Section 4
Part B

Assessment of the Minimum Initial Service Package (MISP) of reproductive health for Sudanese refugees in Chad

Part B of this component of the Inter-agency Global Evaluation of Reproductive Health Services for Refugees and Internally Displaced Persons was undertaken by Dr Wilma Doedens, Technical Officer, UNFPA Humanitarian Response Unit, Geneva, Ms Sandra Krause, Director, Reproductive Health Project, Women's Commission for Refugee Women and Children, and Ms Julia Matthews, Senior Coordinator, Reproductive Health Project, Women's Commission for Refugee Women and Children

Acknowledgements

The Women's Commission and UNFPA would like to thank Dr Sephora Tomal Kono and Dr Togbe Ngaguedeba of UNFPA Chad for their support, without which this assessment would not have been possible. In addition, we would like to express our gratitude to Mr Alphonse Malanda and his staff at United Nations High Commissioner for Refugees (UNHCR) Chad for providing assistance to conduct our visit. We would also like to acknowledge our many colleagues working in Chad during this emergency phase who took the time during a stressful and busy period to speak with us and share their insights on the situation. Great appreciation goes to Dr Nourene for his translation services and overall resourcefulness and Ms Gillian Dunn and Dr Camilo Valderrama of the International Rescue Committee for their excellent logistical support in the field. Finally, we would like to thank the refugees with whom we met for their time, opinions and candid manner.

The report was written and researched by Dr Wilma Doedens, Ms Sandra Krause and Ms Julia Matthews with special thanks to Ms. Sarah Chynoweth for her assistance. The report was edited by Diana Quick of the Women's Commission for Refugee Women and Children. Our thanks also go to Ms Judith O'Heir for her recommendations on report content.

This assessment was made possible by the generous support of the Bill and Melinda Gates Foundation and UNFPA New York.

Section Contents

Tables and Figures

Executive summary

The United Nations Population Fund (UNFPA) and the Women's Commission for Refugee Women and Children (Women's Commission) conducted an assessment of the Minimum Initial Service Package (MISP) of reproductive health services among Sudanese refugees in eastern Chad from April 5-14, 2004. The MISP[1] concept was first developed in 1995 as part of the *Inter-agency Field Manual on Reproductive Health in Refugee Settings*, and established as a guideline for priority reproductive health services required in the initial, acute phase of an emergency.

The purpose of this assessment was to determine the availability and quality of emergency response to reproductive health needs of refugees, which represents the second part of the fourth component of the Inter-agency Global Evaluation of Reproductive Health Services for Refugees and Internally Displaced Persons (IDPs).

The IAWG Evaluation Steering Committee determined that the Sudanese refugee emergency in Chad met the criteria for an assessment of the MISP in an acute emergency based on the total number of refugees, tens of thousands of refugees with a lack of access to basic survival needs, persistent conflict in Sudan with hundreds of new Sudanese refugee arrivals per day, and an established UN coordinated humanitarian response. Attacks by the Government of Sudan (GOS) and the *Janjaweed*, a government-backed militia, on Sudanese civilians in the western border area of Darfur, Sudan for over a year, which escalated in May 2004, resulted in approximately 1,000,000 internally displaced Sudanese in Darfur and 110,000 Sudanese refugees fleeing to eastern Chad by March 2004. In mid-January 2004 ongoing cross-border attacks by the *Janjaweed* and aerial bombardments on the border area prompted UNHCR to initiate its emergency response to relocate refugees from the dangerous border area in Chad to refugee camps at a safe distance from the border. UNHCR divides its emergency response operations on Chad's eastern border into north, central north, central and south and aims to relocate the refugees to camps further inland before the rainy season obstructs access to both new arrivals and refugees. The refugees have been on the border, some for more than a year, without humanitarian assistance and their health and living conditions are rapidly deteriorating.

Using four instruments reviewed and approved by the IAWG Evaluation Steering Committee, the assessment team collected basic site information, conducted semi-structured interviews with 53 field staff, facilitated ten focus group discussions with 108 refugee women, men and adolescents and observed resources and services in twelve health facilities. Activities were carried out in four refugee camps (Kounoungo, Toulum, Iridimi, Farachana), and four spontaneous refugee settlements (Bahai, Tine, Birak, Adré), in the north, north central and central border areas of eastern Chad. Due to the geographic spread of refugees on the 600 km border, difficult road travel and time constraints, the team was unable to visit refugee sites in the south but did speak with two of the major agencies assisting refugees in this region.

MISP assessment findings revealed that most humanitarian actors in Chad were not familiar with the MISP and subsequently did not know the MISP's overall goal, key

[1] MISP Fact Sheets in English and French are available on the RHRC Consortium website www.rhrc.org.

objectives and priority activities. There was no overall reproductive health (RH) coordinator and only one agency with an identified RH focal point. Moreover, there was limited overall coordination of the humanitarian situation and no routine coordination of health or reproductive health activities in this acute refugee emergency setting.

While several protection activities supporting the prevention of sexual violence had been implemented in some camps, the protection needs of the majority of refugees living in spontaneous refugee sites on the dangerous border areas were unmet. Although humanitarian actors had considered women's security in the design and location of some camp latrines and water points and women's participation in food distribution and equal representation on refugee camp committees in most settings, significant protection gaps remained. There were no UN protection officers, focal points or reporting mechanisms for sexual abuse and exploitation. In addition, there was a lack of systematic interventions to address the needs of vulnerable groups such as female-headed households and unaccompanied minors. The *Janjaweed* militia, responsible for abducting and raping women from villages in Sudan, regularly make incursions to the Chad border area to steal refugees' livestock, and placing women at continued risk of sexual violence.

With the possible exception of one agency, humanitarian actors were not prepared to address the clinical management of rape survivors in Chad. Although the assessment team heard widespread reports of women and girls abducted and raped in Darfur, Sudan, there was no initiative to identify women and girls who survived sexual violence and escaped to Chad and to provide clinical management of their health care. Though the assessment team heard indirectly about only a few incidents of sexual violence in Chad, the high-risk situation for women and girls seeking firewood and water, particularly those living in spontaneous settlements along the border or who cross the border into Sudan, was evident.

Priority activities to prevent the transmission of HIV/AIDS in this setting were nonexistent or limited at best. National health structures, with the exception of facilities receiving support from international organizations, were grossly lacking in adequate supplies for the practise of universal precautions, including blood screening, to prevent the transmission of HIV/AIDS and other infections. While international NGOs were adequately supplied to practise universal precautions and also provide informal training on universal precautions to local staff, they did not have written protocols or established guidelines with staff monitoring and supervisory systems.

Free condoms were also not visible or available in this setting. Many humanitarian actors stated that condoms should not be available until the situation stabilizes and said that condoms were culturally inappropriate. However, the limited introduction of condoms by the assessment team to a few local Chadian staff met with immediate increased demand for condoms from other Chadians as well as refugees.

Refugee focus group participants consistently and fervently reported fears about contracting HIV/AIDS and readily offered that they did not know how to prevent becoming infected but were eager to learn. Most participants said that they had never heard of condoms.

None of the three priority interventions to prevent excess maternal and neonatal mortality and morbidity were fully established in this emergency setting. Visibly pregnant women were not provided clean delivery kits. International NGOs reported that they provided clean delivery kits to traditional birth attendants (TBAs) and midwives; however, focus group participants, including some midwives and TBAs, noted a lack of supplies revealing a gap in coverage. National health facilities lacked adequate equipment, supplies and skilled staff to ensure basic EmOC at the primary health care level and, with the exception of one facility, NGOs had not filled this gap. Huge differences existed among the five referral hospitals serving the eight refugee sites assessed in this evaluation. Three of the five referral centres supported by international NGOs did provide comprehensive EmOC, while this care was not available at the two national hospitals that lacked international support.

The final MISP objective - to begin planning for comprehensive reproductive health services integrated with primary health care as the situation stabilizes - was partially implemented through the establishment of general health services, but specific planning for comprehensive reproductive health services was not evident. A notable gap in planning for comprehensive reproductive health care was family planning. Agencies were implementing or planning to implement commonly known components of comprehensive reproductive health services, bypassing the MISP interventions designed for the emergency phase. Examples include: establishing antenatal care (ANC) for pregnant women before ensuring pregnant women have access to life-saving EmOC; planning HIV/AIDS community awareness campaigns before ensuring condoms are simply available to those already interested in using them; and training TBAs and midwives before exchanging basic information with them about the importance of referring sexual violence survivors and women in need of EmOC, as well as meeting their clean delivery supply needs. Taking the time and resources to implement comprehensive reproductive health services without first establishing the priority MISP objectives and activities wastes scarce energy and resources in a difficult emergency setting.

In addition to lack of awareness and knowledge about the MISP among humanitarian actors, other factors, such as a lack of donor and United Nations awareness and support, as well as delays in funding, hindered timely implementation of the MISP in this emergency. Standard supplies of Reproductive Health Kits available from the UNFPA were not in the country until six weeks into the start of the emergency. In addition, humanitarian workers were generally unfamiliar with the contents of the MISP kits and procurement methods. No agency initiated local procurement, assembly and distribution of basic clean delivery kits. Only one agency included the MISP in donor requests and all four of their proposals were pending funding at the time of the assessment.

In this context, as well as in all emergency settings, the implementation of the MISP, a SPHERE health standard, is essential to prevent morbidity and mortality, particularly among women.

The following are the main recommendations of the assessment team. Most recommendations are focused on this emergency in Chad, however, some are more general and can be applied in any emergency setting. (See Conclusions and Recommendations for a list of detailed recommendations.)

- All IAWG members should increase awareness and understanding of the MISP among donors and humanitarian actors by developing user-friendly learning materials, conducting trainings and ensuring MISP standards are reflected in grant proposals aimed at responding to emergencies.

- UNHCR or other lead agency where UNHCR is not present, should ensure that health coordination is in place and appoint an RH focal point early in the emergency.

- International nongovernmental organizations should identify an RH Focal Point in each site for coordination of the MISP, allocate funds to support MISP activities in all settings and ensure coordination with national governments.

- UN agencies and implementing partners should maintain a network of experienced RH health coordinators and an adequate budget to release staff to work in emergencies to initiate RH coordination, when needed.

- UNFPA should receive emergency response funding to second their staff member to UNHCR for the first few weeks of the emergency to facilitate ordering and distribution of the RH kits.

- UNHCR, the Chadian government and international donors should immediately increase its capacity to open more camps in Chad and relocate refugees living in spontaneous settlements on the dangerous border areas to address the protection needs of refugees.

- UNHCR and implementing partners should ensure that female protection officers are available in all camp and non-camp settings and all humanitarian actors should be informed about the responsibilities of these individuals.

- All agencies should seek gender balance in staffing for the emergency.

- All agencies should identify an individual whose job description includes agency or sector-relevant activities that support the systematic protection and participation of refugees, particularly women and children.

- All agencies should consult refugee women and women's groups in camp and non-camp settings about their safe access to water, firewood, latrines, health care and other issues, such as registration and food distribution.

- UNHCR should issue all women—not only female-headed households—their own registration cards.

- All agencies working in the health sector should make adapted protocols and supplies for the clinical management of rape survivors available to humanitarian actors and national health providers as early as possible in all clinical settings. Specific documents include: *Clinical Management of Rape Survivors* (WHO/UNHCR, 2002) and *Guidelines for Prevention and Response: Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons* (UNHCR, 2003).

- UNHCR should inform all agencies and the refugee community of where to report incidents of sexual violence and access available services.

- Humanitarian actors should undertake an information campaign to inform the community, e.g., refugee leaders, women's groups, health workers (CHWs, TBAs, midwives) about the urgency of and the procedure for referring survivors of sexual violence.

- All agencies should develop a code of conduct, including on issues of sexual abuse, inform staff and potential staff, and include the code in all the contracts to be signed by both expatriate and local staff. UNHCR's code of conduct can be used as a model. A trained focal point for reporting should be appointed in each setting.

- Agencies working in the health sector should support national referral level structures early in the emergency, including the provision of sufficient supplies, protocols and equipment to ensure adherence to universal precautions.

- All agencies should make condoms available to humanitarian staff and refugees, even when working with "conservative" populations. Condoms can be made available at registration and distribution of food and non-food items, at clinics, from community health/outreach workers, TBAs, camp managers, etc.

- All humanitarian actors should be reminded of the difference between "making condoms available" and "condom distribution and awareness raising campaigns" in early coordination meetings to ensure that scarce time and resources are used most efficiently on priority activities during the early days of an emergency.

- IAWG member agencies should undertake widespread awareness raising among all humanitarian actors to ensure the distribution of clean delivery kits to all visibly pregnant women as early as at pre-registration or screening. Also, encourage actors to consider local procurement of kit supplies and involving women to assemble and distribute the kits.

- Agencies working in the health sector should identify TBAs and local midwives in camp and non-camp settings and nurses/midwives at the clinic level to assess and address their

supply needs while informing them about the emergency obstetric referral system.

- Agencies working in the health sector should assess and support the equipment, supply and staffing needs of the referral hospital to ensure the provision of comprehensive EmOC services for both the refugee and host population.

- All humanitarian agencies responding to the emergency, including national authorities, should work together to improve the referral level and ambulance systems ensuring that emergency transport to the referral hospital is available on a 24/7 basis.

- All agencies working in the health and community services sectors should plan for comprehensive RH services with the involvement of refugee women, men and youth to include the management of sexually transmitted infections, family planning and gender-based violence programming.

- The RH focal point should collaborate with the health coordinator to ensure that reproductive health data is collected in a standardized manner, collated, analyzed and shared at regular health/reproductive health coordination meetings to ensure coordinated planning and appropriate response.

The assessment team also asked all of the agency staff interviewed for their recommendations in improving implementation of the MISP. A short summary of responses is provided, as follows:

- UNHCR field offices should facilitate communication with UNFPA for RH kits and WHO for the New Emergency Health Kits (NEHK); and establish communication between UNHCR and UNFPA country offices on how to prepare for emergencies to ensure RH kits are readily available.

- Due to the 600 km border area, RH coordination meetings should be organized geographically to facilitate communication among agencies.

- Appoint a UN RH coordinator in the earliest days of the emergency and ensure a stock of MISP supplies is on the ground as soon as possible in an emergency.

- Recruit Chadian personnel to improve and maintain staff skills in the host country and conduct more training on RH in emergencies in national training curriculum.

- Provide information on sexual violence and emergency obstetric referral care to all refugees at registration.

- Provide each camp manager with a supply of condoms to make available to refugees and agency staff wherever feasible.

Introduction

1. As part of the Inter-agency Global Evaluation of Reproductive Health Services for Refugees and IDPs first objective: "to take stock of the range and quality of the reproductive health (RH) services provided to refugees and IDPs and identify factors that facilitate or hinder the provision of these services," the UNFPA Humanitarian Response Unit (HRU) in collaboration with the Women's Commission undertook completion of the second part of the fourth component of the Global Evaluation. The aim was to determine the availability and the quality of emergency response to the RH needs of refugees and IDPs by evaluating implementation of the MISP and the use of RH Kits in an acute emergency situation involving refugees or IDPs.

Methodology

2. Whereas the methodology of the first part of Component 4 consisted of eliciting retrospective feedback through a questionnaire from experienced users of the Reproductive Health Kits, who were aware of the MISP, the current element of the evaluation was undertaken on site during the acute phase of the refugee crisis in Chad in April 2004. The evaluation team, consisting of the director and the senior coordinator of the Reproductive Health Project of the Women's Commission and a technical specialist of UNFPA's HRU, travelled to eastern Chad and conducted evaluations in four refugee camps (Kounoungo, Toulum, Iridimi, Farachana) and four spontaneous refugee settlements (Bahai, Tine, Birak, Adré), in the north, north central and central border areas of eastern Chad.

Evaluation tools

3. The evaluation was undertaken with the use of four evaluation instruments (listed below), which were developed by the study team and reviewed by the Evaluation Steering Committee prior to the mission (see Appendix 4):

- Semi-structured field staff interview questionnaire
- Focus group discussion guide for refugee community interviews
- Observational resource and services checklist
- Assessment site basic information form

4. Semi-structured field staff interviews were conducted with 53 staff members (medical coordinators, health care staff, programme coordinators, protection staff, water and sanitation engineers, construction coordinators and community services staff) and ten focus group discussions were held with 108 refugee women, men, adolescents and community leaders. Observational resource and services checklists were completed for nine health care sites, including health posts, mobile clinics, and referral hospitals. Observational visits were conducted at another three sites, for which no checklist was completed due to an obvious lack of supplies or staff (see Appendix 5 for the list of field staff interviewed and sites visited). Because of the different groups targeted in the two parts of Component 4 (experienced users of the RH kit with assumed knowledge of the MISP versus humanitarian workers

implementing a response in an acute emergency) and the different methodologies used (retrospective desk study versus direct observations and interviews in an acute emergency), the findings of the two studies are reported separately.

Criteria for selecting emergency setting

5. The site for the evaluation (the refugee crisis in eastern Chad) was selected and agreed upon by the Evaluation Steering Committee, according to the following pre-determined criteria:

6. Recent acute emergency involving refugees with an affected minimum population of 20,000; involvement of non-functioning infrastructures; presence of (UN) coordinated humanitarian response activities; presence of IAWG agency field staff willing to facilitate travel; and visa and security clearance easily obtainable.

Host country background

7. Chad, occupied by France until its independence in 1960, is a landlocked country located in north-central Africa. It is the fifth largest country in Africa and is bordered by Cameroon, Central African Republic, Libya, Niger, Nigeria and Sudan. Chad is divided into 14 provinces (préfectures) and 49 districts.

8. Approximately 85% of Chad's workforce relies on subsistence farming and nomadic pastoralism. Chad is a member of the Franc Zone, a consortium of sub-Saharan countries that use the Franc as a common currency. Its chief trading partners are European Union countries, as well as Cameroon and South Africa.

9. A series of military coups and severe droughts have plagued Chad since its independence. Current President Indris Derby promised democratic reform after taking office in 1990, although a new constitution was not drafted until 1996 and international observers disputed the validity of multi-party elections in 1996 and 2001. Fighting between the military and rebel groups has occurred sporadically since the late 1990s.

10. Chad's economy has been impaired by years of drought, food shortages, political instability, high energy costs, governmental corruption and its geographic remoteness. The country is highly dependent on foreign aid. Although corruption and weaknesses in Chad's political institutions dampen its economic prospects, a new oilfield and pipeline project constructed in 2000 are expected to generate between $80 and $100 million in annual government revenues over the next 25 years.

11. The population of Chad was estimated at 8.3 million in 2002, with women representing 52% of the total.[1] The annual population growth rate is 3.15%.[2] According to UNFPA, only 20% of the total population lives in urban areas. The population distribution is uneven, with 59 persons per km^2 in the south-western regions compared to the northern Sahara region, which makes up 50% of the total

[1] World Health Organization, *Core Health Indicators – Chad,* 2002, http://www3.who.int/whosis/country/indicators.cfm?country=tcd
[2] United Nations Population Fund, *Country Profile – Chad*, 2004, http://www.unfpa.org/profile/chad.cfm

land, with an estimated population density of 0.1 inhabitants per km^2. The life expectancy at birth is estimated at 46 and 49 years for men and women, respectively.[3]

12. Years of internal strife have caused an exodus of the population into neighbouring countries. More than 35,000 Chadians had fled the country by the end of 2002.[4] Despite its own political instability, Chad has consistently hosted refugees from other countries. Refugees have come primarily from Sudan, and approximately 1,000 refugees from the Central African Republic were living in Chad and another 500 urban refugees of various nationalities lived in the capital, N'Djamena at the end of 2002.[5]

13. Twenty years of civil war in neighbouring Sudan has created a steady flow of refugees into Chad. In the late 1990s, more than 20,000 Sudanese refugees escaping internal conflict entered Chad. Approximately 5,000 had repatriated back to Sudan by the end of 2001. However, fighting between the Sudanese government-backed militias and rebel groups intensified in the western Darfur region in February 2003. Two new rebel factions, the Sudan Liberation Movement/Army (SLM/A) and the Justice and Equality Movement (JEM), joined forces at this time and demanded an end to the terrorization of their communities by the militias, known as the *Janjaweed*. The Sudanese government responded by greatly increasing support to the militias, who subsequently began a brutal campaign of systematic rape, looting, mass killing, and other atrocities against both rebel and civilian populations. Senior UN officials have characterized the emergency as 'the world's worst humanitarian crisis.'[6]

14. The *Janjaweed's* policy of ethnic-cleansing and scorched-earth tactics have led to the displacement of over one million Sudanese.[7] In May 2004, UNHCR approximated that over 110,000 Sudanese had fled into Chad and another 1,000,000 were estimated to be internally displaced. Access to the IDPs in Sudan by humanitarian actors has been extremely limited.

15. Women and girls have been directly targeted for violence in Sudan. Attacks by the *Janjaweed* resulted in widespread sexual violence towards women and girls searching for water, food and firewood in Darfur. Thousands of these displaced women are pregnant and nursing with little access to health care services.[8]

[3] World Health Organization, *Chad – Statistics,* 2004, http://www.who.int/country/tcd/en/
[4] US Committee for Refugees, *World Refugee Survey 2003 Country Report*, 2003.
[5] Ibid.
[6] UNFPA, *Women Suffer Brunt of Conflict in Western Sudan, UNFPA Warns,* May 6, 2004, http://www.unfpa.org/news/news.cfm?ID=447
[7] United Nations High Commissioner for Human Rights, *Situation of human rights in the Darfur region of the Sudan*, May 7, 2004.
[8] UNFPA, *Women Suffer Brunt of Conflict in Western Sudan, UNFPA Warns.* May 6, 2004. http://www.unfpa.org/news/news.cfm?ID=447

Refugee and host country health context

Table 4B.1: Health Indicators

Indicators	Chad	Sudan
Maternal Mortality Ratio per 100,000 live births	933	352
Infant Mortality Rate per 1,000 live births	115	77
Total Fertility Rate	6.65	4.39
HIV Prevalence Rate (%) M / F	2.35 / 4.30	1.10 / 3.10
Annual Growth Rate	3.0	2.2
Births per 1,000 women aged 15-19	195	55
Contraceptive prevalence (all methods) %	8	8
Contraceptive prevalence (modern methods) %	2	7
Births attended by trained personnel (%)	16	86

Source: State of World Population 2003, UNFPA

National general health services/conditions - Chad

16. Due to years of civil unrest and political instability, Chad's current health care system remains exceedingly deficient. In 2001, the government of Chad spent only 2.6% of its GDP on health care.[9] Primary health care services suffer from an extreme lack of health care workers. Approximately 200 physicians are currently working in Chad and half are based in the capital. Access to services also remains severely limited. Certain areas, particularly in the northern region, do not have any functioning medical structures. Lack of transportation, civil strife and long distances hinder people in rural areas from seeking medical help. Medical equipment and supplies are also scarce, and doctors frequently pay for equipment themselves.[10]

17. Reproductive health services in Chad remain particularly problematic due an exceptionally low rate of modern contraceptive use, high fertility rates and a great cultural emphasis on early marriage and polygamy. As a result, Chad has one of the highest maternal mortality rates in the world. Female health care workers are rare and women are disinclined to seek out medical help from men. Despite a high rate of vagina fistula, only two physicians in the country have been trained in advanced fistula repair.[11]

18. Over twenty years of civil war has hobbled Sudan's health care system. High population growth rates, extreme poverty and a weakened economy have further compounded the decline in health care. Lack of access, scarce medical resources, few qualified health workers and high costs plague the crumbling medical infrastructure. In the 1970s and early 1980s, medicine and medical consultations were free. However, the subsequent privatization of the health care sector caused a great increase in the cost of services. In an effort to combat Sudan's large debt, Structural Adjustments Programmes, advocated by the World Bank and International Monetary

[9] World Health Organization. *Chad: Core Health Indicators.* 2001. http://www3.who.int/whosis/country/indicators.cfm?country=tcd
[10] UNFPA. *Recognizing the needs in Chad*, nd. http://www.unfpa.org/fistula/docs/eng_chad.pdf
[11] Ibid.

Fund, were introduced in the 1980s, resulting in further cutbacks to government health care expenditures. By 1991 Sudan's health care system had virtually disintegrated due to the ongoing civil unrest and economic decline. Many facilities have closed or have been destroyed and military factions often control the few remaining clinics.

19. Reproductive health care services in Sudan are poor and, in some areas, non-existent. Maternal and child mortality rates are exceptionally high and approximately 90% of women and girls in Sudan have undergone some type of female genital mutilation.[12] Despite limited awareness of modern contraception combined with high-risk sexual activity among the general population, Sudan has a relatively low HIV/AIDS prevalence rate. Although the government has funded reproductive health initiatives, few of these projects are developed in the conflict-affected western and southern regions.

20. UNHCR is the main coordinating body for refugees in Chad. The Chad government cooperates with UNHCR and a number of international aid groups in assisting refugees. Among UNHCR's key implementing partners is the Chad National Commission for Refugee Assistance (CNAR), a national organization with primary responsibility for registration. CNAR manages registration while UNHCR monitors the process, including organizing border transports. Refugees in spontaneous settlements receive fixing tokens and upon arrival at a camp submit the tokens to CNAR, which helps the agency to organize families and track the number of family members. Refugees may also receive wristbands in border settlements indicating they will be with the next group transported from the border to a camp. Registration occurs when a convoy arrives at a camp or when spontaneous arrivals reach a camp by foot or donkey. When families arrive at a camp the Chadian Red Cross/Croix Rouge Tchad (CRT) is responsible for receiving the refugees and providing them with necessary information. CRT gives them food and water before they are registered by CNAR. A family registration card entitles refugees to basic necessities, including blankets, a kitchen set, corn-soy blend (CSB)/sorghum, oil, a jerry can, sanitary material, plastic mats, a stove for burning wood and a mosquito net. Depending on the number in a convoy, registration takes about an hour per person, but people are supposed to be registered on the same day as they arrive.

21. The international agencies responsible for the medical and nutrition needs of the refugee population are Coopi in the south, MSF-Belgium and MSF-Holland in the central and central north region and IRC in the north. IRC is not a UNHCR implementing partner but, with its own funding, initiated its activities in March 2004 in Bahai and Kariari, including implementation of an environmental health project and individual health services through a mobile clinic. During the assessment team's visit in April, International Medical Corps (IMC) was preparing to take over health services from MSF-B in Kounoungo and Touloum camps and set up health services for a new camp. UNFPA works with the various health organizations to provide the government and international organizations with reproductive health supplies.

22. The German agency GTZ is managing overall logistics in all regions and in conjunction with Norwegian Church Aid (NCA) and THW (Technisches Hilfswerk—another German agency) is also responsible for camp infrastructure. Camp

[12] UNFPA, *Proposed Projects and Programmes – Sudan*, 2001, http://www.unfpa.org/arabstates/sudan/2sud0206.doc

management was undertaken by Intersos in the south and SECADEV, the local counterpart of Catholic Relief Services (CRS), CARE and Africare in the remaining camps. Oxfam and CRS are providing technical support and capacity building to SECADEV. (See Appendix 6 for a matrix illustrating camp sites and activities by implementing partners, UNHCR March 25, 2004).

23. The World Food Programme (WFP) and UNHCR had agreed that WFP would transport the food to Abéché from N'Djamena and then UNHCR was responsible for organizing transport of food to the warehouses near the camps. During the assessment team's visit, there were delays in food delivery and distribution. WFP was considering transporting the food directly from N'Djamena to the warehouses near the camps. There were too few vehicles to transport refugees from the border into camps as the few that were available were being used for food transport. At this time, food was only being delivered to refugees in camps and no food was going to border areas, partly due to security concerns that any supplies would make these areas targets of the *Janjaweed*. WFP stated that the current ration was 1,935 kilocalories, which was to be increased to 2,066 kilocalories by mid-April.

24. To illustrate the circumstances in which the Sudanese refugees are living in Chad, the following descriptions are provided of two different border areas to which refugees were fleeing during the visit of the assessment team.

25. **Tine** is one of the most destitute spontaneous refugee settlements on the north-eastern border of Chad. The sun beats down upon a sandy, rocky landscape and the stench of dead animals permeates the air. Donkeys, cattle and sheep have slowly died from lack of food and water.

26. The assessment team conducted two focus groups in Tine, one with 11 women and one with 7 men. Although the total number of refugees waiting for assistance in the area is unknown, the overwhelming majority of the refugees were women and relatively few men were seen in the wide-open area. The focus group participants said their first walk was 10 days to cross the Sudanese border to Bamina, Chad. Here the refugees said that they waited for UNHCR to take them to a camp where they could have their basic survival needs met but they were never taken. In search of water, they walked to Tine. They arrived to find that humanitarian assistance for shelter, food and water was not available. Women are forced to walk to the *wadi*, the dry riverbed, to collect water, which is dangerously situated, on the border with Sudan and where women sometimes meet the *Janjaweed* and Governement of Sudan (GOS) soldiers. Sometimes, the *Janjaweed* and GOS soldiers may prevent the refugees from collecting water. Refugees do not have tents or local materials to build adequate shelters. Sometimes the refugee women are compelled to divide their human resource capacity to meet their survival needs. One woman might spend the day walking seven hours to the border to fetch one jerry can of water, another spends all day collecting firewood, while yet another collects meagre seeds to be boiled for food. Some women were able to get small amounts of money by working in Chadian homes washing clothes or by collecting stones or carrying wood. Finally, the refugees said they had not been provided with information from anyone about their situation and both women and men urgently begged the team to help them quickly.

27. Approximately 40,000 refugees are living on the border of Chad and Sudan near the town of **Adré**. The Women's Commission spoke with a group of 17 Masalit men who had arrived in November 2003 after their villages were attacked and burned by

the *Janjaweed*. The refugees reported that sometimes planes reinforce attacks on villages with aerial bombing. They had fled their villages in Sudan: Krenik, Konkoniya, Shoyou, Modoine, Koukoumanda, Sheden, Binediya, Daltaing, Kounti and Dongete – all areas south of El Geneina. They reported that a group of approximately 100 *Janjaweed* divided themselves into two groups to attack the area they were currently living in just three days before our interview to steal cattle and sheep from the refugees. One group stormed the area in the middle of the day to steal the animals while the other waited behind on the border to support the assault from the Sudan side. One man in the focus group had lost most of one of his fingers during an attack by the *Janjaweed* two months ago during which all the other men with him were killed.

28. Based on these events, it is not surprising that the refugees in Adré stated that security was their main concern, followed by lack of shelter and insufficient food. They realized that with the rainy season approaching, the insubstantial shelters they had hastily built from the surrounding grasses would not withstand the upcoming wet weather. They had not received any food distributions from the international community since arriving in this area and had depended upon the generosity of the local villagers from the same ethnic group to support their subsistence. Men also worked for local Chadians to support their families. They knew that they could not return yet to Sudan and did not want to go until there is a stable peace. They desperately wanted to be moved to Farachana camp, approximately two hours west and a safe distance from the Sudan border. Forty people were transported the day of the assessment team's visit and about one-third of the men in the group wore UNHCR wristbands, signifying that they were to be on the next transport to Farachana. However, some men said that if they were not transported soon they would walk three days to get to the camp.

Findings

General assessment findings

29. The primary concerns of the non-camp refugees in April 2004 were food, water and shelter, with an overriding concern for their security. All refugees the assessment team spoke to living in spontaneous settlements, most of whom for several months without humanitarian assistance for food, water and shelter, were eager to be moved anywhere else to access their basic survival needs. A UNHCR senior programme officer reported that malnutrition[13] was increasing. To survive, some refugees did menial labour for local Chadians, such as supplying them with wood and water.

30. While it was clear that refugees had received generous support from their Chadian neighbours over the past year, there was also evidence of the struggle between the refugees and their hosts for vital resources such as water and firewood. In Bahai, refugee women had a well-founded fear of being harmed by Chadian women while collecting water at the public well. They reported that six refugee women were beaten at the public well owned by the local people. An international

[13] A January 2004 exploratory mission by Action Against Hunger (AAH) notes that at the time of their visit nutritional issues were not a pressing issue but food security was a major concern despite a good harvest year in Chad. Based on a lack of transport capacity and that the area could not cope with a large influx of refugees, AAH predicted a hunger gap would start in May.

NGO representative working in the area confirmed that there were seven incidents requiring medical intervention from beatings involving local and refugee women at the public well. Women reported that they went at night to collect water from the well to prevent incidents of violence. In Bahai, the refugee women also reported that women and children made dangerous treks to collect wood from the Sudan side of the border because the local people did not allow them to cut trees.

31. Women and children made up the overwhelming majority of the overall refugee population – even more so in this setting due to the killing of the young male population in Sudan and possibly also attributable to men staying behind in Sudan to fight, or living near the border to safeguard remaining livestock. Some women in nearly every focus group meeting wept openly for the loss of their husbands and sons and explained that many women are widows.

32. Although one UNHCR field office reported its overall goal was to relocate people from the border, the transport of these populations – whose precise numbers are unknown – was severely hampered by the lack of UNHCR capacity to provide transport to existing camps and the slow process of identifying sites to establish new camps with adequate water sources. UNHCR field offices and their implementing partners decried the lack of vehicles. There were six vehicles and they required 60 to move the refugees on schedule before the rainy season, which will severely restrict transport and access to refugees. Furthermore, many of the limited number of vehicles available sat idle due to a lack of petrol.

33. The following comments from field staff highlight the gravity of the refugee situation in Chad:

> *"The situation is very, very bad here – people are in desperate condition. People are calling me from everywhere [for help]."*
>
> *"There are no tents in Chad and they take one month to arrive from Pakistan; the rainy season is applying pressure."*
>
> *"The main problem is to maximize the number of people under tents before the rainy season."*

34. Most refugees participating in focus groups expressed dissatisfaction with the quantity and quality of health services in several camp and non-camp settings. Complaints were heard in two camp settings where health care services were only available two or three days per week for four to five hours. The chief complaint was a lack of medicines at the clinic and difficulties with access to care such as the limited time services were available. Refugees in spontaneous settlements cited long waiting times – up to two days – as they vied for services with the local population. "*We have to wait a long time for a small service.*" In some cases where refugees sought health care at the local clinics and hospitals they were required to pay for medicines and many of the desired medicines, such as syrups for children and injections, were not available.

MISP assessment findings

35. Identify organization / individual to facilitate coordination and implementation of the MISP

- There was no coordination of health activities among humanitarian actors and the assessment team did not identify an organization or individual facilitating coordination and implementation of the MISP. A UNFPA representative stated, "There is no RH focal point; it happened so suddenly that no one was appointed and the country programme officer stepped in to coordinate the ordering and distribution of kits."

- There were no regular official health coordination meetings or reproductive health meetings at any level from N'Djamena to Abéché or the camps and border areas where refugees were living. Organizations appeared to expect another agency to undertake organization of this activity. In response to whether there is a lead agency addressing RH, one humanitarian assistance worker stated that they would probably go to UNFPA if they had questions.

- Another representative of an international organization reported that there were general coordination meetings in N'Djamena every two weeks, however, only a couple of international organizations that the assessment team spoke with were aware of regular meetings in N'Djamena. General weekly coordination meetings were established in most camps and UNHCR regional areas.

- One agency referenced its internal RH coordination activities in a spontaneous refugee settlement, explaining that it initiated coordination with the local administration and ministry of health to begin working with local midwives and nurses. Another agency indicated that there was informal coordination at the camp level with the involved agencies and that they reviewed vulnerable people together and would hold meetings when important issues arose. They also report the number of births and provide clothes for infants and children.

36. The views of field staff regarding coordination and implementation of the MISP vary, as indicated in the following comments:

> *"If we had someone following this [health coordination], it would be helpful."*

> *"There is not a lead agency addressing RH because it's not necessary; 80% of health activities are RH."*

> *"We have no staff dedicated to this issue. Our real focus is food, water and shelter. After that, when we have stabilization the team will probably focus on that [coordination]."*

Prevent and manage the consequences of sexual violence

37. Refugees living in spontaneous settlements on the dangerous border areas where the majority of refugees are located and where the *Janjaweed* regularly cross to steal refugees' livestock were at risk of sexual violence. While the assessment team did not hear of any reports of sexual violence in Chad among the focus group participants living in these areas, abduction and rape of women in Darfur, Sudan are well known and protection measures were not established for refugees at risk in these border areas.

38. In general, some efforts have been made to consult refugee women and women's groups in campsite planning or about issues impacting their situation. In most, but not all camp settings, refugee committees have been established with equal male and female representation from each section of the camp. In one spontaneous refugee site on the border, an international NGO established two groups, one of male and one of female refugees, and consulted them about problems and solutions in their current situation. Due to the importance of locating new camps in water-accessible areas, water points and latrines were already put in place before refugees arrived, therefore women were not involved in the decision-making process for water and latrine site locations. In refugee camps women were involved in food distribution and this was observed in at least one camp and a lead agency on food distribution reported that it is also primarily women who come for food distribution.

39. One international organization responsible for camp design responded to the guidance of a UNHCR protection officer on refugee cultural issues in its plans to transform Iridimi transit centre into a permanent camp. The new permanent camp will have one shelter in every cluster of eight shelters for single women to conform to Sudanese traditional living habits.

40. Security was considered in the design of latrines for the permanent camps at Touloum and Iridimi by limiting the distance to the latrines and ensuring one latrine per 20 people as outlined in the SPHERE standards.

41. Access to firewood is not surprisingly a problem in this desert terrain. One woman from Iridimi transit centre was attacked collecting firewood in the wadi 1.5 km away and her registration card was stolen. Protection problems related to the collection of firewood are likely to escalate in all settings over the next six months to one year as women and children are forced to walk farther and farther to collect this vital necessity.

42. Most respondents were aware of the composition of different ethnic groups in the camps and considered their representation on camp committees and in work with refugee women's groups. In one camp, however, the ethnic group with the smallest numbers in the camp did not have a representative in community service activities.

43. The national community service organization in one camp stated that its activities are specifically targeted to women and that they work with refugee women to reach the men. This organization also works with a provisional male committee comprised of community elders or chiefs.

44. One camp offered a women's centre in each sector that could be used for training, micro-enterprise activities and community health education. Women's groups in this

setting were also involved in disseminating community health messages, e.g., hygiene, efficient cooking, water, etc.

45. Many, though not all, international agencies had a code of conduct signed by contracted expatriate staff. For example, UNHCR staff must sign the code of conduct[14] upon employment and are trained on the code of conduct before coming to the field. UNHCR also requires its local staff and implementing partners to sign a contract that includes the code of conduct. However, the majority of the agencies did not include the code of conduct in local staff contracts. Some agencies were working to adapt the code of conduct from the international NGO to the local NGO partners. One international agency representative reported they had a code of conduct that all staff, including drivers, guards and cooks, must sign but the representative's understanding of the code of conduct was that it involved no alcohol and no prostitution. The representative did not seem to understand the concept of preventing and responding to sexual abuse and exploitation. In addition, most agencies did not have reporting focal points or mechanisms for survivors of sexual exploitation and abuse; however, most said they would bring a case to the attention of UNHCR and one respondent indicated they would bring the case to the attention of their regional director and headquarters.

46. UNHCR reported that its community services implementing partners (IPs) addressed women's participation and protection through women's equal representation on camp refugee committees. The camp refugee committees were involved in camp management and according to UNHCR the concept of addressing the needs of the most vulnerable was well known to their IPs.

47. There had been a UNHCR protection officer in Abéché but there was currently a gap and there were also no protection officers in Iriba or Adré. A UNHCR community services assistant was based in Iriba and had done some work in organizing women and addressing women's issues but had recently left. Some NGOs said they were not sure to whom they would report incidents of sexual violence or exploitation. Humanitarian actors also reported a lack of female protection personnel.

48. Refugee women were rarely employed compared to men in camp construction and community services. A small but noteworthy effort was made to hire female refugees in camp construction in Iridimi camp. Four refugee women out of 60 refugees employed in camp construction were hired to carry construction materials on a donkey – creating a small stir among the men.

49. The lead community service agency had recruited and employed staff from the south because it had been difficult to find qualified people to fill positions from the area.

50. Refugees and humanitarian staff both reported that there were many children without their fathers, but reports on the number of unaccompanied minors varied.

[14] The purpose of a code of conduct is to prevent sexual exploitation and abuse in humanitarian crises. A code of conduct is intended to serve as an illustrative guide for staff to make ethical decisions in their professional lives, and at times in their private lives. Humanitarian staff is responsible for promoting respect for fundamental human rights, social justice, human dignity and respect for the equal rights of men, women and children. While acknowledging that local laws and customs differ from one country to another, a code of conduct is based on international legal standards.

Some children were absorbed into extended families and the assessment team met three women in Bahai responsible for the care of their grandchildren because the children's parents were missing or had died, while some children may live with families unknown to them. Also in Bahai, twelve orphaned children ranging in age from 4-13 were reportedly cared for by a "kind" Sudanese man according to refugee women focus group participants. Adolescent focus group participants in Farachana camp said there were many children without parents and no one responsible for protecting them, while there were many more with only one parent. They also said that relatives such as brothers and uncles supported children without parents.

51. One community service agency respondent said they work in close collaboration with UNICEF on children's issues. Yet another community service agency respondent said, "I think it's a problem, especially unaccompanied minors – there are a lot of them and there are difficulties with spontaneous arrivals." The respondent reported that there was only one unaccompanied minor in Farachana camp and the child was reunited with its family in two days. The respondent also indicated that there was a female protection officer working with UNHCR who accompanied convoys and did some reunification of spontaneous arrivals. However, a family reunification system was not known to the refugees or to field workers with whom the assessment team spoke. In some settings agencies were using various methods to identify and follow up on vulnerable people, including children, handicapped, pregnant women, etc., and one was centralizing the data between the camps in which they were working. However, there was not a consistent way in which vulnerable populations were identified and provided with services.

52. Reports from UNHCR, implementing agencies and refugees themselves stated that an untold number of women were raped in Sudan by the *Janjaweed* before fleeing to Chad. Refugees fled to Chad after they were attacked by the *Janjaweed* and GOS soldiers and their villages were bombed and burned and their cattle, sheep and goats stolen. Almost everyone had heard of the *Janjaweed* raping women and girls in Sudan, though not all groups of focus group participants had experienced rape of women and girls in their villages. Refugees in Iridimi camp said that the *Janjaweed* took young girls, ages 10-17 years, from villages in Sudan such as Abougambrah, Amborou, Jirjira and Maun, to big towns such as Fasher and El Geinena, where the GOS held them. Some of these girls had returned while others had not. In Toulum camp, focus group participants said that in Sudan the men were tied up and the women and girls were taken by the *Janjaweed*, sometimes for one month.

53. There were varying reports among different focus groups about the incidence of sexual violence. Focus groups were quite clear and outspoken on the issue of sexual violence, expressing that it either happened or it did not. Focus group participants in some settings, such as spontaneously settled refugees in Adré and refugees in the Farachana camp (where refugees from Adré would be transported) and the spontaneous settlement in Tine, as well as in Touloum and Iridimi camps, reported extensive rape of women and girls by the GOS soldiers and the *Janjaweed* in Sudan. However, focus group participants in other areas along the border, such as Bahai and Birak, said that while they had heard of this happening it had not occurred in their village or to anyone they knew. It is possible that the groups in these areas may have fled their villages earlier, having been warned of the impending violence.

54. There were rare reports of incidents of sexual violence in Chad. While most focus group participants reported that they felt safe in camp settings there were two incidents reported in focus groups and field staff interviews involving at least one assault while collecting firewood outside of refugee camps. A focus group participant reported that a woman was attacked outside of Touloum camp while collecting firewood. It is unclear whether the incident involved sexual violence, but according to the respondent, the incident was reported to the local police. An international NGO representative from Norwegian Church Aid (NCA) reported that a refugee woman was attacked and her registration card was stolen while she was collecting firewood outside of Iridimi camp. In addition, one international NGO representative had heard that a refugee woman living in a village was raped and subsequently taken to Kariari. Many women in spontaneous non-camp refugee settings reported fearfully walking up to or across the border into Sudan to obtain firewood and water and encountering the *Janjaweed*, though there were no reported incidents of rape.

55. The one currently functioning health-implementing NGO said that in most of their clinics they could clinically manage rape survivors, including post-exposure prophylaxis (PEP). On observation however, clear protocols for the clinical management of rape survivors were not available in the clinics themselves. On the other hand there were very clear instructions on the provision of medical certificates to rape survivors and referring the case to UNHCR or ICRC for protection.

56. In Abéché public hospital rape cases were seen on a regular basis (not refugees). The survivor undergoes a forensic examination, but receives no treatment. None of the national health structures visited had the supplies or protocols needed for clinical management of rape survivors.

57. UNHCR reported that sexual violence services were included in the proposals of their IPs.

58. The community service agency in Farachana camp stated that sexual violence services were in place and that survivors would be referred to the MSF clinic or the main hospital.

59. The following comments from field staff emphasize the lack of a coordinated effort to prevent and manage the consequences of sexual violence:

> *"If a woman is raped we may report to the head of the camp sector – it depends. We would also go to the camp manager and agency director."*
>
> *"I think it's cultural – even with positive discrimination, it's difficult to recruit women."*
>
> *"I haven't heard the words gender, protection, GBV survivor since I've been here."*
>
> *"We focus on food, water and shelter and then six months later you hear about all the rapes."*

60. The following case studies highlight the gravity of sexual violence for this refugee population:

61. **Case Study, Adré.** A group of men from the Masalit ethnic group living in the town of Adré on the Chad border (described earlier in this report) tried to estimate how many women in their community had been raped. They stated that of the 80 families in their area everyone had at least one woman – a mother, a sister, a daughter - who had survived rape. They also described how in October 2003, the *Janjaweed* attacked their villages and abducted young girls and women and would rape them over a 3-4 day period and then return them to the village. If the villagers refused to go, or let the women go, they were killed. The *Janjaweed* continued to attack the villages and most of the people in this area fled in November 2003 – women continued to be raped during this period and during their flight to Chad. Incidents of sexual violence were not reported in Chad; however, a woman collecting reeds for building a shelter was beaten by the *Janjaweed*. Women collect water and firewood from the *wadi*, a dry riverbed, which is near to the Sudan border but never cross the border for fear of being attacked by the *Janjaweed*. There are no extra protection measures in place in the camp to protect women from sexual violence; however the main cause for concern was the overall lack of security from attacks by the *Janjaweed*. There were many women in the camp without their husbands because so many men had been killed by the *Janjaweed*.

62. **Case Study, Bahai**. Bahai is an isolated village along the north-eastern border of Chad and one of the areas where the emergency has been most neglected. Refugees live under scraggly acacia trees and thorn bushes surrounded by the meagre belongings they were able to carry with them on their flight. Mura is a 65-year-old woman who fled her village, Kurbya, in Sudan and arrived in Bahai, with her husband, daughter, son-in-law and six grandchildren. She explained in a quiet voice how the *Janjaweed* stole all their livestock and that the Sudan government soldiers shot at her and her neighbours and burned their village. Her sister was killed and the family lost five other children during the chaos of flight. She estimated that 25 young women around 20 years old were taken by the *Janjaweed*. "The *Janjaweed* always do bad things to the women," she said.

63. **Case Study, Birak.** Birak is a region on the north-eastern border of Chad, which is surrounded by settlements of Sudanese refugees. In September 2003, Fatima, a young married woman, left her village of Houta, Sudan with her neighbour and her 9-month-old baby on her back in search of firewood in the bush. Later that day, their village was invaded by the *Janjaweed* and the two women were taken by force from the bush to Kadja, a village further east. After walking for five days, they arrived in Kadja and Fatima was separated from her neighbour. She was then compelled to work as a shepherdess for the flocks, always closely watched by her captors. On her fourth day in Kadja, one of the *Janjaweed* told her that her husband had been killed during the attack on her village. During her time in Kadja, Fatima was raped during the night by different men and by two men in particular who raped her the most frequently. Approximately, five months later, part of the flock under her care was stolen. As retribution for this loss, the *Janajaweed* who owned the flock grabbed her baby son, now 14 months old, and beat him on the ground in front of her and killed him with crushing blows to the head. The *Janjaweed* tried to justify their actions stating that Fatima would work more effectively without the child. Three months after this incident, Fatima escaped from Kadja to Chad with the help of one of the wives of the *Janjaweed*. She passed through Houta during her journey, where she confirmed that her husband was dead. She travelled alone during the night, hiding herself and fearing for her life throughout the entire journey. Fatima finally arrived

at the MSF clinic in Birak where it was confirmed that she was seven months pregnant.

Reduce the transmission of HIV

64. Most of the functioning international health NGOs had effective and sufficient supplies to adhere to universal precautions. However, national structures typically lacked the necessary supplies and resources to implement universal precautions unless they were supported by an international NGO which provided them.

65. No clinic had visible protocols on universal precautions. Local staff of one international health NGO were trained "on the job," but staff working at national structures needed urgent support to be able to implement and maintain injection safety, sterilization protocols and safe waste disposal.

66. Safe blood transfusions were only available from the international NGOs that had established referral-level services. The national health structures did not have HIV tests available and one staff member admitted that untested blood was transfused in emergencies.

67. Condoms were not made available to refugees in this emergency because the majority of humanitarian actors spoken with believed that the refugees were members of a very traditional society who were not familiar with condoms and would not use them.

68. The refugee population had limited knowledge regarding HIV, with many focus group participants reporting that they had never seen anyone infected with HIV, never heard of condoms and did not know how to prevent HIV transmission. In almost all focus groups, participants reported that HIV is very dangerous and they are worried about becoming infected with it. Some focus group participants identified HIV transmission routes including through blood, unclean shaving instruments, mother-to-child and sexual relations.

69. There was also misinformation about the transmission of HIV. In one focus group, participants said they heard that refugees could get HIV from the clothing of an infected person and the group confirmed that they believe this. They also reported it was possible to get HIV from a toothbrush and drinking water from the same cup.

70. In response to questions about how HIV could be prevented, focus group participants said they must avoid sexual relations, not take blood from others and not use instruments that have been used before. There was some awareness about getting tested for HIV in two focus groups, with one participant stating: "*If you want to get married you should go to get tested for HIV*."

71. Focus group participants frequently offered that they did not know how to protect themselves and requested information on how to prevent HIV. In some areas, focus group participants had heard messages about HIV on the radio but responses indicate that the information provided was not comprehensive. In one focus group that included trained CHWs and TBAs, a participant said they learned that condoms prevent HIV / AIDS and they believed this. However, one respondent interjected that condoms do not prevent against HIV / AIDS every time.

72. Focus group discussions revealed that the population was fearful of HIV/AIDS and was very interested in learning more about how to protect themselves against HIV.

73. Despite a demand for condoms, condoms are not available to local Chadian staff. After discussions about reproductive health issues, local Chadian staff in several sites asked spontaneously for a supply of condoms from the assessment team. When an assessment team member provided condoms to someone and advised him to inquire in the clinic for more supplies, the nurse in this site later received several requests from male staff members and from refugee women for condoms. When asked, young refugee men said that condoms were not available to them anywhere, not even from the market. When asked what they did in this case they said: "*We just take the risk.*"

74. Many agencies still confuse 'making condoms available' with 'condom distribution and awareness raising campaigns.' One international organization received a request from local authorities to provide information on how to prevent HIV/AIDS. Instead of instituting MISP activities to prevent transmission of HIV/AIDS this organization was preparing for more comprehensive HIV/AIDS programming.

75. The following comments suggest that the field staff interviewed have priorities other than the early implementation of activities aimed at preventing the transmission of HIV:

> *"Condoms would probably melt here."*
>
> *"We need to concentrate on basic activities – not complicated activities like HIV".*
>
> *"Up until now we're in an emergency situation … and focused on the relocation process … so we have not addressed the HIV issue."*
>
> *"We have asked questions about HIV several times and they really don't know HIV/AIDS except that HIV is related to shaving, injections and sexual activity. We are at the point of doing the basic services now but we will do HIV at some point."*
>
> *"This issue of condoms has not been addressed yet. The population is very conservative."*

76. The following case study reinforces the need for providing accurate and appropriate information about the transmission and prevention of HIV/AIDS, not only to adolescent boys, but also to the refugee population at large:

77. **Case Study, Iridimi Camp.** Iridimi camp is located 7 km northwest of the town of Iriba, which is inland from the northern Chadian border. Iridimi started as a transit centre for refugees but with a population of over 5,000 refugees was being reconfigured as a permanent site during the assessment team's visit. Adolescent boys participating in a focus group reported (while laughing) that when someone dies of AIDS, their body must be burned because it could infect others in the village. They said that they are worried about getting HIV/AIDS. To prevent HIV, they suggested not eating with someone who has HIV, not taking the infected person's blood, not drinking the water, being near an infected person, and not using their

blanket. They do not know what a condom is and don't know if people in this setting would use condoms. Sex education consists of teachers advising them not to have sex.

Prevent excess neonatal and maternal morbidity and mortality

78. Most women reported delivering in their makeshift shelters or tents. However, in one camp setting, deliveries were reportedly taking place at the health facility. Clean birthing kits for pregnant women were not available in this setting, although many humanitarian actors stated their support and willingness to make the kits available. Focus group participants in Touloum camp explained that most women deliver babies in their tents and that there were seven midwives in the camp to assist them. The midwives had not received supplies. The participants further explained that if women suffer from complications of pregnancy or delivery the health agency's ambulance would transport them. However, the health agency's ambulance was not available in the evenings or at night so women may have to wait or go by donkey. Generally a mother or sister will accompany them.

79. Refugee focus group participants and health agency staff reported that no supplies were provided to pregnant women; however, in two camp settings the community services organization provided a small gift package to mothers after they deliver that included a blanket, soap and infant clothing. Focus group participants, including some midwives, stated that TBAs and midwives did not receive any supplies to facilitate safe deliveries, although one health agency recruited two to four TBAs in the settings in which it worked and provided them with delivery kits. One agency, which had recently undertaken an assessment, identified clean delivery and TBA kits as a need and planned to seek a donation of RH kits from UNFPA. Another health agency was also seeking to order kits from UNFPA.

80. Although the assessment team did not document any reports of maternal or neonatal deaths in camp settings, in spontaneous settlements in border areas both agencies and refugees reported a number of maternal and infant deaths. For example in Tine, women often delivered in their makeshift shelters with the assistance of TBAs and midwives who had no supplies, although some women accessed the clinic managed by an international NGO. If women suffered from complications of pregnancy or delivery, they sometimes went to the clinic or they may not have left the tent at all. Sometimes refugees in Tine hired a car to go to Iriba hospital. "*You have to pay money for the car; if there is no money, women will stay here and die*." Focus group participants said that four women had died over the past several months and that many babies had died. The refugees in Tine estimated 50 and not fewer than 30 children had died in the past three to four months, primarily from diarrhoea. In Senette, there had been one maternal and one infant death. A 25-year-old woman and her infant had died four months earlier. The focus group participants did not know the cause but said that she had been seen at the clinic in Birak and sent home afterward. She had four other children. In addition, focus group participants in Farachana said that two newborns among ten families over a period of three months died while on the border and the mothers were not referred to Adré hospital.

81. The "pregnancy risk-assessment" principle for preventing maternal deaths was still clearly followed by health providers interviewed. It was hard to convince clinicians that current expert consensus is that "every pregnancy is at risk," that most

maternal mortality occurs at delivery, and that safe delivery care must have priority over ANC in the acute phase of an emergency.

82. Three of the five referral centres supported by international NGOs provided comprehensive EmOC, while EmOC was not available at the two national hospitals that lacked international support resulting in insufficient supplies and, sometimes, skills. Normal deliveries and some stabilization of patients can be done in national primary health care (PHC) settings. Only one of the NGOs so far had been effective in providing basic EmOC at the primary health care level, but often only during the day. Other NGOs had had difficulties locating and ordering appropriate supplies. UNFPA also was providing supplies to Iriba, Guerreda and Adré hospitals and would extend services to other referral centres (Abéché and Biltin) if additional supplies were available.

83. Setting up an effective system for the transport of pregnant women with complicated deliveries to a referral facility was not systematic and was accomplished in only a very limited manner. In most settings, emergency transport was not available at night or on weekends. Sometimes women experiencing complications did not have access to an emergency vehicle and may have had to walk or be transported by donkey cart to a referral facility. The emergency referral system was already problematic prior to the refugee crisis.

84. The following comments from field staff underline the problems associated with providing timely EmOC to refugee women in this particular setting:

> *"We have a presence every day, the main problem is that we have no presence at night after 4:30 p.m."*
>
> *"The majority of our referrals are for emergency obstetric care".*
>
> *"A sensitization campaign [on the importance of referring women early for emergency obstetric complications] cannot begin until relocation to the camp is complete. However…already there are five to six newborns. Women are delivering in their tents".*

85. The following case studies highlight the hazardous conditions experienced by refugee women and their children in this setting:

86. **Case Study, Tine.** In the border town of Tine, Chad (described earlier in this report), the assessment team also met a 36-year-old refugee woman, Kadija, from Karnoi, Sudan, who had fled attacks from the *Janjaweed* and the Sudanese military when she was nine months pregnant. Three days into her journey she gave birth under trees on the side of the road without any supplies to make her delivery safe - no soap, clean razor, cord or plastic sheet to keep her and her newborn clean. Luckily, Kadija had no complications and her eighth baby was born healthy. Afraid to be caught by the *Janjaweed* and the Sudanese military, she continued to walk – for eight more days. During the flight, her 14-year-old son was injured in a bombing. Kadija is less worried about her son's physical injuries than about the long-term psychological effects of the attack. At night she has to tie his arms or give him medicines to make sure he does not hurt himself and is able to sleep. He never had these problems before the crisis, Kadija says.

87. In the same setting, one focus group participant made the following comment: “The baby who is breastfeeding is the only one who has what she needs.”

88. **Case Study, Am Nabak.** The village of Am Nabak is close to Chad’s northern border and was being considered as a new campsite for housing refugees during the assessment team’s visit as many refugees were already living in spontaneous settlements in the area. The team met two sisters, Zeinaba, 20, and Salma, 35, in Am Nabak who had walked more than three hours to bring Zeinaba's two children, a four-month-old and a 3-year-old, to Am Nabak's health clinic to treat her infant. Zeinaba and Salma fled their village of Jirjira, Sudan, which is 35 km from the Sudanese border, three months ago when it was bombed by the government of Sudan; the *Janjaweed* burned their homes and stole their livestock. Forty people in the village were killed, including some of their relatives. They fled for their lives with their families and other villagers - some walking and others by donkey - and arrived in the Chadian village of Ogona. A health agency came once to the village to provide some medicine. Zeinaba and Salma, along with the others from their village, say they do not have enough food and water and are living under trees. Four children have died since they have come to Chad. Young children suffer from diarrhoea. They eat one meal a day and have limited access to the local villagers' well. About 10,000 refugees are in the area. The local villagers have collected their meagre resources to share with the refugees - they are from the same ethnic group, the Zaghawa, which settled in both Sudan and Chad. When asked about their plans for the future, the sisters laughed nervously: "*Who knows when this problem will end*?"

Planning for the provisional of comprehensive health services

89. Most agencies were planning for more comprehensive RH services, including doing more outreach activities to the refugee community, developing awareness campaigns and identifying and training health workers and staff.

90. Some elements of more comprehensive services were put in place before the MISP. A number of health actors still believe that it is more important to have functioning ANC services, with pregnancy risk screening, in place before basic EmOC services.

91. In particular, family planning (FP) services, STI management and planning for comprehensive HIV programming had not been addressed. However, one international NGO was treating STIs using the syndromic approach, according to the national protocol, which was developed in 1998 with the help of MSF-Belgium. Both international NGO and national clinic staff reported seeing cases of STI syndromes regularly (mainly urethral discharge, occasionally genital ulcers). The rate at which these cases were seen varied from three cases per month to two cases per week. In the national health centres, treatment protocols were not available and knowledge of staff on treating STIs was limited.

92. One humanitarian assistance provider inquired: “*I would like to know if anyone is planning to address female genital mutilation in this setting.*”

93. Overall, there were a number of efforts to collect RH data but there was a lack of coordination among all humanitarian actors to facilitate standardized collection and reporting. For example, one international health NGO had its own data collection system, which included information on RH issues, and was revising its monthly data

collection sheets to improve data collection coordination with the government's health information system (HIS). Another international health NGO was also implementing an HIS. UNHCR was collecting some health statistics and was informed of births and deaths. In one spontaneous refugee settlement, data collection was initiated through CHWs on the number of live births, deaths and pregnant women. A community services agency maintained a database and had collected population information including an overall census, skills, education level, health problems, vulnerability, conditions in Sudan compared to Chad, etc.

94. Young people had yet to be meaningfully involved in the planning and design of RH services. However, there had been some general efforts to involve youth. UNHCR, through one of the community service agencies, had organized some informal education activities for young people and other agency staff noted that UNICEF supported some activities with educational and recreational materials. A community services NGO had organized sports activities and sewing for women. One agency noted that it had received requests from several people that, as activities for youth are planned, young men and women should not be mixed.

Other MISP-related findings

General awareness and understanding of the MISP

95. Of the 35 field staff queried from nine agencies, eight (22.8%) had heard of the MISP. Only two staff (6%) from one agency could correctly define all or most of the objectives and activities of the MISP correctly and were aware that the MISP is a SPHERE standard.

96. After the purpose and the components of the MISP were explained, some humanitarian actors agreed that the MISP is a necessary and feasible set of activities and that they were willing to contribute to facilitating its implementation. Others believed that MISP activities should not be implemented until the situation had advanced to a more stable phase.

97. Many agencies believed that reproductive health activities must wait until the emergency situation became more stable.

98. One agency coordinator thought that the MISP was feasible in closed camps, but not in a population in flux like in Tine.

99. The following comments emphasize the lack of knowledge amongst field staff regarding the MISP:

> "*Thank you. You have brought this material [information on MISP implementation] at the right time.*"

> "*I understand that RH is not the most pressing need for refugees. We've never applied to UNHCR for RH care.*"

MISP supplies

100. Obtaining supplies to support the MISP early in the emergency was reported as a major problem by one international organization. According to this organization, RH kits were requested in November 2003 without a response. According to the UNFPA representative, in response to an order by the Special Representative of the Secretary General in January 2004, UNFPA secured RH kits, which arrived by the end of February 2004. UNFPA began distribution of kits to one agency on March 10, 2004 and initiated discussions with at least one additional agency at that time. At the time of the assessment, UNFPA had kits 1-6 available in-country.

101. The contents of the various kits with medical supplies (WHO NEHK-98, UNFPA RH Kits, UNICEF kits) and the differences among them were not clear to most humanitarian actors.

102. One international NGO did understand that supplies to implement the MISP could be obtained from UNFPA and representing insightful creativity in securing essential materials noted, "You can make up your own supplies for example, obtaining condoms from the ministry of health or the United Nations Office for Project Services (UNOPS)."

103. The team met and heard that Sudanese refugee health workers were present in the population but the team only heard of two agencies that were working with refugee health workers. One agency identified and initiated work with refugees experienced in health care, trained community health workers (Musharit) and TBAs (Cabillos), midwives and nurses. One agency stated that it had a specific policy against hiring refugees because it believed that refugees should not become dependent upon working with NGOs but rather get involved in long-term community activities.

Funding issues

104. UNFPA submitted a proposal to the United Nations Consolidated Appeals Process (CAP) with a planned launch on April 10. The proposal included funding for a fulltime RH coordinator, training and planning for the future. However, the CAP has not been well funded so far and in addition, there must be another mechanism to ensure funds are available at the start of the emergency. One international NGO submitted four proposals integrating the MISP with primary health care to different donors and all were pending a response during the assessment team's visit. This situation highlights the obstacle of funding to implementing MISP activities; agencies must react swiftly in emergencies and need to have readily available funds to do so.

Limitations

105. The assessment team acknowledges a number of limitations to the assessment. Unfortunately, time did not allow the team to include in the assessment the southern region of eastern Chad, Goz Beida, where approximately 8% (2,056 of 25,597 refugees as of April 13, 2004, UNHCR) of refugees have settled since 2003 and where UNHCR has set up a permanent refugee camp, Goz-Amer.

106. The geographically-wide scattering of the refugee population and camps along the 600 km border, the unfavourable road conditions and the restricted travel times to abide by security protocol resulted in long hours on the road to and from the refugee settlements each day and left limited time to conduct the evaluation in each site.

107. The observational and resource checklist was too extensive for each detail to be completed accurately in the short time available at each setting. An additional constraint was that many staff working in health care facilities, although very helpful and willing to share information, often did not have time to assist the researcher in completing the checklist. Much of the information on available resources (equipment and supplies) is therefore not based on direct observation, but rather on reports from agency staff or on an educated guess from the researcher (a physician who has worked in numerous emergency settings).

108. Given the urgency to undertake the assessment in the early days of an emergency, there was no opportunity to fully pre-test all of the assessment tools. However, all of the tools were based on RHRC Consortium's *Refugee Reproductive Health Needs Assessment Field Tools*, which have been widely used in refugee settings to conduct RH assessments, and were modified to focus on the priority RH activities outlined in the MISP and reviewed by the IAWG steering committee.

109. Furthermore, due to the above mentioned time constraints, it was not possible to conduct field staff interviews with staff from all relevant agencies. The team met with 16 of the 22 (nearly three-quarters) agencies but were unable to meet with THW (Technisches Hilfswerk – a German agency), CARE, Africare, Oxfam, UNICEF and the International Committee of the Red Cross (ICRC). However, field staff interviews were conducted with all health implementing agencies, the two national agencies undertaking camp registration and reception, the main community service partners and most of the organizations responsible for camp infrastructure and management and overall logistics.

110. A limitation of the refugee community focus group discussions was that translation was initially challenged by the limited reproductive health knowledge of the interpreter and at times the need for discussions to be carried on through two interpreters. Furthermore, the discussion of sensitive issues with either women's or men's groups may have been hindered at various times by female interviewers and a male interpreter. However, the male interpreter, a Chadian from the Zaghawa ethnic group, holds a Ph.D. in sociology with studies focused on the diverse ethnic groups residing in Chad and Sudan including women's and girls development and cultural patterns. Thus, often he shared the same ethnicity with many of those interviewed and, being versed in the culture, provided social and cultural insights that otherwise may have been missed.

Conclusions and recommendations

111. In the Sudanese refugee crisis in Chad, few humanitarian actors (i.e., national health authorities, UN agencies and NGOs) had ever heard of the MISP, while many volunteered their awareness of SPHERE standards and the seriousness with which their organizations abided by them. The MISP was added as a standard of care in the most recent revision of SPHERE standards and some field staff were trained in the

SPHERE standards prior to the current revised standards. Only one IAWG and RHRC Consortium member agency was known to specifically plan to implement most of the components of the MISP and their project start-up was delayed by site selection and pending proposals. Although there was little awareness of the MISP, a number of agencies were implementing a few of the MISP activities and addressing the objectives in a limited way.

112. An RH focal point to coordinate a MISP response was not on the ground in this emergency and there were no regular health or reproductive health coordination meetings. Staff in some settings deferred to ad hoc and informal meetings as problems arose. It is not possible to implement the MISP without at least a health coordination structure in place. With regard to the MISP objective to prevent and manage the consequences of sexual violence, spontaneously settled refugees in non-camp settings living close to the Sudanese border had critical unmet protection needs, leaving their security in jeopardy. In camp settings, several agencies had addressed women's participation in decision-making on refugee committees and through food distribution systems, indirectly contributing to women's protection, though it was not conceptualized as an activity that supports the protection of women and prevention of sexual violence. Latrines and water points had been designed and constructed in some settings to promote women's protection. Overall, there was awareness of the need for a code of conduct and contractual procedures were in place for most international and some local agencies; however, this progress had not yet translated to addressing the issue in the field. Sexual abuse and exploitation focal points and reporting mechanisms were not in place and protection officers were not consistently available. While there were mechanisms to identify vulnerable groups such as female-headed households and unaccompanied minors, there were no systematic interventions to address the needs of vulnerable groups. Although there were wide variations in the gender balance of national and refugee staff among humanitarian agencies, there was a significant gender imbalance, with few to no female Chadian and Sudanese refugee staff, in the community service and camp construction organizations.

113. Reports of widespread rape in Sudan had not resulted in any concerted community outreach to identify and address the clinical management of women who had survived rape in Sudan and were new refugee arrivals in Chad. Although the assessment team only heard indirectly of two incidents of rape in Chad, there were clear risks for sexual violence, particularly for refugee women and girls living close to the border and others walking long distances from camp and/or crossing the border back to Sudan for water and firewood. Although one international agency had reportedly established a comprehensive clinical management of sexual violence protocol, fully described at its base office in N'Djamena, it was not available in the field at the agency-supported clinics. However, the agency field staff reported that they had clear guidelines for the medical documentation of incidents and would refer rape survivors to UNHCR and ICRC for related protection issues. Apart from this agency, there were no efforts to manage the consequences of sexual violence for women and girls.

114. National health facilities lacked adequate supplies and materials, with the exception of facilities supported by international organizations, to practise universal precautions including blood transfusion screening. International NGOs appeared adequately supplied to practise universal precautions and provided on-the-job

training for local staff. However, protocols, guidelines and monitoring mechanisms to ensure the practise of universal precautions were not available.

115. All focus groups included participants who reported significant fears about contracting HIV/AIDS and could cite some basic methods of HIV/AIDS prevention but also held misconceptions about HIV/AIDS. Focus group participants readily declared that they did not know very much about HIV/AIDS and expressed a desire to learn more and to protect themselves.

116. Clean delivery kits for pregnant women are an easy and useful intervention which most humanitarian actors in this setting were not aware of. These basic supplies (clean plastic sheet, soap, razor blade, umbilical cord tie) could be identified and procured locally, assembled and distributed by refugee women to visibly pregnant women. They are also available from UNFPA. While some NGOs distributed clean delivery kits to TBAs and midwives, others were planning to and were in the process of ordering supplies. However, based on reports from focus group participants that included TBAs and midwives, there are unmet needs for supplies to ensure clean deliveries.

117. National health facilities lacked adequate equipment, supplies and skilled staff to ensure basic EmOC at the primary health care level and with the exception of one facility, NGOs had not filled this gap. Huge differences existed among the five referral hospitals serving the eight refugee sites assessed in this evaluation. Three of the five referral centres, those supported by international NGOs, provided comprehensive EmOC, although this care was not available at the two national hospitals that lacked international support.

118. In this setting, EmOC referral was largely not available when international personnel were not available, e.g., in the evenings, at night and over the weekends. One of the most difficult elements of the MISP to implement is establishing an effective 24/7 emergency referral system. Creative plans must be devised for this critical coverage during international staff off hours in collaboration with the refugee community and national partners.

119. Other obstacles to implementing the MISP in this setting included a lack of readily available standard MISP supplies and knowledge among humanitarian actors about where and how to order them. Some RH Kits were ordered and distributed but it appears they should have been in place earlier, as the RH Kits were not available in the country until six weeks into the emergency response and there were further delays in field distribution. UNFPA staff responsible for obtaining and distributing kits were not familiar with the MISP prior to this emergency. In this context, as well as all emergency settings, the implementation of the MISP is crucial to prevent morbidity and mortality, particularly among women. Early coordination of the MISP in each emergency and pre-positioning of supplies in region are essential.

120. The MISP objective to plan for the provision of comprehensive reproductive health services, integrated into primary health care, when the situation permits did not appear to be systematically approached. The two most active international organizations working in the health sector in this setting were providing commonly known components of comprehensive reproductive health care such as ANC, basic data collection and treatment of sexually transmitted infections. However, the agencies did not appear to be providing, or planning to provide, comprehensive

reproductive care such as family planning or HIV/AIDS programming. Two additional international organizations preparing to provide an emergency response in this setting, shared programme plans that were also more focused on incomplete comprehensive services integrated with primary health care than priority activities to prevent and respond to sexual violence, prevent the transmission of HIV/AIDS and to prevent excess maternal and neonatal morbidity and mortality in the early phase of the emergency.

121. In summary, there is widespread lack of awareness among humanitarian actors about the MISP and a lack of emergency preparedness by UN agencies and donors to implement the MISP in this emergency setting. This was also demonstrated in the retrospective study undertaken in the first part of Component 4, where no agency indicating they had worked in an acute emergency, reported putting in place all components of and supplies for the MISP within a month after the onset of the emergency.

122. The assessment team's recommendations are presented below. Most of the recommendations are focused on this emergency in Chad, however, some are more general which can be applied in any emergency setting.

Awareness and understanding of the MISP

- An IAWG member agency should develop a distance-learning module and CD-ROM on the MISP to be made available on the Internet, to UNFPA staff, humanitarian actors and donor representatives. All should be encouraged to complete the module, including training on the RH Kits, and receive a certificate of completion.

- IAWG member agencies should conduct short training sessions among existing UNFPA and humanitarian staff, including information on where to obtain supplies and the differences and similarities among the various kits: UNFPA RH Kits, WHO New Emergency Health Kits (NEHK), and UNICEF Kits. All kits should refer to other kits with a description of each kit's objectives and how each kit is complementary to the others. Kit contents and ordering information should be available on UNFPA and other agency websites.

- Humanitarian agencies should develop generic emergency response proposals that include the MISP SPHERE standard so proposals can be quickly generated when an emergency occurs (see Appendix 9 for an example).

- UN country teams should ensure that proposals included in the Consolidated Appeal Document (CAP) for their country address all components of the MISP in a coordinated manner.

- Donors should evaluate all proposals for multi-sectoral (site-planning, community services, water and sanitation, health sectors) activities ensuring MISP interventions, including the protection of

women from sexual violence, and compliance with SPHERE standards.

- Donors should integrate MISP SPHERE standard in donor field operations manuals and in the curriculum of emergency preparedness training courses.

- International nongovernmental organizations should identify an RH Focal Point in each site for coordination of the MISP and allocate funds to support MISP activities in all settings and ensure coordination with national governments.

- When time permits, agencies should undertake emergency preparedness planning to implement reproductive health by training and placing staff and pre-positioning supplies in the region.

Identify organization/individual to facilitate coordination and implementation of the MISP

- UNHCR or other lead agency where UNHCR is not present should ensure that health coordination is in place and appoint an RH focal point (an agency or person, this can be combined with the overall focal point role to provide overall coordination) early in the emergency. This role could be delegated to one of the health-implementing partners.

- UNFPA should receive emergency response funding to second a staff member to UNHCR for the first few weeks of the emergency to facilitate ordering and distribution of the RH kits.

- UN agencies and implementing partners should maintain a network of experienced RH health coordinators and an adequate budget to release staff to work in emergencies to initiate RH coordination, when needed.

Prevent and manage the consequences of sexual violence

- UNHCR, the Chadian government and international donors should immediately increase their capacity to open more camps in Chad and relocate refugees living in spontaneous settlements on the dangerous border areas to established camps to address the protection needs of refugees.

- UNHCR and implementing partners should ensure that female protection officers are available in all camp and non-camp settings and all humanitarian actors should be informed about the responsibilities of these individuals.

- All agencies should seek gender balance in staffing for the emergency.

- All agencies should identify an individual whose job description includes agency or sector-relevant activities that support the systematic protection and participation of refugees, particularly women and children.

- All agencies should consult refugee women and women's groups in camp and non-camp settings about their safe access to water, firewood, latrines, health care and other issues such as registration and food distribution.

- UNHCR should issue all women — not only female-headed households — their own registration cards.

- All agencies working in the health sector should make protocols and supplies for the clinical management of rape survivors available to humanitarian actors and national health providers as early as possible in all clinical settings. Specific documents include: *Clinical Management of Rape Survivors* (WHO/UNHCR, 2002) and *Guidelines for Prevention and Response: Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons* (UNHCR, 2003). Post-rape management supplies and resources include emergency contraception, HIV/AIDS post-exposure prophylaxis and STI drugs.

- UNHCR should inform all agencies and the refugee community where to report incidents of sexual violence and access available services.

- Humanitarian actors should undertake an information campaign to inform the community, e.g., refugee leaders, women's groups, health workers (CHWs, TBAs, midwives) about the urgency of and the procedure for referring survivors of sexual violence.

- All agencies should develop a code of conduct, including on issues of sexual abuse, inform staff and potential staff, and include the code in all the contracts to be signed by both expatriate and local staff. The code of conduct should apply to consultants and contractors as well. UNHCR's code of conduct can be used as a model. A trained focal point for reporting should be appointed in each setting.

Reduce the transmission of HIV

- Agencies working in the health sector should support national referral level structures early in the emergency, including provision of sufficient supplies, protocols and equipment to ensure adherence to universal precautions and safe blood transfusions.

- All agencies working in the health sector should regularly monitor the use of protocols and availability of supplies.

- All agencies should make condoms available to humanitarian staff and refugees, even when working with "conservative" populations. Condoms can be made available at registration and distribution of

food and non-food items, at clinics, from community health / outreach workers, TBAs, camp managers, etc.

- All humanitarian actors should be reminded of the difference between "making condoms available" and "condom distribution and awareness raising campaigns" in early coordination meetings to ensure that scarce time and resources are used most efficiently on priority activities during the early days of an emergency.

Prevent excess neonatal and maternal morbidity and mortality

- IAWG member agencies should undertake widespread awareness raising among all humanitarian actors to ensure the distribution of clean delivery kits to all visibly pregnant women as early as at pre-registration or screening. Also, encourage actors to consider local procurement of kit supplies and involving women to assemble and distribute the kits.

- Agencies working in the health sector should identify TBAs and local midwives in camp and non-camp settings and nurses / midwives at the clinic level to assess and address their supply needs while informing them about the emergency obstetric referral system.

- Agencies working in the health sector should assess and support the equipment, supply and staffing needs of the referral hospital to ensure the provision of comprehensive EmOC services for both the refugee and host population.

- All humanitarian agencies responding to the emergency, including national authorities, should work together to improve the referral system, ensuring that emergency transport to the referral hospital is available on a 24 / 7 basis.

- Agencies working in health and community services sectors should undertake an information campaign to inform the community, e.g. refugee leaders, women's groups, health workers (CHWs, TBAs, midwives) about the urgency of and the procedure for referring women who suffer from complications of pregnancy or delivery.

Planning for the provision of comprehensive reproductive health services

- All agencies working in health and community services sectors should plan for comprehensive RH services with the involvement of refugee women, men and youth to include management of sexually transmitted infections, family planning and gender-based violence programming.

- The RH focal point should collaborate with the health coordinator to assure that reproductive health data is collected in a standardized manner, collated, analysed and shared at regular health /

reproductive health coordination meetings to ensure coordinated planning and appropriate response.

- The RH focal point should organize training of staff to implement comprehensive reproductive health services as soon as possible.
- In planning for comprehensive RH services, STI management should be a priority and national STI treatment protocols should be assessed and upgraded if necessary.
- Agencies working in health should integrate comprehensive family planning services into the primary health care level as soon as routine supply management is functional and needs and staff skills have been assessed and upgraded if necessary.
- All agencies should collaborate to implement comprehensive gender-based violence programming that addresses the protection needs of refugees, particularly with regard to safe access to water and firewood for women and girls, as well as plans to assess and respond to female genital mutilation.
- All agencies should engage youth in community protection issues, awareness campaigns and planning for services in the community.

Suggestions from agencies working in Chad for improving implementation of the MISP

- Agencies ordering supplies should combine orders for WHO and UNFPA kits to facilitate logistics of ordering and delivery.
- UNHCR field offices should facilitate communication with UNFPA for RH kits and WHO for the NEHK. Communication should be established between UNHCR and UNFPA country offices on how to prepare for emergencies to ensure RH kits are readily available.
- Due to the 600 km border area, RH coordination meetings should be organized geographically to facilitate communication among agencies.
- Appoint a UN RH coordinator in the earliest days of the emergency and ensure a stock of MISP supplies are on the ground as soon as possible in an emergency.
- Recruit Chadian personnel to improve and maintain staff skills in the host country and include training on RH in emergencies in national health worker training curricula.
- Provide information on sexual violence and emergency obstetric referral care to all refugees at registration.
- Organize training sessions on basic RH issues and HIV awareness for all staff.

- Provide each camp manager with a supply of condoms to make available to refugees and agency staff.
- Tetanus vaccination for pregnant women should be one of the first things to be implemented once the situation moves from the emergency to a more stable phase.