

Section 3

Evaluation of quality, access to and use of reproductive health services for refugees and internally displaced persons

This component of the Inter-agency Global Evaluation of Reproductive Health Services for Refugees and Internally Displaced Persons was undertaken by Dr James Blogg, Ms Carina Hickling, Ms Leissa Marceau-Pitts, Ms Deborah Raphael, Dr Anna Whelan, Dr Anthony Zwi, and The University of New South Wales, School of Public Health and Community Medicine.

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The principal team members were Dr Anna Whelan, Dr James Blogg and two recent graduates from UNSW's Master of Public Health programme – Carina Hickling, a gender-based violence specialist working with NSW Attorney-General's Department and Leissa Marceau-Pitts, currently working with Family Planning Australia.

UNSW established an advisory group for this project including Professor Anthony Zwi, Ms Deborah Raphael, Dr Rachel Burdon, Dr Pascale Allotey and Dr Eileen Pittaway. The advisory group reviewed the material and planned the evaluation methodology.

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Executive Summary

The School of Public Health and Community Medicine (SPHCM) at The University of New South Wales (UNSW), Australia conducted evaluations of reproductive health services for refugees and internally displaced persons (IDPs) in three countries: Uganda, Republic of Congo (RoC) and Yemen between February and April 2004. This study was the third component of the Inter-agency Global Evaluation of Reproductive Health Services for Refugees and IDPs. The objectives of the study were to: evaluate the range and quality of reproductive health services (RHS) provided to refugees and IDPs and identify factors that facilitate or hinder the provision of services; and identify factors that facilitate or hinder access to, use of and satisfaction with RHS, from the perspective of the beneficiaries of these services.

Eleven sites in three countries were evaluated and 46 group discussions were held with over 800 refugees. Audits were carried out on 14 health facilities and interviews were organized with their staff.

Findings indicate that reproductive health was clearly on the agenda at policy level in all countries and sites, but that there are still gaps and problems in implementation, resources and funding.

The quality of services is variable, with health staff often experiencing 'burnt out' and living in difficult environments with poor infrastructure. High staff turnover meant that training needed to be repeated frequently, and that lessons learned may not be sustained. Differences were found in the levels of technical skills and knowledge in reproductive health, and cooperation with traditional birth attendants (TBAs) who usually provide the majority of maternal care was not consistent. In some sites, they are an integral part of the health service; in others they are unknown.

Gender-based violence (GBV) is probably the least developed aspect of reproductive health. Women are being raped within marriage and entering into early and underage marriages for bride price. Adolescents, particularly the girl child, are at increased risk of being exposed to GBV in refugee and IDP communities, requiring additional support and resources, especially in relation to their experiences of rape, forced marriage, access to and knowledge of reproductive health services.

IDPs experience a critical lack of access to reproductive health services due to a range of factors. Insecurity and political instability continue to impact directly on health care provision in some sites and regions and recovery from previous conflict in terms of human resources is an ongoing impediment.

The basic health infrastructure in most countries with refugee populations is already poor and overstretched. The majority of refugee populations are being hosted in developing countries, where basic infrastructure such as roads, electricity and running water may not exist, basic health services such as safe blood for transfusion are not available, and referral hospitals are not equipped to provide high quality care to their local populations. Combined, these deficiencies greatly affected access to emergency obstetric care.

Refugee access to treatment for common sexually transmitted infections (STIs) was usually poor or inadequate. This is a major concern considering the high prevalence of HIV/ AIDS in most of the host and refugee populations assessed.

Safe and adequate water, sanitation systems, electricity, and communication systems were not always available in the camps and settlements visited. In addition, food for refugee populations is at times in short supply. Malaria and infectious diseases take their toll on pregnant women and young children, and preventable maternal deaths due to inadequate transport and inappropriate health seeking behaviours. This situation applies to both locals and refugees and requires further attention from donor agencies and host governments before any further gains or improvements can be made in reproductive health.

The following conclusions and general recommendations are applicable to the three study countries.

Referral was problematic for most health services due to location, transport, communication and personnel issues. Referral centres were often also unable to offer comprehensive services necessary to ensure good reproductive health (RH) outcomes (e.g. limited access to blood, drugs and appropriate investigations). Host governments need to participate in planning for refugee health services and may need extra support.

- Formalize referral networks and strengthen referral systems with strategic planning.

Work needs to continue with host governments on developing safe and accessible blood supplies, for both locals and refugees.

- Assist host governments to develop and implement safe blood supply systems.

Training in syndromic STI management and in emergency obstetric care (EmOC) will ensure that drug supplies are used more efficiently.

- Ensure availability of essential drugs for managing STIs and for EmOC at health centres in all sites.

Women continue to die of and suffer with the sequelae of incomplete and unsafe abortion, and without appropriate post abortion care training and supplies, this will continue.

- Ensure availability of essential equipment for post abortion care at health centres in all sites.

Violence against women constitutes a significant impediment to poverty reduction and development and has a major negative impact on women's reproductive health. Medical personnel generally needed more training to recognize the signs of GBV. Awareness raising should include culturally appropriate methods, involving traditional leaders and legal authorities, including camp security committees.

- GBV awareness raising activities should take place in all refugee camps and with all staff working in camps.

New strategies need to be developed and implemented to address sexual exploitation of the young. Services need to target the young to ensure that they have good access to treatment for STIs and EmOC including health promotion and outreach programmes, if necessary.

- Target young girls with support for specific income generating programmes to alleviate poverty and sexual exploitation.

Health services need to offer appropriate and affordable models of care for refugees that routinely incorporate the view of users.

- Review health services to ensure that they meet the needs of refugees/IDPs. The review process should include analysis of: clinical activities (measure against community needs); staffing allocations and human resources management (to minimize problems such as 'burn-out'); pharmacy dispensing against clinical guidelines; and data collection systems.

Malaria is a significant cause of morbidity and mortality among refugees and IDPs. The volume of cases threatened to overwhelm services at some sites. High treatment failure rates indicate that effective treatment regimens need to be used.

- Support introduction of effective malaria case management and prevention strategies.

Where TBAs are active in communities but not affiliated to existing health services, implementing partners (IPs) should seek to work with them. New strategies need to be developed to identify active TBAs, determine their level of skills, knowledge and attitudes to RH issues. Training needs to be assessed and implemented to address concerns of late presentation. TBAs who undertake training and can demonstrate safe practises should receive Safe Delivery Kits. TBAs who perform extensive roles in the health service should be recognised with incentives, similar to Community Health Workers (CHWs). A review of the role and workload of TBAs is indicated.

- IPs should develop a strategy to understand the role and build on the capacity of TBAs, who perform the majority of births in refugee settings. Training and supply of kits should be linked to provision of safe care. The role of TBAs should be reviewed in relation to midwives, and ensure appropriate recognition.

In some cases, refugee camps and settlements have existed for lengthy periods of time, calling for community-based approaches to behaviour change. Any new approaches should seek to go beyond simple Information, Education and Communication (IEC) campaigns and embrace Behaviour Change Communication (BCC) strategies.

- Support introduction of effective community-based education and development programmes.

In many cases, data are recorded but on closer examination, the wrong information is being collected. All data needs to be useful and fed back regularly to health facility staff, not only to UNHCR and IPs. All maternal and infant deaths require a systematic review to look for root causes and lessons to be learned.

- Improve data collection methods on RH and educate staff on how to establish rates and set up simple systems that provide useful information. Establish audits and root cause analysis of maternal and infant deaths.

Introduction

1. In support of the Inter-agency Global Evaluation of Reproductive Health for Refugees and Internally Displaced Persons, the School of Public Health and Community Medicine at The University of New South Wales undertook an evaluation of the quality, access to and use of reproductive health services for refugees and IDPs in Uganda, Republic of Congo, and Yemen, which comprises Component 3 of the Global Evaluation.

Methodology

Selection of countries

2. Out of the 33 inventoried countries (see Section 2 of this report) six countries were excluded due to recent RH evaluations (Angola, Zambia, Kenya, Tanzania, Democratic Republic of Congo, and Thailand). Myanmar, Colombia, Philippines were excluded from the evaluations because of the small numbers of refugees currently on their territories. Five were excluded due to travel warnings and security concerns emitted by UNSW and the Australian Government (Liberia, Burundi, Afghanistan, Pakistan and Occupied Palestinian Territory). A further five were excluded due to ongoing repatriation of refugees, as well as the small number of mandated refugees or lack of IDPs (South Africa, Libya, Namibia, Syria and Lebanon).

3. Of the remaining 14 countries, six were in Africa, three in Central Asia, two in the Middle East, one in Central America, one in South Asia and one in South-east Asia. The UNSW team submitted the list of countries to the IAWG Steering Committee. The aim was to select countries that provided a sample with:

- regional and cultural balance;
- significant refugee and IDP populations;
- multiple sites with refugees and /or IDPs;
- a range of contexts and providers (camps, settlements and urban), including areas that were stable and unstable; and
- reasonable security and access.

4. The final selection by the Steering Committee of four countries included Uganda, Republic of Congo, Yemen and Nepal. Subsequently it was found that WHO/UNHCR had recently undertaken a joint evaluation of health services (including RHS) in Nepal. UNHCR country staff in the three selected countries identified suitable sites, facilitated field visits and assisted with contacting IPs. UNHCR also allocated staff to assist the team to carry out the evaluation in RoC and Yemen. IPs in the selected sites were contacted and arrangements were made for recruitment of refugee participants and appropriate interpreters.

5. A Focus Group Discussion (FGD) was held in Brussels at the RHRC Consortium Conference in October 2003 with participants from Uganda, Nepal, Yemen and RoC

to gain ideas and insights on the range and quality of RH services and how best to incorporate the views of beneficiaries into this component of the evaluation. Specific advice was sought on the methods to recruit refugee participants, the appropriateness of small gifts to participants, as well as a range of other cultural and religious considerations. One major issue emerging from the group was the view that institutions from the selected countries should have been involved in the evaluation from the outset.

Ethical considerations

6. The research team was very aware of the ethical issues relating to working with refugee populations.¹ A key concern in evaluation methodology has been how to incorporate the views of beneficiaries so that a participatory approach is adopted.² UNSW required approval from the Human Research Ethics Committee (HREC) before fieldwork could proceed. Essentially ethical considerations revolved around 'arms-length' recruitment of refugees for focus groups; assurances that no coercion would be involved in recruitment; subject information sheets and informed consent; assurance that no adverse effects would result from the study nor any physical or emotional distress. Confidentiality of participants would be ensured and data collected would be stored securely for seven years. After several clarifications, approval was given in two stages (HREC 03190 and 03246).

Proposed evaluation tools

7. Evaluation tools were selected from the RHRC Consortium's Health Needs Assessment Field Tools and Monitoring and Evaluation Toolkit³ (www.rhrc.org) — the Health Facility Questionnaire and Checklist, Group Discussion Questions and Refugee Leader Questions and the Client Exit Interview Protocol. These tools were refined and submitted to the Steering Committee, with several modifications suggested to make them more relevant to assessing the quality of RHS from the viewpoint of beneficiaries (see Appendices 1-3). The Health Facility Checklist was also modified to include the most recent treatment recommended for STIs and EmOC from WHO as well as the essential drugs for managing complications in pregnancy and childbirth.

Data collection methods

8. Briefings. On arrival in country, briefings were held with UNHCR and NGOs prior to leaving for the field. Once in the field, briefings were conducted with the Camp Commandant (where appropriate) and IPs, prior to the group discussions and Health Facility Checks. Data on the camps and services was often presented in these meetings. This provided a sound background and context and raised issues of concern of the service-providers. Protocol in some areas also required that

¹ Learning J. Ethics of Research in Refugee Populations. *Lancet*, 2001, 357 (9266): 1432-1433.

² Kaiser T. *Participatory and beneficiary-based approaches to the evaluation of humanitarian programmes*. Geneva, UNHCR EPAU, 2000.

³ RHRC Consortium. *Refugee Reproductive Health Needs Assessment Tool Kit*.
http://www.rhrc.org/resources/general_fieldtools/needs_menu.htm

introductions to the Chief of the Village be conducted as well as formal introductions to the Refugee Camp Leaders.

9. Focus Group Discussions. In some cases, focus group discussions were larger than optimal or the norm, however, we worked around this by using group discussions as community consultations. Each team member conducted group discussions separately in Uganda and Yemen. However, in RoC where French was the official language, group discussions were attended by all team members visiting the site. One or more interpreters was allocated to each team member, and was briefed and shown the question list and ethics information sheet, and agreed to comply with confidentiality. Whenever possible, interpreters were chosen from existing refugees or paid interpreters rather than health staff. It was not always possible in all group discussions to exclude health staff as they sometimes had the appropriate language combination (English/French and the particular refugee dialect). Nor was it always possible to provide a female interpreter for women's discussions. For example, in the case of the integrated Rwandan women's group discussion, a male leader had to act as interpreter from French into the local dialect. All groups were asked if they were happy to have an interpreter who was not of the same gender and only in one case did women (TBA group, Yemen) refuse a male interpreter. On this occasion, a female TBA interpreted the proceedings.

10. The questions asked in group discussions were occasionally modified to elicit more information and clarifications on certain points were sought by the team and sometimes by the interpreters as well. At various points, interactions were highly animated and rather than disrupt group dynamics and to steer the discussion away from issues the refugees wanted to discuss, pre-prepared sets of questions were on occasion left aside. Questions were also rephrased to meet the requirements and sensitivities of a particular age and gender group being consulted. The principal aim was, at the end of the group discussion session, to have obtained in-depth information on the key technical areas of RH services – Safe Motherhood (including EmoC); Family Planning (FP); STIs including HIV/AIDs; and gender-based violence (GBV); and the perceptions of participants regarding accessibility, utilization of, and satisfaction with, these services.

11. Refugees participating in the discussions were chosen by IPs to provide a representative sample of various locations within each camp or settlement. Representatives included a cross-section of patients who had presented on the day as well as those who had been invited specifically by local refugee leaders. Team members shared small food items with the groups during the discussions where appropriate. This was not always the case and a clear assessment of the given situation was required prior to the sharing of goods or food. In some cases such as Uganda, IPs provided refreshments for participants at the end of lengthy group discussions.

12. A written and taped record of discussions was kept. At the end of each session, team members met with the interpreter to clarify issues and points from that particular group. The entire team then met to summarize the day's findings. Whenever possible, notes from all the groups were transcribed within a day or two of group discussions. At the end of each country mission, a report was drafted, circulated between team members and then sent to country IPs and UNHCR for verification and clarification, the only exception to this was in the case of Yemen.

13. Health Facility Checklist. The Health Facility Checklist (HFC) was a powerful tool and was used to provide a clear framework to assess the state of clinics visited. A few modifications were made to this tool as some of the questions proved to be repetitive, poorly sequenced or were sometimes shown to be unnecessary. In general, one or two team members conducted different aspects of the HFC with several health staff. While this was time-consuming, it was considered vital to check and clarify issues raised by the refugees during group discussions. We found that it was preferable to conduct the briefing first with the camp commander, and then meet refugee leaders, followed by completion of the HFC and then to cap these activities, hold group discussions and walks through the camps or settlements. It was vital to understand the standard and administration of each health facility before undertaking discussions with users. Fourteen HFCs were carried out in all: four in Uganda, six in Congo and four in Yemen.

14. Referral Hospital Review. In addition, the nearest hospital to each camp/settlement for emergency referrals was also reviewed, although it was not usually possible to complete the HFC in full at these facilities. However the Medical and/or Nursing Directors were welcoming and provided relevant information and data on transfers from camps/settlements and permitted detailed observation and questioning of hospital staff. In one case, seven staff were called in to review maternal mortality cases occurring in 2003 and 2004 (Moyo, Uganda).

15. Supplementary Methods. The Exit Interview protocol was less useful as clients had usually been waiting long hours and were reluctant to prolong their visit. However, the team succeeded in holding seven interviews with people seen in the OPD at Kiryandongo, Uganda. These interviews complemented the picture presented through group discussions. In addition, team members walked through a section of each camp/settlement to collect supplementary data through observations and chance encounters chatting with refugees in their homes. This allowed the team to validate some of the information already collected in group discussions. In Congo, the evaluation team slept the night in a Health Centre located in the centre of the settlement. These supplementary methods provided opportunities for the team to validate some of the information already collected from group discussions on conditions mentioned by refugees.

16. Sample Sizes. The sampling frame was based on the notion that individual perceptions of health care services may be influenced by a number of factors including gender, age and ethnicity. Thus, the sample attempted to reflect the various sub-groups found within a large camp population (including formal and informal leaders both male and female, women's groups, youth, users of RHS and non-users if possible).

17. It was estimated that the total sample for the three countries would include approximately 90 key informant interviews, as well as interviews with 10 health workers and field staff in each site (three sites within each country). Four focus group discussions (FGD) were held in each site, and focus groups would have around eight to ten participants, this meant that there were approximately 360 beneficiaries in all. In reality, the sample size was much greater in the group discussions because of the number of refugees who insisted on participating. Given that the aim of the study was to gain views of beneficiaries, it was considered vital to include as many as possible of those who volunteered and consented. In one site, participants had

walked 7-10 km to participate. In another, men from a range of ethnic backgrounds insisted on being represented and there was some tension when it became apparent that a FGD of 8-10 would not allow this. The facilitator quickly decided that, in order to reduce the tension, all who had turned up would be included. This gave an unwieldy number of 48 in that group, which was then managed over two hours with each sub-group representing all the ethnic groups in the camp being consulted sequentially (5 Somalis, 10 Sudanese, 1 Burundian, 24 Rwandans, 5 Congolese and 3 Ethiopians).

18. In effect, as mentioned earlier, these larger groups functioned more as community consultations, although there was still a dynamic interaction between participants. Team members recorded how many people spoke up during the group discussions, with an average of 80% speaking in the smaller groups of less than 25. This indicates that there was participation from individuals even though the groups were large for a focus group (normally 8-10). In larger groups (more than 25), the participation rate was less than 80% but many FGD members exchanged opinions amongst themselves.

19. The total sample of refugee participants was 816: 379 in Uganda, 287 in Congo and 150 in Yemen (see breakdown in each country section).

Timing of the evaluation

20. The evaluations were conducted in Uganda in February 2004, in the Republic of Congo in February-March 2004 and in Yemen in April 2004. Timing was a significant factor as the Sudan Peace Talks were underway, and this affected the camps and settlements in Uganda. For example, Sudanese refugees were asking the team what they knew of the talks from their understanding of the situation from the radio. In Uganda, refugees expressed their concerns about the future and possibility of repatriation into an uncertain security situation in Sudan. In Congo, the large population of IDPs camped on the edge of Brazzaville were repatriated to their homes in Pool, shortly after our visit. They were concerned about security, returning to destroyed infrastructure and the difficulty of returning to a place where no resources were available to help them resettle. In Yemen the status of Ethiopian refugees had not yet been resolved and we arrived just after a 'sit-in' outside UNHCR headquarters in Sana'a. The tensions in Iraq and threat of terrorism were also a constant concern. This external context is important to consider as this report provides only a snapshot in time, and some of the events clearly were uppermost in the minds of refugees, some of whom insisted on discussing such concerns before they would talk about reproductive health services.

Findings - Uganda

Evaluation sites

21. Three sites, each with different UNHCR implementing partners (see Table 3.1), were evaluated in Uganda including Kiryandongo in the west of the country (International Rescue Committee - IRC), Nakivale in the south-west (Ugandan Red Cross Society - URCS), and Moyo-Palorinya in the north (African Development and Emergency Organization - ADEO).

22. In some sections of this country report, comparisons are made with the statistics provided by the MoH in the HSSP report and with data supplied by UNHCR and IPs. The quality of the data is not possible to verify, and in some cases, there were clearly errors when we reviewed them; for example antenatal coverage figures are given as a percentage that is greater than 100%.

23. The findings reported here are based on the HFCs at four HCs (at least one in each site), 19 group discussions with over 350 refugees (six-seven group discussions in each site), observation of services and informal discussions with refugees during walks, interviews with health staff and managers and observation of the referral hospital for each settlement. In addition, briefings from government officials and health staff provided background information.

Table 3.1: Population of refugee settlements - Uganda

District (Settlements)	Site no. (IP)	No. Refugees	No. Nationals	IDPs
1. Masindi (Kiryandongo) Established in 1990	Site 1 (IRC)	14,435 Sudanese (99%) Rwandans (1%)	11,000	6,000 resident in area since 1989
2. Mbarara (Nakivale) Originally established in 1962 for Tutsi refugees. Then received Hutu exodus in 1994.	Site 2 (URCS)	15,304 Rwandans (83%) Burundians (19%) Congolese (8%) Somalis (6%) Sudanese (0.5%) Ethiopians (0.4%) Kenyans (0.02%)	5,080 A further 1500 squattling within settlement	
Mbarara (Oruchinga)		4,258	23,600	
3. Moyo Palorinya settlement. Established in 1994	Site 3 (ADEO)	31,520 refugees (end of January 2004)	20,319	

Source: UNHCR annual and monthly refugee statistics, 2003 findings.

24. **Kiryandongo.**⁴ The camp was settled in 1990, largely with Sudanese refugees. The current figures are 14,385 Sudanese and 19 Rwandans. About 7,000 Sudanese had been transferred from the Kitgum transit camp in 1990 after unrest in 1989 from the Lord's Resistance Army (LRA). Between 1990 and 1994 many Rwandans were voluntarily repatriated. Locals and refugees are settled in the same area. The aim of Uganda government policy is self-reliance. All services are available to both refugee and local populations. The current peace talks in Sudan were considered to have a major impact on the future of the settlement, with possible voluntary repatriations in the next 5-10 years.

25. The Kiryandongo settlement is made up of three ranches. Each ranch is about five square miles in size and divided into 30 clusters. The area has been plotted and surveyed so that allocation of land is perceived as fair. Thirteen thousand residents are considered as self-reliant and 1,000 still require relief aid and are considered as extremely vulnerable individuals (EVIs).

⁴ Based on briefings with Camp Commandant (OPM), and Deputy Camp Commandant, Field Manager.

26. The settlement is the result of a tripartite agreement between the Government of Uganda, the Director of Refugees in the Office of the Prime Minister and UNHCR. The government's role is to issue land and provide a Police Post to enforce law and order amongst local and refugee populations. The major implementing partner is the IRC, which has multi-sectoral responsibility for education, health, community services, water and sanitation and gender-based violence services.

27. Local administration is decentralized (as is Ugandan policy) with Settlement Committees in the 3 Ranches and 30 Clusters. There are Refugee Welfare Committees (RWCs) who are elected, made up of ten people, including women⁵. In addition there were Elders Councils (with a strong culture) and Church organizations and groups. It was estimated that literacy rates were about 50%. The major health problems described were malaria, skin diseases, and STIs including HIV.

28. IRC was relatively new in Kiryandongo and had made several changes in staff and procedures when they took over in 2002. Services include: public health - health promotion, disease prevention, health education and outreach. Eighteen CHW refugee volunteers were trained in July 2003. Health education includes Maternal Child Health (MCH), Antenatal Care (ANC), Family Planning (FP), and breastfeeding advice. There are about 70 TBAs but not all of them were trained or in active service. IRC works closely with the Catholic Church and run education campaigns with them. The RH Officer position was vacant and was, at the time of the visit, to be filled in a few weeks. The 'safe area' for women to report GBV was not being used while the position was vacant. There were four midwives and one TBA supervisor on staff who offer ANC, birthing, Postnatal Care (PNC), FP, STIs and EmOC. One midwife had been trained to use Manual Vacuum Aspiration (MVA) to manage complications of spontaneous and unsafe abortion, but very few of these procedures are carried out.

29. **Nakivale.** The camp was settled in 1994 with largely Rwandan refugees. An influx of asylum seekers in 2001 was being housed in a transit area but they made a high demand on services. The total population is 15,062 (4,874 families) - 12,537 are Rwandans, 1,233 Congolese, 861 Somalis, 290 Burundians, 80 Sudanese, 58 Ethiopians, 3 Kenyans in a 84.5 square mile area. There is a tripartite agreement with UNHCR, the Government of Uganda and URCS to provide protection and services for the refugees. URCS is a multi-sectoral IP providing community services, health, education, water and sanitation, logistics and supplementary food distribution. The IP for environment is IRDI. Prior to 1994 and the arrival of URCS there were no health services, few staff and no drugs.

30. The settlement is divided into 22 zones with a number of levels of camp coordination as well as refugees welfare committees (RWC) and Local Committees in each zone. There are also support committees including Health, Water and SGBV Committees. Women formed part of four of the nine existing committees. Pit latrines are encouraged but have to be constructed by refugees. Water is pumped, treated and supplied to a number of sites, but not all zones get water. There is a rainwater-harvesting programme to assist the distant areas but in some areas, SPHERE standards for water are not met.

⁵ It was pointed out that Uganda had progressive gender attitudes, with several women parliamentarians.

31. Income generating activities include training in brick-making and tailoring skills, as well as poultry and pig farming. Girls are actively encouraged to go to school and incentives are given. There are 15 nursery schools for 1-3 year olds (about 3,000 children), with porridge provided in the mornings; there are three primary schools with about 2,500 pupils.

32. GBV was said to be a major problem. Men drank a lot of *waragi* and domestic violence (DV) was common. However, women claimed they did not want their men 'taken away' because they would lose their source of support. In 2001, UNHCR facilitated all stakeholders to develop and implement a workplan for the period 2001-2003. Actions included banning imported *waragi* (only local brews were tolerated as they "were not as strong"); night movements after 10pm were restricted; local patrols questioned all people out late and if drunk they were locked up and released the next day. DV rates were said to have decreased significantly.

33. **Moyo-Palorinya Settlement – North.** The settlement was established in 1995 with services provided previously under Aktion Africa In Need (AAIN) followed by Aktion Afrikan Hilfe (AAH) and then Africa Education Fund (AEF). The African Development and Emergency Organization (ADEO) have provided services in the settlement since 1999. The refugees were said to have similar cultural practises and languages to the locals and that relationships between them were generally harmonious and reciprocal.

34. The Palorinya settlements are home to 31,520 refugees, most of who are Sudanese (as of the end of Jan 2004). There are a total of 27 settlements with a population ranging from 177 for the smallest settlement to 7,984 for the largest settlement. Living in the vicinity of these settlements are Ugandan nationals totalling 20,319 who actually share amenities, including health services with the refugees. Adjumani, on the other side of the Nile River, had 35 settlements and was said to be 'full'. The population at Moyo has been steadily increasing, with an influx of 6,000 people in May 2003. The total area of the Moyo refugee settlement is 10,636 hectares. Each household is supposed to be allocated one hectare of land so that they can be self-reliant. The fertility of the land is variable, which was said to cause difficulties for some households.

35. Food production is thought to have gradually improved between 1999 and 2003. In 1999, there were reported floods, crops were lost and many people died from malaria and diarrhoeal diseases. Since then there have been periods of rain and drought but not floods. UNHCR and WFP undertake a Joint Assessment Mission (JAM) on a bi-annual basis to assess needs and the food self-sufficiency of the refugee population. Distribution was now being phased out with some 60% receiving aid from the World Food Programme (WFP). Food rations have been scaled down as self-reliance has increased. The aim is to ensure that everyone has a daily 2,100 kcal intake but problems have been encountered, particularly in the distribution chain. At the time of the assessment, the WFP was conducting an evaluation of food needs and distribution. ADEO runs a random Food Basket Monitoring (FBM) to ensure that supplies are fairly distributed. Boreholes for water are maintained by the villagers, who either contribute labour or money.

36. SPLA infiltration into settlements presents a security problem, in some cases reportedly sending their children to schools and their wives to settle. The LRA has also abducted women and children, asked for food to be given to them and taken

boys to join their army. Recent rape and murder cases by the UPDF were documented and taken to the Military Tribunal. The main issue for UNHCR is seen as one of 'care and maintenance' or 'marking time', maintaining human dignity and rights, until there is peace in Sudan. Another local concern is the number of cases of possible poisoning or 'witchcraft'. There were nine such cases in 2003, these cases are sometimes classified as 'suicides'.

37. Services are integrated following the PHC concept. The curative services include six HCs (four are Grade 2 and two are Grade 3). The Grade 3 facilities have inpatient beds, and at one of these facilities (Kali HC) there is a laboratory service, which provides HIV testing. Ambulance services run 24 hours a day and priority goes to obstetric and paediatric emergencies. At Kali there is also a Therapeutic Feeding Centre where severely malnourished children are rehabilitated. To support these services there is a Community Based Health Care Programme run by CHWs, TBAs, and CBDAs.

38. RH services include: ANC and PNC (coverage for which was said to be very good); FP (the contraceptive prevalence rate was said to be low); prevention and management of the consequences of GBV (some cases of GBV are reported but many are not); maternity services (deliveries at health units and by TBAs in the community); EmOC, including management and referral (the nearest referral hospital where there are facilities for surgical intervention is in Moyo); and STI and HIV/AIDS services, using syndromic case management.

39. There is a strong HIV/AIDS component, reportedly including the following: VCT in Kali and through outreach to other health units; community sensitisation; IEC campaigns using posters, pamphlets, T-shirt messages, multimedia shows, etc.; peer educators in and out of school, and focal teachers; parent involvement; community leaders' participation; condom promotion and distribution, through static points and also community outlets run by CBDAs; and coordination meetings at settlement and district level.

Access to Health Facilities

40. Health care staff estimated the average distance travelled by the people in their catchment area to reach health services; the distance ranged from a maximum of 10-20 km in Nakivale to 2-3 km at Palorinya. Alternative modes of transport are used, if available. An ambulance was available at all locations, with the exception of Palorinya.

41. Access to health facilities was poorer in some areas than others. For example, Kiryandongo had one sub-group of refugees that had a first aid post run by the CHW but they lived 10 km away; this group expressed their need for better access to the HC. Refugees have to walk long distances in some sections of the settlements, and there are few bicycles or boda-bodas (motorbikes). Roads are also difficult in some parts, depending on weather and degrading of surfaces.

42. Transport is a major issue in all sites, with a limited number of vehicles to transport patients in an emergency and provide outreach services. This is a critical issue for RH emergencies when late referrals may result in maternal morbidity or deaths.

Health facility infrastructure

43. All HCs assessed had no indoor running water, limited access to electricity, freezer facilities, or to blood for transfusion, but all had an EPI cold box and a refrigerator operating on gas/kerosene. At Nakivale HC there was often a problem obtaining water as taps were hundreds of metres from the facility. Mobile phones were available at the HCs at three sites, although at two sites the phones belonged to private individuals. Likewise, radio communication was available at the HCs at three sites. All HCs assessed, except for Belameling, had reasonable inpatient facilities, with the number of beds ranging from 4 at Belameling HC to 67 at Kiryandongo (Panyadoli) HC.

Service statistics

44. Clinics in all sites offered ANC, PNC and FP services but only Kali and Belameling HCs offered these services on specified days. Palorinya also offered STI counselling on Friday mornings and review visits for VCT on Wednesday mornings.

45. At the five HCs in the Moyo area there was a total of 1038 live births in 2003 that were supervised by trained personnel, 66% refugees and 33% nationals.⁶ In the other HCs, the number of births ranged from 122 to 767.

Table 3.2: Service statistics for refugees - Uganda

Health facility	Panyadoli HC	Nakivale HC	Belameling HC	Kali HC
Period	2003	2003	2003 (% refugees)	Jan-Dec 2003 (% refugees)
ANC visits (new and revisits)	5537 (58%)	1,573	540 (170%)	1371 (144%)
TT immunization			116	421
No. of RPR tests	1499 (57%)	1,482	143 (6.3%)	508(11.4%)
Prevalence (% positivity)	17% (16%)			
No. of deliveries	739 (78%)	767	116	421
Caesareans	-		0	1 (Moyo)
Maternal deaths	4	1 (anaemia)	0	1
FP attendances	2904 (88%)	190 (Jan 2004)	1448	2255
STIs diagnosed & treated	1011 (68%)		616	1649
Positive HIV tests		12 / 213	2 / 166 (133	28 / 1137 (68%)
Prevalence		5.6%	refugee) 1.2% (1.5%)	2.5% (1.8%)
SGBV counselled	9		0	2 (reported at health centre)
Attendances		150-200 / day OPD	12752 refugees 2668 Nationals	1145 refugees 139 Nationals
Transfers referred		922	4	13

Source: HFC and monthly reports

⁶ ADEO Service Statistics, 2003.

Equipment and drugs

46. The HCs assessed were generally well stocked with the drugs included on the HFC list. However, ciprofloxacin was not consistently available because it is not included on the standard drug order form and must be ordered separately. It therefore tends not to be ordered regularly.

Table 3.3: Inventory of drugs and equipment – Uganda

Health facility	Panyadoli	Nakivale HC	Belameling HC	Kali HC
Basic surgical equipment and gloves	Yes	Yes	Yes	Yes
Autoclave	Yes	Yes (paraffin)	Yes	Yes
Contraceptives / FP kit	Good stock of OCPs and depo provera	OCPs and depo provera	OCPs and depo provera	OCPs and depo provera
STI drugs	Well stocked including acyclovir	Yes, but no ciprofloxacin . Has acyclovir	Yes, small stock of ciprofloxacin and erythromycin	Yes, no ciprofloxacin & only 5 erythromycin capsules
EmOC drugs	Yes	No IV MTZ	No IV MTZ	No IV MTZ
Oxytocics	Ergot, oxytocin and methylergot	Ergot and oxytocin	Ergot only	Ergot only
Basic gynae instruments	Yes	Yes	Yes	Yes
Vacuum extractor	Yes (not used)	Missing parts	At Kali	Yes
IV catheter & fluids	Yes	Yes	Yes	Yes
Drug storage (dry, dark, off ground)	Excellent storage facility	Yes, good store	Yes, good store	Yes, good store

Source: Health Facility Checklist

47. At Moyo, there appeared to be some communication problems with the HC staff and the programme medical officer (PMO) who supervises the six clinics. The two HCs assessed in Moyo experienced drug shortages, even though the required drugs were held in the ADEO stores in Moyo and the doctor visited the clinics once a week. ADEO is currently expanding its operations to include maintaining the drug stores of all six HCs. UNHCR provided training on drug management for all IPs in October 2003, however the training needs to be conducted regularly due to high staff turnover within IPs. Communication problems should be identified and urgently addressed, if this is not done, it is likely that drug stores at the two HCs assessed are likely to deteriorate.

48. Acyclovir was stocked at two of the HCs that were assessed and is used in the treatment of herpes zoster. Clinical usage has expanded in these HCs to include treatment of genital herpes simplex, which is appropriate and may be beneficial to the prevention of HIV / AIDS transmission.

*Staffing and coverage***Table 3.4: Profile of health staff at facilities assessed - Uganda**

Health workers	Panyadoli HC (Kiryandongo)	Nakivale HC (Mbarara)	Belameling (Moyo)	Palorinya (Moyo)
Midwife	4 (1 refugee)	2	1	3 (1 refugee)
Nurse	4 (1 refugee)	2	1 refugee	3
Nurses asst	9 (4 refugees)	6	2 refugee	6 (5 refugees)
Clinical Officer	2	1	1	2
Doctor	1	1	0.2	0.4
Support staff	3 nutritionist aids (refugees) 1 lab asst. 2 lab attend. 1 health asst.	6 cleaners (refugees) 3 guards driver 1 lab asst.	3 cleaners (2 refugees) 2 guards (1 refugee)	Asst PHC supervisor (refugee) 5 cleaners (all refugees) 4 guards (3 refugee) 2 refugee cooks, lab assistant and lab attendant (refugee)
TBA	70 in community (all refugees)	23 active community volunteers	9 rostered at facility	17 rostered at facility (16 refugees) volunteer
CHW (refugees)	18 refugees	8 (given incentives)	2 volunteers	5 volunteers

Source: Health Facility Review

49. Most of the IP staff were nationals, some of their employees were also refugee. Both doctors interviewed at Nakivale and Kiryandongo were expected to manage the health field operations as part of their role, i.e. they were expected to spend 20-30% of their time on administrative issues and 70-80% on clinical issues. Unfortunately, this was not well understood by the refugees who believed that the doctors should be more accessible to provide clinical services. The allocation of doctors is based on population (i.e. one doctor per 15,000 to 20,000 population).

50. In Kiryandongo, at the time of the assessment, the doctor was the acting Field Manager for the whole refugee programme at Kiryandongo. At Nakivale, a junior doctor was acting in the Field Health Coordinator position and therefore had to allocate 20-30% of his time to management. When the FHC position is filled, he will be expected to allocate 50% of his time to managing the health programme.

51. All sites reported a high staff turnover particularly for medical positions. The main reason cited for this was that working conditions for staff were not very attractive. In all sites, there was limited access to electricity and in Nakivale, staff had to collect water from the river or bores themselves, or pay refugees to do it for them. Salaries for the IPs staff are approximately 25% higher than government salary levels across all staff groups. Government employees who are seconded to refugee health facilities are provided with a salary top-up or allowances. However, salaries were said to be not much greater than in the government system but with limited training opportunities, a much higher workload, more responsibility, and no opportunities to supplement salary with private practise.

Organization, management and policies

52. Each site had different organizational structures and human resource management styles that were influenced by the organizational culture and philosophy of the particular NGO. For example, there were different views on the level of staffing incentives given, what categories of staff were eligible (e.g. nurses did not receive incentive payments but doctors did), and whether refugee CHWs or TBAs were given incentives or benefits. In one site, CHWs received incentives but not TBAs, in accordance with the policy of the organization. The official policy is that allowances are paid to CHWs but not to TBAs who are remunerated as per tradition when they attend births; however some TBAs worked in antenatal clinics and accompanied mothers to referral hospitals when complications arose.

53. The issue of sustainability and training of refugee staff to take over care when repatriated is a major concern to the NGOs. Health staff also commented that, due to administrative reasons, salary payments were sometimes delayed in the first few months of the year, which often led to difficulties for their families.

54. There was also variation in coordination mechanisms such as the level of consultation and involvement with Refugee Welfare Committees (RWCs) and leaders and the number of meetings held with refugee staff (TBAs met midwives monthly in one site and quarterly with the RH coordinator but not in others). All sites had extensive guidance in terms of policies from their head offices, but varying levels of contact with them. MoH guidelines and protocols, such as for transfer between health facilities, were available and guided practise, despite concerns expressed by refugees. All staff employed received Staff Standing Regulations that they signed and agreed to comply with.

Review of reproductive health components

55. Refugee views on RH were elicited through 19 group discussions with a total of 379 refugees, including female and male leaders, female and male users of RH services, female and male adolescents, and TBAs and CHWs. Most groups included either men or women, although one leader group and refugee health worker group included both.

56. Based on the number of refugees and nationals who use the health services and participate in other activities at the HCs, the health services on offer are, in general, overstretched. In addition, some sites need reorganization of services or more staff, which is difficult due to budgetary constraints. Where possible, interpreters are provided, but minority tribal groups may have a problem. Professional behaviour is expected of health care providers and reports or complaints are investigated on presentation.

Safe motherhood

57. Antenatal Care ANC was provided in clinics in all settlements. Health staff - midwives, doctors and clinical officers (COs) - reported that ANC included the detection and management of complications, routine testing, and treatment of STIs (see section on STIs). Records for antenatal visits varied in quality of information, and also in terms of usefulness. In terms of satisfaction and access to antenatal clinic

services, most of the women who participated in the group discussions said that they had usually waited two hours or more to be seen. Some women considered that waiting times were too long, while others said that they had to be patient as the service was free.

58. General comments reflected in all group discussions included concerns that *“staff don’t listen to the end of what you say. They are already writing out the prescription before you have completed your story. Some don’t speak the language and don’t use interpreters”*.

59. Health staff stated that women received health education and counselling on pregnancy-related topics, although this was not observed. Many women in the group discussions were able to cite complications that required referral to the HC. Participants in some of the groups were also well informed on what should take place during an antenatal visit, although some claimed that resources for ANC were inadequate. Women in some of the discussion groups (Nakivale) said that the midwives were so busy that they did not always have time to weigh them or take their blood pressure.

60. The estimated coverage rate of pregnant women attending ANC (number of first ANC visits / number of live births) in 2003 at Kiryandongo HC was 2.2% for refugee women and 5.8% for nationals. This estimate is possibly distorted by the tendency for women to deliver at home and there is also an issue of national figures being based on estimates that have an impact on the denominator. Access to investigations for antenatal complications was problematic due to the poor availability of referral services and transport difficulties. However, UNHCR pays for health care at Masindi or Kampala for all referrals. Kiryandongo Hospital lacked ultrasound and X-Ray facilities due to its limited electricity supply and staff shortages, requiring referral on to Masindi Hospital.

61. Iron and folate prophylaxis, tetanus toxoid immunization, antihelminthic treatment (mebendazole) and Vitamin A supplementation were available in adequate supplies at all health centres assessed in Uganda. The assessment team was, however, unable to verify if these were given routinely. Some women complained that they did not receive tetanus toxoid, but this may have been due to a completed immunization record.

62. Syphilis was described as a common problem in discussions with both health staff and refugees. This problem was attributed to high mobility of refugee men between settlements, low awareness of the problem, and polygamy. Rapid plasma reagin (RPR) is the standard screening test for pregnant women in Uganda. In Palyorinya, RPR screening had been conducted during ANC, with almost 20% of women screened having a positive result (of 606 refugees tested, 116 were positive; of 262 nationals tested, 50 were positive). Staff claimed that refugees have higher syphilis rates and lower HIV rates than nationals, and expressed concern that HIV will increase within the refugee population in the future. About 60% of positive cases were said to come back to the HC for treatment, although treatment of partners was inconsistent. There is some active follow up and contact tracing but this differed between sites.

63. Kali HC in the Moyo area appeared to be the only one of three visited sites that appeared to be providing syphilis screening, on a consistent basis, as part of ANC (Nakivale HC had performed 1,482 tests in 2003 but had run out of reagents at the

time of the assessment). Moyo reported antenatal syphilis screening rates of 93% for refugees and 86% for nationals. Testing was only available at the laboratory at Kali HC, and this required that transport was available to take specimens from other antenatal clinics to Palorinya. The patient then had to return to the clinic for their result and to receive treatment, if necessary. Appropriate treatment was available for positive cases of syphilis at all HCs assessed.

64. Even though Panyadoli HC at Kiryandongo tested a large number (1499) of women for syphilis in 2003, women interviewed outside the antenatal clinic, and during group discussions, commented that they had not been offered an RPR test despite wanting to be tested for syphilis.

65. The use of RPR as a screening test was also found to be problematic due to the high rate of false positives for people who had already received treatment (16% tested positive for RPR in Kiryandongo). For this reason, it was proposed that the Venereal Disease Reference Laboratory test (VDRL) should replace RPR. VDRL titre levels should drop to undetectable or to less than one in four after treatment.

66. Communicable diseases contribute more than 65% to the national disease burden. Malaria is the greatest cause of morbidity and mortality, accounting for 29-50% of outpatient consultations, 30% of inpatient admissions, and 9-14% of inpatient deaths (20-23% of deaths in those aged under 5 years). Following the drought of 1992 there have been sustained epidemics of malaria in semi-immune populations.⁷

67. The four health facilities assessed in the three sites visited provided intermittent preventative treatment (IPT) for pregnant women at antenatal clinics. For this purpose, adequate stocks of sulphadoxine-pyrimethamine (SP) were available: Kiryandongo provided 1145 doses to refugee women and 757 doses to national women in 2003 (although, it is unclear how many women received two doses as per the national protocol).

68. Two districts have piloted insecticide treated net (ITN) distribution using the voucher system where retailers provide nets in exchange for vouchers purchased at a minimal cost from health units. The retailer is then reimbursed for the cost of the net. However a problem with providing free ITNs to refugees and IDPs is that there is a temptation to sell them for cash.

69. **Childbirth.** A skilled birth attendant is a healthcare provider (a midwife, a doctor, or a nurse with midwifery and life-saving skills) who has the knowledge and skills necessary to give safe and effective care during pregnancy and childbirth to women and their newborn, in a variety of settings. The national average of skilled attendants at births in Uganda is 20.3%. The visits districts had below national average for deliveries taking place in health facilities, with rates of 15.7%, 18.1% and 18.2% for Moyo, Masindi and Mbarara, respectively. Some other districts achieved rates of over 50%. The factors related to the low rates of delivery at health facilities include perceived poor quality of services (e.g. lack of equipment, light, water, and privacy); poor physical access to health services (e.g. lack of transport); attitudes and behaviours of health workers; preference for TBAs; and cultural barriers.

⁷ Ministry of Health, Uganda. *Annual Health Sector Performance Report, Financial Year 2002-2003*, Kampala: October 2003.

70. The national figure is consistent with the rate quoted at Moyo Hospital (20% of women deliver in HCs, nationals and refugees alike), although ADEO reported that 90% of births in the settlements were attended when TBAs were included. The reasons that health staff at Moyo Hospital gave for the low rate, were that women were busy at home with children, lacked good clothes or a towel to carry the baby in, did not like the lithotomy position, feared having an episiotomy, and found the midwives rude. At Mbarara Hospital, 38% of births were reportedly supervised by midwives or COs, although this included women transferred to the HC or hospital after the TBA had been unsuccessful with the delivery.

71. In settlements, midwives were available in all sites visited on a 24-hour per day basis. TBAs and trained refugee staff were also available and most IPs consider that developing the refugee workforce is a priority before repatriation occurs. COs were available on-call, and usually the doctor in case of emergencies. There has been training of TBAs by midwives in the past but not recently in one site. Thirty-five TBAs had been trained at Nakivale but few were active.

72. In Kiryandongo, nearly all of the women who participated in group discussions had had a baby in the HC, but some said they would not go to the smaller clinics because they were concerned about the competence of staff there (some women reported stillbirths after prolonged labour). In Nakivale women complained that if they came to the HC to have their babies, they had to bring their own soap. In addition, they were not given a drink after the birth and they were sometimes asked to clean the basin that contained their placenta. Others said that they received good care from the midwife and were very happy with the service.

73. Women also stated that they used refugee TBAs who were highly valued as they were accessible and effective. A voluntary gift to the TBA was considered appropriate (either soap or 1,000-3,000 Uganda schillings). Some young women said they used the HC *“because it was free. We can’t afford the TBA.”*

74. Participants in the women’s and leaders’ discussion groups indicated that they were concerned that in some cases the ‘cost’ of a gift for the TBAs prevented some poorer women utilising them. Women in Moyo said that they were not expected to give TBAs a gift, but that their husbands felt some pressure to give soap or sugar. In Nakivale women said, *“TBAs are refugees like you, we have nothing to offer. Maybe a gift of soap sometimes.”*

75. Women in Kiryandongo advocated on behalf of the TBAs, saying that they did not all have foetoscopes and had to use their ears to listen for the baby. While there were kits provided, not all TBAs received them, and some kits did not contain the correct equipment (e.g. some kits were said not to have any ligatures). Women considered that TBAs needed gumboots, raincoats and torches.

76. During group discussions with TBAs, all of those present indicated that they had received training either in their home country or in the settlement. In Paloryina, TBAs had received refresher training. In Nakivale, the last period of – highly regarded – training occurred in 1998 for a period of three weeks. All TBAs in the group discussions could correctly identify when a woman should be referred to the clinic or hospital. In addition, they were able to describe appropriate antenatal care and birthing practises. They prepared monthly reports and some assisted in antenatal clinics in the HC. One of the major problems TBAs said they faced was

with the women who 'hide' and think they can deliver without help. *"Only when there are problems do the husbands call me"*.

77. TBAs in all of the settlements said that kits were incomplete or that there were not enough kits for all TBAs, corroborating what the women in Kiryandongo had said. Some kits did not have a foetoscope, while others had no sucker. In addition, TBAs were not provided raincoats, torches or gumboots, which they considered essential for conducting births at all hours and in all kinds of weather.

78. TBAs expressed concern about maternal deaths, as there could be repercussions for them, e.g., they feared *"getting a beating if a woman dies."* They stated that the major issues affecting maternal mortality and morbidity were late presentations and long distances to travel to get assistance when complications arose.

79. No incentives were given to TBAs in any of the sites assessed. This was considered by TBAs to be inequitable, as CHWs received incentives (e.g. salaries) in some sites. In one site, the IP gave baby clothes to women who deliver in the HC as an incentive to increase the number of health facility deliveries. Women delivered by TBAs in Paloryinya complained about this, although all other aspects of their care were considered satisfactory.

80. Emergency Obstetric Care. The maternal mortality ratio in Uganda has remained persistently high. The main causes of maternal death are postpartum haemorrhage (PPH), postpartum sepsis, complications from unsafe abortion, and hypertension of pregnancy. The blood supply at referral hospitals is irregular and most women tend to present late when they experience a complication. The national maternal mortality ratio (MMR) is 505/100,000 live births (MoH 2003), whereas for the refugee settlements it is estimated at 147/100,000 in Palorinya (Moyo), 306/100,000 in Oruchinga, 413/100,000 in Nakivale, and 924/100,000 in Masindi, including deaths of nationals and refugees.

81. At Kiryandongo Hospital the MMR in 2003 was 714/100,000, with the causes reported as PPH, ectopic pregnancy and uterine rupture. Nakivale HC reported one maternal death in 2003 due to anaemia. There were 500-700 deliveries at Moyo Hospital in 2003 and no maternal deaths were reported, but two deaths were reported in January-February 2004. One of these deaths was due to septicaemia with uterine rupture and the other to complications from self-induced abortion. Adjumani Hospital had 1,448 deliveries in 2003 and no maternal deaths were reported. These data correspond to the UNHCR data for 2003.

82. At all other refugee health services visited, recall of maternal deaths in 2003 was different to the number reported to UNHCR. In Nakivale the midwife reported one maternal death in December, a national woman with anaemia and PPH and no access to a vehicle or doctor. Significantly, between the two HCs visited in Moyo, together with the hospital, only one maternal death was recalled for 2003 (at Kali HC).

83. There is no doubt that preventable maternal deaths are occurring for both refugees and nationals, however reported MMRs need to be viewed with caution as the quality of the data is questionable. For example, one district reported 43 maternal deaths in one month, the same number as the reported number of total births.

Maternal deaths 2004 – TBA accounts

Two TBAs (site 3) recounted some recent incidents of maternal deaths they had witnessed. One case was in January 2004, with the TBA called “*when the mother was ready to push.*” The woman had already collapsed and the husband called the TBA, who urged her to push. But she was too weak. The TBA was clearly upset at telling this story, saying how she tried all she could to assist the woman to push, as she held her. In the end, she told the husband to tell the Chairman to come and the woman told them all: “*I am going to die.*” The community mobilized a stretcher but “*she shouted out loud and died on the way to the health centre.*”

Another TBA told a story of a woman who she said had a malpresentation and was sent to the referral hospital. She was examined but the baby had already died, so they gave her an injection to get the dead baby out. After that, her uterus ruptured and was repaired. She had already had seven babies, four of which were still alive. She died of complications, leaving behind her four children and husband.

84. This story was verified by the staff at the referral hospital who said that the woman had had premature rupture of membranes (possibly for a week) in the settlement and that she had not come into the HC until she had a high temperature. When she arrived at the hospital, she was treated with antibiotics but died of puerperal sepsis.

85. Antibiotic treatment was available for infections during pregnancy and the postpartum period in the four HCs assessed. However, only intravenous ampicillin and gentamycin were available (i.e. intravenous metronidazole was not available). For cases that do not respond to this regimen or are hypersensitive to penicillin, alternatives such as IV cloxacillin and ceftriaxone were unavailable. Drugs were available at no cost in the sites visited, although in one site refugees complained that, in the past, they had to pay for such treatments. This situation has since been resolved by the new IP.

86. Oxytocic drugs were usually available in the HCs assessed and included both an ergot and oxytocin (except in the case of the HCs in the Moyo area which had only ergometrine). Oxytocics were not routinely used by TBAs, and given the high rate of TBA assisted births, this could be an issue of concern. Most HCs assessed had diazepam and the option of at least one other anticonvulsant (usually magnesium sulphate).

87. All HCs reported being able to perform manual removal of the placenta, with midwives trained to do so. Women who were delivered at home by TBAs had to be transferred to the HC or referral hospital for this procedure, when necessary.

88. Post-abortion care is carried out when women present with incomplete abortion. In 2003, for example, 121 women were treated in Palorinya, where doctors and the CO can perform manual vacuum aspiration (MVA). Alternatively, the woman can be sent to Moyo hospital, if there are serious complications. There were problems with the supply of MVA kits in Kiryandongo and Nakivale. In relation to post-abortion care, it was unclear whether FP advice and counselling were given routinely.

89. In one site midwives reported that COs and midwives had been trained to do vacuum extraction. However, no assisted deliveries were performed at the HCs

visited and women had to be transferred to referral hospitals, if an assisted delivery was necessary. In Kiryandongo, women said if they had complications, someone would borrow a bicycle or walk to fetch the ambulance. One case was mentioned where the CHW had come on bicycle, but the ambulance was out on another call. Emergencies in childbirth were considered a major problem *“There is only one ambulance – it is not enough. At night we need to have the CHW telephone to call the ambulance.”* In Palorinya, an innovative bicycle ambulance had been used to transport mothers with complications to the HC. In 2003, there were 26 refugee and seven national referrals for obstetric emergencies.

90. The major concern in all sites was that when transferred to the referral hospital, there was often a shortage of blood for transfusion. In all of the referral hospitals visited, there was an inadequate supply of blood, drugs, and equipment, an intermittent supply of electricity, and no running water.

91. During group discussions, women reported that referral hospital staff “see you as a refugee and don’t care for you. Your treatment or blood comes late. My child died because of that late treatment. All children taken there die. Sometimes you don’t even know where you are to go and get lost”. Palorinya had a hospital liaison nurse, although it was unclear whether refugee patients were aware of this service.

92. Essential Newborn Care. All settlements reported exclusive breastfeeding, although group discussion participants reported varying lengths of time before solids were introduced, sometimes as early as three months. In several women’s group discussions, early introduction of solids was said to be necessary as the mothers did not *“have strong enough milk”* due to poor nutritional status. It did not appear that there were any health education programmes to correct misconceptions about breastfeeding and early introduction of solids.

93. Tetracycline eye ointment was available in appropriate quantities at all HCs assessed but eye prophylaxis was not observed during the assessment. There were no reports, from either mothers or health staff, of problems with cord care. Equipment for newborn resuscitation varied between sites, as well as the skills of midwives and COs in basic newborn resuscitation.

94. No births were observed during the assessment, but the assessment team saw some babies a few hours after birth. It appeared to be standard procedure to dry and wrap the baby, so it is unclear whether there is initial skin-to-skin contact after births conducted at HCs; although skin-to-skin contact is advocated it may not be traditionally practised.

95. Postpartum Care Assessment of mother and newborn was routine practise for midwives and TBAs, and women who deliver at home were supposed to be checked by the TBA at least once after the birth. Some TBAs mentioned that they also provided health education but it was not clear what topics they covered. Participants in women’s group discussions reported that they went for a postpartum check at the same time as the baby’s first immunisation, at about six weeks postpartum. FP options were often considered then but most women waited for six months to consider them.

Family planning and birth spacing

96. The MoH identifies a high unmet need for FP, with 35% of Ugandan women stating that they want to stop, space or delay fertility. Family planning methods were generally in good supply in the HCs assessed; condoms, oral contraceptive pills (OCPs) and depo provera injections were all available. The government had stopped the supply of female condoms and a new brand was about to be launched.

97. All sites reported that at least one FP method was offered. OCPs and injectable hormones were the most commonly used methods. Condoms, while available, were not favoured by men or women (as reported in group discussions), although HC staff reported stock movement and the need to re-order condoms. None of the sites offered hormonal implants (Norplant or Implanon), or intra-uterine devices (IUDs), while voluntary surgical contraception (bilateral tubal ligation - BTL) was available only by special arrangement. Counselling on contraceptive choice was reportedly offered in all sites, usually at the first postnatal visit when babies were immunized. Midwives, who primarily dispensed injectables, OCPs and condoms, ran FP clinic sessions at the health units. In Palorinya, there is also an outreach service by midwives and community workers trained to dispense contraceptives.

98. Health staff generally expressed the view that low contraceptive use was due to cultural reasons or the perceived need to re-populate after the war. At Kiryandongo the contraceptive prevalence rate (CPR) was 2% for refugees and 1% for nationals, but had increased to 10% since September 2003 for refugees. Staff at IRC said that condoms and depo provera were more popular but husband resistance, political unacceptability, alcoholism, and men owning women as assets made FP difficult. BTL and Norplant were available from Kiryandongo Hospital when a surgeon visits. In Moyo the CPR of 6% was blamed on cultural factors, the influence of the church, and men's attitudes.

99. Women generally reported having one baby every year, while the ideal, from their point of view, was one every two to three years. When asked what the ideal number of children was, the most common answer in all sites and with all ethnic groups was between four and six children. Women reported that they used 'natural family planning', including abstinence for six months while breastfeeding. Despite this desire to space births, there was clearly a range of barriers including negative perceptions and misinformation regarding hormonal methods, lack of availability of other methods that might be acceptable, and a low acceptance of condoms amongst women, despite availability.

100. Some views from women about condom use for FP included the following:

"Telling people to use a condom encourages prostitution, or they may not use it right."

"Some are taught to use condoms but are too shy to try it."

"It is too shameful to use them. They look oily and slippery."

"They may break and I hear they are unreliable."

"They are not easy to use – and men don't like them."

101. There were many misconceptions about other family planning methods and serious doubts and misinformation expressed about the most commonly used method – injectable hormones. Anecdotes included fears that the woman would not be able to conceive after stopping depo provera treatment; that they would produce a deformed or large baby after stopping; that many women had multiple births after; that you had heavier and intermittent bleeding and got pale; that you got fat; and that you had more painful periods, got backaches and headaches. Women also said they could not afford soap and needed to wash more with heavier periods.

102. In Kiryandongo, the referral hospital offered, free of charge, hormonal implants (Norplant) and saw about five or six women a day requesting either injections or implants. Condoms were also free and available but few youths came to get them. In Moyo Hospital, confidentiality for women using contraception was assured by keeping the depo provera record cards in the hospital rather than giving them to the women. The female condom was also available in Moyo Hospital, with good acceptance by those who tried it, but they were out of stock at the time of the assessment. During one group discussion a woman with 12 children (nine living) asked what permanent method there was for her. The midwife explained BTL and five women in the group expressed interest in this method and asked that their names be placed on the list for the next visit of the team that performs the procedure.

103. In all sites, participants in women's discussion groups stated that girls as young as 12 were having sex and some were having babies as young as 13. Quite a few girls were reported to have had babies at the age of 15 to 16, although the preferred age was considered to be between 18 and 22 years. It was generally believed that girls who did not get secondary education were not sufficiently occupied and would therefore get pregnant and marry young. This was considered to be different to expectations in Sudan, where boys met their future wives' family and courtships were supervised.

104. Participants in discussion groups with women and adolescents in all sites were aware that women were resorting to abortion for unwanted pregnancies, despite it being illegal in Uganda. Health staff and women reported that girls under 16 years of age would try various methods to induce abortion, including herbs, tying the abdomen, and using a grass *enanda* or sticks to push through the cervix. After attempting one of these methods, some girls presented at the hospital with complications, including ruptured uterus.

105. In summary, FP is a major concern to women, men and adolescents. However there is relatively low acceptance, poor education, and concerns about the range of services available. In all group discussions with women, they asked "*what other choices do we have for family planning*", particularly when families were complete.

STIs including HIV

106. Uganda has reportedly achieved a contraction in the size of the HIV/AIDS epidemic since 1992 and established sexual behavioural change. According to government reports there has been a decline in antenatal HIV prevalence rates from 30% in 1992 to 6.2% in 2002. This decrease in prevalence was most marked in women aged 15 to 24 years. Prevalence also dropped dramatically amongst STI patients, from 44.2% in 1989 to 19% in 2002. However, researchers from Uppsala University in

Sweden found that 80% of teenage girls attending a health service, primarily providing treatment for STIs (targeting 14 to 24 year olds), had gonorrhoea in 2002.⁸ The high rate was attributed to unprotected sex, severe poverty, and prostitution.

107. Uganda has instigated a broad strategy to encourage sexual behavioural change that utilizes video productions, billboards, mobile film shows, radio programmes and advertisements, and TV programmes. In addition, district health coordinators communicate IEC messages. Awareness of HIV/AIDS is reported as universal, with knowledge of two or more prevention practises estimated at 90%.

108. The World Bank HIV/AIDS control project procured 80 million condoms in 2002-2003, of which 50 million were distributed through the MoH and NGOs, 20 million were distributed through social marketing groups and 5 million through private vendors. The large social marketing group, Population Services International, will increase its monthly supply to 3 million from February 2004.⁹

109. Condoms were found at all sites assessed. ADEO reported a marked increase in their condom coverage per thousand population from around 70 and 100 in early 2003 to 280 and 240 in late 2003 for refugees and nationals, respectively, across all sites assessed. In Kiryandongo, a stable coverage rate of around 40 was reported for both groups; however, it was noted that this figure did not vary in the months when no condoms were distributed to nationals.

110. In Palorinya, new condom distribution sites were being trialed, such as in consultation rooms and in the maternity clinics. Peer educators had been used to encourage adolescents to use condoms and there were also community distribution points, such as in bars and discos. This was so successful that elders complained about disposal of condoms around disco halls. Health staff reported, however, that they were unsure whether or not CHWs and TBAs were happy to promote condom use. Nonetheless, CHWs in the Moyo area reported that condoms were freely available, importantly, at the local disco for those aged older than 17 years. In addition, leaders in Nakivale agreed that condoms were freely available there.

111. All sites had medication to treat and prevent opportunistic infections associated with HIV/AIDS. Antiretroviral therapy (ART) was reportedly going to be made available in 2004, through the MoH, for 80% of people living with HIV/AIDS (PLWHA). Few health workers interviewed believed this to be possible. Despite the nation-wide availability of interventions, in 71 sites in 31 districts, for Prevention of Mother to Child Transmission (PMTCT), only one referral hospital (Moyo) was able to offer this service at the time of the assessment.

112. Voluntary counselling and testing (VCT) for HIV/AIDS has been established in 160 sites with 150,000 people tested during 2002-03. In refugee settings, all HCs assessed had the capacity to provide VCT, however none were actually doing so when assessed, largely due to a lack of testing reagents. In Kiryandongo, a training programme in VCT was anticipated within a month, before the testing programme was commenced.

113. A VCT clinic in Palorinya was established in the health unit in May 2003, including an outreach service. Four staff had been trained as VCT counsellors and

⁸ The New Vision (Ugandan Daily Newspaper), February 2004.

nine as counsellor assistants. Two lab assistants have been trained to do the test and have so far found 28 HIV positive persons (14 nationals and 14 refugees). There have been problems, however, with the supply of reagents; between November-December 2002 until March 2003, HIV/AIDS test kits were out of stock countrywide. In addition, there was a change in suppliers and the testing protocol, introduced by the government. However, UNHCR now has a buffer stock of test kits and the national supply has resumed.

114. Palorinya staff had also set up Post-test Clubs, and were currently running eight, with more planned. Two club facilitators have been trained for the district and will be establishing branches in the catchment area. Some 28 people volunteered to give testimonies to reduce fear and stigmatisation in the community, but this was considered to be a slow process. PLWHA were encouraged to speak out and were given supplementary food if they did so. However, health staff felt this posed an ethical dilemma because they felt unable to distribute extra food to those who did not speak out, due to confidentiality reasons. Staff said that they could only give them blankets, but there were no drugs, no income-generating activities, and no additional food. As one staff member said, *“I felt ashamed – I had nothing to offer them (PLWHA).”*

115. Improvements in the delivery of STI services have focused on training in syndromic case management, improved ANC syphilis serological testing, improved STI surveillance, and a better supply of STI drugs. Syndromic case management was practised in all sites assessed, with supplementary laboratory investigations available. However, the possibility of delayed treatment while waiting for results from laboratory investigations remained. Partner treatment for STIs was encouraged in all sites but there were practical limitations to providing this. For example, the partner may be unavailable or unknown. At some HCs, treatment for his/her partner was given to the patient.

116. In all sites, women were aware that STIs were common and said they were very concerned about contracting HIV/AIDS from their husbands, who had multiple wives and partners. In Kiryandongo, they said that VCT was not yet available in the settlement but that you could go to the referral hospital in Kiryandongo to have the test if you were really concerned – *“Very many of our husbands are promiscuous and we worry a lot about HIV. We know there is no treatment for it.”*

117. In all sites assessed, women said that treatment for STIs (i.e. injections) was available in the OPD and that it was kept confidential between the woman and service provider. They said there was a separate place to be seen confidentially. They considered that they got appropriate treatment; *“better than in the village clinic where they give you an aspirin and tell everyone.”* Because men had multiple partners they understood that all needed to be treated but that sometimes one partner may refuse. In Nakivale, women pleaded for *“health workers to move from the health centre to reach us in the zones, to treat our partners. We cannot get them to come to the health centre to be treated, so the staff say if your man doesn’t come, we can’t treat you or help you.”* Women knew about syphilis testing and what to do when there was a positive result; however, they were concerned that if a woman was not pregnant, she would not be tested or treated.

Gender-based violence

118. The role of women in one settlement was seen to have changed in recent times, attributed to the work of the GBV worker and a Catholic church programme (Kiryandongo). Women reported that the GBV programme was helping to 'spread the message more'. When probed about whether there were perceptible changes, and after some very vocal interactions, one woman commented: *"A few men have changed, but most don't accept that women have the same rights."*

119. Peace and Conflict Resolution education was considered by leaders in Palorinya to be very useful. In Nakivale, GBV was thought to have fallen thanks to sensitization programmes. However, few GBV cases were referred to the HC; in Palorinya, in 2003 only seven cases were reported. Usually, cases of GBV are settled at home, with the OPM, or they may go to Moyo hospital, if necessary. Since 2001, UNHCR has been funding and supporting training on GBV, however cultural and traditional factors often prevent changes in behaviour in the short term.

120. Rape and domestic violence were considered to be very different issues during group discussions. Domestic violence was reported as frequent in most sites, but falling in one site. There had been some sensitization programmes, but the main problem was alcohol, even though in recent years there had been a reduction in the drinking of *Waragi*. Some settlements had tried to reduce alcohol consumption and restricted movements at night, with increased patrols and confinement of drunken men overnight, which were considered effective strategies.

121. Participants in group discussions with women, TBAs, men, and adolescents reported that domestic violence was very common: "When the husband wants something to eat, he beats his wife. He goes out to drink then comes home and beats her again. They look for any excuse or problem to beat women." In other discussion groups, participants said the problem was related to a combination of poverty and alcohol abuse. For some, poverty was a greater problem than the trauma of war or fleeing their homes: "It is poverty more than war that traumatizes." In Nakivale, a woman said, "At times, we even fight over food we get from the distribution."

122. During group discussions with women, it was said that they are considered as property; an attitude that leads to potential violence against women. If they were beaten badly, participants in the discussion groups said that they would either run to their father or the Chairman's place. In Nakivale women expressed concern that their husbands may bribe the Chairman who would then not care about them, if they were beaten. Some women who had been badly beaten had requested voluntary repatriation to escape the situation.

123. Women in Kiryandongo and Nakivale considered rape to be very rare (about one case per year). While there were more incidents in the past, the work of local committees in combination with the police was said to have led to a decrease in the number of cases. However, staff at the referral hospital in Kiryandongo said that rape was common, particularly among underage girls, with about three cases reported to the police per day. Very few of these girls went to the hospital within 24-72 hours of the incident. Nonetheless, the procedures followed when a rape case presented at the hospital included physical examination, high vaginal swab, counselling, and emergency contraception (EC) if requested. According to women leaders, girls who

were raped were taken to the HC by their parents, although during group discussions with younger women it was said that girls who had been raped were taken to their elders, rather than to a health care facility.

124. The TBAs and women who participated in group discussions in Palorinya also reported rape of underage girls as common. Most discussion group participants stated that they would go to the chairperson or camp committee to report rape of a young girl. However, during discussions with leaders it was reported that they were under extreme pressure from the families of the perpetrators, if rape or domestic violence was reported to them. Often an arrangement was made with the perpetrator who would negotiate with the girl's father by giving money.

Conclusions and recommendations - Uganda

125. In Uganda, there were difficulties recruiting and retaining doctors in rural areas and refugee settlements. High turnover of some staff categories means that training needs to be conducted regularly.

- Develop recruitment campaigns that include a career development plan

126. Due to limited resources and the poor state of government health services outside of Kampala, referral of emergency cases is likely to remain a problem in most refugee camps and settlements in Uganda for the foreseeable future. However, clear guidelines and procedures provide staff with support when managing critical cases. These guidelines need to be communicated to refugees who may not understand protocols.

- Formalise referral networks and strengthen referral systems with strategic planning.

127. Drug supplies, adequate staffing, supervision and communication will help to ensure that appropriate treatment is available for key RH conditions. Refresher training in syndromic STI management will ensure that drug supplies are used more efficiently.

- Ensure availability of essential drugs for managing STIs and for EmOC at health centres in all sites.

128. Family planning was considered important, but concerns about side effects and misinformation often negated the desire to space pregnancies. Education and standardizing FP choices in the postnatal period should occur in all sites. Choices such as BLT were clearly desired by some women who had completed their families. Access to such options was limited.

- Continue to promote FP choices and opportunities for men and women, including opportunities to discuss their concerns about side effects. Organize BTL on a regular basis and communicate dates widely.

129. At all sites visited, refugees described morbidity and/or mortality related to hunger and malnutrition, particularly in relation to women and children. While this

was less of a problem in Uganda, women who had families or were breastfeeding, still had to tend crops and expressed concerns about the effect this physical work had on their milk supply.

- Implement monitoring systems to regularly assess levels of food security and malnutrition at all settlements / camps.

130. The water supply was not assessed as part of this study but it was an issue for refugees in some Ugandan sites. Bore holes had been apparently sunk but some water sources were no longer functioning.

- IPs should ensure that boreholes are maintained.

131. Improved communication is essential to help refugees maintain and adopt behaviours that minimize the risk of becoming infected with HIV / AIDS and access services for those people living with HIV / AIDS (PLWHA).

- HIV / AIDS awareness raising activities should take place, utilising BCC strategies, particularly relevant to youth.

132. Broad population awareness of GBV is a key component in preventing violence against women. Ugandan sites provided some examples of positive change.

- GBV awareness raising activities should take place in all refugee camps and with all staff working in camps. Medical personnel should be trained in the signs of GBV and awareness raising should involve traditional leaders and judicial structures, including camp security committees.

133. The sexual exploitation of young girls was commonly reported, which is consistent with findings from other studies. Young girls and women refugees have limited access to income generating activities. Women and girls who are supporting other family members need to be identified as vulnerable and given access to income generating activities.

- Target young girls with support for specific income generating programmes to alleviate poverty and sexual exploitation.

Findings – Republic of Congo

Background – health sector

134. The Republic of Congo (RoC), referred to by locals as Congo Brazzaville (or Congo B), has experienced years of conflict. This has greatly affected the provision of health and education services for locals as well as refugees.

135. RoC is an urbanized country with most of the population living in towns or city centres. Outside the cities, infrastructure is generally poor; for example, in the north where most of the refugees live, public facilities and infrastructure are generally non-existent or in poor condition due to neglect. Refugees in the south may have rights to land access when they register with UNHCR. However, both refugees and IDPs in the south have been forced to integrate as the logistics have made it

impossible to maintain distribution of food and services to these groups. Many refugees around Brazzaville and in the south live with their relatives or with local families. It has been a government policy to discourage refugees from living in camps as this is seen to lead to instability and political liability. More recently, IDPs in the south were also discouraged by the government from forming camps, as this was thought to create a dependency on aid in the displaced population.

136. The healthcare system in RoC is generally based on a 100% cost recovery system. Refugees recognized by UNHCR receive free healthcare through the IP and contracts with government health facilities. IDPs in the south are able to access free healthcare through MSF and IRC supported clinics. Some concerns were raised that the provision of free healthcare to IDPs might create tension with the local population.

137. Healthcare and other public services declined steeply during the war and, as a consequence, there is still extremely limited access to government health services outside of Brazzaville. On a more positive note, the IDPs from Pool who were still living in desperate circumstances on the edge of Brazzaville during the evaluation have since been repatriated.

Evaluation sites

138. The five sites visited in RoC as part of the evaluation were: Loukolela, Ndjoundou and Liranga in the north (services for refugee populations provided by CEMIR); Sangolo and IDR in Pool south of Brazzaville (government health services for IDPs were supported by MSF Holland), Brazzaville services for urban refugees and peri-urban IDPs (services for refugee populations were provided by CEMIR).

139. Although the team were unable to travel to Betou in the far north due to logistical difficulties, a briefing was received from the IRC country director in Brazzaville. IRC is the implementing partner providing RH services for refugees in the Betou region.

140. The total population of settlements/camps in Congo is 91,362 refugees and 3,224 asylum seekers. A total of 29,719 refugees reside in camps or centres. The largest population of refugees (50,433) in RoC resides in Impfondo in rural/dispersed settings.

Table 3.5: Population of refugee settlements - RoC

Settlement	Refugees	Nationals	IDPs
Loukolela (established 1999 ^a)	2,278 DRC 2,573 Rwandese		
Ndjoundou	2,456 DRC	2,000	
Liranga	1,448 DRC	4,000	
Bacongo (9 camps) 4 HCs			12,300 registered
IDPs for 16 months			12,000 unregistered (793 families) ^b
Catholic Sangolo			255 families (345 returned home)
IDR (ex rural training college)			404 families
Betou^c	22,395 DRC 252 Cameroon		

Brazzaville (urban) Includes Kintale camp to north (Rwandese and Burundians)	5,547 DRC 55% Rwandese 29% Cameroon 8% also refugees from Chad, Togo, RCA & Uganda. CEMIR estimates 2,500 but reports 1,239 for Jan 2004		
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Source: Annual statistical report, UNHCR, 2004

Notes: ^a Loukolela area: managed by MSF until 2001. CEMIR took over 9 months later.

^b Family size has been distorted by food aid benefit for smaller families. WFP distributes their food packages per family.

^c It was not possible to visit Bétou.

141. Brazzaville. CEMIR operates a stand-alone clinic in central Brazzaville serving a catchment area of about 2,500 refugees from Sierra Leone, Rwanda, DRC, Cameroon and Liberia. Patients who require further investigation or hospital treatment are usually referred to Centre Hospitalier et Universitaire de Brazzaville (CHUB). In January 2004, 32 of the 36 referrals to hospital by CEMIR were to CHUB.

142. Makelekele Hospital is a large government hospital in Baongo (south of Brazzaville) established in 1969, which provides a full range of RH services for about 200,000 of Brazzaville's residents on a strictly user-pays basis.⁹ A delivery typically costs 3000 F ¹⁰ plus 2000 F for costs associated with the stay in hospital. Some of its maternity services were recently rebuilt and equipped with UNFPA funding. Government support includes providing drugs, which are sold by the hospital pharmacy.

143. Sangolo and IDR in Pool south of Brazzaville The outbreak of fighting in Pool region in late March 2002 resulted in widespread population displacement. MSF-H established a team of 50 personnel (including three expatriates) to support IDPs at four HCs; however, support for these services was scaled back as the number of patients seen at each HC decreased with the IDPs gradual return to their homes.

144. Gangolingolo HC in Pool has been rehabilitated with funding from UNFPA and adopted the cost recovery model after it was handed over to government. A drug-hamper rotating fund¹¹ was established under PNDS (EU funding), which is seen by MSF as "pure development as opposed to relief development". It is therefore considered by MSF to be no longer appropriate that such services receive their support.

145. MSF currently supports the provision of minimal PHC services at Sangogolo EEC with the objective of providing emergency relief for IDPs. This support includes the supply of malaria diagnostic kits and therapy using artesunate and fansidar. At present there are more attendances for clinical services at Sangolo by IDPs from each of the four sites in the Baongo area than for local residents.

146. A referral service to Makelekele Hospital, for RH cases, is supported by MSF with the daily presence of an outreach nurse at Baongo to provide supervision to

⁹ Makelekele Hospital receives no direct support from any NGO.

¹⁰ 1US\$ = 544F

¹¹ Cost recovery system where a drug stock or hamper is provided – this is then replaced using income generated from the sales of drugs.

staff, and support with basic drugs and transport to Makelekele. Drugs and full subsidies for treatment services are provided for those patients referred to Makelekele. The majority of consultations that occur at Sangolo HC cost between 1000-2000^F. Staff at the HC are all civil servants and include a financial officer who manages the cost recovery system.

147. **Loukolela Area.** The three sites visited in the north were all in the Loukolela area and services were administered by CEMIR, the IP for UNHCR since October 2001. CEMIR provides health care exclusively for refugees, including medical, logistics and social services.¹²

148. Loukolela and Liranga are busy trading centres on the Congo River with regular market days and overnight stops by ferries. The camps are located at the edge of Ndjoundou and Liranga and are within walking distance of the village stores and markets. Ndjoundou has a smaller local population and is situated a significant distance from Loukelela (5 hours by standard motor boat) up the Oubangui River. Ferry and trading boats generally take a week to travel to Brazzaville from Loukelela.

149. Both UNHCR and CEMIR have field offices at Loukolela. There is also a HC based in the refugee camp and a government referral hospital on the other side of the village. In Liranga, the CEMIR clinic is situated in a room at the government hospital between the village and the camp. Ndjoundou HC is a freestanding mud hut in the centre of the camp next to the school, although a new brick facility (funded by UNHCR) is nearing completion.

150. The referral hospitals in Loukolela and Liranga were poorly staffed, lacking basic resources such as mattresses and bed nets, and had only minimal clinical and technical supplies available for RH care. Loukolela Hospital provides inpatient services to equal numbers of refugees and nationals.

151. Liranga Hospital used only one of its rooms. In it there were three beds used for inpatients, while the rest of the hospital had no beds and was unoccupied. Rat nests and excrement were evident throughout the facility. Both hospitals have no access to electricity, potable water, blood supply or drugs, apart from those provided by CEMIR.

152. The CEMIR doctor and midwife provide clinical care to all refugee patients admitted to Loukolela hospital although the government charges CEMIR 2,500,000 F annually for using the facility.¹³ Loukolela Hospital also charges CEMIR a fee for each inpatient admitted (i.e. per bed per night).

153. At Liranga, the CEMIR nurse, who works with the government employed medical assistants, provides clinical inpatient services when in the village. Loukelela is the referral hospital for both Ndjoundou and Liranga HCs.

154. Betou. The IP for UNHCR in Betou is IRC. The Bétou area consists of 26 villages with a refugee population of 50% in each. At the end of 2003 there were a total number of 21,265 DRC and CAR refugees in the District of Bétou. There is an

¹² Members of the local population are treated by CEMIR in case of emergency or social disadvantage. Treatment is free although they have to pay for medicines.

¹³ This charge also covers the cost of hospitalizing patients that have to be evacuated to Brazzaville.

expectation that the number will decrease in response to the ongoing stability in CAR and DRC. Although the evaluation team was not able to access Bétou, the Country Director and the Bétou Health Director were both interviewed in Brazzaville, as mentioned earlier.

155. IRC has had a presence in Bétou since 2000, providing services for refugees and locals, including integrated refugees. Many of the refugees in Bétou regularly travel back and forth across the border with DRC, to do business, access health facilities and visit family. IRC's health programme is present in 12 sites (three fixed health posts and nine mobile clinic sites).

156. IRC implements a comprehensive programme, which includes provision of teachers, community services, health promotion and clinical services, a GBV programme, an agricultural project, and a water and sanitation programme. IRC supports three permanent health posts and two mobile clinics. The health programme provided 43,254 medical consultations in 2003. This figure includes nationals who attend refugee health services due to the poor capacity of the state clinics. IRC uses three boats to operate weekly mobile clinics to the villages. It is currently running a programme to support the Comité de Santé (COSA) or village health committees achieve self-sufficiency after UNHCR support ends. COSA committees have been established in all 12 sites. A COSA consortium has been formed to purchase drugs for the clinics using 100 F fees charged for each clinic consultation. In 2003, the main reasons for attending health services were malaria, respiratory infection, diarrhoea and STIs. MSF-France (MSF-F) operates the hospital in Bétou.

Access to health facilities

157. Refugees in the Loukelela, Liranga and Ndjoundou camps have at least one type of health facility within a ten minutes walking distance. Access to a local HC was more of a logistical problem for peri-urban refugees and IDPs in the Pool region. Transport was available by public bus but cost and after hours access to transport and health services remained major problems for these communities. The estimated distance to a health facility ranged from 0.5 km to 1.8 km, with the exception of Kintele camp, which was 18 km from Brazzaville. Walking time was estimated at 5 to 60 minutes. The lack of road rehabilitation is reported to impact negatively on health care provision and repatriation of IDPs.

Health facility infrastructure

158. Water supply was not formally reviewed during field visits but access to potable water was raised in group discussions as a major issue amongst refugees living in Liranga and Ndjoundou in relation to the burden of chronic disease and its impact on health service visits. Refugees indicated an urgent need to have the existing bores rehabilitated.

159. The three camps in the Loukelela area had no access to power. The referral hospital had an operating table with surgical lights that had recently been donated by UNDP. The generator had not worked for some months, and there had been no

surgeon or doctor based at the hospital for several years. There was no surgical or anaesthetic equipment.

160. Electricity was not available at Ndjoundou and Liranga HCs. Running water was available at the CEMIR Clinic in Brazzaville and Sangolo EEC HC, while at the other sites tank or river water was available. There were no phones or radio communication at the facilities outside of Brazzaville.

Service statistics

161. Most HCs offered specific clinics for RH, as follows:

- Ndjoundou: ANC - Wednesdays.
- Liranga: ANC & FP - Thursdays.
- CEMIR Brazzaville: ANC, FP and baby checks - Wednesday mornings.
- Sangolo EEC: ANC - Monday, Wednesday and Friday.

Table 3.6: Service statistics for refugees - RoC

Service Period	CEMIR Brazzaville Jan 2004	Ndjoundou Jan 2004	Liranga Jan 2004 & 2003	Loukolela Jan & Feb 2004	Makelekele Current & 2002	Sangolo EEC Current
ANC visits	16	29	15 (Jan)	45 in Jan & Feb 2004	80-100 / mth in 2004	
No of births		3	2 (Jan)	11 in Jan & Feb 2004	600 / mth 2004 8383 in 2002	
Caesarean section			0 (Jan)		41 in 2002	
Maternal deaths	0	0 0 for 2003	1 in 2003	1 in 2003 (PPH)	Average of 1 / mth 2004 4 PPH in 2002	
FP visits	12	5-10	9 (Jan) 60 in 2003	34 in Jan & Feb 2004	No STI clinic	5-10 / mth
STIs diagnosed & treated	29	10	5 (Jan)	283 in 2003		
MVA					334 evacuations in 2002	
SGBV counselled		2	6 in 2003	4 in 2003	113 cases in 2003	
Attendances	463 consults Jan 2004	286 more detail avail	314 in Jan Feb 2004 3254 in 2003	16,802 for all 3 CEMIR HCs 2003		

Source: Health facility review

Staffing and coverage

162. The health facilities in Liranga and Ndjoundou were understaffed and under resourced for the number of refugees requiring clinical services, when compared to the better-resourced centres in Brazzaville and Loukolela.

Table 3.7: Profile of health staff at facilities assessed - RoC

Health workers	Brazzaville	Ndjoundou & Liranga	Loukolela	Makelekele	Sangolo EEC
Level	HC type I	HC type I & II	HC type I (beds at Loukolela Hosp)	Obstetric Referral Hospital	HC type I
Midwife			1	14	
Nurse		Both HCs had a single male refugee nurse	2 refugee nurses	10	2
Nurse-Midwife					1
Med Asst.	2	MA in Liranga Hospital	2	1	
Doctor	1		1	6	
Obstetrician				2	
Support staff	Cleaners & Drivers shared with CEMIR admin offices	Ndjoundou has 3 voluntary Health Committee members SECR/Fin, Hd VRC	Logistics/Water / sanitation Psychologist CS/Social worker Watchman Cleaner		3 (Lab tech, Social asst, Finance officer)

Source: Health facility review

163. There is one refugee nurse based at each HC at Ndjoundou and Liranga, compared to the health team of six clinicians at Loukolela. This imbalance is due to security concerns. There are also four technical staff and two watchmen based in Loukolela who are employed to look after the water system.

164. The supervisor of the referral hospital in Loukelela was a qualified sanitation officer who worked with two sanitation assistants. There is a crisis in staffing government health facilities due to the diminishing number of trained staff available for employment. No doctors have been recruited into the government system since 1986 and no nurses since 1993. The head obstetrician at Makelekele Hospital plans to retire at the end of this year and there is no specialist available to replace him, apart from a Chinese doctor who speaks no French or any local language. Three other doctors at Makelekele also plan to leave at the end of the year.

Equipment and drugs

165. Makelekele Hospital had all of the resources expected for an obstetric referral hospital, including a blood bank. Loukolela HC had minimal facilities to perform gynaecological examinations, necessitating transfer to Loukolela Hospital. HCs in Liranga and Ndjoundou had minimal capacity for obstetric/gynaecological examinations.

166. CEMIR Brazzaville and Loukolela had a system of supplementing the generic drugs provided through UNHCR with drugs bought from private pharmacies. There were a number of plastic bags full of recently bought drugs on the floor of the Brazzaville clinic.

167. Due to the infrequent visits to Liranga and Ndjoundou by CEMIR staff for supervision and clinical support (18 visits were carried out during 2003), the options for communication with CEMIR senior staff are limited to letters delivered to Loukolela by a passing ferry. The supply of drugs and equipment at HCs reflected the poor level of support and supervision provided to the solitary nurses that were responsible for providing services.

168. At Sangolo HC it was reported that since the most recent military insurgence in the area equipment to undertake necessary clinical work had not been replaced.

Review of reproductive health components

169. Refugee views on RH were elicited through 16 group discussions with a total of 287 refugees, including female and male leaders, female and male users of RH services, female and male adolescents, and TBAs. All groups included either men or women.

Table 3.8: Inventory of drugs and equipment - RoC

Health facility (level)	Brazzaville CEMIR Clinic (type I)	Loukolela HC (type I)	Ndjoundou HC (type I)	Liranga HC (type II) combined with govt clinic	Sangolo EEC HC (type I)
Basic surgical equipment, gloves	Yes	Yes, but no needle holder	Yes	Yes	Some forceps only
Autoclave	Yes	No	Yes	Yes	No
Contraceptives FP kit	100 OC	5 OC & 3 depo provera	6 OC & 4 depo provera	1 OC & 11 depo provera	11 OC only
STI drugs	Doxycycline, benzyl penicillin, tetracycline, bactrim, MTZ	Only procaine penicillin doxycycline, tetracycline, bactrim, MTZ	Tetracycline, bactrim, procaine penicillin, MTZ, nystatin suppositories	Bactrim, procaine penicillin, MTZ, nystatin suppositories	Very small store of doxycycline, bactrim, MTZ
EmOC drugs	Yes	No, at CEMIR store / LK hosp	No IV MTZ	No IV MTZ	No IV treatment
Oxytocics	Oxytocin	At hospital	Ergot & oxytocin	Ergot & oxytocin	No
Basic gynae instruments	Yes, well stocked	No	Yes	Yes	Fetal stethoscope
Vacuum extractor	No	No	No	No	
IV catheter & fluids	Yes	Yes. 2 NS only	Yes, good range of fluids	Yes, good range of fluids	
Drug storage (dry, dark, off ground)	Most drugs in bags around clinic	Yes	No cupboard, drugs in boxes on earth floor	Cupboard but most on desk or in box on floor	Most drugs out on desks

Source: Health facility review

Safe motherhood

170. **Antenatal Care.** ANC was reportedly provided in HCs or hospitals for all settlements and camps visited except for the Sangolo EEC in Pool. The capacity to provide reproductive and sexual health education was limited and depended on a

range of factors including quality of the nurses' training, the resources that were available, and reported security concerns. When questioned on their approach to clinical problems and use of medications, the refugee nurses at Liranga and Ndjoundou appeared to have a good level of clinical knowledge. The nurse at Ndjoundou had worked with MSF, when they ran the original refugee health services there.

171. Access to investigations and services for management of complications was only available to those attending referral hospitals such as Makelekele. A budget line exists for CEMIR to relocate a patient to Brazzaville, if the UN plane is in the area (it visits Loukelela once per week) and if the patient is transported to the airstrip in time.¹⁴ Otherwise, all RH services provided by referral hospitals in Congo are strictly user-pays, although IDPs who attend Makelekele have the cost of treatment and investigations subsidized by MSF.

172. Iron and folate prophylaxis, antihelminthic treatment (mebendazole) and Vitamin A supplementation were available in adequate supplies at all HCs providing ANC except CEMIR Brazzaville, which had no stock of mebendazole at the time of the assessment.

173. Tetanus toxoid immunization was reportedly provided in Ndjoundou and Liranga but there were no vaccines evident and there was no refrigeration. Other sites that provided ANC were able to provide tetanus toxoid immunization, although the cold chain in Loukolela was compromised (see below).

174. Syphilis screening (RPR/VDRL) was performed at Makelekele Hospital (IDPs were supported by MSF), although the CEMIR clinic in Brazzaville had provided screening in the past. Otherwise, both services provided comprehensive ANC; however, the internally displaced women who were interviewed seemed uncertain as to the availability or location of ANC.

175. Loukolela HC, which had a midwife available to assist with ANC, performed syphilis screening. However, reagents for the RPR test kits were stored (together with vaccines) in the fridge at UNHCR, which was turned off each night when the generator was shut down. When examined, the contents of the fridge appeared to be in poor condition. The freezer blocks were not able to be frozen and therefore were unsuitable for use during outreach EPI work to the other HCs.

176. All centres visited provided SP during ANC but this was likely to be delivered sub optimally. For example, Ndjoundou reported providing only a single dose at 16 weeks instead of the recommended regimen of two doses. In addition, access to bed nets at all sites visited was poor.

177. In Loukolela, women said they were not happy with the ANC provided: *"The equipment used here is no good, the same is true for the treatment they provide, for example you get the same treatment if you come in with a headache as you would if you had malaria."* *"They can't check you properly because they have no equipment."* The men in Loukolela said that women go to the clinic but:

¹⁴ An annual fee, paid by CEMIR to MoH, covers the cost of inpatient care at Brazzaville.

“They are not happy with what happened in the clinic. When they go, they receive medication without testing, need microscopes and a laboratory. The pregnant women are not happy, not tested, need examination before they are treated. They deliver at the hospital, where they are well received but not well treated”.

178. Refugees from Rwanda are now integrated into the Loukolela community and are obliged to attend ANC at the government hospital, as they are unable to access CEMIR-run health services. They expressed little confidence or satisfaction in the services provided at the hospital. They were charged 5000 F for ANC and a further 1,000 F for the birth, with extra charges for medications and dressings. They preferred to travel by boat across the Congo to DRC to deliver as there they considered they were treated better: *“We don’t receive the treatment we think we should deserve. We can’t be sure we’ll receive adequate treatment for a serious illness. The incompetence of the clinics is such that we to prefer to be treated in DRC.”*

179. **Childbirth.** TBAs provided care in Loukolela, Liranga and Ndjoundou. In Liranga and Ndjoundou, the women said that in many cases they would prefer to see a female TBA rather than a male nurse. However, in general, TBAs were found to be poorly resourced and trained and were unsupervised.

180. The women at Ndjoundou said that the TBAs do not accompany them to the HC and have no role in monitoring ANC. Although TBAs can assist deliveries at home, they try to avoid doing so. The young women in this settlement said that many prefer to deliver at the private clinic (run by a self-employed male nurse) rather than give birth at the HC or at home with the assistance of a TBA. However, other women said they preferred to deliver at the HC where they liked the way the nurse treated them.

181. The nurse in Loukolela reported that:

“Most women give birth at home because of the problem of finding transport to go to hospital. For the time being, there is no transport. Women in Loukolela choose to have their babies at the clinic, but sometimes they gave birth at home. In some cases, they go to the clinic after their child is born to check whether it is in good health”.

182. The young men at Liranga said that most women delivered at the hospital (and usually attend ANC there). There were a few TBAs available for home deliveries and payment for their services is optional although there were many who had no equipment such as gloves or soap. The women leaders and TBAs in Liranga said, *“In the past the nurses would blame us and tell us that we had to pay to use the health facility.”* TBAs also said that: *“...we supported women giving birth at home... but they preferred to give birth at the clinic, but there were no midwives available so they couldn’t.”* TBAs complained of poor facilities: *“We need midwives and plastic sheets to allow women to give birth on the ground. They can’t spend the night in the hospital as there were no mattresses on the beds. We really need a clinic specifically for refugees.”*

183. The Rwandan women said that they had no TBAs in their community. They go to hospital only if they cannot go to DRC, and they go before it is too late, especially if they have a past history of delivery problems. However, the internally displaced

men said that all deliveries took place at the hospital, whereas previously women used to go to Gangolingolo for deliveries, but the service was no longer free for IDPs.

184. **Emergency Obstetric Care.** Both Liranga and Loukolela reported maternal deaths in 2003 from less than 30 and 70 deliveries, respectively. The chief obstetrician at Makelekele Hospital reported that they usually had one death from postpartum haemorrhage each month out of about 600 deliveries (an MMR of 167/100,000 which is close to the national MMR of 205/100,000). This occurs despite good access to blood for transfusion and trained staff. Mothers have to provide their own drugs for the delivery and are encouraged to have their own kit of drugs ready by the eighth month of pregnancy, unless they are IDPs supported by MSF.

185. The women in Liranga recalled two maternal deaths in the previous year due to complications. There was no clinical or TBA support for the women in labour. The women of Ndjoundou said that there had been no recent deaths in the camp, but that many women were sick from complications and loss of blood: *“Sometimes, a woman was in pain for two weeks and wanted to give birth – but no transport was available for women to have a caesarean operation. No doctors were available and we couldn’t tell the position of the baby while we also don’t have good equipment here.”*

186. With the exception of Loukolela, oxytocic drugs were available at all HCs visited, at the drug store at the CEMIR office, and at the hospital. Anticonvulsive drugs were not available at any of the HCs visited, and all three nurses said that they would use chlorpromazine instead of diazepam.

187. Manual removal of the placenta was practised by the refugee nurse at Ndjoundou, when required, but not at Liranga. At Loukolela Hospital, the midwife would perform this procedure. The removal of retained products of conception was performed only at Makelekele Hospital or at CHUB, as was assisted vaginal delivery.

188. For the refugee camps of Loukolela, Liranga and Ndjoundou referral presented great difficulty, unless an emergency happened to occur on a day when the UNHCR plane flew into Loukolela for Brazzaville.

189. Rwandan women, who were integrated into the community, said that women with a past history of complications go to DRC, in advance, rather than deliver in Loukolela. It takes 1.5 to 2 hours by motorboat or 3 to 4 hours by canoe to cross the river to the hospital at DRC. The women have to pay an extra charge of 3000 F to cover immigration. The hospital in DRC has a supply of blood for transfusion and asks for double the price for treatment compared to the price paid to DRC locals; RoC nationals using the service also have to pay double. Patients that cannot pay had the option of repaying their debt by providing services such as cleaning or working in the hospital garden.

190. Treatment for obstetric emergencies was limited at most of the HCs visited. The basic drugs needed to treat postpartum/post-abortion sepsis were available at the CEMIR in Brazzaville, but only some of the drugs were available at other HCs. There were no drugs available at Sangolo for EmOC, which meant that women who needed emergency treatment had to be transferred to Makelekele Hospital where MSF would provide the necessary drugs for internally displaced women; despite long admission delays, the patients received medication and treatment was begun.

191. **Essential Newborn Care.** Exclusive breastfeeding was common practise for newborns, although women commented that their poor nutrition impacted on their capacity to breastfeed newborns and infants. There was no supplementary food provided to women when pregnant or lactating.

192. Tetracycline ointment for newborn eye prophylaxis was available in sufficient quantities at all sites apart from the CEMIR clinic at Brazzaville, which had no stock, and Sangolo, which had only three tubes of the ointment.

193. Neonatal deaths were said to be common at all sites visited, including Makelekele Hospital. At this facility, poor or absent resuscitation equipment was blamed for some neonatal deaths. Rwandan men interviewed in Loukolela said: *“children have died due to incompetence ... last year, a premature child died due to lack of equipment.”* Men at Liranga also mentioned that there had been five neonatal deaths in 2003-2004.

194. Postpartum Care. Assessment of mother and newborn (within 24-48 hours after birth) was considered by participants in group discussions to be desirable; however, young women in Liranga reported that the nurse had refused to assess babies in the past that had not been delivered at home.

Family planning and birth spacing

195. All sites were able to offer at least one family planning method. OCPs and condoms were the most commonly available methods, followed closely by injectable hormones. With the exception of CEMIR in Brazzaville, all sites had a limited supply of OCPs and depo provera was out of stock. In addition, at Sangolo EEC there were no condoms available. At this facility there was a charge of 500 F for OPCs and 1,500 F for depo provera (when available). At Makelekele Hospital the charge for OPCs was also 500 F and 1000 F for depo provera. This was the only facility at which IUDs were available. Contraceptive implants were available for 10,000F at a special clinic located outside the hospital. Voluntary surgical contraception could also be arranged. Some degree of counselling on contraceptive choice was reportedly provided at all sites.

196. In group discussions on family planning, some men said they wanted very large families, while others preferred to have fewer children. On the other hand, group discussions with young women (15 to 24 yrs) revealed that they tended to have two to four children, giving birth to their first child at between 15 and 18 years of age. Men reasoned that families were needed because: *“many people were killed in our villages – we want to repopulate.”* *“Our African heritage is to have many children.”* *“It is will of God.”* *“Children bring wealth.”* *“Husbands want their wives to have more children even though they may not want any.”* During discussions with Rwandan men, they said that they now had smaller families because the living conditions as refugees were so difficult.

197. One woman who participated in the FP group discussions thought that contraception was *“up to families – some people wanted to have many children, others don’t really want so many as conditions are hard...”*, *“even if we do not want to we are obliged to have children.”* When asked how many children a woman would ideally like to have,

many women stated that they would prefer to have fewer children, and expressed a desire to have greater access to contraceptive methods for birth spacing.

198. Some women had been exposed to FP education with mixed results, as indicated in the following statements:

- *“Liked the idea of FP, but men forced them to have sex even though they would sometimes rather avoid it. After birth a women should wait until she sees the running of blood, if not she will get pregnant immediately when she has sex.*
- *“Don’t accept FP - Together we stand divided we fall.”*
- *“I agree with FP as an idea but I don’t observe it. Falling pregnant can come as a nice surprise.*
- *“Some women simply don’t wish to be given any advice”.*
- *“I’m not against such methods, our living conditions are so poor.”*

199. Women and men wanted more information about FP and access to a wider range of methods. Misconceptions regarding some FP methods were expressed as follows: *“Women are afraid of condoms. They tear the inside of a woman’s body and are dangerous.”* *Most women do not want the injection because they do not want to be sterile forever.”* *“Family Planning can be a good thing.... prefer to reduce [numbers of children]...* In particular, young men and women were adamant about the need to be better educated about family planning, as expressed in the following: *“If we are not informed then how can we be expected to choose”* (young man) *“Sometimes they do not know how to control themselves and they have to give birth like pigs”* (young woman).

200. In discussion groups with IDPs, similar views were expressed: *“We’d maybe like to have fewer children, say around four or five children. Education is the problem.”* *“We don’t have the means to feed these people, it would be better to have fewer children.”* However, in most discussion groups (whether with refugees or IDPs) it was felt that the decision to undertake FP should involve both the husband and wife.

201. Unwanted pregnancy was a common problem and in all group discussions there were reports of clandestine abortions, predominantly amongst young women. Unfortunately, many young women in this situation felt ashamed and did not seek help at a health care facility. Ultimately, deaths occurred following unsafe abortions. The unsafe techniques described to induce abortion included the use of herbs, salt, traditional drugs, and bitter flowers. Some of the men who participated in group discussions said that access to FP methods would reduce the number of abortions.

STIs including HIV

202. Some methods of STI/HIV prevention, such as condoms, were available at most HCs visited during the assessment; Sangolo EEC, which served the IDP population. However, the staff at CEMIR Brazzaville said that they were given only 300 condoms each month and were therefore only able to give each man wanting to use them, a maximum of four or five. In Loukolela, on the other hand, men said that condoms were available and free in the camp.

203. Universal precautions were unlikely to be practised correctly at the HCs visited, as there was an inadequate supply of water at these facilities (Liranga and Ndjoundou). In addition, gloves were in limited supply. While the sites visited had autoclaves, an insufficient supply of fuel prevented their regular use. Moreover, Makelekele Hospital was the only facility with proper containers for sharps disposal. Of the HCs visited, CEMIR Brazzaville used a plastic rubbish bin for sharps disposal (and other rubbish), and later emptied the bin into an incinerator.

204. RoC had a higher rate of STIs than was apparent from STI statistics derived from HC attendances, possibly for the following reasons: a high fertility rate also meant a high rate of unprotected sexual intercourse; the policy of cost recovery precluded many from treatment services; stigmatisation was associated with seeking treatment for STIs; use of traditional healers was popular for STIs; and a high rate of unregulated self medication for STIs.

205. In the refugee setting, there were specific problems related to treating STIs, which included: a low level of staff training in STI management; poor adherence to treatment protocols; problematic contact tracing; and low levels of condom access and use. In Ndjoundou and Liranga, the inadequate level of staff supervision, combined with an inability to refer for investigation or treatment, meant that STIs were poorly managed. Syndromic case management was the only option available in all sites visited, apart from CEMIR Brazzaville, which used laboratory diagnosis for difficult cases. HIV tests were sent to CHUB (three of five HIV tests recently referred by CEMIR Brazzaville were positive).

206. A major concern related to the management of STIs was the absence of appropriate drugs at the HCs visited. For example, none of the drugs recommended for the treatment of gonorrhoea were found at the three HCs in the Loukolela area, and Liranga HC had no drugs for the treatment for chlamydia. Procaine penicillin rather than benzylpenicillin was stocked at all of these HCs, which may cause compliance problems with the syndromic management of syphilis. For instance, treatment of syphilis with procaine penicillin requires a 10 day regimen of daily intramuscular (IM) injections, whereas, benzylpenicillin requires a single IM injection.

207. A check of the CEMIR store in Loukolela revealed that there was a stock of ciprofloxacin, doxycycline, tetracycline, benzylpenicillin, and IV MTZ were available. The ciprofloxacin and MTZ had come into stock shortly before the assessment team arrived, providing an opportunity to supply HCs during visits to these facilities. However, the CEMIR doctor was concerned that the refugee nurses would use the drugs indiscriminately.

208. During group discussions, young women in Liranga said that they would like testing for STIs to be available, but with regard to treatment they said: “... *there are no drugs here, zero. We have to use traditional herbs, others buy them from small chemists, but they are expensive.*” In Liranga, the men said that many people had gonorrhoea and that “*They quickly go to see the nurse. The nurse will then try to treat the couple. Some patients get the medicines first. Otherwise they have to rely on traditional herbs.*” In Ndjoundou, the women said that some girls were sterile as result of STIs, and in Sangolo, some internally displaced women believed that untreated STIs (i.e. treatment was not available to them) had caused infertility.

209. With regard to HIV/AIDS, community-based education was provided at all refugee sites. For example, in Loukolela the women said that they had seen a video on HIV, whereas the women in Liranga had heard about it on the radio.

210. The latest sentinel surveys (conducted in 2003), showed national prevalence rates of 3-5%, depending on location, although some groups in Brazzaville and Pointe Noire had rates in the range of 7-8% and rural sites generally had lower rates. A small study of soldiers indicated a prevalence rate of 10%.

211. During all group discussions underage sexual behaviour was reported, although concern was predominantly related to girls and young women rather than boys and young men. Boys generally stated that sexual activity started from 16 or 17 years of age. However, in one camp it was reported that girls become sexually active as young as 10-12 years of age, often with older men and often for money or food. Male leaders in Liranga expressed concern about this trend.

212. Treatment of opportunistic infections for HIV-positive individuals, services to reduce MTCT, and anti-retroviral therapy (ART) were available only at Makelekele Hospital and for patients referred to CHUB. No home-based care for PLWHA was reported to be available.

213. A recent UNHCR review of HIV/AIDS programmes for refugees identified problems with medical coordination of IPs. Hence, a UN Volunteer with a public health background was being recruited to strengthen the technical capacity of UNHCR offices in Brazzaville and Kinshasa.

Gender-based violence

214. GBV was reported in the three refugee camps visited but the psychosocial support and counselling received by survivors was likely to be less than adequate due to the limited training and resources available to health workers in these camps. There were no programmes for GBV prevention and response in the Loukolela area, and community education and awareness raising related to GBV had not taken place in any of the refugee camps visited.

215. Domestic violence (DV) was reported to occur frequently. Alcohol was often a precipitant and the reasons given for men beating their wives included: *“lack of respect by women don’t show sufficient respect to men, they are impolite, cook late and sex can only be had through force, any refusal will lead to a beating.”* In addition, women in Loukolela and Ndjoundou said that sex against their will is common. Young girls aged 13 - 14 years were said to have had the same experience. The current process for dealing with rape in Ndjoundou was to either take the perpetrator to the police or beat him. However, most discussion group participants said that reporting cases of rape was uncommon, except in serious cases. Nonetheless, the situation in Loukolela was described as follows:

“A girl first informs her parents who, in turn, inform the camp leader. The perpetrator is caught and then punished. He is then beaten and forced to pay reparations to the families and to the leader. The leader will then take the perpetrator to the police who will ask for money. The rape survivor will then receive a check up at the clinic.”

216. Emergency contraception (EC) was available to survivors of rape at all services visited but only CEMIR Brazzaville and the MSF-F centre at Makelekele Hospital had specific pre-packaged pills. At other centres OCPs were said to have been used.

217. UNHCR currently supports one GBV programme in the Bétou area. Negotiations are underway to increase the coverage to all refugee sites in RoC. This would include training of all staff involved with refugees. The GBV programme at Bétou consists of medical, psychological and judicial support, all of the services being confidential. Material support to rape survivors can also be arranged through the community services programme. The programme provides GBV awareness raising activities for the whole population. More than 400 individuals have been identified as community leaders and 270 (64%) have attended four training sessions on GBV, DV and strategies for community sensitisation and psychosocial response to victims of GBV. There are drop-in centres operating from HCs servicing both the refugee population and locals. Rape constitutes 20% of the consultations to the drop-in centres of which 50% are children. Eighty percent of the total cases are DV-related. Physical injuries are referred to MSF-operated facilities in Bétou. IRC provides victims with two counselling sessions and also supports women choosing to seek redress by judicial means; however, there are few examples of women who have taken the matter to court. A judge represents the legal system in Bétou but to attend court a woman would need to go to Impfondo 160 km to the south. There is also the option for women to settle matters in the traditional courts, which often involves a monetary transaction from the perpetrator's family to the family of the victim. In 2003 there were 134 GBV cases (all women) seeking support from the drop-in centres. There are no statistics collected on who the perpetrator is. If a rape victim presents within 72 hours, she is sent to MSF for EC and ART and IRC provides the psychosocial follow-up.

218. According to the Department of Family Services, 512 women became pregnant after being raped between 1998 and 2000. Many of the children born to these women were left in the care of humanitarian organizations. DFS is currently aware of 56 such children and 36 who were left in the care of non-family members. In the 1998-2000 period, 2017 rape victims came for treatment; however, the breakdown of IDPs and locals is not clear. DFS also acknowledged that some women may not come forward to report rape or seek medical attention after the incident. There has been a lot of publicity promoting the rape crisis clinics. However, IDPs in Pool, who are referred to the MSF-F clinic at Makelekele Hospital, may not be able to reach the clinic within 72 hours of the incident to receive ART. None of the drugs are available outside the two existing rape crisis centres operated by MSF-F. In 2003, 113 cases reached the Makelekele Hospital within 72 hours of the incident, and for Talangi the figure was 72 cases. In recent months people presenting to MSF-F rape crisis clinics have mainly been Brazzaville residents; in July 2003 30 clients were seen and, more recently, approximately 20 clients/month have attended the clinics. MSF-F has run the rape crisis centre for four years and is a unique programme implemented at the Makelekele and Talangai hospitals. It provides counselling by trained psychologists with EC and ARV drugs for rape victims who reach the centre within 72 hours. They also have social workers to ease the reintroduction into communities and ensure drug compliance. Before MFS involvement there was a national programme, but women reported that they were not well treated. MSF-F supported the programme and moved it to its present locations. If the survivor arrives after 72 hours she receives STI treatment for gonorrhoea and syphilis and EC. The social worker, who

does home visits when required, provides important follow-up for clients who are given ARV drugs, to ensure maintenance of treatment for 28 days.

219. A decline of cases since the height of the conflict has been noted, and the service operators think that women found it easier to seek medical and psychological support during the war when the perpetrators were uniformed soldiers. In peacetime it may be harder to address GBV, as the perpetrator is often known to the victim and may also share their social life in the village. DFS also reported that younger women find it harder to talk about their rape experiences. In 2003, 55% of the victims were aged between 13 and 25 years. The programme was reportedly compromised by the lack of legal follow-up. In 2002 there were no convictions passed in the courts relating to sexual violence. In response to the lack of legal process MSF-F has challenged the legal system by putting forward 'water-tight' cases, which so far has not resulted in any convictions. Currently there are no lawyers prepared to work on a pro-bono basis, which makes it difficult for rape victims to have a legal representative. MSF-F implemented a highly visible anti-rape campaign in March 2003, which appears to have reached a large number of people through posters, street-theatre, radio messages and open forums.

Conclusions and recommendations - Republic of Congo

220. In the RoC, the quality of RH services appeared to be primarily compromised by staffing issues. A serious imbalance in staffing of facilities was observed across the three CEMIR sites in the Loukolela area. In addition, the facilities in Ndjoundou and Liranga were understaffed for the number of refugees requiring clinical services.

221. Provide more senior health staff for HCs in Ndjoundou and Liranga. As a minimum, each HC needs a midwife and a clinical officer on site, with weekly supervision provided by a doctor. As an interim measure, the current level of weekly supervisory visits to Liranga and Ndjoundou by senior CEMIR clinical staff should be continued.

222. Perform a security review of all refugee settlements with limited HC services due to reported security concerns. Such a review should primarily focus on sites where staffing of health services is compromised. If the review concludes that any site is unsuitable to base appropriate levels of staff, an alternative IP, specialized in delivery of services in such situations, should be appointed to deliver services to that site.

223. Due to limited resources and the poor state of government health services outside of Brazzaville, referral of emergency cases is likely to remain a problem in most refugee camps and settlements in Congo for the foreseeable future. However, clear guidelines and procedures provide staff with support when managing critical cases. A key component of such planning would be improved communication and transport.

- Formalise referral networks and strengthen referral systems with strategic planning.

224. An adequate drug supply and strengthened staffing, supervision and communication should help to ensure that appropriate treatment is available for key

RH problems. Refresher training in syndromic case management, for example, should ensure that the drug supply is used more efficiently for the treatment of STIs.

- Ensure availability of essential drugs for managing STIs and for EmOC at HCs in all sites.

225. At all sites visited, refugees described morbidity and/or mortality related to hunger and malnutrition particularly in relation to women and children.

A monitoring system should be implemented to regularly assess levels of food security and malnutrition at all settlements/camps.

226. Access to potable water was a major issue for refugees at both Ndjoundou and Liranga camps. Bore holes had apparently been sunk when services at these sites were established; however, these water sources were no longer functioning. It was noted that CEMIR was employing a large work force to maintain the water supply at Loukolela without providing support for potable water at the other two sites. In addition security guards are currently employed by CEMIR to protect the refugee water system in Loukolela. It may be appropriate for refugees to take responsibility for the system's security themselves and receive training to help maintain the system. As part of its water and sanitation programme, IRC provides potable water in Bétou in accordance to the SPHERE standard; it has also established community water committees.

- A standard of access to potable water should be agreed upon for all camps and IPs must ensure that this agreed standard is maintained.

227. Improved communication is essential to help refugees maintain and adopt behaviours that minimize the risk of becoming infected with HIV/AIDS, and to help PLWHA access services. The capacity of service providers to deliver testing and management for HIV/AIDS in RoC requires significant improvement of social marketing, as well as the implementation and evaluation of strategies that minimize discrimination of PLWHA.

228. Broad awareness of GBV is a key component in preventing violence against women. While rape appears to be considered a crime when committed by an outsider (e.g. armed soldiers or militia), domestic violence or rape within the marriage is not. Violence against women constitutes a significant impediment for poverty reduction and development and has a major negative impact on the reproductive health of women. There is, therefore, a strong incentive to implement a GBV awareness programme.

- GBV awareness raising activities should take place in all refugee camps and with all the staff working in the camps. Medical personnel should be trained in the signs of GBV, and awareness raising should extend to traditional leaders and judicial structures, including camp security committees.

229. The sexual exploitation of young girls was commonly reported during group discussions held in the refugee camps. This finding is consistent with findings from other studies. Young girls and women refugees, who are supporting other family members, have limited access to income generating activities.

- Target young girls with support for specific income generating activities to alleviate poverty and sexual exploitation.

230. Government hospitals provide services to refugee patients that require referral and inpatient care. However, the observed standard of these services appeared compromised. For this reason, the relationship between government hospitals and IPs requires clarification.

In Loukelela, there is an option for the HC to be expanded to provide inpatient care for refugees, as an alternative to using government hospitals for admissions. A similar model could also be developed at the new HC at Ndjoundou.

231. Cold chain storage is pivotal to the provision of viable drugs, reagents and vaccines to refugee populations. In Loukelela, the cold chain is dependant on a generator to supply power for refrigeration. However, the generator does not operate around the clock, thus breaking the cold chain.

- Remote sites without a reliable power source for cold chain support are better suited to using battery-operated fridges with solar panel sources of power.

Findings - Yemen

Background

232. Yemen continues to be a centre for transitory population movement. The latest influx of refugees has increased in the aftermath of the outbreak of civil war in Somalia in 1992.

233. UNHCR carried out a registration exercise over a 12-month period for Somali refugees in 12 cities in Yemen. Four registration phases were completed in June 2003 (Table 3.9). A further phase was carried out to register non-Somali refugees. The majority of refugees in Yemen are from Somalia (Table 3.10).

Table 3.9: Somali refugee registration - Yemen

Phase	Governorate	Refugees
I	Sana'a	17,360
	Hodeidah	281
II	Aden	13,153
	Al-Mahara	680
	Hadramaut	692
	Shabwa	458
	Taiz	2,858
III	Sa'ada	140
	Dhamar	235
	Al-Baidha	322
	Rada'a	282
IV	Kharaz Camp	10,145
	TOTAL	46,606

Source: UNHCR, February 2004

Table 3.10: Refugee caseload - Yemen

Nationality	Registered Refugees
Somalia	46,976
Ethiopia	1,826
Iraq	222
Palestine	422
Sudan	63
Eritrea	91
TOTAL	49,667

Source: UNHCR, February 2004

234. Yemen grants *prima facie* refugee status for Somali nationals on the basis of the 1951 Convention and the 1967 Protocol. Somali asylum seekers are granted refugee status in cases when: they have no travel documents or visas issued by a third state; are registered with Yemeni National Refugee Committee; and have refugee documentation (UNHCR/GOY co-signed refugee cards).

235. The documentation allows refugees to enjoy legality of stay, freedom of movement, and access to employment and basic education. Health services for locals and refugees are provided on a cost-recovery model in government services and the private sector, while health services in refugee settings are subsidised by UNHCR. Prices for health services have doubled in recent times under new health sector reforms, but childbirth services are supposed to be provided free of charge and family planning services is available at a minimal charge.

236. Somalis and Ethiopians usually cross the Arabian Sea from Bossasso in Somalia to Bir Ali on the southern Yemeni coast. There are 14 other entry points along Yemen's vast coast. UNHCR has established the Mayfa'a transit centre at Bir Ali to register new Somali arrivals and provide basic assistance (water, shelter and medical services), as well as information about the refugee camp at Kharaz.

237. Since September 2003, the majority (82-87%) of new arrivals have been Ethiopians. This change can be linked to the deterioration of the economic situation Ethiopia and the forced expulsion of 82,000 refugees from Djibouti (most of whom are from Ethiopia and Somalia).

238. It is estimated that less than 10% of registered Somali refugees live in the Kharaz camp on a regular basis. Most prefer to base themselves in the major urban areas, where the chances of employment are greater. Due to the high rate of unemployment (50-70%) in Yemen, most refugee men can only obtain casual employment, e.g. daily work on roads or washing cars. Refugee women (particularly those from Ethiopia) can sometimes find domestic jobs in urban centres. For this reason, few refugees plan to stay in Yemen. Only 2-3% of new arrivals proceed to the Kharaz camp, the majority (estimated at 50-60%) go to urban centres before heading to the final destinations of Saudi Arabia and Oman. A circular route has developed for some individuals, who are subsequently deported from Saudi Arabia and must again enter Yemen as refugees. Even though 74% of Somali new arrivals from 1998-2004 were male, 70% of the population at Kharaz camp consists of women, children and the elderly, which supports the notion that most Somalis come to Yemen on transit to other countries.

Evaluation sites

239. Three sites were evaluated in Yemen: Sana'a, the country's capital; Basateen, close to Aden in the south of the country; and Al Kharaz camp, outside Aden. Each site had a different IP, as indicated in Table 3.11.

240. The findings reported here are based on completion of the HFC at four HCs (at least one HC in each site), 13 groups discussions with over 150 refugees, observations of HCs, informal discussions with refugees during walks, interviews with health staff and managers, and observation of the clinic sessions at Kharaz, CSSW and IHD. In addition, background briefings were held with UNHCR and NGO representatives.

241. Around 20,000 refugees and 10,000 Yemenis (mostly comprising of returnees from Somalia) live in Basateen on the outskirts of Aden (Islah estimate).¹⁵ Accommodation is cheaper in Basateen than in Aden, and opportunities exist to gain casual employment and the refugee community can provide support for each other. Triangle Génération Humanitaire (TGH), a French NGO, provides support services in social welfare in both Basateen and Kharaz.

242. An estimated 4,500 - 6,500 refugees live at Al Kharaz camp with a further 3,000 Yemenis living in the neighbouring village or in the surrounding area. However the exact numbers are difficult to determine as people move between the camp and Basateen frequently, making any distinction between urban or camp refugee statuses meaningless.

Table 3.11: Population of refugee settlements - Yemen

Area (District)	Site no. (IP)	No. Refugees	No. Nationals
1. Sana'a	Site 1 (MSI for RH; IHD general)	22,000 UNHCR est. 27-30,000 MSI est.	1 million
2. Aden (Basateen)	Site 2 (Islah; TGH)	20,000 est.	10,000 est.
3. Kharaz camp (Lahj)	Site 3 (COOPI; TGH)	4,500-6,500	3,000

Source: UNHCR annual and monthly refugee stats, 2003 Findings.

243. **Sana'a.** Marie Stopes International (MSI) operates a clinic for urban refugees in Sana'a. The focus of the health services on offer is on reproductive health, but a staff paediatrician is on hand to run a children's clinic five days a week. The clinic is not open after 7:30 pm; therefore many women who attend MSI for ANC deliver in hospital. All MSI services are free to refugees, but Yemenis are required to pay for services. Patients who are referred to hospital for more complex treatment must return to Interaction in Health Development (IHD) to be reimbursed the costs of their hospitalisation. IHD is a local NGO providing general medical services (including RHS) to urbanized refugees until 2003, when UNHCR transferred responsibility for refugee RHS in Sana'a to MSI.

244. **Aden.** The Charitable Society for Social Welfare (CSSW) operates the Islah Clinic in Basateen, as well as providing the general medical services for the refugees residing at the Kharaz camp. An agreement has been signed by UNHCR providing

¹⁵ UNHCR estimates that there are only 13,153 registered refugees in Basateen.

support for Islah Clinic. At present refugees (although not Ethiopian asylum seekers) receive free medical consultations,¹⁶ but they are obliged to pay for all investigations and treatment, although they receive a discount of 30-50% on rates charged to locals. COOPI is an Italian NGO that began providing comprehensive RHS at Kharaz camp in March 2004.

245. UNHCR estimates that around 22,000 refugees live in Sana'a. The IHD clinic is conveniently located in the suburb of Safia where most refugees, whereas the MSI Clinic is located in a less accessible part of Sana'a. Refugees must use public transport to get there, which usually involves a change of buses. Otherwise RHS in Yemen were generally highly accessible.

Staffing and Coverage

Table 3.12: Profile of staff at facilities assessed - Yemen

Health Service	Marie Stopes International	IHD	CSSW (Islah)	COOPI
Location	Sana'a	Sana'a	Basateen	Kharaz
Health workers				
Midwife	2 (one refugee)			1 refugee
Nurse Midwife		1	4 (one refugee)	
Nurses	1		3 (two refugees)	2 (unqualified refugees)
TBA				1 refugee
Medical Asst			1	
Doctor	1	2	3 (1 half time)	1
Gynaecologist			1 (half time)	1
Physician	1 Paediatrician		1 Paediatrician & 1 Physician (both 0.33 time)	Programme Coordinator (Public Health Physician 0.6)
Pharmacist	1	1	1	
Lab Tech	1	1	2 (one refugee)	
Specialist areas		Social Worker Legal advisor Counsellor (Sudanese)	Radiographer Ultrasonographer x 2 (both half time) TB ward Food programme	
Support staff	Receptionist Administration Guard (refugee) Cleaner (refugee) Driver (refugee)	Receptionist x 2 Secretary Security x 2 Guard x 2 (1 refugee) Cleaner x 2 refugees Driver	Administration x 2 (one refugee) Guard x 3 (1 refugee) Cleaner x 3 refugees Driver (refugee)	Cleaner (refugee)
Teachers		Kindergarten x 2 (1 refugee)		
CHW			6 recently trained	

Source: Health Facility Review. Note: All staff are paid nationals unless otherwise stated as refugee.

¹⁶ Yemenis must pay 50YR to see a Primary Care Doctor and 100YR to consult a specialist.

246. Even though CSSW has a strong team of specialist doctors and other clinicians at their Basateen service, they were observed to practise medicine in a manner that was unnecessarily costly, ordering large numbers of tests and inappropriately referring patients to hospital. To better address the health needs of refugees there appears to be a need to reorient the focus of Islah Clinic to primary health care.

Health Facility Infrastructure

247. All sites had electricity, running water, flushing toilets and good communication systems. In terms of infection control and universal precautions, all health services visited had a good water supply and hand washing facilities.

248. All health services assessed were outpatient services except for those based at Kharaz. The CSSW general health facility at Kharaz was visited but not separately reviewed, as COOPI was responsible for the delivery of RHS at Kharaz camp. COOPI has three maternity beds and two post labour beds at Kharaz.

249. In general, all health services assessed were well resourced, but access to blood for transfusion in Yemen was seen to be very difficult. Although the services provided by the Blood Bank in Sana'a were reviewed in 2000 and again in 2002, there has been limited progress implementing recommendations to create three regional blood banks. Blood transfusions are performed in emergency situations but screening of blood is not usually possible, and this increased the risk of disease transmission.

250. All services are open five days a week (Saturday to Wednesday) except for Islah Clinic, which is also open on Thursdays. Most clinics operate in the mornings and evenings except for IHD and COOPI, which are open from 8 am until 2 pm, although COOPI have an 'on-call' clinic from 4 – 6 pm. In terms of infrastructure, all HCs had running water, power, refrigeration, and phone communication.

251. With the exception of MSI, special clinics operated on particular mornings, as follows:

- *IHD*: Chronic Diseases Clinic (e.g. diabetes mellitus, hypertension and epilepsy) on Mondays.
- *Islah*: Family planning on Mondays and Wednesdays, ANC on Mondays.
- *COOPI*: ANC on Mondays, Gynaecology on Tuesdays, Vaccinations on Wednesdays and Thursdays, and FP, Health Education and Postnatal Clinic on Wednesdays.

Equipment and Drugs

252. The facilities assessed had good quality and relatively large-scale autoclaves in working order. An adequate supply of gloves was also available at these facilities. In general, all sites and IPs had adequate equipment for RH services, including ultrasound at CSSW and MSI. CSSW (Islah Clinic) had an extremely well stocked

pharmacy (containing ciprofloxacin and a range of cephalosporins). Given the assessment team's impression of clinical practise and record keeping, the question arose as to whether the drugs were being appropriately used. The manager said that the cephalosporins were often dispensed to patients referred from GPs in the area. As these drugs were in an injectable form, it is questionable that they were being used appropriately on outpatients. Some refugees said that Islah Clinic regarded their pharmacy as an important commercial outlet.¹⁷

Table 3.13: Inventory of drugs and equipment - Yemen

Health facility (level)	MSI	IHD	CSSW (Islah Clinic)	COOPI
Basic surgical equipment and gloves	Yes	Yes	Yes	Yes
Autoclave	Yes	Yes	Yes	Yes
Contraceptives/FP kit	Yes, small supply of condoms	No FP equipment, apart from few condoms	Yes	Good stock
STI drugs	Yes.	No STI drugs apart from vaginitis treatments	Very well stocked	Limited stock, no ciprofloxacin
EmOC drugs	No IV MTZ or ampicillin	No IV ampicillin	Good range of drugs, well stocked	No gentamycin at CSSW
Oxytocics	Methylergometrine	No	Methylergometrine	CSSW
Basic gynae. Instruments	Yes	Yes	Yes	Yes
MVA kits	Yes	No	No	No
Ultrasound	Yes	No	Yes	No
IV catheter and fluids	Yes	Yes	Yes	Yes at CSSW
Drug storage (dry, dark, off ground)	Yes, good store	Yes, good store	Yes, good store	New service – developing independent capacity

Source: Health Facility Review

¹⁷ There are no controls on drugs available from pharmacies in Yemen. Everyone is free to buy whatever they like, whether it has been prescribed by a medical practitioner or not. Islah had provided drugs to refugees free of charge in the past.

*Service statistics***Table 3.14: Service statistics - Yemen**

Health facility	MSI	IHD	CSSW (Islah)	COOPI
Period	Annual rate from 2003 refugees report	Annual / Monthly estimates (all RHS now at MSI)	Annual statistics Registration books	Only started providing RHS in Al Kharaz in March 2004
ANC visits	813	-	619	55 (14 complications identified)
TT immunisation	670	-	-	55 (1 st dose only)
RPR tests Prevalence	-	-	34 tests Jan. to Apr. 2004: (22 positive results)	-
No deliveries	33	-	-	22
Caesareans	-	-	-	0
Maternal deaths	-	-	-	0
FP attendances	929	-	441 refugees 981 total	39 visits 12 new acceptors
STIs diagnosed & treated	1,295	50 / mth diagnosed (26 treated & 24 referred to MSI)	307 in Jan 04	62
Positive HIV tests Prevalence	-	8-10 diagnosed each year	-	
SGBV counselled	6	3-4 / mth	-	
Attendances	10,268 refugees	763 refugees in January 2004	8,671 refugees 13,251 total	288 refugees in March 2004
Transfers referred	Recorded through IHD			One obstetric referral

Source: Health Facility Review

Review of reproductive health components

253. Refugee views on reproductive health were elicited through 13 group discussions with 150 refugees, including female and male leaders, female and male users of RH services, female and male adolescents, and TBAs and health workers. All groups included either men or women, although one refugee health worker group included both.

Safe motherhood

254. **Antenatal care.** ANC was provided in clinics at all sites. Health staff - midwives, doctors and obstetricians - reported that ANC included the detection and

management of complications, but not routine testing and treatment of STIs (see section on STIs). In Kharaz, an antenatal clinic session was attended and several routine checks were observed to be well conducted, with good communication and care provided. One issue that was mentioned by women and health staff as being a significant problem in the camps was toxoplasmosis in pregnancy.

255. In terms of satisfaction and access to antenatal clinic services, most women said during group discussions that they were satisfied with the services. In Aden and Sana'a, however, women reported that many of their friends did not attend the antenatal clinic, because they worked or could not understand the need to attend. Other reasons given for not seeking ANC included the opportunity cost for women who worked in urban areas and the cost and time to travel to the clinic. Women in Basateen also reported that they had to pay for ANC.

256. Health staff stated that women received health education and counselling on pregnancy-related topics. During group discussions, many women were able to cite complications that required referral to the HC but expressed concern about government health services (see childbirth section).

257. Access to investigations for antenatal complications was excellent in urban areas; MSI and CSSW had ultrasound facilities, as did local hospitals. However, out of 330 births in Kharaz camp in 2003, 39 were recorded as stillbirths, indicating some concerns with detection of complications during late stages of pregnancy and in labour.

258. Iron and folate prophylaxis, tetanus toxoid immunization, antihelminthic treatment (mebendazole) and Vitamin A supplementation were available at all HCs assessed. However, the assessment team was unable to verify if these were given routinely, although women in Sana'a and Aden complained that they were not given vitamins to supplement their poor diet. Syphilis testing was not routinely conducted during ANC, despite reportedly high rates of syphilis among Somalis.

259. IPs reported that malaria was a major problem, affecting women's health mainly due to anaemia. A limited paediatric prevention programme was run by TGH for the children attending after school care. Adult cases of malaria were referred to hospital for treatment. No antenatal prophylaxis was available at MSI or at Al Kharaz, although treatment was available at the camp clinic and at IHD.

260. **Childbirth.** It was reported that the majority of refugee and Yemeni nationals do not seek hospital or clinic care in childbirth and instead use family members or TBAs, while some deliver unassisted; about 85-90% of woman birth at home.¹⁸

261. Women reported that the cost for birthing in hospital was high. For example, in Aden it was 1,000YR for the birth alone, plus extra if drugs or blood for transfusion were needed. Women also reported that *“even in hospitals you have to pay bribes to the nurse or she won't care for you.”* Hospitals apparently demanded immediate payment for services rendered. Women without husbands said they were embarrassed to attend hospitals, as they would be asked for documentation (e.g. marriage certificate or husband's ID card) that they did not have. As a consequence, they preferred to use

¹⁸ Shamsuddin F H. A Research Study of Refugee Women's Health and Reproductive Health Status in Yemen. Yemen: Marie Stopes International, 2001.

community midwives/TBAs who charged more but provided a comprehensive service close to home. Some women from Aden who knew they had complications requiring an assisted birth would travel to Kharaz, so they could be transferred from there to the hospital free of charge.

262. If a woman in Aden or Sana'a had to go to hospital in an emergency, the hospital would start treatment regardless of payment; however, the woman would not be discharged until the bill was paid. Women leaders in Aden said that often the Refugee Committee would collect funds from the community to assist these women. In Sana'a, it was said that there was a woman who, at the time of the assessment, was being kept in hospital because she could not pay 1,500YR. The women who related this story wanted MSI to give the hospital a letter and follow the woman up, so that she could be released.

263. In Kharaz, midwives or the TBA were available on a 24-hour basis, and there was a woman doctor on call for emergencies. Women expressed satisfaction with the midwife and the quality of service at Kharaz.

264. In Sana'a, women said that local 'midwives' were considered to be better although their fee was 3,000YR. Payment also could be made in instalments or postponed until the woman could afford to pay. Midwives were considered the best option, as they were handy and known and trusted by women. In Aden, an Islah clinic midwife also assisted with homebirths, but she was not favoured if the community midwives were available.

265. In Aden, the four community midwives (or TBAs) in the urban setting had extremely busy practises, each with about 30-40 births per month. One community midwife had qualifications from Somalia as a public health nurse-midwife (obtained in 1976) and had been practising for 15 years; the other three had learned from their relatives in Somalia and had been practising for 6, 18 and 20 years, respectively. They were accessible for women in Basateen, within a 10-15 minute walk away and offered antenatal care, however some women only called them when they were in labour, while others, who had no money or were frightened, would call them only when it was too late.

266. The community midwives were able to detect abnormal pregnancies and referred the women to hospital, sometimes putting them in taxis to ensure they got there. The major complications reported were PPH and eclampsia, and they had seen three maternal deaths when women refused to go to hospital. Twins and breech presentations were managed by community midwives at home. In addition, they were able to manually remove the placenta, when necessary, suture episiotomies, and give antibiotics (usually oral or intramuscular amoxicillin) if there was concern about infection. Gloves were used for births and sterile scissors for episiotomies, and intramuscular ergometrine (purchased from local pharmacy for 70YR) was used at births.

267. The standard charge for a community midwife was 10,000YR¹⁹ for antenatal, birthing and postnatal care in the community. The cost of a normal birth in the Yemeni hospital was said to be 3,000YR, approximately 15,000YR for a caesarean section, or 20-30,000YR for private hospital care. If the woman had a card, UNHCR

¹⁹ 1000 YR=US\$5.42

would pay for hospital care. The MoH and UNFPA plan to train community midwives and upgrade the skills of TBAs. However, it was difficult in Yemen to recruit young women who are allowed to work at night and go to homes to deliver.

268. Female genital mutilation (FGM) or cutting has the potential to affect childbirth as well as cause numerous health problems. Women referred to it as female circumcision and claimed that staff at public hospitals did not know how to deal with it properly and several complained of pain and poor healing after bad repairs. Women in Sana'a said that female circumcision was less of a problem than in the past, claiming that Somali men used to insist on it.

269. One male Oromo leader in Aden said that doctors became more familiar with the phenomenon of FGM a few months after the refugees began to arrive in Yemen. In Aden, women said the community midwives knew how to cut them properly, using two cuts diagonally with the sterile scissors they (the women) brought with them. Midwives also knew how to repair women properly after birth to prevent problems. The doctor at IHD said that women would commonly present soon after getting married to have a minor release of scar tissue performed to allow easier sexual intercourse. It was believed that the key to changing this behaviour (the practise of FGM) was through male decision makers. However, many Oromo leaders interviewed regarded the continuation of such practises as essential for preserving their culture: *"Nothing has changed [since coming to Yemen]: it is continuing as it should."*

270. **Emergency Obstetric Care.** The MMR in Yemen is 366/100,000 live births based on census data, although an estimate of 1500/100,000 was made in 1997. UNICEF has recently made a further estimate of 800-1000/100,000 based on small-scale research.

271. In Basateen, women reported that they knew of five maternal deaths in 2003, from bleeding and eclampsia. A maternal death was reported in Kharaz around eight months ago; the woman was diagnosed with placenta praevia and antepartum haemorrhage at term, and had had no antenatal care. She was transferred to hospital and the family were asked to consent to a caesarean section, they refused for two days, and the woman subsequently died.

272. Antibiotic treatment for infections during pregnancy and the postpartum period in the four HCs assessed was limited to IV ampicillin and gentamycin. Oxytocic drugs were usually available in the form of methylergotamine and most clinics assessed had a stock of diazepam ampoules.

273. Manual removal of the placenta was possible at all HCs assessed, with obstetricians and midwives trained in the procedure. Community midwives and TBAs also reported that they performed manual removal of the placenta, when necessary, on women who delivered at home. MVA was available at MSI for post-abortion care, but not at CSSW and Kharaz. In addition, Kharaz clinic had obstetric forceps for use in case of emergency. If a woman was transferred from Kharaz to a local hospital she had to travel for 2 to 3 hours but the cost of services was covered by UNHCR; however, women who had to transfer from urban settings, had to pay or organise reimbursement from IPs after discharge.

274. At all sites it was reported that women, when they are desperate, resort to self-induced abortion using a variety of methods, including taking chloroquine tablets

(available over the counter at local pharmacies) and drinking one cup of honey (which was said to leave no side effects), inserting a stick into the cervix, and boiling a particular bark/leaf and drinking it. When asked if there were concerns about infection or sepsis, they said that women who used such techniques did not care about complications, as they were desperate to end the pregnancy.

275. **Essential newborn care.** Breastfeeding was described as a major concern in nearly all the group discussions. Women and men complained that there was no supplementary feeding programme for breastfeeding women in urban areas, and many had to return to work soon after the birth, in order to survive. In Sana'a, for example, women said that they had to return to work cleaning so they could pay for rent and food for the family, and so stopped breastfeeding. Some said that their milk was not strong enough as they were malnourished themselves. They said there was no food supplementation for breastfeeding women, and that this issue was of serious concern to them. In Aden, women said some mothers took their babies begging with them so they could get money for food. This is illegal in Yemen but they felt some women had no choice.

276. Tetracycline eye ointment was available at all clinics assessed. Clean cord care was practised and there were no reports from either mothers or health staff of any problems with cord care. Equipment for newborn resuscitation was good in all sites, and a number of staff had been trained in basic newborn resuscitation.

277. Although we did not observe any births during the assessment, it appears to be standard procedure to dry the baby and wrap it, so it was unclear whether there was initial skin-to-skin contact at births conducted in hospitals or clinics; although skin-to-skin contact was advocated it may not be traditionally practised.

278. **Postpartum Care.** Assessment of mother and newborn was routine practise for midwives and TBAs; the TBA checked women who delivered at home at least once after the birth. It was reported that fear of needles meant that there was a very low rate of vaccination for ADT and measles, whereas oral polio vaccination has a high compliance rate. Women also reported that they could not afford special solid foods for babies when weaned and that they would feed infants roti. IPs offered childcare in Sana'a and Aden for working mothers.

Family planning and birth spacing

279. In Sana'a, Somali leaders said, *"If a woman goes for family planning, it is good. They cannot afford more children to feed."* However, FP was also considered *haram* or forbidden by older male leaders. Nonetheless, younger men said they used various FP methods, including condoms that could be readily purchased for 2YR each. Women leaders were able to list available methods and considered that OCP was the preferred method. Participants in the mixed leaders group listed complications from various methods and considered that condoms were preferable to other methods that they thought were associated with complications (bleeding and heart disease). Hormonal implants were unavailable at refugee health services in Yemen.

280. During group discussions with women, ideal birth spacing was considered to range from 2 to 5 years, whereas ideal family size was reported as ranging from 4-5 children during the discussion groups in both Sana'a in Aden. However, some young

men said there should be as many babies as god planned, although one said, “*spacing children was good for wife and husband.*” Ethiopian Oromo leaders said that they do not use or believe in FP.

STIs including HIV

281. Condoms were available at all the health facilities visited but were often in relatively short supply, with the exception of COOPI and Islah (refugees were able to buy condoms from Islah for 2YR each). However, there is currently a low demand for condoms in Yemen and the estimated monthly number distributed by MSI was possibly somewhat inflated.²⁰ Their pharmacy store had only 90 in stock, although there was apparently a much larger supply at the nearby MSI Head Office. MSI estimated that 67% of these condoms were distributed to refugees. Since taking over RHS at Kharaz, COOPI reported a rapid increase in distribution of all available FP methods, including condoms.

282. A recent initiative by MoH is aimed at improving the quality of STI data; for example, there were 307 STI cases treated at the Islah clinic in the month of January 2004, 75 of these cases were recorded by the gynaecologist using the recently implemented MoH form.²¹

283. In male patients treated at the Islah clinic, the diagnosis of urinary tract infection (UTI) appears to have been confused with urethritis. For example, in January 2004, there were 912 cases of UTI in males compared with 632 cases in females; UTIs are rare in men, whereas they are a common problem for many women. The Islah clinic and the one run by MSI had a supply of ciprofloxacin, but this drug was not available in Kharaz. However, COOPI plans to expand their range of drugs so that they will have an independent supply for treating RH conditions.

284. Men to be checked for STIs at Kharaz, especially as 52 out of 62 people recently screened for STIs were found to have an infection. Records of men being treated at MSI for STIs only appear in the last quarter of 2003 (there was zero attendance previously). In this quarter, there was the same number of women as men who received treatment for PID. The other men recorded as attending MSI for treatment of an STI were for cervical polyp, cervicitis and candidiasis, which are of course women's conditions. It appears that the only treatment men are receiving is that which is brought home by their wives after they have been treated for an STI at MSI.

285. Men who present at MSI for health services would be assumed to be seeking treatment for an STI, as this is the only service that MSI provides for men. This lack of privacy is clearly a deterrent for men to use the service. However, IHD has an experienced male Somali doctor on staff and the clinic provides more privacy for the men who attend.

286. The large number of cases of syphilis in the sample of 62 people recently screened further highlights the need for universal ANC screening for syphilis. There was some confusion at the Islah clinic, however, about the indications for syphilis

²⁰ All the monthly service estimates that were provided during interviews were much larger than the actual numbers recorded in their reports.

²¹ All other Islah clinicians will record STI cases using this form in the future (including the nurse-midwife, primary care doctors and the physician).

testing.²² At present it is at the discretion of the treating clinician, although syndromic management is used (the algorithm was on the clinic's walls in Arabic). As UNHCR is now providing funding to support the Islah clinic, it would be advisable to provide free RPR tests for all refugee women attending the antenatal clinic. The high number of positive RPR test results from those ordered by specialists at the Islah clinic (22 positive RPR tests out of 32 ordered since the beginning of 2004) supports the establishment of such a screening programme. However, RPR tests are not being performed at MSI, and the only case of syphilis was recorded in their statistics in February 2004, which may indicate that this condition is not being addressed by MSI.

287. There is a major emphasis on the treatment of vaginitis, as all pharmacies visited (except for COOPI) had an extensive range of treatments for candidosis and trichomonas.²³ For example, while STIs account for 32% of adult services at the MSI clinic, candidosis accounts for 91% of cases.

288. Discussions with both women and men revealed that there was little knowledge or understanding of HIV/AIDS demonstrated, and no requests were made for VCT (unlike other refugee settlements evaluated). HIV/AIDS prevention programmes at the Islah clinic usually involved videotapes that seemed to lack relevance to the Somalis or Ethiopians, as they were in the wrong language or were culturally inappropriate. In terms of HIV testing, the only refugee service that had this capacity was IHD. However, the tests were primarily used for screening patients that require referral to hospital for surgery. HIV tests are compulsory before surgery, and tests from outside centres are not considered valid by the hospitals. Therefore, a positive result at IHD will simply exclude a patient from surgery.

289. One thousand three hundred and seventy cases of AIDS have been reported in Yemen and all have been confirmed serologically. However, it is estimated that there are around 11,000 people that are HIV positive. There is no surveillance system, although a strategic framework to implement such a system was recently supported by MoH and will include increased availability of VCT and some ART. At present there are few treatment options available to PLWHA.

290. The diagnosis of HIV/AIDS in refugees is a sensitive issue, as each time this topic was raised in group discussions the refugees said that: *"the camp is clean – there are no STIs."* However, they conceded that there might well be cases of HIV/AIDS elsewhere and added *"We are here to tell you that, generally speaking, cases come from outside [the camp]. There are no cases here."*

Gender-based Violence

291. Women in Sana'a and Aden reported that Yemeni men often harassed them. There were reports of women who were asked for sex by their employers and if they refused, were accused of theft or beaten. Women were afraid to report this harassment, as they would lose their jobs.

²² The laboratory records listed the tests as both VDRL and RPR. When we got the test kit out of the fridge it was labelled "VDRL" in large letters but the box contained an RPR test kits!

²³ The COOPI Programme Manager was interested in developing an STI protocol for the newly established RH service and getting their small pharmacy fully stocked with the necessary drugs.

292. During group discussions, women said that they and their children were constantly discriminated against. For example, they were called ‘blacks’ and offered money for their children. Some women said they kept their children away from school because of the discrimination and bullying.

293. ‘Wife beating’ was common according to the male leaders who also act as mediators with the people creating the problem. *“If it happens more than twice they are forced to stop according to the law or they must grant the partner a divorce.”* One woman in Sana’a said that domestic violence was something experienced: *“every night. Men don’t go to work; they don’t pay rent. They say ‘give me money for qat or I will beat you. They accuse us of selling our bodies if we have money.”* The situation for her was that there would be domestic violence regardless of whether or not she gave her husband money. Other women said that there was no tradition of men helping women and their social culture was different to the one found in Europe or elsewhere.

294. During group discussions in Aden, women were asked what they would do if they were involved in domestic violence; their response was *“hit back.”* In Kharaz camp, doctors reported that men frequently attended the clinic for treatment of cuts and bruises, after disputes with their wives. However, normally *“the woman runs away, and when her family finds her, she comes back. Mediation then takes place and she either returns to her husband or there is divorce.”* Women in Sana’a said that they would go to their *“tribes to try to solve the problem. If they had no tribe they might go to the police.”* When asked what the police might then do, they said that they *“would help the woman and arrest the man.”* During discussions with Ethiopian women in Sana’a, they said that they would not go to the police, as 90% of them have no ID cards. *“It is between us and the elders. It is a big problem. The community tries to solve the problem. If there is no solution, we try the cultural way. If there is no solution, then they separate.”*

295. With regard to rape, Basateen leaders reported that it was rare, although women said that Yemeni men came into Basateen to find prostitutes, and some innocent women had been raped by mistake. This was a crime and *“the rapist had been imprisoned.”* However there was no concept of rape in marriage as: *“a husband has the right – she cannot refuse.”*

Conclusions and recommendations - Yemen

296. A model of health services should be defined to meet needs of target populations in Basateen and to ensure sustainability of services. This should be undertaken through workshops/meetings with key staff at UNHCR and Islah and involve a review of the following: clinical activities (measure against community needs); staffing allocations at both Basateen and Kharaz (look at staff utilisation and problems such as burn out); pharmacy dispensing against clinical guidelines (develop clinical pathways); data collection system; links with TBAs in area; possibility of rotation of staff between Kharaz and Aden; and outreach and home visiting services, particularly for family planning.

- Develop an appropriate model of care for refugees in Basateen.

297. Devise indicators for new services (MMR is too infrequent to be of value, SBR may be appropriate, immunisation rates, STIs diagnosed and treated, time to

negative smear for TB presentations, TB/STI treatment compliance) and develop a clinical data collection system to assess activity levels, clinical outcomes and costs.

- Develop protocols for investigation and referrals (considering clinical outcomes against cost) and clinical pathways.

298. In Yemen, medical staff in some services practised expensive and sometimes inappropriate medicine.

299. Develop primary health care training modules for doctors working with refugee health services.

300. Refugees who live in urban areas face difficulties when accessing local hospitals, requiring documentation and payment before discharge. Many complain of discrimination and poor quality care while in local health facilities. Prompt assistance and follow-up of refugees who have been hospitalised need to be implemented

- Formalise referral networks and improve complaint mechanisms for refugee patients.
- Develop a follow up system with hospitals for all refugees admitted.

301. Drug supplies, adequate staffing, supervision and communication will help to ensure that appropriate treatment is available for key RH conditions. In Sana'a, RHS for men may be more appropriately provided at IHD. Refresher training in syndromic case management should ensure that drug supplies are used more efficiently.

- Ensure availability of essential drugs for treating STIs and for EmOC at HCs in all sites. Review men's sexual health services in urban settings to ensure that they receive confidential and appropriate treatments.

302. Family planning was considered important, but concerns about side effects and misinformation often negated the desire to space children. Education and standardizing FP choices in the postnatal period should occur in all sites. Choices such as bilateral tubal ligation were clearly desired by some who had completed families. Access to such options was limited.

- Continue to promote family FP choices and provide opportunities for men and women to discuss their concerns about side effects.

303. At all sites visited, refugees described morbidity and/or mortality related to hunger and malnutrition particularly amongst women and children in urban settings. While monitoring processes are regularly undertaken in Kharaz camp, the situation for urban refugees can be compromised, resulting in food movements in and out of the camp.

- Implement monitoring systems to regularly assess levels of food security and malnutrition for urban refugee women and infants.

304. The water supply was not assessed as part of this study but it was a source of concern for refugees in Kharaz. Access to potable water was a major issue for refugees in the summer.

- Review conditions in Kharaz camp, including sustainability of water. A standard of access to potable water should be agreed upon for all camps.

305. Improved communication is essential to help refugees to maintain and adopt behaviours that minimize the risk of becoming infected with HIV/AIDS and in accessing services for those people living with HIV/AIDS. Serious discrimination and stigma exists for PLWHA in Yemen.

- HIV/AIDS awareness raising activities should take place, utilising new innovations, particularly relevant for youth.

306. Broad population awareness of GBV is a key component in preventing violence against women.

- GBV awareness raising activities should take place in all refugee camps and with all staff working in camps. Medical personnel should be trained in the signs of GBV. Awareness raising should involve traditional leaders and judicial structures, including camp security committees

307. The sexual exploitation of young children was reported, including trafficking out of the Yemen. This is consistent with findings from other studies. Young girls and women refugees have limited access to livelihood, which limits their income generating options. Women and girls who are supporting other family members need to be identified as vulnerable and given access to income generating activities.

- Target young girls with support for specific income generating programmes to alleviate poverty and sexual exploitation.

308. Refugee women in Kharaz camp reported that security personnel had harassed them and, while there had been some action to deal with this problem, the situation had resumed.

- Ongoing monitoring and action by UNHCR and IPs of the security concerns of women in camps should take place.

Limitations

309. This evaluation had a number of limitations that were mostly due to difficulties of conducting fieldwork in uncontrolled settings.

310. In some cases, focus group discussions were larger than optimal or the norm, however we worked around this by using them as community consultations. It would have been ideal to have interpreters who were refugees and always of the same gender as the groups, however this was not always possible. In general, health staff should not have been present or acted as interpreters as this could affect the way that refugees voiced their concerns, however in the few cases where this

occurred, our experience was that refugees were expressed their opinions, regardless of the presence of health staff. It would have been preferable to have both a moderator and scribe – but this was impossible given the number of focus groups scheduled. It would also have been preferable to have the group discussion/community consultations taped and translated, but there was insufficient time and resources to be able to do this.

311. The level of reliability of data provided was a major issue as denominators were often not explicit nor were data expressed as rates. Data we considered to be good data was, on closer investigation, not really adequate. We had limited access to IDPs in Uganda due to security concerns and also only access to the camps of one IP in Congo. This has made it difficult to compare across countries or IPs.

312. Both settlements and camps assessed in Uganda and Yemen had been longstanding, hence the response to refugee needs was more established. In the RoC, there had been more recent periods of instability, and some sites assessed provided few health and reproductive health services. Additional assessments in more conflict-prone settings are likely to have provided a different snapshot of the RH response, however that was beyond the scope and feasibility of this study.

Discussion

313. Refugees in Uganda, RoC and Yemen could be said to have access to the same, if not higher quality services than nationals, at least in some cases. However there are still major refugee health concerns that need to be addressed in these countries. Many of the refugees that we met had been in camps or settlements for ten years or more and some of the youth could not recall their 'home country'. Providing for long-term housing and protection of refugees is an enormous challenge, and future handover of health services to local authorities and repatriation of refugees are immediate issues that require planning and ongoing donor commitments.

314. Detailed information on each country has been presented and while each has a different context and background to the conflicts and refugee and IDP movements, all had substantial refugee populations that had been there for many years. The responses of the host governments differed, as did the capacity for their health and education systems to respond to the influx. As with most host countries to the world's refugees, Uganda, RoC and Yemen are in the lowest Human Development Index²⁴. In other words, the local populations in these countries have poor health indicators, particularly in the rural areas, where refugees were generally settled. IDPs are in more vulnerable situations, with security concerns clouding attempts to provide health and other services to them.

315. The range of RHS included all the basic components from safe motherhood, including EmOC, FP, prevention and treatment of STIs, including HIV/AIDs, and GBV. The quality of services in these areas varied between countries and sites, with the biggest gaps seen in EmOC and GBV initiatives.

316. Factors that **hindered access** to RHS included **external** factors such as:

²⁴ UNDP Human Development Index 2004. Measures life expectancy, educational attainment and adjusted real income. Uganda, RoC and Yemen were in the lowest ranked category.

- Poor or no roads (Congo especially);
- Insufficient transport (e.g. ambulances) ;
- Limited communication systems (e.g. sometimes not even mobile telephone access);
- Lack of water and poor sanitation in rural areas for local populations as well as refugees;
- Poor security (e.g. refugees in some cases must travel through unsafe territory to reach services).

317. Other factors related to the health facility and implementing partners included:

- Distance to health facility;
- Perceived competence of health staff (e.g. related to inadequate training and supervision;
- Hours of operation;
- Cost for services;
- Perceived poor quality of services (e.g. related to lack of equipment, essential drugs, light, water, hygienic conditions and privacy).

318. Refugees held strong views on the **quality of services** and their own satisfaction with RHS, and many voiced complaints. Many also expressed gratitude for high quality services and caring staff. Concerns were expressed by some about the:

- Quality and availability of appropriate drugs;
- Perceived inappropriate use of drugs;
- Poor communication between staff and patients;
- Attitudes and behaviour of health workers (e.g. rude midwives and other staff);
- Perceived discrimination (e.g. need to bribe nurses in local hospitals).

319. The **health-seeking behaviour** of refugees also affected their reproductive health outcomes, as follows:

- Preference for TBAs;
- Cultural and religious barriers to FP;
- Women were too busy at home with children or at work (urban) to go to health centre / hospital for antenatal care and birth;

- Embarrassment due to lack of good clothes or a towel to carry the baby in;
- Dislike of the lithotomy position;
- Fear of having an episiotomy.

320. Improvements in RH services could be gained by:

- Implementing better data collection systems on routine procedures;
- Audits of all maternal and infant deaths;
- Communicating and coordinating regularly with TBAs;
- Regular training and supervision of midwives, TBAs and doctors in all aspects of RH;
- Better use and availability of appropriate drugs for STIs and EmOC;
- Availability of and training in procedures such as vacuum extraction;
- Improved management and prevention of common infectious diseases (i.e. malaria) that overwhelm services;
- Improved community-based FP and ANC models.

321. A number of themes emerged when comparing the three sites, namely:

- The need for a primary health care code;
- The need to address basic determinants of health, such as the relationship between poverty and health;
- The relationship between public health initiatives and RH;
- Definitions of 'vulnerability';
- Mental health;
- Organizational culture;
- Consultation, communication and coordination mechanisms;
- Human resource management;
- The needs of special groups (e.g. adolescents);
- Improving local health services; and
- Sustainability.

322. Refugee settings in many cases have become long-term, and there is a need to adopt a more ecological approach if changes are to be made and improvements to be

gained. IPs have variable experience in more primary health oriented and community-based approaches to improving health.

323. The underlying issue of poverty and consequent poor nutrition will continue to impact on the health of refugees (and locals), particularly on women and young children. For example, user fees for attending school mean that for many refugees, a choice has to be made regarding how long a child can attend; often this means that young girls leave school and start sexual activity early. This is likely to have long-term consequences; for some the choice is early/forced marriage or even illegal migration to other countries. The issue of bride price is a complicated one to address for the future of young women. While under the protection of UNHCR, a key concern should be to prevent rape, unwanted sex, and underage prostitution. Support for income-generating activities, including piecework for families, and skills development and vocational training for young people, should be increased.

324. Broader public health issues such as access to safe water and sanitation remain a concern in some sites. Security is a major concern in some settlements and reviewing current strategies to overcome security concerns is fundamental to the effective delivery of services. Malaria is still a major cause of preventable deaths and not enough attention is being paid to interventions that could save the lives of many women and children and reduce the number of cases that threatened to overwhelm many of the HCs visited. Malaria, anaemia and poor nutrition greatly affect women's health and must be considered basic to improving RH.

325. Access to services and treatment is still affected by inadequate infrastructure such as poor roads, insufficient transport, and limited supplies of electricity and telephone lines. This also affects the consistency of blood supplies. These basic issues have a major impact on maternal and child mortality and morbidity.

326. Identifying extremely vulnerable individuals only applies to acute cases and as one IP stated was a 'drop in the ocean'. A woman with many children and a husband, who does not give a helping hand on the land or even help with the children is vulnerable, yet is not considered so. A reasonable proportion of the men in the camp settings used alcohol or other drugs to deal with the situation, while the women struggled on. Such a situation is the norm for many families in settlements and camps in the three countries. For IDPs the situation is even more unstable and services may be poorer than for refugees.

327. Each site had different organizational structures and human resource management styles that would have been influenced by the organizational culture and philosophy of the particular NGO. For example, there were differing styles of practicing medicine from highly interventionist to more primary health care oriented. Referral to various specialists was sometimes over used and extra diagnostic procedures were not essential in some cases (e.g. ultrasonography, X-ray, spinal taps, antibiotic sensitivity tests, etc.), thus misusing resources.

328. NGOs had different views on the level of staffing incentives given, what categories of staff were eligible (e.g. nurses were said to not have received any "incentive payments" but doctors did), and whether refugee CHWs or TBAs were given incentives or benefits. In one site, CHWs received incentives and TBAs did not. The official policy is that allowances are paid to CHWs but not to TBAs, who are

remunerated as per tradition when they attend births; however, some TBAs work in clinics or transport women to hospitals when there are complications.

329. There was also variation in coordination mechanisms such as level of consultation and involvement with Refugee Welfare Committees and leaders and the number of meetings held with refugee staff (e.g. in one site, TBAs met midwives monthly and the RH coordinator quarterly, but this was not the case in other sites).

330. Facilities at all sites assessed had extensive guidance provided by head offices in terms of policies, but there were varying levels of contact with these offices. MoH guidelines and protocols, such as for transfer to other level health facilities, were available and guided practise, despite concerns expressed by refugees. Often organizations did not communicate policies to refugees well, resulting in complaints and misunderstandings.

331. Feedback on services and acting on the concerns expressed needs to be evident to refugees. A culture of inadequate or inappropriate care might easily develop in such difficult conditions, and if monitoring systems by central offices are not put in place, the quality of services may deteriorate.

332. Training and support for TBAs and health staff were not consistent and attention should be paid to a package that ensures a standard of training and regular upgrading. All IPs should be working closely with TBAs as they often attend more births than health service staff. If their knowledge and care is poor, then it is more likely that complications and deaths will occur.

333. Living and working conditions for many local staff are extremely hard and there is little incentive for them to remain the job for long periods. High staff turnover and 'burnout' are issues for most IPs, which affect the quality of care for refugees. It is not just a matter of 'training' staff better or more often. Improved staff accommodation and food and water supplies may provide an environment that is more conducive to staff welfare and thus reduces staff turnover. Health staff also commented that salary payments were sometimes delayed in the first few months of the year, which often led to difficulties for their families.

334. In terms of RH, more options for family planning, birth spacing, and sexual health education were requested; the proposition that refugees want large families was not uniformly the view, particularly of women and young people. Syndromic case management for STIs, antenatal RPR testing and VCT need to be standardised throughout the settlements and camps. High quality supervision is essential for these programmes to be successfully maintained.

335. Programmes to prevent and respond to GBV are probably the least developed aspect of RH. In some instances, women are being raped within marriage, with no sanctions, and entering into early and underage marriages for bride price, largely due to poverty.

336. Intensive community sensitisation and education on PLWHA has worked in some sites. It is essential in addressing discrimination, reducing stigma and enhancing the capacity of VCT to minimise HIV transmission. Education, promoting supportive environments and social mobilisation around HIV needs to be addressed in a number of sites as a matter of priority

337. Sexual activity in RoC and Uganda typically begins between the ages of 11 and 18 years; sexual activity at a young age is common in all sites assessed, as is underage marriage, pregnancy, and clandestine abortion. Women in Uganda and RoC tend to marry at a young age although many young women interviewed who were mothers were unmarried. This was associated with marriage as an event where goods are traded. IDPs in RoC identified that marriage generally did not occur because the men were too poor. In Yemen refugee girls were supposedly officially married, then abandoned by men after a number of sexual encounters.

338. Sex education in Uganda in refugee settlements was relatively good in terms of access to structured peer group support and education programmes. Radio programmes and peer education were used to encourage discussion and inform young people. Generally, where peer education was provided young people seemed to have a greater understanding and speak more openly about their RH needs. However, in RoC the situation was very different where it was not evident that young people were provided with RH education or resources, in their schools or by health care providers. Young people invariably commented on their need to know more and be provided with more choices about their RH. Young men and women generally discussed early and unwanted pregnancies as a matter they would prefer to change given more resources and information

339. Young people generally did not feel they had supportive environments that promoted effective use of RHS except in the use of safe motherhood services. Although social mobilisation regarding HIV in Uganda has led to behaviour change and has subsequently effected HIV transmission rates, overall STI prevention and testing, contraception access and use, and HIV prevention and management (in Congo), were issues that young people believed needed to be addressed.

340. The basic health infrastructure in the countries with refugee populations is already poor and stretched. The majority of refugee populations are being hosted in developing countries, where the basic infrastructure such as roads, electricity and water supplies may not exist. In addition, health services are generally of poor quality.

341. In refugee settlements and camps, there is not full coverage of safe and adequate water, sanitation systems, electricity, and communication systems, and at times there may be insufficient food for refugee populations. Diseases such as malaria take their toll on pregnant women and young children, and there are preventable maternal deaths related to inadequate transport and inappropriate health seeking behaviour of women.

342. Given the longer-term nature of refugee settings, to achieve health gains it is important to adopt more community-based approaches. Building the capacity of local NGOs and training and developing refugee staff are solutions that should be beneficial in the longer term, particularly if conflicts are able to be resolved and repatriation is possible. Promoting the capacity of the community through targeted training and formal vocational education was identified both by community leaders and NGOs as a significant strategy in addressing current and longer-term health issues from a primary health care perspective. Developing vocational skills training opportunities in fields related to health and education helps to address community health needs, promotes individual capacity beyond school, and enhances the potential for the communities when they either return to their home countries or

integrate into the communities. The reorientation of resources to promote community skills eases the burden on already scarce resources and promotes self-sufficiency. Essentially, excellence in management and organization would improve RHS (and general health services) in refugee and conflict settings.

Recommendations - general

343. The following general recommendations apply to the three study countries:

344. Referral was problematic for most health services due to location, transport, communication and personnel issues. Referral centres were often also unable to offer the comprehensive services necessary to ensure good RH outcomes (e.g. limited access to blood, drugs and appropriate investigations). Host governments need to participate in planning for refugee health services and may need extra support.

- Formalise referral networks and strengthen referral systems with strategic planning.

345. Work needs to continue with host governments on developing safe and accessible blood supplies, for both locals and refugees.

- Assist host governments to develop and implement safe blood supply systems.

346. Training in syndromic STI management and EmOC will ensure that drug supplies are used more efficiently.

- Ensure availability of essential drugs for managing STIs and for EmOC at HCs in all sites.

347. Women continue to die of and suffer with the sequelae of incomplete and unsafe abortion, and without access to appropriate post abortion care this will continue.

- Ensure availability of essential equipment for post abortion care at HCs in all sites.

348. Violence against women constitutes a significant impediment to poverty reduction and development and has a major negative impact on the RH of women. Medical personnel generally needed more training to recognise the signs of GBV. Awareness raising should include culturally appropriate methods and involve traditional leaders and judicial structures, including camp security committees.

- GBV awareness raising activities should take place in all refugee camps and with all staff working in camps.

349. New strategies need to be developed and implemented to address sexual exploitation of the young. Services need to target the young to ensure that they have good access to treatment for STIs and EmOC including health promotion and outreach programmes, if necessary.

- Target young girls with support for specific income generating programmes to alleviate poverty and sexual exploitation.

350. Health services need to offer appropriate and affordable models of care to refugees that routinely incorporate the views of users.

- Review health services to ensure that they meet the needs of refugees and IDPs, including clinical activities (measure against community needs); staffing allocations and supervision (assess staff utilisation to minimise problems such as burn out); pharmacy dispensing against clinical guidelines; data collection systems.

351. Malaria is a significant cause of morbidity and mortality for refugees and IDPs. The volume of cases threatened to overwhelm services at some sites. High treatment failure rates indicate that effective treatment regimens need to be used.

- Support the introduction of effective malaria case management and prevention strategies.

352. Where TBAs are active in communities but not linked to health services, attempts should be made by IPs to work with them. New strategies need to be developed to identify active TBAs, determine their level of skills, knowledge and attitudes to RH issues. Training needs to be assessed and implemented to address concerns of late presentation. TBAs who undertake training and can demonstrate safe practises should receive Safe Delivery Kits. TBAs who perform extensive roles in the health service should be recognised with incentives, similar to CHWs. A review of the role and workload of TBAs is indicated.

- IPs should develop a strategy to understand the role and build on the capacity of TBAs, who perform the majority of births in refugee settings. Training and supply of kits should be linked to provision of safe care. The role of TBAs should be reviewed in relation to midwives, and appropriate recognition ensured.

353. Many of the refugee settings are longstanding, requiring more community-based approaches to behaviour change. Innovative approaches should be trialled that go beyond simple IEC campaigns and include BCC strategies.

- Support introduction of effective community based education and development programmes.

354. In many cases, data are recorded but on closer examination, the wrong information is being collected. All data needs to be useful and fed back regularly to staff, not only to UNHCR and IPs. All maternal and infant deaths require a systematic review to look for root causes and lessons learned.

- Improve data collection methods on RH and educate staff on how to establish rates and set up simple systems that provide useful information. Establish audits and root cause analysis of maternal and infant deaths.

Table 3.15: Summary of factors adverse to refugee reproductive health

Factors adverse to RH	Uganda	Congo	Yemen	Suggested Intervention
IP staff unable to deliver effective RH services	Generally well trained and supervised staff	Limited supervision and support of IP field staff	Imbalance of staffing; isolated staff at camp; coordination issues	Improve monitoring of IP performance and assist IPs to develop appropriate service models
Malaria	Presentations overwhelm service; anaemia of pregnancy increases maternal mortality; high rates of clinical failure using official treatments	Anaemia of pregnancy common; high rates of infection in some camps; high rates of clinical failure using official treatments	Less common problem; many undetected infections	Support introduction of effective malaria case management and prevention strategies; improve access to ANC intermittent treatment and blood for anaemic mothers to lessen risk of PPH
Limited access to RH services	Services generally good quality; some refugees are relatively isolated	Low quality RHS; very limited support available for referral	Many refugees do not reside in camps and cannot afford treatments offered locally	Development of appropriate service models
Limited drug supply for STIs & EmOC	Variable supply; distribution problems	Poor	Limited supply of drugs for some STIs	Supervision to ensure recommended drugs are available
Limited access to investigations	Good access to investigations apart from radiology	Generally limited access to even basic investigations	Variable access to ANC tests; other investigations available but costly	Development and application of appropriate clinical pathways
Untreated abortion sepsis	High rates of unsafe abortion	High rates of unsafe abortion	Limited knowledge of risks of unsafe abortion	Education to all refugee women; improve availability of post abortion supplies and equipment and access to post abortion care
High rate of MMR due to haemorrhage	Limited access to blood; referral problems	Extremely limited access to blood, trained personnel and limited referral options	Limited access to screened blood	Work with governments to improve blood banks and blood screening; instigate audit to identify correctable problems in the health system after any maternal death
Maternal and child nutrition	Difficult with SRS	Concerns expressed	Concerns expressed, especially about breastfeeding	Assurance that food supplementation programmes are implemented; issue for urban refugees

Factors adverse to RH	Uganda	Congo	Yemen	Suggested Intervention
Cases of GBV common	Variable levels of reporting and programme implementation	High rates of GBV in camps; incidents of “uniform” rape	Unreported cases by security personnel	GBV awareness raising activities; medical personnel to be trained; control alcohol access in camps; more activities and opportunities for employment; ensure that cases are reported and acted on effectively; deal directly with armed services to address cases of rape involving services personnel, when possible
Underage sex	Reports of high rates of STI in young	High rates of underage sex work	Low age for marriage	Target young girls with support for specific income generating activities, with provision of specialised services where appropriate
FGM	Common in some groups of refugees	In some groups of refugees	Common problem causing high morbidity	Community education programmes involving decision makers
Family planning	Well stocked and well trained staff; cultural resistance	Health staff with limited expertise in FP, and limited FP supplies	Well stocked and well trained staff; cultural resistance	Community education programmes; assurances that IPs are able to provide comprehensive FP services
Access to safe and clean water	Variable, sometimes requiring long distances to bores.	Variable, sometimes long distances to river	Difficult in Kharaz camp; very hot in summer	Continuation of work on increasing bores and safe water supply
Access to sanitation facilities	Variable pit latrine coverage	Variable	Reasonable	Community campaigns to encourage greater coverage of pit latrines

