy

Jonathan Ndzi
Ada Pouye
Amadou Sagnon
Dueme Patrick Safi
Mbunzama Mpongo Poupon
Nguyen-Toan Tran
Yao Bi Bakayoko Zegueta

5. Regional Strategy

Sarah Onyango
Fred Akonde
Jennifer Miquel
Nicole Fulton
Susan Igras

6. Safe Motherhood

Nadine Cornier
Bill Powers
Biruk Tafesse Amare
Hanadi Omer Mohammed
Lisa Thomas
Melaku Maru
Rogaia Abuelgasim Abdelrahim
Saidkasim Sakhipov

7. Family Planning

Nathalie Kapp
Jennifer Nantale
Khanlar Hajiev
Megan O'Brien
Theresa Shaver
Udaya Thomas

8. HIV/AIDS/STIs

Wilma Doedens
Fartun Abdi
Herman Tirwosha
Namubiru Lydia Mugalu
Selestine Akoth Otom

9. Gender-based Violence

Jennifer Miquel
John Mbugua
Bouchta Mourabit
Catherine Ayuko
Deman Mahamoud
Florah Bukania
Istarlin Abdullahi Sheikh Ali
Lauren Bienkowski
Lilian Manyonga
Odete Cossa
Odimgbe Deborah Ify
Yaya Sidi Sackor

9. Adolescent RH

Susan Purdin
Mihoko Tanabe
Atholl Kleinhans
Faisal Ishag
Leah Elliott
Meredith Walsh
Pamela Onduso
Zaitoon Qazi

Annex VI: Agency Updates on Reproductive Health in Crises Efforts



Thailand – Burma Border Adolescent Reproductive Health Network Mae Sot and Chiang Mai, Thailand



Mission

The Adolescent Reproductive Health Network aims to promote awareness of and access to adolescent rights and sexual and reproductive health in order to prevent STIs, including HIV, and unintended pregnancy among young people from Burma aged 15-24.

Thai-Burma Border

There are an estimated 1-2 million migrants from Burma living in Thailand,⁶ most of whom are undocumented. There are an estimated half million internally displaced persons (IDPs) living inside Burma.⁷ Young migrant workers living unaccompanied in factories are especially vulnerable due to a lack of social support from their families and communities. Teenage pregnancy among delivery clients at Mae Tao Clinic in Mae Sot increased from 21% in 2003 to 30% in 2005.⁸ Complications due to unsafe abortions account for roughly one third of inpatients at Mae Tao Clinic's reproductive health department.

Adolescent reproductive health network

Since 2003, a total of 19 community-based organizations (CBOs) have collaborated to promote reproductive health for young people from Burma. Two networks in Mae Sot and Chiang Mai, Thailand, respectively, represent various ethnic nationalities (Karen, Lahu, Tavoy, Palaung, Shan, Kachin, Karenni, Chin, and Burman) to coordinate curriculum development, training skills, and project management.

The network model has been successful in Thailand due to the strength of collaboration between community-based organizations. Where organizations lack logistical, financial, and technical support for implementing projects, the network provides a web of support and encouragement through peer supervision and evaluation, as well as a forum for sharing ideas and overcoming obstacles. A standardized training curriculum ensures the same information is being disseminated in each community and prevents unnecessary repetition of curriculum development.



Recent and ongoing success

- Over 1,000 young people trained in adolescent reproductive health
- Knowledge, attitudes, practices survey conducted among 400 migrants aged 12-24
- Reproductive rights training of trainers
- Emergency contraception training of trainers
- Plans for urban youth center to provide peer counseling, distribution of contraceptives, training facility, referrals, and safe house

⁶ International Rescue Committee and Jesuit Refugee Services. Nowhere to Turn: A Report on Conditions of Burmese Asylum Seekers in Thailand and the Impacts of Refugee Status Determination Suspension and the Absence of Mechanisms to Screen Asylum. July 2005.

⁷ Shukla, Kavita. Ending the Waiting Game: Strategies for Responding to Internally Displaced People in Burma. Refugees International, June 2006.

⁸ Mae Tao Clinic Annual Report. Mae Sot, Thailand, 2005.



The Australian Reproductive Health Alliance (ARHA) is an educational and advocacy agency based in Canberra, Australia, close to the federal Parliament. One of its key activities is liaison with government and parliamentarians about increased funding for reproductive health activities in the Asia Pacific region. It acts as the Secretariat to the *Australian All Party Group of Parliamentarians on Population and Development* servicing 50 federal parliamentarians with information about national and international SRH issues. It has been successful in raising the profile and increasing funding for a range of SRH activities in Australia's aid program and assisting in ensuring that RU486 became available to Australian women.

Together with the University of New South Wales in Sydney and IPPF EASEOR, ARHA's advocacy assisted funding of a \$A3m initiative, Sexual and Reproductive Health Programme In Crisis and Post-Crisis Situations in East South-East Asia Pacific known as SPRINT. This funding will address the need for better policy and practices in conflict and refugee settings in the region. The goal of SPRINT is **“To increase access to Sexual and Reproductive Health information and services for populations in crisis and living in post-crisis situations in East, South East Asia and the Pacific Region by enhancing the capacity of key stakeholders in the region to deliver the Minimum Initial Service Package (MISP).”**

To date no international government agency has supported a 3 year strategic investment to address this constraint. The Australian government through its aid agency AusAID has taken a global lead in supporting this proposal. The model could potentially be duplicated in other regions to enhance global outcomes in the sector.

ARHA's role in the SPRINT is to:

- establish links with parliamentary and regional advocacy campaigns for policy-makers, donors and the public.
- organise seminars and the distribution of IEC materials to sensitise a wider audience of stakeholders, in particular the Australian Government Officials and the Australian Parliamentary Group on Population and Development on the SPRINT.
- ensure that Asian Forum of Parliamentarians on Population and Development are provided with appropriate materials and conduct regular awareness raising.
- ARHA will also liaise with the European, African and British Parliamentary Groups in promoting existing donor support for the MISP. Political leadership and support to remove barriers to access, is integral to sustainable service delivery in this sector.
- Organise study tours for parliamentarians to observe, learn, discuss debate, negotiate and plan priorities on issues of sexual and reproductive health needs in emergencies. Providing closer links between Parliamentary Forums should lead to closer collaboration, especially on international policy and establishing national/regional priorities particularly in emergency preparedness.

These educational and advocacy roles are vital to ensuring on-going support by key stakeholders, especially parliamentarians and government officials, and to improving the likelihood of continued support and extension of IAWG/MISP initiatives in the Asia Pacific Region.

Jane Singleton, AM, Chief Executive Officer, ARHA
(jane@arha.org.au)



INTRODUCTION

In 1994, the International Conference on population urged governments to make reproductive health services available, accessible, acceptable and affordable to young people. The Government of Kenya developed a National Adolescent Reproductive Health and Development policy in 2003, following this recommendation. The policy highlights key adolescent reproductive health issues e.g. S.T.I., including HIV, teenage pregnancy, gender based violence and drug and substance abuse. The policy is expected to contribute to the achievement of the Millennium Development Goals, especially MDG 3, (promote gender equality and empowerment of women) MDG 4 (reduce child mortality); MDG 5 (improve maternal health) MDG 6 (Combat HIV/AIDS, Malaria and other diseases).

According to the Kenya Demographic and Health Survey (KDHS 2003) the Maternal Mortality Ratio is 414/100,000 live births, percent of women who attend ANC clinic at least once is 88%, women delivered by a skilled attendant 41%. All these indicate deterioration in the health status in safe motherhood and child survival.

Western Province Emergency Problem

The major emergency issue in Western Province relates to the perennial flooding in Budalangi division of Busia district due to bursting of dykes by river Nzoia. Many people get displaced and exposed to many health problems, including violence, diseases transmission and hunger. Unfortunately it is women and children who suffer the most.

How I intend to apply new skills and knowledge in:-

1. Capacity building

After the training I will organize to share/transfer the skills/knowledge gained with colleagues in the project, our collaborators and partners to raise awareness on the problem and to improve planning and coordination of the services to be provided.

2. Increased collaboration with civil society, F.B.Os, C.B.Os

I will attempt to facilitate formation of a stakeholders working group to coordinate, plan and implement the integrated services in the area to avoid duplication and resource wastage.

3. Encouraging youth friendly services.

The services to be provided will meet the following criteria, safe, comprehensive range, provider competence and attitude, quality and consistency, privacy and confidentiality.

4. Community sensitization and involvement

Community leaders, church leaders and parents will be mobilized to support the initiative and to disseminate information to the youth. These leaders after training will create awareness, provide counseling and create links.

5. Provision of integrated and comprehensive services

AMREF jointly with Ministry of Health and other stakeholders will prioritize the issues and attempt to provide integrated services at one clinic (temporary camps). The one stop shop idea will be promoted especially addressing young people. The services will include ANC, Post natal, HIV/AIDS counseling, family planning etc.



For more than 25 years, the American Refugee Committee (ARC) has provided life-saving and local capacity building services for refugees and internally displaced persons in emergency and conflict-affected settings around the world. Through their services, ARC strives to address reproductive health needs in a comprehensive manner from the onset of an emergency. ARC views reproductive health care as a necessity and is continually improving efforts to incorporate it into primary health care programs as a comprehensive and routine service. ARC takes a community-based and participatory approach to developing and implementing all health programs and utilizes rights-based knowledge as a foundation to support the programs. ARC's reproductive health care core areas of focus include: Emergency Obstetric Care, Safe Motherhood, Gender based violence, Family Planning, and STI/HIV/AIDS.

Currently, ARC has reproductive health programs, in 8 regions: Southern Sudan, Uganda, Darfur, Liberia, Pakistan (earthquake and flood relief), Pakistan (Afghan refugees in Balochistan), Thailand and Rwanda. The current RH projects range from providing comprehensive RH services including EmOC to focusing on one or two RH technical areas such as GBV. ARC has a good reputation in many of these countries, and a history of collaborating with government agencies as well as with local and international NGOs.

ARC is one of seven members of the Reproductive Health Response in Conflict (RHRC) Consortium, a group of NGOs working towards improved health care for all persons displaced by armed conflict. The goal of the RHRC Consortium is: "to increase access to a range of quality, voluntary reproductive health services for refugees and displaced persons around the world." RHRC has increased access to reproductive health services in 30 countries around the globe through the collaboration with governments and NGOs. ARC has helped as a member of the Consortium in producing learning materials for improving reproductive health care services, designing training modules to be used with local staff in project countries, and participating in numerous conferences to discuss with and inform donors and fellow humanitarian organizations about the potential methods of improving reproductive health care.

ARC is one of the partners in the Reproductive Health Access, Information and Services in Emergencies Initiative, also known as RAISE. The focus of this initiative is to address Comprehensive Reproductive Health (RH) including GBV, Safe Motherhood/EMOC, FP and STI/HIV/AIDS. This 5-year program is being funded by an anonymous donor, with emphasis on field work in Darfur and South Sudan and institutionalization of RH globally throughout ARC programs. The overall premise of the initiative is to provide humanitarian response agencies with technical guidance, field research, supportive policy from organizations and global agencies, and financial resources to ultimately contribute to quality comprehensive reproductive health services for refugees and IDPs from the earliest stages of emergencies as a matter of routine.

BE ALIVE UGANDA

P. O.-Box 28552, Kampala – Uganda

E-Mail: bealiveug@yahoo.com

Main office Bulenga – Kikaaya 7 KM Kampala – Mubende Rd
Wakiso District.



Our interest in working on reproductive health related issues

1. Providing Postal Abortion Care

Introduction: Unwanted pregnancy is the outstanding and determining factor in a chain of events whose outcome is often abortion, frequent morbidity and mortality of pregnant women.

All these could result from sexual violence and finally leading to induced criminal (Illegal) abortion which is usually done under unhygienic traditional methods which in most cases end into septic abortions.

We are interested in the reducing of morbidity and mortality of women and girls by providing postal abortion care using the following principles:

- Resuscitation with intravenous fluids
- Administration of parental broad spectrum antibiotics
- Evacuation of the infected products of conception as soon as possible
- Postal abortion counseling
- Referring complicated cases (like severe anemia) to the hospital for further and proper management

2. Providing the following services to the women/girls affected by sexual violence

- Providing emergency contraception
- Proper management of STDs/STIs
- Proper management of birth canal injuries sustained during sexual violence



**CAMEROON BAPTIST CONVENTION
HEALTH BOARD**

Director of Health Services
P.O. Box 1, Bamenda
NORTH WEST PROVINCE
REPUBLIC OF CAMEROON

E-mails: Piustih@aol.com
bamendadhs@yahoo.com
BBHCameroon@aol.com
Cell phone: (237) 776-4781

**CAMEROON BAPTIST CONVENTION HEALTH BOARD
BACKGROUND INFORMATION ON REPRODUCTIVE HEALTH**

CBCHB is a non-profit; faith based health care organization whose mission includes: "... to assist in the provision of health care to all who need it, as an expression of Christian love and as a means of witness...." It comprises five 250-bed hospitals, 24 integrated health centers, 43 primary health centers, pharmaceutical production and distribution, a Private Training School for Health Personnel, and other critical health services for a population base of 8 million people in six of Cameroon's ten provinces. CBCHB works in partnership with governmental and non-governmental health care organizations in Africa and with multiple international organizations and funding agencies. Such as USAID, UNICEF, and a US-based micro-enterprise program, EGPAF, KWIHEED, giving priority to women infected with HIV AND AIDS, reproductive health and foster families that support AIDS orphans. The organization runs a Maternal and Child Health (MCH) committee which meets regularly to review issues relating to mothers and babies.

CBCHB runs a comprehensive Prevention of Mother to Child Transmission of HIV (PMTCT) program which started in 2000 with 2 pioneer sites and now supports activities in 355 sites. More than 215,000 women have been counseled and tested for HIV through this program while their babies are given prophylactics to prevent vertical transmission. This program was recognized by USAID & Action for West African Region (AWARE HIV/AIDS & AWARE Reproductive Health) as a "best and promising practice in the west and central African region. CBCHB has benefited a lot from the several capacity building training sessions organized with support from AWARE RH and Engenderhealth with focus on improving on women's health in Cameroon and the region. Their PMTCT initiatives include the Men as Partners (MAP) Program to encourage women to bring their spouses to get HIV testing and to foster healthy family relationships. Staff have been trained on various family planning methods and the service has been revitalized in the board. Couples' clinics have been established to increase male involvement in reproductive health services and all FP methods are available at very affordable prices due to donations of commodities from USAID.

Cervical cancer is the 2nd most common cancer in women worldwide and the leading cause of cancer death in women in developing countries. In 2007, CBCHB began a partnership with the University of Alabama's Cervical Health Program in Zambia, East Africa, which is pioneering a new method of cervical cancer screening, using digital photo-cervicography instead of Pap smears (which are neither available nor affordable for most African women). We also coordinate with the Cameroonian National Fight against Cancer in program planning and patient referral. We plan a mobile cervical cancer screening clinic, using a large donated US Army ambulance, to travel to various clinics and support group meetings, with a priority of screening HIV-infected women, who are at highest risk. We are developing expertise in cryotherapy and the loop electrical excision procedure (LEEP) to treat pre-cancers and plan training in radical surgery techniques and cancer staging.

Our participation in this meeting is going to help us very much to further develop our reproductive health services and bring in innovative modules which will go a long way to improve on the health of the family.



CARE- International
Summary of Reproductive Health Response
in Complex Emergencies –
 October 2007

- CARE has a decades-long history of RH programming – both clinical and community-based.
- CARE currently implements 86 reproductive health projects in over 40 countries, and at least 73% of these projects working to increase access to and quality of services.
- We have a strong history of RH programming for refugees and in emergencies, through good relationships with donors such as OFDA, ECHO, UNFPA, BPRM, Packard and Gates Emergency funding. We continue to work in partnership with networks, including the RHRC Consortium and most recently, with Columbia University's RAISE program.
- Currently operational in humanitarian aid response to crises and refugees/IDPs in:
 - **Great Lakes region:** Northern Uganda, Southern Sudan, Northern Sudan, Darfur, Chad
 - **West Africa:** Cote D'Ivoire, Sierra Leone
 - **Southern Africa:** Angola, Zambia, Mozambique, Zimbabwe, Madagascar
 - **South Asia:** Afghanistan, Pakistan, Nepal
 - **East Asia:** Thailand, Myanmar, Indonesia, Timors
 - **South America:** Colombia
- Two examples of CARE's recent programs:
 - **Indonesia:** Recently, CARE responded to the tsunami emergency in Banda Aceh by focusing on immediate restoration of emergency obstetric services. CARE staff worked directly with tsunami-affected communities in affected areas to support the revitalization of reproductive health clinical services, including establishment and referrals for obstetric emergencies, antenatal care, and education on nutrition and breast-feeding, providing clinical supplies where needed to local health care providers. The project also aimed over the longer term to reestablish sustainable, high quality emergency obstetric and other reproductive health services.
 - **Eastern Democratic Republic of Congo,** CARE has focused on rebuilding & expanding services and choices of family planning for 600,000 women of reproductive age in Maniema and East and West Kasai provinces through a large grant from USAID. The project has made very impressive gains in terms of results indicators: as of October 2005, only one year since the project was awarded, the project area's contraceptive prevalence rate has increased from 1.5% to 8.15%. This provides the base from which the newly – starting RAISE project will work, with a focus on comprehensive maternal health / RH care.

CARE is operational and has existing programs in the following countries:

Country	Region/Province	SRH Program components	Donor
Northern Uganda	▪ Gulu and Pader Districts	Preventive and curative outpatient reproductive health services, including rehabilitation and equipping maternity centers, training midwives	Bill & Melinda Gates Foundation
Eastern DRC	▪ Maniema, East and West Kasai	Improving FP clinical services and district supervision in over 15 districts. Improving community capacity of CBOs in FP outreach in HC catchment areas (FP Expansion project) Improving clinical and community services in a subset of districts in Maniema Province, above, with focus on maternal health, FP, HIV, and GBV (RAISE)	USAID Columbia University/RAISE
Chad	▪ Camps across from Darfur ▪ Djamena ▪ Southern Chad with refugees from CAR	HIV prevention program in the south	
Darfur	▪ South Darfur ▪ [North & West Darfur]	RH as part of PHC in South Darfur [present and implementing non-health programs in North and West Darfur]	Bill & Melinda Gates Foundation
South Sudan	▪ Jonglei State ▪ Unity ▪ Upper Nile state ▪ Twic East ▪ Duk County	One of first NGOs to integrate RH into PHC services with ECHO funding in southern Sudan. Currently rebuilding PHC services with integrated MH and FP clinical services where no PHC services existed at all. There is only one hospital for 2.7 million war-affected people	USAID, OFDA
Myanmar	▪ Yangon	HIV programming	

La Cellule des Femmes de Média en action en faveur de la SR Deux campagnes pour promouvoir la SR de la femme et de la jeune fille

A sa création le 06 Octobre 2006, notre organisation se dénommait : **Cellule des Femmes de Média engagées dans la Lutte contre le Sida en faveur de la Femme et de l'Enfant en Côte d'Ivoire (CFMS-CI)**. Aussi n'organisait-elle que des séances de sensibilisation à la prévention du VIH et du Sida par rapport aux spécificités de la femme. Cela en faisant du porte en porte auprès des femmes et des jeunes filles, dans leur association de quartier, sur leur lieu d'apprentissage et de travail.

Mais la Cellule des Femmes de Média contre le Sida et pour la Promotion de la Santé Reproductive en Côte d'Ivoire (CFMS/SR-CI) a été désagréablement surprise de savoir par les statistiques que les femmes de Côte d'Ivoire mourraient autant ou presque plus lors des accouchements et de la grossesse que du Sida. Même si la féminisation de la pandémie était sans aucun doute une réalité en Côte d'Ivoire. Un décès de femme toutes les deux heures selon la direction du Programme National de Santé de la Reproduction et de Planification Familiale ou PNSR/PF (voir à ce sujet un reportage dans notre journal en ligne: www.femmesensantecotedivoire.org).

C'est pour braquer les projecteurs sur ces morts anonymes et silencieuses, se produisant entre les quatre murs dans les suites d'accouchement, dans les salles de repos des structures de santé, que la Cellule des Femmes de Média tout en continuant ses sensibilisations à la prévention du VIH et du Sida a lancé en 2006 sa campagne : « **Donner la Vie et Vivre** ». Elle a aussi décidé à l'issue d'une assemblée générale extraordinaire de modifier sa dénomination au regard de la prise en compte de la nouvelle donne. C'est ainsi que notre ONG s'appelle depuis le 16 Novembre 2005 : **Cellule des Femmes de Média contre le Sida et pour la Promotion de la Santé Reproductive en Côte d'Ivoire (CFMS/SR-CI)**.

Avec sa campagne « **Donner la Vie et Vivre** », faite de causeries débats, de production d'émissions télévisées, de dépliants et de tout autres supports et outils de communication, la CFMS/SR-CI a sensibilisé à la réduction de la mortalité maternelle et infantile en faisant la promotion des consultations prénatales, l'accouchement dans les centres de santé, la planification familiale etc. auprès des femmes et sur la contraception et les grossesses à risque auprès des jeunes filles.

Le lancement de la campagne a été l'occasion de regrouper plusieurs associations de femmes autour du syndicat des sages femmes, du Programme de Santé de la Reproduction et de Planification pour des échanges sur les réalités de la mortalité maternelle et infantile

Par la suite et chaque fois que nos moyens nous le permettaient ou sur invitation, la CFMS/SR-CI est allée à la rencontre de plusieurs associations de femmes et de jeunes filles pour échanger en français et en langues (selon le contexte) tant sur le VIH et le Sida que sur la SR notamment dans ses composantes grossesses à risque, planification familiale, consultations prénatales, mortalités maternelle et infantile.

La CFMS/SR-CI qui fait la promotion du préservatif féminin, finit toujours ses causeries débats dans les communautés par la démonstration de l'utilisation de ce préservatif sur mannequin avec des tours d'essayage pour les femmes. Qui reçoivent tee shorts et autres gadgets en plus d'échantillons du préservatif féminin.

Cette année encore, la CFMS/SR-CI n'a pas failli à son engagement de faire de la promotion de la Santé de la Reproduction son cheval de bataille. Elle a tablé sur les violences sexuelles faites aux femmes tout en restant dans la Lutte contre le VIH et le Sida. Aussi sa **campagne 2007** s'est-elle intitulée : « **Femmes, violences sexuelles et VIH/sida : brisons le Silence** ».

La CFMS/SR-CI a voulu faire passer un message essentiel à travers cette campagne : « **Femmes, jeunes filles, si tu as été violée, même si tu ne veux pas dénoncer celui qui a commis ce forfait, pense à ta santé. Rends toi dans la structure de santé le plus proche pour éviter le VIH et une grossesse indésirable. C'est possible** ».

Ce message traduit en langue, écrit sur banderoles et dépliants a, été diffusé.

Pour briser le silence sur les violences sexuelles, en particulier sur sa prise en charge, la campagne a été lancée par une conférence de presse, avec la présence de spécialistes du service de maladies infectieuses du CHU de Treichville et de gynécologues de l'UNFPA afin de mieux instruire les journalistes pour qu'il en fasse un large écho. **D'autres atouts:**

- Une émission radiophonique « **Femmes En Santé** » sur une radio communautaire du nom de radio Bonne santé
- Un journal en ligne du même nom : www.femmesensantecotedivoire.org
- Un site (en réaménagement) : www.celluledesfemmesdemediaticotedivoire.org
- Un magazine télévisé intitulé « **Femmes SanSida** » sur la 1^{ère} chaîne de télévision.
- Une pétition sur la réduction du prix du préservatif féminin
- Une enquête sur le préservatif féminin et la PTME
- **NOTRE ENGAGEMENT**

NB : nos maigres ressources nous avons amené à arrêter le magazine télé



Reproductive Health for Refugees Activity Division of Reproductive Health

CDC's Division of Reproductive Health (DRH) began a formal reproductive health for refugees activity in 1998. Since that time it has broadened its target populations to include refugees and internally displaced persons (IDPs) in the emergency phase, post emergency camps, returning to their countries of origin, and those who have integrated into the local host community. This allows public health officers to follow the full continuum of health from the emergency setting to that of viable communities.

CDC/DRH collaborates with a wide range of partners to understand the burden, causes, and risk factors for negative reproductive health outcomes in very low resource settings, including humanitarian emergencies. Assessing barriers to health care access also helps guide reproductive health policies, programs, and interventions.

CDC/DRH has the following goals for its reproductive health for refugees activity:

- Create tools that can be used by humanitarian relief partners.
- Design and conduct evaluations to learn from field partners and develop best practices.
- Promote the use of data to inform reproductive health programs and policies.
- Strengthen the capacity of field partners to collect and use data to improve services.
- Translate and communicate study findings and best practices to conflict-affected populations, the humanitarian relief community, and donor agencies.



In May 2007, CDC/DRH released a new resource aimed at improving the reproductive health of women and their families in conflict-affected areas throughout the world. The Reproductive Health Assessment (RHA) Toolkit for Conflict-Affected Women provides user-friendly tools to quantitatively assess the reproductive health needs of conflict-affected women aged 15–49 years. The RHA Toolkit enables field staff to collect data to inform program planning, monitoring, evaluation, and advocacy. It promotes using the collected data to enhance services and improve the reproductive health of women and their families.

CDC/DRH is conducting 2-day regional trainings on how to implement the RHA Toolkit. The first training will be held in Nairobi, Kenya, 11–12 October 2007. Trainings are tentatively planned to be held in Southeast Asia and West Africa.

For more information contact:

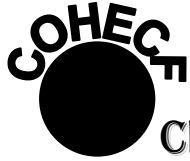
Stacy De Jesus
+1 770 488 6393
sdejesus@cdc.gov

<http://www.cdc.gov/reproductivehealth/Refugee/ToolkitDownload.htm>



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

SAFER • HEALTHIER • PEOPLE™



COHECF - CIG

Christian Community Health Care Foundation

Head Office: Bonadikombo , P.O. Box 1073 Limbe, Cameroon.

Tel: (237) 3333 29 74 / 7784 42 67 ; Fax: (237) 3333 3091 Email: cohecf2000@yahoo.com

REPRODUCTIVE HEALTH IN CRISIS SETTINGS

During crisis (wars, earthquake, ethnic conflicts, famine etc) wherever in the world, huge number of persons are partially or entirely affected. Morbidity and mortality rate use to be very high depending on the type of crisis.

Back in the year 2001 we had a landslide case in Limbe municipality (Cameroon) that lead to the rendering of hundreds of persons homeless. COHECF took part in relieving the displaced ones, mostly children and women of their deplorable state.

Today more crisis are coming up globally and COHECF is as of this meeting appealing to the global community, IAWG, and other stake holders, not to relent their effort or put a blind eye to victims of crisis wherever they are. COHECF is willing to provide the necessary support available to victims of crisis and also to work in close collaboration with other international organizations.

The training of humanitarian workers alongside the provision of tools to cater for refugees in every nation is a welcome idea. Any nation with standing order of health care tools and workers will not find it very difficult upon the onset of crisis before the intervention of foreign support.

COHECF had embarked on the training of humanitarian workers upon the MISP Module. This will as well educate both sex of health and non health personnel, refugees and non refugees, how to cater for displace women and children refugees wherever they are.

COHECF can easily achieve this goal of training MISP Module personnel through effective technical assistance of some interested organisation willing to cater for the life of the affected masses.

COHECF had of recent receive some close to 100 MISP Module package from WOMEN'S COMMISSION FOR REFUGEE WOMEN AND CHILDREN. This is to render COHECF offer effective training to humanitarian workers though in one way we lack computers and internet provision to facilitate the trainees answer their quizzes online. A gesture of such, by providing COHECF computer and internet connection will enable us fast.

Let's cater for RH by caring about rape, ST, accommodation, medical care for the internally displaced.

COHECF wishes a good reproductive health to all the displaced masses within the globe.

Director:	Dr. Asomba A. T.	Tel:	(237) 7784 42 67
Project Manager:	Mr. Takem Martin A.		7735 21 83
Secretary General:	Mr. Kang Akime F.		7573 93 46
Treasurer:	M. Anyah Evelyn E.		7545 12 56



Constella Futures

During 2006-2007 Constella Futures, under USAID Health Policy Initiative Task Order 1, implemented two projects in the area of reproductive health in crisis settings. This is a new area of intervention for the project and these initial activities focused on bringing expertise from non-conflict settings into this new environment.

1. Building Capacity to Reposition and Improve Access to Family Planning for Refugees and Internally Displaced Persons (IDPs)

This activity focused on identifying and advocating for the removal of operational barriers to family planning in Sierra Leone. Recognizing the importance of a sound policy environment, including the operational guidelines necessary for putting policies into practice, the USAID | Health Policy Initiative, Task Order 1 identified the following objectives for the work in Sierra Leone:

- Explore refugee/IDP family planning needs before, during, and after conflict;
- Determine the root causes of the barriers to quality, accessible services;
- Build capacity of local groups to analyze operational barriers to services; and
- Devise policy actions and recommendations for overcoming barriers, applicable to both in-country and in other conflict-affected countries.

Tools were developed to collect quantitative and qualitative data from Liberian refugees living in camps in Sierra Leone and from Sierra Leoneans who had both fled the country and stayed during the decades-long civil war. Information was collected on operational barriers before, during, and after the war to understand the relationship between demand and access to family planning across the conflict continuum. To ensure the study adequately considered the family planning needs of refugees and IDPs, the Health Policy Initiative worked closely with the U.S. Agency for International Development (USAID) and the RHRC Consortium in planning the study.

Recommendations are being developed for stakeholders in Sierra Leone and the international community in an effort to reduce operational barriers to family planning during and after conflict situations.

2. Advocacy Training for Local NGOs in Sierra Leone

The training occurred in February 2007 and provided participants with the skills to advocate for improved and more accessible reproductive health services. Specific topics covered in the training include: effective communication; the policy process, including analyzing the policy process; prioritizing policy issues; introduction to advocacy; identifying support and opposition to advocacy messages, developing advocacy action plans; and persuading and moving to action. The activity built on previous capacity-building work among local NGOs implemented by JSI. The workshop resulted in completed advocacy plans that local organizations planned to use to advocate for enforcement of laws regarding rape and sexual violence.



German Foundation for World Population (DSW) Uganda

The German Foundation for World Population (DSW) is an international development organisation. It was founded in 1991 as a private non-profit foundation. Besides the Head Office in Hannover, DSW also has Country Offices in Ethiopia, Kenya, Tanzania and Uganda, as well as an EU Liaison Office in Brussels. DSW is politically and religiously independent. We rely on private donations and financial support from other organisations, foundations and agencies to carry out our project work.

DSW has been present in Uganda since 1999. In 2000 our Sexual and Reproductive Health Training Centre was established. The Training Centre is dedicated to provide SRH training to youth as peer educators and, pre- and in-service for professionals. The training centre offer courses in Gender, Advocacy, HIV/AIDS policy development and mainstreaming, SGBV, Youth Friendly Services and we also develop tailor made training packages on demand.

DSW Uganda has a strong advocacy profile. Our mandate is the SRHR of young people, 10-24 years. There are many issues that negatively affect young Ugandan's SRH; lack of access to information and services, high prevalence of HIV and STIs, early pregnancies high levels of SGBV, including forced marriages, poverty and the general stigmas associated with youth and sexual health.

DSW work with young people directly through a network of youth clubs as well as with partners to implement our Youth to Youth programme to improve young people's SRH, self-esteem and social participation. The program is based on a peer education approach. Each youth club receive continuous training as well as IEC materials and infotainment.

The DSW 'Youth Truck' is providing outreach to all parts of Uganda. It brings a highly skilled team of young social workers to mobilize youth in all settings around issues of SRHR. We work closely with our partners – the Youth Truck is demand driven and can go anywhere as long as there is a local contact that ensures continuity and follow up.

DSW in Uganda, Kenya and Ethiopia together with our liaison Office in Brussels are implementing the 'Euroleverage project'. The main aim is to ensure that there is continued and hopefully increased spending on SRHR from the European Commission as well as the European development partners. On country level, DSW monitor and track the spending on SRHR, and advocate for increased budget allocations. We support local NGOs and consortia to apply for European Commission funding.

DSW Uganda is increasingly getting involved in the implementing programmes in the conflict affected North of Uganda, both by direct programme implementation and in advocacy. In the near future we envisage to be part of direct program implementation targeting newly resettled IDPs in Uganda's North.



International Medical Corps RH Interventions in Somalia

IMC's Safe Motherhood program in south central Somalia is being funded by the UK's Department for International Development (DFID).

South central Somalia is a challenging environment in which to implement reproductive health programs. Protracted conflict has reduced the operational space for humanitarian actors in the country. Despite the security challenges, however, there are some notable efforts to provide RH services in some parts of the country. In South central Somalia, IMC is working in four technical areas of RH: safe motherhood, family planning, gender-based violence (GBV) and HIV/AIDS/STIs.

On safe motherhood, IMC has made reducing maternal mortality and pregnancy related disabilities its top priority. IMC's overall objective is to reduce maternal morbidity and mortality through improved accessibility and utilization of quality services for the treatment and management of complications during childbirth and pregnancy in specific locations in south central Somalia.

The main goal of IMC's safe motherhood program is to build on the 4 key interventions that can help reduce maternal morbidity and mortality: Post/Antenatal care, clean and assisted delivery, family planning and basic emergency obstetric care. Training of health staff is a priority for the program. Thus IMC trained nurses, midwives and TBAs on safe delivery, antenatal care, newborn and post-natal care. TBA's were also trained the three common delays that limit access to Emergency Obstetric Care: *1) the delay in deciding to seek care, 2) the delay in identifying and reaching a health facility, and 3) the delay in receiving appropriate care at health facilities .*

A system of quick referral, including a plan for transport, is in place. In addition, a referral system for emergency cases requiring surgical interventions has also been established. IMC collaborate with MSF-Swiss to ensure that those urgently needing surgical interventions are referred to the MSF-Swiss and reduce the incidences of maternal deaths.

On GBV, IMC has just started implementing Gender Based Violence (GBV) Project in Baidoa district, south central Somalia. The project's interventions are designed both to prevent gender-based violence and to respond to the needs of thousands of IDPs in the district as well as those of the host community. For the past few weeks, IMC has been working closely with the communities in Baidoa to assess the extent of GBV and design a culturally appropriate response.

Founded in 1952, IPPF is a global network of 151 Member Associations working in 183 countries and the world's foremost voluntary, non-governmental provider and advocate of sexual and reproductive health and rights. IPPF works in five priority areas: [Adolescents](#), [HIV/AIDS](#), [Abortion](#), [Access](#) and [Advocacy](#) (the '5 As'). IPPF's position as both provider and advocate of sexual and reproductive health and rights is unique. It is a people's movement, volunteer-led, grassroots organization connected directly with governments, civil society, communities and individual globally, regionally and nationally. IPPF's work enables people to make informed choices about their sexual lives and to receive care, counselling, diagnosis and treatment. IPPF aims to improve the quality of life of individuals by campaigning for sexual and reproductive health and rights through advocacy and services, especially for poor and vulnerable people (in 2005, the estimated total number of clients served by Member Associations was 36 million; in the 25 countries with lowest human development index according to UNDP, an estimated 73 per cent of IPPF's clients served were poor, marginalized and socially-excluded). IPPF is divided into six regions worldwide: Western Hemisphere, European Network, Africa Region, Arab World Region, South Asia Region and ESEAOR (East Southeast Asia and Oceania Region).

IPPF ESEAOR

The East & South East Asia and Oceania Region (ESEAOR), with a population of approximately 2 billion and covering 27 countries, is the largest of IPPF's six regions. The Regional Office of ESEAOR is based in Kuala Lumpur, Malaysia, with a Sub Regional Office in Suva, Fiji, for the Pacific Islands, and a Project Office in Vientiane, Lao PDR.

IPPF ESEAOR and SPRINT

In December 2007, under the auspices of AusAID, IPPF ESEAOR, in collaboration with the University of New South Wales (UNSW), UNFPA and the Australian RH Alliance (ARHA), will launch the SPRINT programme (Sexual and Reproductive Health PRogramme In Crisis and Post-Crisis Situations in East South-East Asia Pacific), which aims to increase access to SRH information and services for populations surviving crisis and living in post-crisis situations in ESEAP. We will reach this goal by: 1. Increasing the regional capacity of key stakeholders with regard to SRH response in crisis and post-crisis situations; 2. Strengthening the coordination of SRH responses in crisis and post-crisis situations; 3. Raising awareness on the importance of addressing SRH in crisis and post-crisis situations at the national, regional and international levels; 4. Responding in a timely fashion to SRH needs in crisis situations; 5. Enhancing access to SRH information and services for populations surviving crisis and living in protracted post-crisis situations.

The programme will span from 1st December 2007 until 15 December 2010. After the 37 months of programme activities, it will achieve i) an increased regional capacity of key stakeholders to respond to crisis and post-crisis situations in ESEAOR, ii) coordinated emergency and post-emergency responses in SRH (at least 9 sites to be determined: 6 emergency and 3 post-emergency), iii) the integration of SRH into regional and national emergency response agenda, and iv) availability of access to SRH information and services for populations living in crisis situations and for selected internally displaced populations (IDPs) living in protracted post-crisis situations.

REPRODUCTIVE HEALTH IN CRISIS SITUATIONS

Background and Areas of Interest

The Ipas Africa Alliance for Women's Reproductive Health and Rights is a network of partnerships working in concert at the regional, sub regional, and country levels. Led by Ipas Vice President for Africa since 2001, Amb. Dr. Eunice Brookman-Amisshah, the Alliance seeks to improve African women's reproductive health, with a focus on preventing the death and injury of women from complications of unsafe abortion. Unsafe abortion remains one of the leading causes of maternal mortality in the region, and a key obstacle to attainment of the Millennium Development Goal of improving maternal health. (WHO, World Bank, 2004)

The Alliance addresses the issue of unsafe abortion comprehensively, drawing on the tools, experiences and resources available to Ipas and its partners throughout the world. In addition to leadership in advocacy and policy dialogue, the Alliance provides technical assistance for training and service delivery improvement; facilitates research and evaluation; and supports efforts to ensure sustainable availability of needed reproductive health technologies and supplies. The Alliance brings together a wide range of partners able to address the personal, social, and economic impacts of unsafe abortion and abortion-related morbidity and mortality.

Ipas response to RH in Crisis situations

In all situations, women seeking post abortion care are usually in crisis and in trauma of undergoing unsafe abortion and they will usually arrive at medical center in emergency situation. Ipas response to such situations is based on the premises that every women should have a right to access safe reproductive health choices while in such a crisis.

Ipas experience in reproductive health in crisis situations within East Africa includes a pilot project in two large refugee camps in Northern Kenya with nearly 180, 000 refugees in partnership with UNFPA and NCKK. Ipas work at Dadaab and Kakuma refugee camps focused on incomplete abortion and conducted training in Post Abortion care and services. The project established that there was a great need to integrate post abortion care along with other reproductive health services.

In Kenya Ipas is currently working with the office of the Attorney General as a member of the national Task force of implementing Sexual offence Bill. In this initiative, Ipas is focusing on reproductive health needs of sexual violence victims who in all cases are in crisis and traumatized. Ipas is therefore providing technical assistance in developing minimum reproductive health service package for sexual violence victims as well as participate in other advocacy and awareness creation activities of the Act.

Ipas Global

Ipas has been involved with the Inter-Agency Working Group since the development and review of the MISP kits and the inter-agency field manual. We are currently partnering with a number of organizations to improve the capacity within their organizations to provide high quality PAC services to persons in crisis settings and to monitor and evaluate these services. In addition, Ipas is part of the IAWG Partnership, participating in the development of training partnerships in the Asia-Pacific and sub-Saharan Africa regions to build the capacity of midwives, nurses and doctors to deliver clinical reproductive health services in emergency settings. We are developing "short course" training material for PAC/MVA.

Ipas staff have recently completed several documents that may be of interest to you:

A - *the abortion magazine*. 2006. Issue focused on reproductive health care in disasters. *Ipas*; summer.
Available on-line at: http://www.ipas.org/Publications/asset_upload_file202_2893.pdf

Fetters T. 2006. Abortion care needs in Darfur and Chad. *Forced Migration Review*, 25: 48-49. Available on-line at: <http://www.fmreview.org/FMRpdfs/FMR25/FMR25full.pdf>

Lehmann A. 2002. Safe Abortion: A Right for Refugees? *Reproductive Health Matters*; 10(19):151-155.

For more information feel free to contact:

Mary Kairu (mkairu@ipas.or.ke)
254.20.387.7239

Tamara Fetters (fetterst@ipas.org)
1.919.960.5629

Bill Powell (powellb@ipas.org)
1.919.960.5707



INTERNATIONAL RESCUE COMMITTEE Reproductive Health and Gender-Based Violence Programs

IRC's *Reproductive Health Programs* increase the accessibility, use and quality of reproductive health services for conflict-affected populations around the world. IRC offers a package of reproductive health (RH) services integrated within its overall primary health care programs. IRC's *Gender-based Violence Technical Team* provides hands-on support to 12 field programs and coordinates GBV-related expertise that ensures cross-sectoral pollination of GBV in other sectors (including reproductive health, education, protection and environmental health).

IRC implements reproductive health and GBV programs in Azerbaijan, Burundi, Central African Republic, Chad, Côte d'Ivoire, the Democratic Republic of Congo, Ethiopia, Indonesia, Kenya, Liberia, Nepal, Northern Caucasus, Pakistan, Rwanda, Sierra Leone, North and East Sudan, South Sudan, West Sudan (Darfur), Tanzania, Thailand and Uganda.

IRC's reproductive health programs address four main areas:

- ♦ *Safe Motherhood*: Reducing the pregnancy-related death and disability of mothers and newborns by providing emergency obstetric care and treatment of obstetric complications; training local health workers in high quality pre-natal, post-natal and safe delivery care; and establishing referral mechanisms.
- ♦ *STI/HIV Prevention and Treatment*: Reducing the risk of exposure to sexually transmitted infections and HIV through health education, free condom distribution, voluntary counseling and testing, prevention of mother-to-child transmission and enforcement of universal precautions against HIV/AIDS in all primary health programs, and caring for people living with HIV/AIDS through the provision of antiretroviral medications.
- ♦ *Family Planning*: Providing information and an array of modern methods of contraception; promoting the benefits of birth spacing for the health of mothers and children.
- ♦ *Clinical Response to Gender-based Violence*: Providing compassionate clinical care for survivors of sexual violence by identifying and treating injuries and medical complications of rape, including prevention of HIV infection; providing referrals to other services such as legal and psychosocial care; and protecting survivors' right to dignity, privacy, information, health, self-determination and confidentiality.

Program Highlights, October 2006 – September 2007:

- ♦ *RAISE Projects*: IRC is one of the implementing partners of RAISE (2006 – 2011), a multi-agency and multi-country comprehensive reproductive health program. Under RAISE, IRC is providing RH services in DRC and Darfur and providing technical assistance to these two field programs.
- ♦ *Multi-media training tool on clinical management of sexual assault*: IRC is working with the University of California in Los Angeles' (UCLA) Center for International Medicine to produce a multimedia based training tool to help international health clinic staff provide compassionate, confidential, and competent care for survivors of sexual assault. The final DVDs will be available in early 2008.
- ♦ *BCC Training Package*: IRC developed and piloted a BCC training package at its 10th Annual Reproductive Health Conference in Tanzania in May 2007. The training package builds on existing BCC models, but is tailored to the conflict contexts where IRC operates. The BCC package aims to ensure that standardized, correct messages that are not stigma or fear-inducing are used throughout BCC projects in IRC's health programs.
- ♦ *GBV Information Management System (GBVIMS)*: IRC is an implementing partner in this multi-agency project which aims at creating of an information management system to effectively and safely collect, store and share GBV incident data. The GBVIMS' main purpose will be to enable analysis of trends in gender-based violence, thereby allowing GBV practitioners to design effective and strategic community-based programs.
- ♦ *A Global Crescendo Project*: Through its GBV programs, IRC is providing women innovative advocacy techniques (photography and story-telling) and concrete opportunities to voice their vision for a life free from violence, exclusion and discrimination. The photographs and narratives collected in the project will also be used to raise awareness in the international community about GBV in conflict affected settings.

IRC's Reproductive Health Technical Team: Susan Purdin, Senior Technical Advisor for RH ♦ Wendy Venter, Senior Technical Advisor on HIV ♦ Anne Langston, Technical Advisor for RH ♦ Katy Mitchell, Technical Advisor for RAISE Projects ♦ Ela Anil, RH Program Manager

IRC's Gender-based Violence Technical Team: Heidi Lehman, GBV Senior Technical Advisor ♦ Kristin Kim Bart, GBV Program Officer ♦ Karin Wachter, GBV Technical Advisor ♦ Sonia Navani, Emergency GBV Coordinator ♦ Anna Dabrowska-Radtke, GBV Information Managements Systems Manager ♦ Meghan O'Connor, GBV Program Manager

For more information contact Ela Anil (Ela.Anil@their.org) or Meghan O'Connor ([Meghan.OConnor@their.org](mailto: Meghan.OConnor@their.org))



J H P I E G O

An Affiliate of
Johns Hopkins
University

WORKING TO IMPROVE THE HEALTH OF WOMEN AND FAMILIES THROUGHOUT THE WORLD

JHPIEGO continues to expand its work in disaster and conflict settings around the world—from the shores of Indonesia, to the mountains of Pakistan, to the deserts of the Sudan. JHPIEGO's foray into such challenging situations began with our efforts to rebuild midwifery services in Afghanistan after the fall of the Taliban. And after the devastating tsunami in Aceh, Indonesia, in December 2004, JHPIEGO was well placed to undertake a similar effort there because of our strong presence in the area before the disaster.

Based on JHPIEGO's successful work in Aceh, the American Refugee Committee International (ARC) sought our expertise to implement a pilot project for reproductive health providers working in camps for internally displaced persons (IDPs) in Bagh, Pakistan. This area was ravaged by the October 2005 earthquake. The objective of this project was to update health care providers to deliver high-quality reproductive health services as well as to begin training other providers in relevant skills. This effort was a success, although the training took place under challenging circumstances. For example, because there was no official training space, the JHPIEGO trainers had to conduct the activity in a large tent in extreme heat.

JHPIEGO continued its successful collaboration with ARC—this time in Darfur, Sudan. JHPIEGO staff traveled to Nyala in southern Darfur in December 2006 to conduct training for local health care providers, similar to the one conducted in Bagh.

Darfur presented even more challenges than Pakistan because of the ongoing conflict and security concerns. Participants said they were grateful for the training opportunity and expressed their gratitude. "They're working in such harsh conditions. This training really boosted their morale and gave them important tools to use in their work," said Program Officer Udaya Thomas, one of the JHPIEGO trainers. JHPIEGO's collaboration with ARC in Pakistan and Sudan has continued in 2007 with follow-up technical support.

JHPIEGO has worked extensively in Pakistan since 2003, and was in a strong position to partner with the International Rescue Committee (IRC) on "Primary Health Care Revitalization, Integration and Decentralization in Earthquake-affected areas (PRIDE)," another disaster-relief effort in Pakistan. The four-year USAID-funded program, which began in August 2006, focuses on improving primary health care services for the populations in the earthquake-devastated districts of Bagh and Mansehra in northern Pakistan.

Reproductive and primary health care are often overlooked in conflict and disaster settings, but clearly these services are still needed. JHPIEGO's collaborations with IRC and ARC illustrate the potential of merging the strengths of relief and development—such partnerships are critical to offering hope to these populations, and to helping those affected rebuild their lives.

In addition, JHPIEGO has joined efforts with Columbia University in the RAISE Initiative to put together a training package for RH providers. Dr Zahida Qureshi- JHPIEGO consultant assisted by 2 other master trainers and program staff of JHPIEGO conducted a 5 day Instructional Design Workshop (25th to 29th June) in Nairobi for participants from Raise Initiative Kenya, Columbia University New York and other RH specialists from Nairobi. At the end of this workshop, the first set manuals in Reproductive Health- "Family Planning Training Manual for Service Providers in Emergency Situations"—with its accompanying trainers and participant's handbook were developed and later reviewed extensively.

These documents were pre-tested at a 2 week clinical skills update training in August—in Nairobi, 9 participants from Southern Sudan, Kenya and Uganda were trained by Raise Kenya trainers together with Ms Dorothy Andere—JHPIEGO master trainer. The documents were finalized by early September. Under this JHPIEGO- Columbia collaboration other training manuals for providers in emergency situations are planned for Emergency Obstetric Care, Post Abortion Care, as well as STI/HIV/AIDS and Gender-based Violence.

JHPIEGO looks forward to continuing to provide assistance and preparing RH providers in Crisis to respond to those most in need.

KACO CI

Karimojong Community Child Welfare Initiatives

Tel: 0072 820 839/ 0772 527116/ 078 2973727

Reproductive Health Activities

KACO CI is a Community Based Organization established in June 2005, registered in 2007 and based in Moroto district operating in the sub counties of South Division, North Division, Nadunget, Katikekile and Rupa. It focuses on children and women rights.

It receives funding from collections of the members.

For the past years, one of KACO CI's main activities is preventing and responding to Sexual Gender Based Violence under the Reproductive Health section.

The activities carried on include:

- Sensitization of the women on their right to health in relation to GBV cases
- Data collection on forms of GBV and its implication on the health of the women
- Advocating for easy access to quality health services
- Formation of women groups
- Documentation of cases
- Provision of IEC Materials
- Medical follow up for survivors
- Psychosocial support
- Monitoring victims and survivors

These activities are continuously being done by the community service providers.

Jimmy Jennie Arikwanga

PROGRAMME COORDINATOR

***Plot 42, Lia Street
P.O BOX 18 Moroto, Uganda
Email address: Kacoci2006@yahoo.co.uk
Bankers: Stanbic Moroto***



KINTAMPO HEALTH RESEARCH CENTRE (KHRC)



Kintampo Health Research Centre is a well-established health research centre. KHRC is one of three field research centres of the Health Research Unit of Ghana Health Service established in 1994. KHRC is situated in the middle belt of Ghana in the Brong Ahafo Region. However the work of KHRC has implications for health policy and practice throughout Ghana and Africa.

STAFFING

KHRC technical staff are multidisciplinary and comprises various cadres of researchers, social scientists, laboratory, data management and financial and accounting professionals. There are over 500 employees at KHRC. KHRC has accumulated over 12 years of experience in health research in Ghana.

The Kintampo Demographic Surveillance System (KDSS) Over the years, KHRC has developed one of the largest demographic surveillance systems (DSS) and study populations in Africa and has established a reputation for quality research. As a result KHRC is highly regarded and is the preferred partner of governments, organizations and donors in health research initiatives in particular large-scale health research trials.



Fig1. Fieldworker interviewing a study participant

Funding Collaborators

Our funding collaborators include government, bilateral and multilateral institutions, private corporations, private charities and international organizations from Africa, Europe, Canada and the USA.

Priority Research Areas

- Communicable diseases (CDs), particularly Malaria, TB and HIV/AIDS
- Sexual and Reproductive Health
- Maternal, Neonatal and Child Health
- Mental Health
- Non-communicable diseases (NCDs) such as hypertension and cancer
- Health Systems
- Using the DSS to track progress towards MDGs using indicators such as mortality levels, patterns and trends

Our Mission

Our mission is to conduct public health research and develop health research capacity which will contribute to a significant reduction in ill-health and the achievement of the Millennium Development Goals for Africa's most disadvantaged communities.

Our Vision

Our vision is to provide practical needs based research of the highest quality which has a pro-poor and gender equity focus and is used to shape health policy and practice. Furthermore we will build health research capacity of health and health related professionals so that they can effectively address the challenges of health in Africa.

Reproductive Health Research in Times of Emergency

With emerging of crises in Ghana and the West African sub region, especially flooding and occasional armed conflicts and also Ghana being a host to displaced people in the sub region, there is the need for situational analysis of reproductive health needs of those displaced especially as soon as the emergency occurs. Also research among the stable populations after they have been displaced and settled in camps is needed for monitoring and evaluation, policy-making, planning and programming. KHRC has the professionals to conduct such situational analysis and other follow up research.

Kintampo Health Research Centre, P. O. Box 200, Kintampo, BAR, Ghana
Website: <http://www.ghana-khrc.org/>
Member of INDEPTH Network: <http://www.indepth-network.org/>



The Child Health and Development Centre (CHDC) is an interdisciplinary/multi-Sectoral research and training department under the Faculty of Medicine, Makerere University. The Centre has been providing expertise on many health and development issues including conducting and teaching quantitative and qualitative research. The research has covered areas that included among others: Maternal and Child Health, Reproductive Health and HIV/AIDS.

The centre has developed and maintained linkages with the university, government and some communities that work in conflict areas. Some of these institutions include among others PATH, DANIDA, GOAL (Ireland), OXFAM, UNICEF, USAID, World Bank, and World Vision. Government Ministries that have used the Centre's expertise to work in conflict areas include the Ministry of Health, Ministry of Education and Ministry of Finance.

CHDC researchers have been involved in more than 200 studies some of which are in conflict areas on northern and north-eastern Uganda and the Horn of Africa as shown below.

- Kivumbi GW (2006) Baseline Study for Home-Based Care for OVC-HIV/AIDS Prevention and Empowerment (Hope) Project in Hargeisa Somaliland, World Vision International
- Kivumbi GW (2007) Baseline Study for Home-Based Care for OVC-HIV/AIDS Prevention and Empowerment (Hope) Project in Wajid and Tiye glow Somalia, World Vision International
- Kivumbi GW and Nakakande M (2006) Morbidity, Health Seeking, and Mortality Baseline Survey in Karkar Region, Puntland State of Somalia, Save the Children UK
- Arube-Wani, J. and Kivumbi GW (2005). Women against AIDS project evaluation. Funded by Pentecostal Churches of Uganda.
- Jitta, J., Sekiwunga, R. and Nangendo, F. 2002. Facts on HIV/AIDS, STDs and sexual and reproductive health in Nakapiripirit district, Uganda. Funded by DANIDA Kampala.
- Jitta, J. et al. 2002. Facts on HIV/AIDS, STDS and sexual and reproductive health in Kitgum district, Uganda. Funded by DANIDA Kampala.
- Jitta, J., Nangendo, F. and Sekiwunga R. 2002. Facts on HIV/AIDS, STDs and sexual and reproductive health in Kotido district, Uganda. Funded by DANIDA Kampala.
- Jitta, J., Nangendo, F. and Sekiwunga R. 2002. Facts on HIV/AIDS, STDs and sexual and reproductive health in Gulu district, Uganda. Funded by DANIDA Kampala.
- Jitta, J. et al. 2002. Facts on HIV/AIDS, STDS and sexual and reproductive health in Pader district, Uganda. Funded by DANIDA Kampala.
- Jitta, J. et al. 2002. Facts on HIV/AIDS, STDS and sexual and reproductive health in Moroto district, Uganda. Funded by DANIDA Kampala.
- CHDC, 2005. Sanitation levels and factors associated with current practices in Karamoja region: A study of Nakapiripirit district. Funded by DANIDA.
- Kivumbi GW, Oola, L. and Odong, V. 1997. Monitoring the socio-economic impact of AIDS in Gulu district, UNICEF.
- Okone, N. K. 1996. The beliefs and perceptions of out-of –school youth towards HIV testing and counselling in Ibuje sub-county, Apac district.



MBOGO HEALTH CARE & MATERNITY

Nammere Zone, Mpererwe P.O. Box 10993 Kampala - Uganda

Tel: 256-712-804403, 256-753-804403, 256-712-449417

Email: mbogohcm@yahoo.com

We care where others don't

Date: 03rd October, 2007

Mbogo Health Care and Maternity is an agency which runs health care programs and maternity services in the three years of its existence, it has been able to educate women and adolescents in child bearing age about the risks they are likely to face and the related problems in reproduction.

We have been able to carryout the following activities successfully and results show us that there is an impact in the society where we operate.

MATERNITY AND HIV/AIDS IN MOTHERS

- Women in Wakiso District and Kawempe Division have been educated and awareness created to them through seminars and counselling sessions about;
 - Pregnancy complications hysterectomy.
 - To practice safe motherhood by those who became pregnant while they are HIV-AIDS positive.

EARLY PREGNANCY PROBLEMS IN YOUTH

- Adolescents in surrounding villages and schools have been educated and awareness has been created to them on how;
 - To avoid an intended pregnancies and not to carry out abortions.
 - To overcome rape crisis if it happen and how to avoid it in case it has not happened yet.
 - To avoid early sex because it causes unwanted pregnancies, cancer of the cervix, STIs like gonorrhoea, syphilis and HIV-AIDS.
 - To overcome abandonment by men who impregnant them.

• IMMUNIZATION

We carryout immunization services in conjunction with KCC Health Office Kawempe Division and this has been so every Wednesday of each month.

• FAMILY PLANNING SERVICES

The agency carries out family planning services to families around in places like Kiti, Kawempe, Kyanja and Ttula. Many people come for services like getting condoms, pills, moon beads, injections and counselling.

Summarily, awareness has been created, women and adolescents have been educated and also given support especially those affected and infected.

Namubiru Lydia Mugalu

Health Care and Maternity Programme Officer



The Marie Stopes International (MSI) Global Partnership is a sexual and reproductive health (SRH) information and services provider that works in 38 countries worldwide.

MSI has a solid and longstanding track record in SRH service delivery in emergency settings and has been at the forefront of international initiatives to institutionalise reproductive health (RH) in refugee settings. These initiatives include the Inter-Agency Working Group on Reproductive Health in Refugee Settings (IAWG), the Reproductive Health for Refugees Consortium, the development of the Minimum initial services package, the Inter-Agency field manual, and most recently, the **Reproductive Health Access, Information and Services in Emergencies (RAISE) – Initiative**.

The MSI emergency response is targeted at refugee and internally displaced people (IDP) and include services such as family planning, safe motherhood (including antenatal, delivery and post partum care), emergency obstetric care (including treatment of abortion related complications), and the prevention and treatment of sexually transmitted diseases and HIV. Some current examples of emergency activities conducted by MSI partners include:

- **MSI Afghanistan (MSIA):** Establishment in 2002, MSIA is among the few organizations providing comprehensive RH service in the country. MSA has built good relations with the government and is closely involved in the building of a post conflict health system. MSI trained more than one thousand health professionals from Government, NGO and the private sector. It provides RH/MCH services and information through 15 clinics, 2 mobile units and community based workers and uses social marketing to expand access and availability of contraceptives (condoms, pills, IUDs).
- **MSI Bangladesh (MSCS):** As an immediate response to the 2007 floods, which affected nearly 10 million people across the country, MSCS has been providing primary health care, RH services, as well as safe drinking water to affected populations. Working closely with government authorities, MSCS provides services through 23 satellite camps, supports government health centres, and has five mobile clinic teams operating continuously.
- **MSI Sri Lanka (PSL):** For many years, PSL has been providing SRH services to IDPs in conflict affected districts in the north and east of the country. In addition to MCH and RH services, PSL is conducting education and awareness raising programs in IDP communities addressing a wide range of issues varying from nutrition to gender awareness. Social marketing is used to expand access and availability of contraceptives (pills, condoms).
- **MSI Timor Leste (MSTL):** In February 2007, MSTL opened a centre in Dili to respond to the enormous unmet need for SRH information and services, which had been further heightened due to the recent conflict that led to the displacement of nearly 130.000 people. In addition, MSTL started a 'midwives on bikes' - outreach program to provide door to door services and information to vulnerable populations and isolated communities, including IDPs.
- **MSI Uganda (MSU):** MSU has a long history of providing services to IDPs in conflict affected areas in the North. In addition to the provision of comprehensive SRH services through its static and mobile clinics, MSU, in collaboration with district health authorities and other stakeholders is focusing on training and capacity building of health workers. It uses social marketing to increase the availability of condoms to IDPs in the camps. MSU is also extending its services through the RAISE program.



PATHFINDER INTERNATIONAL
Addressing Gender Based Violence in Refugee Camps

Background

The Extending Service Delivery (ESD) project, funded by USAID's Bureau for Global Health, is designed to address unmet need for family planning (FP) and increase the use of reproductive health and family planning (RH/FP) services at the community level, especially among underserved populations, in order to improve health and socioeconomic development. To accomplish its mission, ESD strengthens global learning and application of best practices; increases access to community-level RH/FP services; and improves capacity for supporting and sustaining RH/FP services. ESD works closely with USAID Missions to devise tailored strategies that met the RH/FP service delivery needs of specific countries. A five-year Leader with Associate Cooperative Agreement, ESD is managed by Pathfinder International in partnership with IntraHealth International, Management Sciences for Health, and Meridian Group International, Inc. Additional technical assistance is provided by Adventist Development and Relief Agency International, the Georgetown University Institute for Reproductive Health, and Save the Children.

In November 2006, the ESD project secured agreement and financial support from the USAID East Africa Mission to implement activities to strengthen efforts of United Nations High Commission on Refugees (UNHCR) to improve RH/FP and increase awareness about gender based violence (GBV) among refugees living in camps in Dadaab and Kakuma, Kenya. ESD made a commitment to work with implementing agency staff in the camps, refugee community champions, and religious leaders through a series of trainings of trainers (TOT), cascade trainings, and subsequent community mobilization activities focused on RH/FP and GBV.

In collaboration with UNHCR, ESD identified the following gaps with respect to GBV:

- Inadequate knowledge and skills among refugee community health workers related to community engagement on GBV.
- Refugees' understanding of GBV was limited to a rights-based approach. They did not understand the determinants and consequences of GBV, specifically how gender norms and constructions of masculinity and femininity promote GBV.

ESD's approach

Given that men are the gatekeepers in this society, i.e., they control women's mobility, social contacts and/or access to health services and other resources, ESD's intervention is designed to help male youth and men find non-violent ways to resolve conflicts in private and public life, as well as to encourage them to develop alternative and healthier ways of defining their own masculinity. Because youth is a critical stage of gender role formation, ESD decided that involving youth is an opportunistic time to change their gender attitudes and norms, and transform their notions of gender power dynamics, before they become deeply ingrained. ESD's Healthy Images of Manhood (HIM) program promotes positive images of masculinity (loving, caring partners and fathers) whereby men take responsibility for their actions towards themselves and their partners. Two best practices, The Raising Voices, "Domestic Violence: A Training Process for Community Activists" and the Promundo "Project H" curriculum were adapted for the "HIM" program that completed in September 2007.

ESD's accomplishments

To date ESD has accomplished the following training activities:

- Trained more than 200 refugee health workers on RH/FP and GBV and strategies for community mobilization;
- Trained more than 150 refugee Gender Champions on The Raising Voices, "Domestic Violence: A Training Process for Community Activists" curriculum, which uses participatory approaches and group discussions to analyze community gender norms and their relationship to GBV;
- Trained 30 refugee trainers on Healthy Images of Men (HIM);
- Trained 30 refugee and community Religious Leaders on RH/FP and GBV.

For more information please contact:

Extending Service Delivery Project

1201 Connecticut Avenue, NW, Suite 7000, Washington, DC 20036

Tel: 202-775-1977

Fax: 202-775-1988

Email: esdmail@esdproj.org



Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative

Developed by Columbia University's Heilbrunn Department of Population and Family Health in the Mailman School of Public Health and Marie Stopes International (MSI), the **Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative** is a 5-year multi-agency, multi-country programme which brings together leading service delivery and advocacy partners to bring about change in the way reproductive health (RH) is addressed in emergencies, both at grassroots and international levels.

The overarching goal of RAISE is to ensure that after five years, the full range of RH needs - including emergency obstetric care (EmOC), family planning (FP), prevention and treatment of STIs, prevention of HIV/AIDS and response to gender-based violence – is addressed in refugee and IDP situations as part of standard humanitarian response to emergencies.

One critical step in attaining both service delivery and advocacy objectives has been the collection of essential baseline data in the field in RAISE focus countries (Colombia, Uganda, Sudan and Democratic Republic of Congo) and on relevant global policies and funds. The baseline studies, which are near completion, provide a unique tool that enables RAISE and its partners to identify RH needs and gaps, to determine action, as well as to monitor and evaluate progress in RH service delivery on the ground and within global policies and funding.

Another core development has been the opening of the RAISE Training Centre at Marie Stopes Eastleigh Nursing home in Nairobi, Kenya, earlier this year. At the centre, staff working in RAISE-supported facilities receive vital clinical training to enable them to provide the highest quality of RH care in emergency settings. Participants take part in competency-based training sessions following a modular format. The first training was held on FP in August and all areas will be covered in forthcoming trainings. The next training will take place in November focusing on EmOC.

To increase provision of RH services in the early stage of emergencies, the RAISE Emergency Fund has been established to enable rapid disbursement of small grants to partners.

The RAISE Initiative also advocates for policies and funding that will systematically address the RH needs of IDPs and refugees. By raising awareness of RH challenges in IDP and refugee situations and of the consequences of inaction, RAISE works to mobilize key humanitarian actors - including UN agencies, international bodies, donor governments and host countries - to include RH as an integral part of humanitarian response and action.

RAISE is committed to the dissemination of research and programme results through published articles in leading journals, technical meetings and through the website (www.raiseinitiative.org). A major information sharing event in this regard will be the RAISE Reproductive Health in Emergencies Conference 2008, to be held in Kampala, Uganda from June 18-20, 2008.

RWANDA VILLAGE CONCEPT PROJECT

Contacts: Jean Claude Mugunga, rvcp_coordinator@yahoo.com,
jcmugunga@gmail.com,
www.rwanda-vcp.org +250 08843370 +250 08483135

ACTIVITIES ON REPRODUCTIVE HEALTH AND HIV/AIDS PREVENTION

A. Introduction on Rwanda-VCP:

The RVCP is a non political, non governmental, non profit making and voluntary, development organization aiming at improving the health and the living standards in underprivileged communities at village level as well as student's capacity building.

Rwanda has been deeply upset by the 1994 genocide, and the ensuing events, and is yet to come to terms with its past. The event caused the uprooting hundreds of thousands orphaned and widowed. Most of the population (98%) in the project's target area has been resettled there since 1994. The villages there have accordingly experienced massive unrest due to the newly settled population, widows and orphans, which now represent the majority of the population, causing demographic imbalance with huge economic impact. The living standards and the health conditions of the population have deteriorated considerably due to domestic crisis in Rwanda. The needs assessment showed various needs apart from health, with strong inter-linkage and inter-dependencies. However, health remains the central focus.

Currently the RVCP activities are mainly based in the Huye District/Southern Province of Rwanda. The RVCP was initiated in 2000 by Medical Students at National University of Rwanda in collaboration with the International Federation of Medical Students Associations (IFMSA) and the field work started in 2002.

RVCP follows the guidelines of the Village Concept Project Document, created in co-operation between

IFMSA and WHO in Geneva, 1998 and revised in 2003.

Is currently conducting 5 micro projects (MP) and 2 initiatives(In): Reproductive health ,HIV/AIDS Prevention and family planning MP, Malaria prevention MP, Hygiene, Water and sanitation MP ,Women/girls empowerment(Pyramid) MP, Income generation MP, LLCCM Orphanage Center support In, and Huye Health Center Support In.

B. Reproductive health, HIV/AIDS Prevention and Family Planning Activities:

Focus:

Target group: All the people mostly the non schooling adolescents
Anatomy and the physiology of the genitals.

Love and sexual relationships to promote behavior change.

HIV/AIDS (symptoms, methods of transmission, prevention, voluntary testing as well as

Culture, Gender and HIV/AIDS and Reproductive health
Sexual transmitted diseases (STDs) and Family planning.

Methodology:

-Train local youth leaders.

8 weekly 2-hour sessions with target group: Use of IECs materials
Sessions (PEER EDUCATION) include: Practical demonstration,
Mobile cinema, Interactive games

-Testimonials from HIV positive youth

- Voluntary Counseling and Testing

-Formation of Anti-HIV/AIDS Clubs with drama groups and Vocational skills promotion

-Economic support for PLWH through promotion and initiation of vocational skills projects



Unmet Needs in Reproductive Health

Childbirth, already a leading cause of death among women in many resource poor countries, becomes even more life-threatening in situations of conflict and crisis. Globally, one in seven women will face a complication during pregnancy or childbirth leading to over 500,000 maternal deaths each year, with 99% of this mortality in the developing world.

Many of these pregnancies are not planned or not spaced at least two years apart, which can contribute to the risk associated with pregnancy and childbirth for the mother and newborn. Research has shown that more than 130 million couples would like to delay or prevent pregnancy, but are not currently using any form of contraception to help them achieve this goal.

While reproductive health services and practices in 'stable' refugee situation have improved, serious shortfalls exist in internally displaced person camps. Globally, by December 2006, there were an estimated 9.9 million refugees and 24.5 million persons internally displaced due to conflict⁹

Countries in conflict or some form of instability continue to have the highest maternal and neonatal mortality rate, and poor reproductive health indicators.

- Fewer than 15 percent of births are attended by skilled health personnel in Afghanistan, Chad
- Less than 5 percent of women use modern contraception in Chad, Democratic Republic of the Congo (DRC), Afghanistan, Guinea

Increasing Quality and Access

Save the Children's RH program recognizes the needs and rights of individuals to protect and maintain their reproductive health, and the critical relationship of a woman's health to the well-being of her child. We are committed to working with partners at the global, national and local levels to heighten understanding and awareness of these needs, to work to address them, and to build capacity to implement high quality and sustainable, RH programs. Maternal and newborn deaths are clustered around the time of labor, delivery, and the immediate postpartum period. It is estimated that, if there was universal access to key reproductive health services, and practices during this critical time two thirds of maternal and newborn death could be averted.

⁹ Internal Displacement Global Overview of Trends and Developments 2006

Save the Children RH programs and activities promote:
Community participation: in the provision of reproductive health formation and services

Maternal and Newborn Health: Save the Children supports the Household to Hospital Continuum of Care, the Minimum Initial Service Package (MISP) for Reproductive Health, and is testing the feasibility and effectiveness of community-based prevention of PPH. Save the Children supports the integration of essential newborn care services and practices in all its maternal health programs

Family Planning: Save the Children supports, access to high quality, voluntary family planning information and services. It strengthens community-based delivery of family planning, and is currently testing the feasibility and acceptability of outreach injectable contraception.

Adolescent Reproductive and Sexual Health: Save focuses on behavior-centered life skills development and the adoption of positive practices that will protect and improve young peoples' reproductive health outcomes.

Case Study: West Darfur, Sudan. Save the Children began its program in West Darfur in early 2004. Sudan has the highest number of internally displaced persons, estimated at 5 million, in the world. Save the Children currently provides health care to more than 200,000 conflict-affected persons in West Darfur. Through its health program, Save the Children provides emergency obstetric care in seven locations, family planning in ten centers, and medical care for children. Save the Children, with grants from OFDA, the RAISE initiative, ECHO, and NOOW plans to expand its reproductive health program by opening new emergency obstetric centers, and expanding its family planning service points.

Save the Children supports reproductive health programs in Afghanistan, Bangladesh, Bolivia, Egypt, Ethiopia, Guatemala, Guinea, Indonesia, Mali, Malawi, Mozambique, Nepal, Pakistan, Philippines, Sudan, South Sudan,



Uganda, Vietnam, Malawi, he
Save the Children
54 Wilton Road
Westport, Connecticut 06880
1-800-728-3843
www.savethechildren.org

Amsalu – ramsalu@savechildren.org and Winifride Mwebesa – wmwebesa@savechildren.org



UNHCR progresses towards Reproductive health needs quality comprehensive coverage September 2007



Provision of reproductive health (RH) care is essential to meet UNHCR core role in protecting the rights of the refugees. UNHCR strategies and activities aim to reduce maternal and newborn morbidity and mortality, to reduce the transmission of STIs and HIV, to prevent and manage the consequences of sexual and gender based violence and to prevent unwanted and mistimed pregnancies with special attention to adolescents.

Advocacy - Improvement of safe-motherhood as well as SGBV and HIV are UNHCR priorities and got special support in 7 countries through the High-Commissioner (HC) special project since early 2007. Pending assessment of the impact of the special project, more countries should be included in 2008. However the first and tangible impact is the rise of programme managers' awareness on reproductive health and the commitment to work towards clear objectives contributing to the UN Millennium Development Goals 3, 4, 5 & 6.

Monitoring - Although Health Information is collected in all operations, the quality and relevance still varies greatly. However compared to previous years, data collection in general, and data collection of reproductive health information more specifically, has greatly improved through the implementation of the new standardized Health Information System designed by UNHCR and partners. We shall continue to strengthen monitoring and guidance in order to improve reproductive health services. Data analysis and assessments of the reproductive health services provided to refugees and other people of concern to UNHCR, suggest that considerable progress was achieved in coverage of services, but critical shortfalls still exist in the quality and comprehensiveness of services.

Minimum Initial Services Package (MISP) - Since the MISP training is online all UNHCR health and nutrition coordinators have been requested to do the training. In 2005 and 2006, all UNHCR health coordinators as well as Implementing Partners (IPs) working in West-Africa and Great Lakes region had been trained on MISP implementation. Today the MISP components are implemented as a baseline in UNHCR operations.

Maternal and New-born Care - Antenatal coverage is generally high in most settings (over 95% in Ethiopia and in Nepal) but the lack of qualified midwives, ill-equipped delivery rooms, and traditional/ cultural believes often combined to prevent deliveries taking place in health posts (10% in Ethiopia, 17% in Nepal end of 2006). The detection of obstetric complications depends fundamentally on routinely available quality obstetric services and trained and qualified staff. The upgrading of health structures, the special attention given to strengthen emergency obstetric care and the improvement of staff skills, covered by the High Commissioner Special Project, dramatically improved the quality of services rendered to pregnant women. Improvement of access and quality eases services promotion and result in the slow increase of service utilisation and better pregnancy outcomes (rise to 40% health centre deliveries in Ethiopia by mid-2007). As part of efforts to restore women's dignity, UNHCR has been trying with some success to facilitate access to refugee women to fistula repair programmes.

Family Planning - Acceptance to family planning services remains low, though slowly increasing, with quite satisfying results in countries such as Nepal (29%), Bangladesh (25%) or Chad (17%). Cultural norms and the continued gap between male and female perspectives on the issue form obstacles that require continuous efforts, commitment and active involvement from health care providers, community services and refugee communities. Acceptance of family planning services among the refugees is increased through improvement of the quality of the services, positive attitudes of service providers, proper supplies provision and continues information of all members of the community.

GBV - Whilst it remains difficult for survivors to come forward and to seek care, UNHCR and its partners endeavour to generate as much sensitisation and awareness as possible amongst the refugee community. Health care services in most camps have been upgraded to provide emergency care and treatments such as STIs management, Emergency Contraception and Post Exposure Prophylaxis. The clinical management of survivors of sexual violence has been further strengthened through training and increased community awareness. Long-term communication efforts have been either initiated or continued to reduce rape incidence, domestic violence and traditional harmful practices such as Female Genital Mutilations. Though it is difficult to show figures that prove success of these efforts, we believe that progress has been made towards reduction of these problems, in particular in protracted situations in Asia and Africa.

STIs including HIV/AIDS - UNHCR strives to develop well-coordinated multi-sectoral and multi-partner approaches in close partnership with refugees, hosting communities, governments, civil society, UN partners and UNAIDS, ensuring that conflict-affected communities have access to the full spectrum of services: prevention, care and mitigation. As a result of UNHCR advocacy both in the field and at Headquarters, there has been a marked increase in the number of host countries including refugees in their HIV/AIDS National Strategic Plans (NSPs). Without inclusion in NSPs, protection and programming refugee populations are often overlooked. As the UNAIDS designated lead for HIV/AIDS and IDPs, UNHCR is also steadily increasing advocacy for this under-represented population of concern.



UNFPA Working in Humanitarian Response

Since 1994, UNFPA has supported emergency projects in more than 60 countries and territories in order to meet the emergency reproductive health needs of population affected by crisis. From contingency planning to post-conflict reconstruction, UNFPA strives to make every birth safe, every pregnancy wanted, and every girl and woman treated with dignity and respect.

Capacity Development and Training

1. UNFPA Staff and partners capacity strengthening as part of an internal 3 year strategy:

In the past year UNFPA recruited additional number of staff at regional and country level: Two regional coordinators for East and West Africa and 11 dedicated humanitarian staff to work in country offices to increase country offices capacity. In addition GBV coordinator and logistician were hired at headquarter level to focus on improving UNFPA response and prevention to gender based violence and the efficient and prompt delivery of RH commodities in settings of humanitarian concern. A humanitarian officer's workshop was organized in Nairobi for UNFPA staff from 17 countries and territories in Africa and Middle East. The participants were trained and oriented on MISP and UNFPA role in emergency response. In August two day workshop was conducted with UNFPA partner Mercy Malaysia to build the capacity of their staff and volunteers (50 participants) in RH and Gender within their emergency response. UNFPA is advocating and working very closely with the Indonesian Ministry of Health to integrate MISP into their emergency response and curriculum, accordingly a national workshop was conducted in August 2007 in Jakarta with participation of more than 100 participants from central and regional government to promote the inclusion of MISP in emergency response at national level.

2. UNFPA Initiatives on Training:

GBV coordinator is continuing with training activities among partners on the "Clinical Management of Rape" trainings with an outcome of more than 400 people had been trained, IASC GBV Guidelines roll-out covering 3 regions and 5 countries (Colombia, North Uganda and Thailand) IAWG-Training partnership with IPPF and the University of New South Wales (UNSW) on Sexual and RH Program in Crisis and Post-Crisis Situations in East, Southeast Asia Pacific" also known as "SPRINT", which aims to implement the SRH Minimal Initial Services Package in emergency situations (MISP) at the regional, national and local levels.

Coordination

With partners UNFPA works and coordinates closely with many UN and non UN agencies at global Level to promote ICPD agenda in the new humanitarian reform agenda; such as cluster approach e.g. (Health, Protection, Early Recovery), IASC Sub-Working Group on Gender, including the GBV group and newly created HIV Task Force, UN Action and IAWG Annual meetings.

Data collection

UNFPA supports and actively involved with data collection; example of this support is in the reproductive health survey conducted by CDC and JSI in Liberia and GBV-HIV/AIDS Survey conducted in Cote d'Ivoire.

Technical Support

UNFPA provides technical support and evidence base in the development and revisions of normative tools such as: revision of the IAWG Reproductive Health Manual, rapid diagnostic testing for syphilis, revision of the RH kits and on the evidence of utilization of the new kiwi reusable OmniCup vacuum extraction device.

Activities

Support Interagency RH kits for orders, distribution list by country and by partners see annex 1. 2006 UNHCR and UNFPA are targeting population for raising awareness in the Positive Lives Exhibition which toured refugee camps and settings in West Africa and developed a community discussion guide. UNFPA works very closely with DPKO and uniformed services on HIV/AIDS and security in several countries. UNFPA in partnership with UNICEF is working on targeting adolescent needs in emergency settings



Women's Commission for Refugee Women and Children

The Women's Commission for Refugee Women and Children (Women's Commission) works to improve the lives and defend the rights of refugee and internally displaced women, children and youth.

Recent Activities - Over the past year, the Women's Commission:

- participates in the Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative and partners with JSI, MSI and Columbia University to collect data on RH policies in emergencies and conduct advocacy;
- spearheaded and now co-leads, along with WFP and UNHCR, an Interagency Standing Committee (IASC) Task Force on Safe Access to Firewood and alternative Energy (SAFE) in Humanitarian Settings as well as an International Network on Household Energy in Humanitarian Settings;
- contributes to the update and revision of *Reproductive Health in Refugee Settings: An Inter-agency Field Manual*;
- participates in the Humanitarian Health Caucus and leads the advocacy and information sharing working groups;
- successfully advocated to include the MISP in OFDA's guidelines for health and nutrition programming;
- successfully encouraged UNFPA to include the MISP Module in its orientation packet for new staff;
- conducted an RH assessment in northern Uganda and advocated for increased attention to RH services, particularly family planning;
- traveled to Jordan to conduct interviews with Iraqi refugee women and youth on their RH needs and disseminated findings through videos, reports and presentations;
- **provides ongoing support to two adolescent RH networking groups using the information provided by local and international partners for advocacy purposes at the international level;**
- collaborates with NGOs in the development of a Global Campaign to Stop Rape in War;
- works to maintain current U.S. government and increase European and Canadian support for RH services in displaced settings;
- manages RHRC Consortium website and the IAWG electronic community.

Documentation & Dissemination - The Women's Commission, mostly on behalf of the Reproductive Health Response in Conflict (RHRC) Consortium, has published the following tools for humanitarian workers to address reproductive health (RH) in crises. All of these resources can be downloaded at www.rhrc.org or www.womenscommission.org.

- *Minimum Initial Services Package (MISP) for RH in Crisis Situations: A Distance Learning Module*, 2006
- *Field-friendly Guide to Integrate Emergency Obstetric Care in Humanitarian Programs*, 2005
- *Emergency Contraception for Conflicted-Affected Settings: A Distance Learning Module*, 2004
- *GBV Tools Manual: For Assessment, Program Design, Monitoring and Evaluation in Conflict-Affected Settings*, 2004
- *GBV Communication Skills Manual*, 2004 (with Family Health International and the International Rescue Committee)
- *Guidelines for the Care of Sexually Transmitted Infections in Conflict-Affected Settings*, 2004
- *HIV/AIDS Prevention and Control: A Short Course for Humanitarian Workers. Facilitator's Manual*, 2004

Next Steps - The Women's Commission will work to:

- advocate to UN agencies, donor governments, foundations and INGOs to prioritize comprehensive RH in crises to improve the RH policy and program environment to promote the delivery of quality RH services to women, men and youth affected by armed conflict;
- continue to monitor and collect data on the policies of UN agencies, donor governments, foundations and INGOs related to comprehensive RH in crises;
- achieve a commitment from humanitarian organizations to institutionalize implementation of the MISP in their health sector emergency response;
- continue to advocate and monitor reproductive health recommendations from Uganda and Jordan missions.
- conduct an RH assessment mission (possibly in collaboration with UNFPA) to Occupied Palestinian Territory
- integrate the MISP Module into humanitarian emergency courses;
- advocate for the successful completion of the MISP Module by all relevant UN and NGO representatives;
- facilitate IASC Task Force SAFE completion of field-friendly guidelines to address fuel-related issues in all phases of an emergency;
- plan the first conference on fuel-related initiatives and technologies in humanitarian settings;
- develop policy paper and document advocating for more attention and resource to family planning in emergencies;
- advocate for the inclusion of and specific outreach to men and boys in all RH programming;
- promote dissemination of critical knowledge to humanitarian workers to address the HIV pandemic;
- support the increase of capacity (knowledge, skills and funding) of local and international NGOs and their staff to provide RH services to conflict-affected women, men and youth.

September 2007

For more information and to receive copies of reports and resources contact:

Mihoko Tanabe • Women's Commission for Refugee Women and Children

122 East 42nd Street • New York, NY 10168-1289

mihokot@womenscommission.org • www.womenscommission.org

IAWG Tenth Annual Meeting

72