

## Section 2

### Evaluation of coverage of reproductive health services for refugees and internally displaced persons

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### **Acknowledgements**

We would like to express our gratitude to all of those who completed questionnaires for the study, and in particular those who helped us to disseminate and collect questionnaires in those areas under their responsibility. We could not have completed the study without their assistance.

The funding for this component of the Inter-agency Global Evaluation of Reproductive Health Services for Refugees and Internally Displaced Persons was provided by UNHCR

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**Appendix 2:** Refugee and IDP populations by country of asylum included in the study (Criteria for inclusion: Non-OECD countries hosting more than 10,000 refugees or IDPs)

**Appendix 3:** Forms A and B (study questionnaires)

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\* The appendices are available on a CD-ROM containing the report and other documents related to the evaluation.



## **Executive summary**

The purpose of this evaluation was to establish a baseline of RH services available to conflict-affected populations and to identify the gaps in service provision. Countries with a minimum of 10,000 refugees or IDPs were identified and a questionnaire, posing questions about the RH services available to the refugee and IDP populations in a single settlement, was emailed to key informants in 73 countries in March 2003. The questions referred only to the availability of services, as quality of care and usage were beyond the scope of this evaluation. Key informants were followed up through email, phone and fax to collect completed forms and to clarify any missing or questionable information.

One-hundred-and-eighty-eight questionnaires were received from refugee and IDP settings in 33 countries in Africa, Asia and Latin America, covering approximately 8.5 million displaced people (82% refugees, 18% IDPs), three-quarters (76%) of whom lived in camps, 6% in urban areas, and the remainder in non-camp settings. More than two-thirds of sites (68%) had 2-4 elements of antenatal care (ANC), while 32% offered comprehensive ANC. Basic emergency obstetric care (EmOC) was available in 45% of the sites, while comprehensive EmOC was available directly or through referral in 39% of sites. Nearly all sites reported offering at least one method of family planning with oral contraceptive pills (96%), condoms (95%) and injectable hormones (89%) the most commonly available methods. Some aspects of HIV prevention were reported to be widely available, such as condoms (94%), the correct practise of universal precautions (90%), and community-based AIDS education (89%), while diagnosis and treatment of STIs were available at 84% of sites. In over half of the sites, programs for the prevention (57%) and the response (59%) to gender-based violence were in place; community education and awareness-raising took place in 79% of sites, while psychosocial support and counseling were available in 64% of the sites. Additionally, in 60% of sites, emergency contraception was available to survivors of rape, and two in three (66%) sites had guidelines for medical personnel's response to incidents of sexual violence, while one in three (33%) had such protocols for security personnel and protection officers (39%).

The results, by technical area, suggest that coverage of RH services is fairly good. In contrast, GBV is weak, and other areas such as HIV/AIDS prevention and EmOC could (and should) be stronger. Coverage decreases with the newness of the technical area; GBV, the newest, least familiar and most difficult area, has the lowest coverage, while antenatal care, the most familiar, most standard and easiest to provide, has the highest coverage. Despite some shortfalls, given the status of RH for populations affected by armed conflict in the mid-1990s, the results are promising. Even if they overestimate care, it is clear that a wide range of sites and a meaningful absolute number of sites provide RH services.



## Introduction

1. In support of the Inter-agency Global Evaluation of Reproductive Health Services for Refugees and IDPs, the Heilbrunn Department of Population and Family Health (HDPFH) of Columbia University's Mailman School of Public Health undertook an evaluation of coverage of reproductive health services for refugees and IDPs. The purpose of the coverage study, which is the second component of the Global Evaluation, was to establish a baseline of the RH services available to conflict-affected populations and to identify the gaps in service provision.

## Methodology

2. A list of countries of the world and the number of the population of interest (refugees and IDPs) residing in each was compiled (*Annex 1: Refugee and IDP Populations by Country of Asylum*). This list was drawn from the UNHCR *Statistical Yearbook 2001*<sup>1</sup> and the US Committee for Refugees' *World Refugee Survey 2002*<sup>2</sup> as well as the IDP Project (<http://www.idpproject.org/>) website and other relevant sources. In addition to displaced populations that fall under the purview of UNHCR, the list includes refugee and IDP populations that are not considered "persons of interest to UNHCR," such as Palestinian refugees (information gathered from UNRWA <http://www.un.org/unrwa>).

3. Criteria to identify the specific countries to be included in the study of coverage of reproductive health services were defined in consultation with the steering committee of the global evaluation. Only countries with a minimum of 10,000 refugees or IDPs were included, and member countries of the Organisation of Economic Development and Cooperation (OECD) were excluded.<sup>3</sup> Countries that were excluded by these criteria but retained in the study, by decision of the Steering Committee, include Turkey (which is an OECD member) and countries neighbouring Colombia that may be hosting more refugees than reported given the worsening situation in Colombia. (*Annex 2: Refugee and IDP Populations by Country of Asylum included in the study*)

4. With the assistance of the Steering Committee, potential field-based key informants for each country or site were identified. Key informants included health or reproductive health coordinators, country representatives, and others with responsibility for the (reproductive) health of the population of interest in UN, governmental and non-governmental organizations. These key informants were asked to identify an individual responsible for (reproductive) health in each refugee or IDP settlement in the country or region they cover who could complete a basic inventory of the RH services available to the population in the specific site.

5. Two brief questionnaires were developed (*Annex 3*). Form A asked for a list of the settlements or camps and the displaced population in the area. Form B posed

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<sup>1</sup> UNHCR Statistical Yearbook, 2001, *Refugees, Asylum-seekers and Other Persons of Concern -Trends in Displacement, Protection and Solutions*, October, 2002.

<sup>2</sup> US Committee for Refugees, *World Refugee Survey 2002: An Annual Assessment of Conditions Affecting Refugees, Asylum Seekers and Internally Displaced People*. Immigrations and Refugee Services of America, Washington, DC. 2002.

<sup>3</sup> [www.oecd.org](http://www.oecd.org)

questions on the RH services available to the refugee or IDP population in a single settlement. Questions covered all aspects of RH services: safe motherhood including emergency obstetric care, family planning, sexually transmitted infections (STIs) including HIV/AIDS, gender-based violence (GBV) and RH services targeting adolescents and men. Respondents were asked to include all RH services that are available to the population, including those provided directly in the site and those for which clients are referred. In addition, respondents were asked to take into account all providers of health services (government, NGO, religious, private). The questions, mostly asking the respondents to mark 'Yes' or 'No', refer only to the availability of services; quality of care and usage were beyond the scope of this study.<sup>4</sup> The questionnaire was pre-tested in several field sites and revised accordingly. Finally, the questionnaire was translated into both French and Spanish.

6. Data collection took place from 5 March through 21 May 2003. Questionnaires were distributed via email and fax to key informants in 73 countries. Both forms were sent to an initial key informant who was asked to complete Form A by listing the names, type and population of all refugee and IDP settlements in the area under his/her responsibility. He or she was then asked to identify an individual with responsibility for (reproductive) health in each settlement and ask each to complete Form B for his or her specific site. Key informants were followed up primarily through email, but also through telephone and fax, to collect completed forms and to clarify any missing or questionable information. In addition, if a key informant was unable to provide the requested information, he/she was asked to identify someone else who had the information. An effort was made to contact a second or third key informant in cases of non-response. Data were entered, cleaned and analysed using EpiInfo 2002.

## Findings

7. One hundred and eighty eight questionnaires were received from refugee and IDP settings in 33 countries in Africa, Asia and Latin America. Data was thus received from 33 of the 73 countries included in the study (see Annex 2 for the results of contacts with each country). Some Form B questionnaires include only one settlement per questionnaire (the intended use of the form), while others included information from multiple sites on one form.

8. The results cover approximately 8.5 million displaced people, representing approximately 24% of the estimated 34.8 million refugees and IDPs around the world.<sup>5</sup> Over four in five (82%) of these people were refugees, while 18% were IDPs. Approximately three-quarters (76%) lived in camps, 6% lived in urban areas, and the rest lived in gatherings, neighborhoods, or other non-camp settings. The number of people per health facility can be found in Table 2.1. Nearly two in three sites (65%) reported having a reproductive health coordinator.

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<sup>4</sup> Another component of the global evaluation will pursue questions regarding quality of the RH services provided to refugees and IDPs and factors that facilitate or hinder the provision of these services.

<sup>5</sup> US Committee for Refugees. *World Refugee Survey 2003*.



**Table 2.1: Displaced population per health facility**  
IAWG RHR Coverage Study, May 2003

Health facility type	Population per facility
Health post	23,917
Health centre	21,464
Hospital	36,048

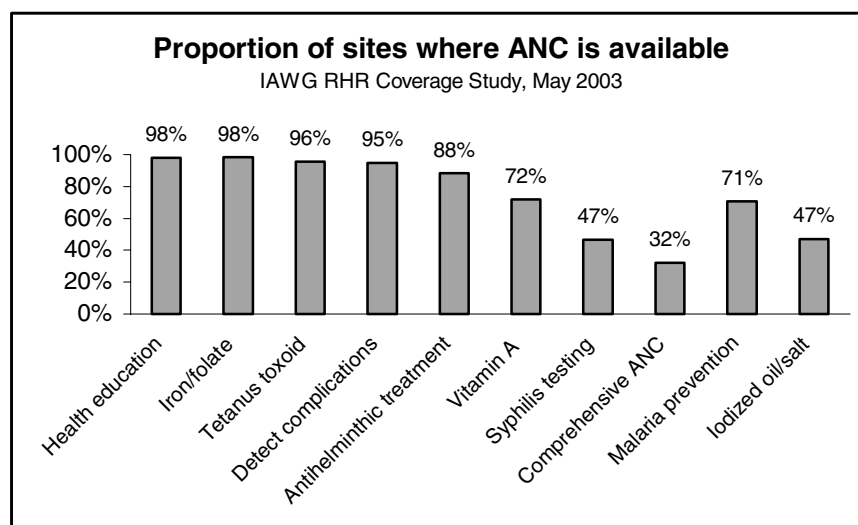
### Safe motherhood

Antenatal care includes the following services:

- Health education/counseling about pregnancy-related topics;
- Iron and folate prophylaxis;
- Tetanus toxoid immunization;
- Detection and management of antenatal complications;
- Anthelmintic treatment (mebendazole);
- Vitamin A supplementation;
- Routine syphilis testing and treatment (RPR, VDRL);
- Routine malaria prevention (effective drugs, bed nets);\*
- Iodized oil/salt (in areas of moderate to severe iodine deficiency).

9. All sites (100%) reported having at least one element of antenatal services; more than two-thirds (68%) had 2-4 elements. One in three (32%) sites offered comprehensive antenatal care (including the first seven elements listed above). Routine malaria prevention was provided in 71% of the sites, and iodized oil or salt was provided in nearly half (47%) of all sites.<sup>6</sup>

**Chart 2.1**



\* In those locations where this problem is relevant.

<sup>6</sup> Respondents who indicated malaria and/or iodine deficiency is not a problem in their location were excluded from the respective denominator.

10. Nearly three in four (74%) sites provided clean delivery kits for safe home deliveries. More than half (56%) used the partograph to monitor the progress of labor in health facilities.

11. The six elements of basic emergency obstetric care (EmOC) are:

- Parenteral antibiotics;
- Oxytocic drugs;
- Anticonvulsive drugs;
- Manual removal of placenta;
- Removal of retained products;
- Assisted vaginal delivery.

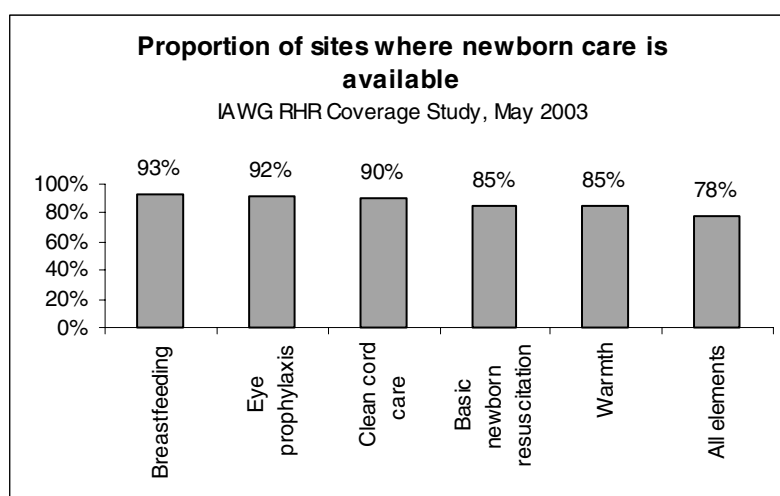
12. Basic EmOC was available to the population in 45% of the sites. Comprehensive EmOC, which includes all six elements of basic EmOC in addition to obstetric surgery (including anesthesia) and safe blood transfusions, was available directly or through referral in 39% of sites.

13. Essential newborn care includes the following services:

- Early and exclusive breast feeding;
- GC prophylaxis (tetracycline eye ointment);
- Clean cord care;
- Basic newborn resuscitation;
- Warmth (drying and skin-to-skin contact).

14. While most sites reported having at least one element, all elements of newborn care were available in 78% of sites.

**Chart 2.2**

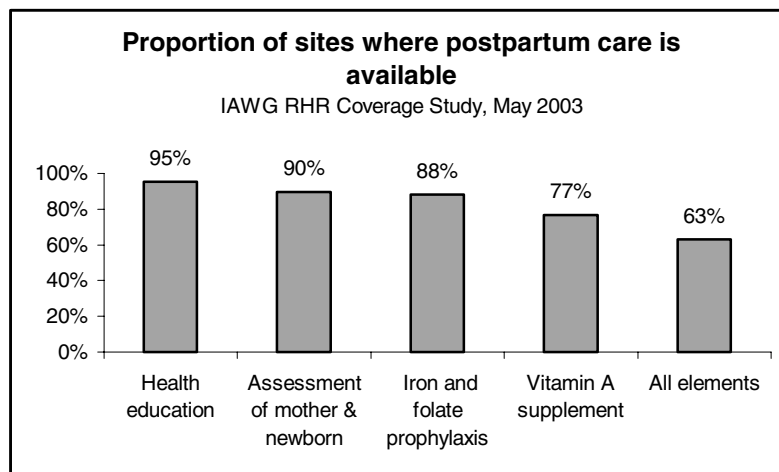


15. Postpartum care includes the following services:

- Health education;
- Assessment of mother and newborn (within 24-48 hours after birth);
- Iron and folate prophylaxis;
- Vitamin A supplementation.

16. While most sites reported having at least one element, 63% reported that all elements of postpartum care were available.

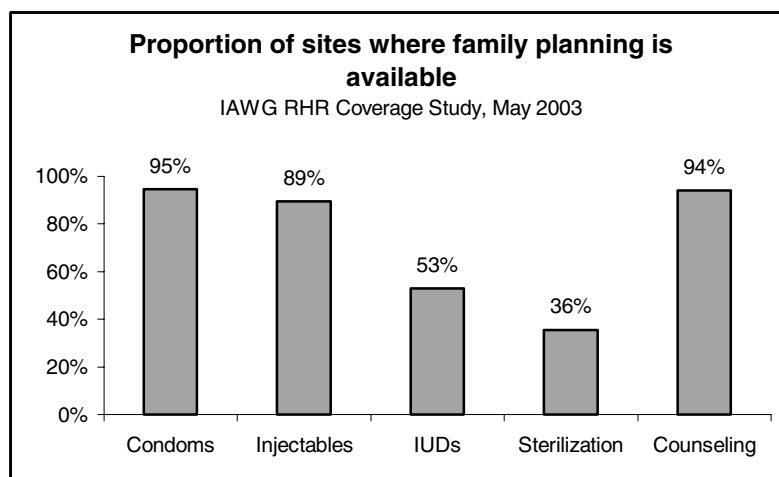
**Chart 2.3**



### *Family planning*

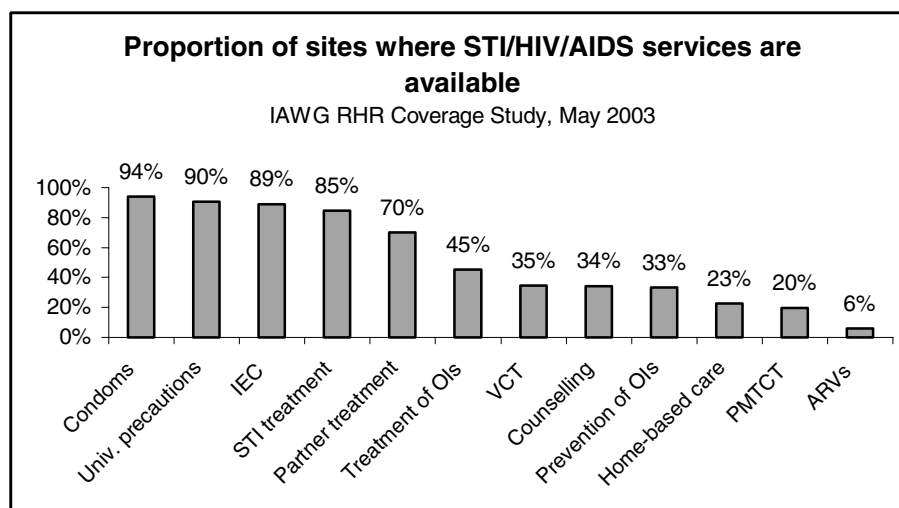
17. Aside from a handful of sites in Afghanistan and Pakistan, all sites reported offering at least one method of family planning. Oral contraceptive pills (96%) and condoms (95%) were the most commonly available methods, followed closely by injectable hormones (89%). In just over half (53%) of sites, intra-uterine devices (IUD) were available, while voluntary surgical contraception was available in approximately one of three sites (36%). Finally, counseling on contraceptive choice was offered in 94% of sites.

**Chart 2.4**



*Sexually transmitted infections, including HIV/AIDS*

18. As might be expected, some aspects of HIV prevention were reported to be widely available, such as condoms (94%), the correct practise of universal precautions (90%) and community-based AIDS education (89%). Diagnosis (syndromic or laboratory-based) and treatment of STIs were available in 84% of sites, and partner notification was encouraged in 70% of sites. Just over one-third (35%) of sites reported that voluntary counseling and testing for HIV was available to the displaced population. One in three sites (33%) reported preventing and 45% treating opportunistic infections for HIV-positive individuals. Home-based care for people living with AIDS was reportedly available in 23% of sites. One in five (20%) sites provided services to reduce mother to child transmission of HIV, while just over one-third (34%) counseled HIV-positive pregnant women on infant feeding choice. Finally, anti-retroviral therapy was available in only 6% of sites.

**Chart 2.5***Gender-based violence*

19. In over half of sites, programs for the prevention (57%) and the response (59%) to gender-based violence were in place. Community education and awareness raising took place in 79% of sites, while psychosocial support and counseling were available in 64%. Site design was addressed in 53% of sites to increase security for women. In 60% of sites, emergency contraception was available to survivors of rape. Two in three (66%) sites had guidelines for medical personnel's response to incidents of sexual violence, while one in three (33%) had such protocols for security personnel and protection officers (39%).

*Special target groups*

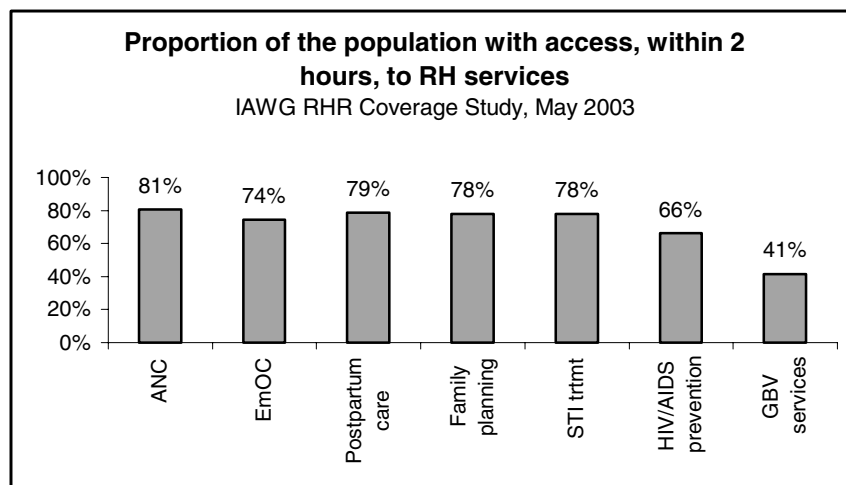
20. More than two-thirds of sites provided information and education about RH and sexuality to adolescents (70%) and men (69%), but only one in three provided youth-friendly RH services after school or work hours (36%) or RH services targeted specifically to men (32%).

### Access to RH services

21. Note that the results discussed above refer to the proportion of *sites* with each service; since sites contain greatly different numbers of people, these figures do not necessarily reflect the proportion of refugees and IDPs who have access to RH care. Therefore, respondents were asked to provide their best estimate of the percentage of the population who has access, within two hours by common local transportation, to RH services. The proportion of the population with access to the different services, weighted by population, can be found below.

22. At least half of the population was reported to have access to all seven categories of RH services in 47% of sites.

**Chart 2.6**



### Limitations

23. As with any study, there are potentially confounding limitations that are discussed here to prevent misinterpretation of the results.

24. Although an attempt was made to gather information on RH services for refugees and IDPs in all countries that met the criteria for inclusion in the study, the analysis is limited to those sites for which a response was received. Sites for which a key informant took the time and effort to respond and ensure that respondents in the sites under their responsibility completed the appropriate forms may be different from countries where no one responded. It is possible that those countries with an RH Coordinator or better RH programmes were more likely to respond leading to an overestimation of RH coverage. Likewise, these data primarily cover refugees (82%) in camps (76%), and are not representative of displaced populations around the world.

25. This study addressed only the availability of RH services; questions about quality, detailed accessibility or usage, which are extremely important, were beyond the scope of the survey. Interpretation of the results should take into account the fact that just because services are available does not mean they are accessible, of good quality or that the population uses them.

26. Respondents were asked to mark 'Yes' or 'No' to a list of RH services available, either directly or through referral, in their site. Although this is relatively

straightforward, some may have interpreted the questions differently and marked 'Yes' only to services available to a majority of the population or most of the time, while others may have indicated 'Yes' if the service was ever available at all. Further, definitions of services may have been inconsistently applied. For example, some respondents may have interpreted prevention of mother to child transmission of HIV to mean that nevirapine is available, while others may have marked 'Yes' even if no antiretrovirals were provided.

27. Some countries host both refugees and IDPs. Although attempts were made to gather information on both populations, information about IDPs was often more difficult to access. For example, efforts to gather information on IDP populations in Eritrea and Indonesia were unsuccessful although IDPs are more numerous than refugees in both countries.

28. Population numbers gathered from UNHCR and the US Committee for Refugees differed in many cases from the numbers reported by the key informants on the ground. In Togo and Kazakhstan, for example, officials told us that the country has no refugee population, while the data indicated they had at least 10,000 people. Although numbers can change quickly in the humanitarian field, it is unclear why such large disparities exist, how the original numbers were calculated, and what is the reality.

## Discussion and conclusions

29. Given the limitations discussed above, the results provide a general overview of the availability of reproductive health care to refugees and IDPs around the world. Looking at the results by technical area, coverage of RH services appears to be fairly good. GBV is weak however, and other areas such as HIV/AIDS prevention and EmOC could (and should) be stronger. There is no excuse for less than 100% coverage on some services, such as antenatal care and EmOC.

30. Coverage decreases with the newness of the technical area. GBV, the newest, least familiar and most difficult area, has the lowest coverage, while antenatal care, the most familiar, most standard and easiest to provide, has the highest coverage.

31. Despite some shortfalls, given the status of reproductive health for populations affected by armed conflict in the mid-1990s, the results are promising. Even if they overestimate care, it is clear that a wide range of sites and a meaningful absolute number of sites provide RH services. This is impressive especially given a starting point of few if any RH services available ten years ago.<sup>7</sup>

32. Identifying the cause of the improvement in RH care from the mid-1990s up to now was not a part of this study; however it may be reasonable to posit that attention to RH and the work of UNHCR, UNFPA, IAWG and member agencies was instrumental. The development of policies and guidelines may have been useful in expanding the provision of RH services to displaced populations. We know from program experience that attention must be maintained to keep services and quality high; therefore updating this database regularly is recommended.

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<sup>7</sup> Wulf, Deirdre, *Refugee Women and Reproductive Health Care: Re-assessing Priorities*, Women's Commission for Refugee Women and Children, June 1994.