TOWARDS A COMPREHENSIVE APPROACH OF SEXUAL AND REPRODUCTIVE RIGHTS AND NEEDS OF WOMEN DISPLACED BY WAR AND ARMED CONFLICT

A Practical Guide for Programme Officers

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LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
CBO	Community Based Organization
DGDC	Directorate General for Development Cooperation
FP	Family Planning
HIV	Human Immunodeficiency Virus
IAWG	Interagency-Working Group on Reproductive Health in Refugee Situations
IDP	Internally Displaced Person
IEC	Information, Education, Communication
IUD	Intra-uterine Device
MISP	Minimum Initial Service Package
NGO	Non-governmental organization
PHC	Primary Health Care
RH	Reproductive Health
SRH	Sexual and Reproductive Health
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UNHCR	United Nations High Commisioner for Refugees
UNFPA	United Nations Population Fund
VCT	Voluntary Counselling and Testing
VAW	Violence against Women
WHO	World Health Organisation

I. INTRODUCTION

Since the International Conference on Population and Development (Cairo 1994) and the Fourth World Conference on Women (Beijing 1995) the awareness about the sexual and reproductive rights and needs of women affected by war and armed conflict has been steadily growing. According to the definition given at the Cairo conference reproductive health includes a wide variety of services such as family planning, safe motherhood (including abortion – where legal –, prevention of abortion and post-abortion care), prevention and care of sexually transmitted infections including HIV/AIDS, education and counselling on human sexuality (with special attention for violence against women) and active prevention of harmful practices, such as female genital mutilation.

Although humanitarian aid programmes are paying more and more attention to the provision of sexual and reproductive health (SRH) services, the development of a comprehensive approach of SRH still constitutes a real challenge for donors, international humanitarian agencies, national authorities, national and international non-governmental organizations, and community based organizations.

The development of this guide is part of an interdisciplinary policy research for the Belgian Development Co-operation into the sexual and reproductive rights and needs of women displaced by war and armed conflict. The basic assumption of the guide is that sexual and reproductive rights are human rights, and more specifically women's human rights, which are an inalienable, integral and indivisible part of universal human rights. Taking this rights approach as a starting point the promotion and protection of these rights should be considered in all humanitarian relief operations and should be a priority of all SRH programmes.

A first draft of the guide was based on a preliminary literature review and desk study. It was first tested in a field visit to the Palestinian Occupied Terrotiries. Subsequently adapted versions were discussed with programme officers at the Belgian Directorate General for Development Cooperation (DGCD) and at the First International Meeting organised by UNFPA in Brussels for the Project on *"Reproductive Health and Gender Needs of Adolescent Internally Displaced Persons"* (Brussels, 7-11 October 2002), a programme supported by the Belgian DGCD. At the ICRH international expert meeting on *"Sexual and Reproductive Needs and Rights of Women Displaced by War and Armed Conflict"* (Ghent, 25-27 November 2002) the draft was peer reviewed. A more final version was discussed during a lunch conference organized by the Belgian Technical Cooperation.

As it happens, this kind of guides will always need continuous adapting and updating, but we hope that it will be a useful tool for all involved in the development, implementation , monitoring and evaluation of SRH humanitarian aid programmes in paving the way for a more comprehensive, gender sensitive and culture sensitive approach of displaced women's SRH.

II. PURPOSE AND USE OF THE GUIDE

1. OBJECTIVES

1.1. OVERALL OBJECTIVE

The guide is meant as a tool for programme officers to support a comprehensive approach of SRH rights and needs of women displaced by war and armed conflict.

1.2. SPECIFIC OBJECTIVES

- To get an overview of the key issues to be taken into account for a better understanding of the impact of conflict on the SRH rights and needs of women displaced by war and armed conflict.
- To assure a multidisciplinary, multisectoral and integrated approach of women's sexual and reproductive rights and needs by including legal, political, economical, social, cultural and health aspects which determine women's SRH status.
- To identify needs and gaps in the approach of sexual and reproductive rights and needs of women displaced by war and armed conflict.
- To guide the development of comprehensive SRH programmes in conflict situations within a long term perspective.
- To gain insight in the contribution of a specific SRH project to the improvement of the SRH status of women displaced by war and armed conflict.

1.3. TARGET GROUP

This guide has been developed for programme officers in charge of humanitarian aid programmes in SRH who are not necessarily medically trained and may not be familiar with all aspects of SRH of refugees and internally displaced persons.

1.4. PROCESS

The development of comprehensive SRH services in conflict situations should be seen as a process evolving from the delivery of emergency aid in SRH to the planning of more sustainable SRH programmes as the situation stabilizes. Obviously specific SRH projects may focus on only one or just a few aspects of SRH but they should always be embedded in a coordinated effort to achieve a sustainable improvement of the SRH of women displaced by war and armed conflict. The guide is

has been conceived as a tool 1) for screening SRH humanitarian aid programmes in order to identify needs and gaps for reaching this goal; 2) for assessing the contribution of specific projects to coordinated efforts in the field of SRH.

The guide focuses on the sexual and reproductive rights and needs of women in emergencies and in the stabilized phase of conflict. It is divided into different chapters comprising a series of topics concerning the different aspects that should be taken into account. It does not only include medical aspects of SRH, but equally emphasizes the need for the development of an enabling political, legal, economical, social and cultural environment. The list of topics is not exhaustive and can be adapted to each specific situation. It is mainly meant as a supportive and orienting tool in discussions with the counterpart and other stakeholders involved in the provision of SRH services in the context of humanitarian operations.

As the emphasis is on a comprehensive and coordinated approach, the formulation of the conclusions should focus on the overall SRH related issues as well as on the specific role and contribution of the counterpart in the kind of SRH services provided, their quality, accessibility and affordability. These conclusions can be translated into recommendations which may contribute to the development of strategies to enhance full respect of displaced women's sexual and reproductive rights and needs.

1.5. ROAD MAP

Ideally, the following steps should be taken when preparing field visits and meetings with the different stakeholders.

1. Literature review	- Basic information on the conflict, the situation of displacement. - Basic information on the SRH status of women in the country or region of origin. - Basic information on the SRH provisions in the host region or community. - Policy documents, reports and publications of stakeholders involved.

2. Identification of stakeholders in the provision of SRH services	In principle a wide variety of stakeholders involved in SRH programmes for refugee and internally displaced women should be contacted such as: - humanitarian organizations: o active in the field of refugee health o local, national as well as international o preferably organizations working on one or more aspects of SRH - human rights organizations: o active in the defense of human rights of refugees/IDP, and more specifically of women's rights - women's organizations: o women's organizations active in the refugee/IDP communities o committees and organizations of refugee/internally displaced women themselves - governments: o local and national authorities responsible for refugee/IDP settlement and care - security forces: o local, national and international forces responsible for the security in and around the refugee/IDP settlements - others: o other organizations and persons who may be able to provide important insights in the SRH situation and care for refugees/IDP in general, and for refugee/internally displaced women in particular (such as universities and research centres).
3. Programme	Organization of the mission agenda: meetings with the stakeholders involved and visits to the displaced communities.
4. Interviews	Semi-structured and open interviews with a representative number of key informants among the broad scope of stakeholders using the guide as a support for the discussions.
5. Focus group discussions	Semi-structured focus group discussions with displaced women and health providers using the guide as a support.

6. Preliminary conclusions and recommendations	Formulation of preliminary conclusions and recommendations on basis of the outcome of the literature review, the interviews, the focus groups discussions and the visits to the camps and settlements.
7. Feed back	Discussion of the preliminary conclusions and recommendations at a joint meeting with representatives of the counterpart and other directly involved stakeholders.
8. Report	Report of the field visit with final conclusions and recommendations.
9. Dissemination	Dissemination of the report among the stakeholders involved.
10. Strategy formulation	Formulation of a joint strategy in close concertation with the counterpart in order to develop a more comprehensive approach of SRH of women displaced by war and armed conflict.

III. GUIDE

1. CONFLICT ANALYSIS

Since the end of the Cold War there has been a dramatic increase in the number of armed conflicts and wars, most of them taking place in developing countries and more particularly in Least Developed Countries. In these countries the massive displacement of people and the vast flow of refugees often provoke devastating effects on the already scarce economic and natural resources and put a heavy burden on the often precarious social and medical services. Moreover most conflicts no longer take place between regular armies of recognized states but also involve non-state actors, such as guerrilla organizations, armed rebel organizations and local militia, with all sides intentionally targeting civilian populations and violating the regulations of international humanitarian law.

In conflict and displacement different phases can be distinguished: 1) pre-conflict, 2) conflict and emergency, 3) stabilization and 4) return and post-conflict. Each one of these phases requires different kinds of interventions to be undertaken by humanitarian organizations although phases may overlap and the transition between one phase and the other is not always very clear.

When developing SRH programmes it is important to identify the specific characteristics of the conflict that may seriously hamper the implementation of SRH programmes for refugee and internally displaced women.

The following topics in a conflict analysis[1] should be considered:

[1] REYCHLER Luc, *Een wereld veilig voor conflict. Handboek voor vredesonderzoek.*, Garant, Leuven-Apeldoorn, 1995 (p.215-288)

State of the conflict	- Phase of conflict: pre-conflict phase, an emergency situation, a protracted conflict or a post-conflict situation. - Degree of violence: kind of violence (conventional war, terrorist war, guerrilla warfare), kind of weapons used. - Kind of human destruction: casualties, injured, traumatization, refugees, internal displaced persons, main victims (military, civilians, ethnical groups; women, elderly, children, young men). - Kind of socio-economical destruction: damage to infrastructure (buildings, houses, hospitals, roads, energy supplies, transport). - Kind of ecological destruction: drinking water supply, agricultural production, mines. - Geographical spread of the conflict: capital, main towns, certain areas. - Peace efforts: economical aid, peace keeping forces, care for refugees and internally displaced persons, care for injured persons.
Conflicting parties	- Number of parties. - Kind of parties: conflicting states, military forces (national, regional, international), guerrilla, paramilitary, armed groups, armed civilians.
Causes	- Interests: political, economical power, territorial autonomy.. - Values: cultural, religious, ideological. - Collective identity: ethnicity, nationalism - Irrational: hatred, revenge, aggression.

2. DISPLACEMENT

Forced displacements of people and refugee movements are no longer side effects of war and armed conflict but are increasingly used as tactics in war. Moreover, the situation of refugees and IDPs is urging humanitarian organizations to revise their policies and programmes and to reconsider them within a long-term strategy as there is a strong tendency of conflicts to remain unsolved for many years.

A difference should also be made between refugees and internally displaced persons (IDP). According to international humanitarian law, refugees cross national borders and are protected by international legal standards. Internally displaced persons also flee violence and conflict but as they stay within their country, they should be protected by national legislation. On the whole IPS are subject to hostility of both the hosting community and the public authorities. In very few countries IDPs are registered though many people are reluctant to do so out of fear for persecution.

Refugee and IDP communities do not constitute homogeneous, a-political entities. Refugees and IDPs carry their political ideologies, preferences and strives with them and camps and settlements are often used as a battleground to continue power struggles and fights. Camps can be open or closed. People can also live dispersed among the host population and large self-settlements may gradually turn into camps. Refugee and IDP camps and settlements are not necessarily safe-havens and are often located in remote regions in the midst of or close to the conflict area often hampering access of humanitarian relief aid.

Having a clear insight in the kind of displacement, the characteristics of the displaced population and the organization of the displaced communities is extremely important in order to be able to design appropriate SRH interventions.

The following topics should be considered[2]:

[2] OJEDA Gabriel, MURAD Rocío, *Salud Sexual y Reproductiva en Zonas Marginales. Situación de las Mujeres Desplazadas.”*, Asociación Probienestar de la Familia Colombiana PROFAMILIA, Bogotá, 2001 (p.9-42).

Displacement	- Causes (armed conflict, insecurity, forced displacement, family reunion, employment, health, famine). - Massive or individual. - Place of origin. - Migration movements. - Duration.
Displaced population	- Number. - Socio-demographical characteristics (sex, age, civil status, family composition, education, employment). - Registration system. - Access to social services, including SRH services. - Special provisions for sole female headed households.
Living conditions	- Settlement (closed camps, open camps, refugee centres, dispersed among hosting community). - Housing (tents, slums, brick houses). - Access to basic goods and services (water, food, fuel, sanitary provisions). - Measures to guarantee women's access to basic goods and services. - Security and protection (presence of military forces, armed groups, gangs, civil security patrols).
Management and organization	- Institutions and authorities in charge (national, international, governmental, non-governmental, community based organizations). - Organization of the displaced population. - Organization of the displaced women. - Participation of the displaced in the management. - Active involvement of women in the management.

3. STAKEHOLDERS

The provision of comprehensive SRH services to displaced women in conflict situations may involve different stakeholders including donors, international institutions, governments, local authorities, national and international non-governmental organizations (NGO) and local community based organizations (CBO). At governmental level the organization of SRH programmes for displaced women should not only be restricted to the participation of the Ministry of Health, but also involve other Ministries such as the Ministry of Education (sexual education programmes), the Ministry of Justice (gender based violence), the Ministry of Social Affairs (social security and assistance to widows and sole female heads of household) and even the Ministry of Defence (prevention of violence against women, prevention of HIV/AIDS, security). In order to improve the efficiency and effectiveness of the SRH humanitarian aid programmes, coordination among stakeholders should be encouraged and supported, and more particularly coordinating mechanisms for the improvement of the displaced women's SRH should be set up.

In view of a comprehensive approach of the sexual and reproductive rights and needs of displaced women, the stakeholders community should not only include organizations with a specific medical approach but should also include women's organizations and human rights organizations that promote and defend women's human rights, and more particularly women's sexual and reproductive rights.

The following topics should be considered:

Identification	- Stakeholders involved in humanitarian aid for the displaced population (donors, international organizations, national and local authorities, international and national NGOs, and CBOs including human rights and women's organizations). - Stakeholders involved in SRH humanitarian aid.
Coordination	- Coordinating mechanisms (members, mandate, objectives, effectiveness, efficiency). - Participation of national NGOs and authorities. - Participation of national women's and human rights organizations. - Participation and role of the counterpart in these mechanisms.

SRH coordinating mechanisms	- - Specific mechanisms for coordinating SRH mechanisms (members, mandate, objectives, effectiveness, efficiency). - Participation of national NGOs and authorities. - Participation of national women's and human rights organizations. - Participation and role of the counterpart in these mechanisms.

4. IMPACT OF THE CONFLICT ON THE SRH STATUS OF DISPLACED WOMEN

4.1. IMPACT ON THE POLITICAL ENVIRONMENT

Conflict situations and massive displacement of people may seriously affect the national and local health system. The kind and scope of SRH services that can be provided in a certain setting are highly dependent on the national health policy in the host country, and more particularly on the national protocol and guidelines on SRH of the host country. These protocol and guidelines do not necessarily provide for all SRH related services - including family planning (FP), safe motherhood, sexually transmitted infections (STI) and HIV/AIDS, and violence against women.

SRH services for displaced women should always respect the existing health structures, practices and policies of the host countries or the host community and reinforce them where necessary. In this way humanitarian SRH interventions in conflict situations may contribute to the development of a more integrated and comprehensive SRH policy in the host country in the long term.

The following topics should be considered:

National health policy	- National protocol and guidelines on SRH.
	- Inclusion of SRH issues such as:
	  o safe motherhood: antenatal and postnatal care, safe deliveries, emergency obstetric care.
	  o family planning: counselling and delivery of modern contraceptives.
	  o STI/HIV/AIDS: prevention, treatment, care and support.
	  o gender-based violence: prevention, medical assistance, psychosocial support, referral system for legal aid.
	- Impact of the conflict/displacement on the implementation (disruption of the policy implementation, initiation of new programmes, reinforcement of ongoing programmes).
	- International support.

Humanitarian organizations, national and international NGOs	- SRH policy (protocol, priorities, mandate). - Compliance with national SRH policy. - Support to development/reinforcement of national SRH policy.

4.2. IMPACT ON THE LEGAL ENVIRONMENT

The promotion of women's sexual and reproductive rights is fundamental for improving women's SRH. The awareness among stakeholders involved in the provision of SRH services about the importance of women's human rights, and more particular of women's sexual and reproductive rights, is gradually growing but is still no real priority for most of them.

Women's and human rights organizations which pay attention to women's sexual and reproductive rights can help to gain a better insight in the national regulations and standards that affect the SRH of women, and more particularly the SRH of the displaced women. Comprehensive SRH programmes for displaced women should include support to advocacy and counselling efforts aimed at improving the legal status of women as well as support to the development of a legal framework for the protection of women's sexual and reproductive rights.

The following topics should be considered:

Domestic law	- Recognition of women's rights as human rights in domestic law. - Legal standards concerning SRH related issues such as: marriage, widowhood, unwanted pregnancies, gender-based violence, harmful traditional practices (such as early marriage, female genital mutilation, dowry, honour killings), support to HIV/AIDS infected.
Other legal systems	- Impact of customary law on displaced women's SRH. - Impact of tribal law on displaced women's SRH. - Impact of religious law on displaced women's SRH.

Women's rights	- Collaboration with human rights and women's rights organizations. - Support to women's rights and sexual and reproductive rights initiatives (awareness raising, training, referral system for legal aid and counselling, advocacy).

4.3. IMPACT ON THE SOCIO-CULTURAL ENVIRONMENT

Information about the social and cultural environment of displaced women' SRH is needed to gain a better insight in the social and cultural factors that affect the displaced women's SRH. Culture and customs affect women's SRH in multiple ways and are highly determinant for their SRH knowledge, needs, beliefs and attitudes. They may also be a main cause of under-utilization of the SRH services provided. In times of conflict and displacement women may become even more vulnerable in their SRH as a result of their sex and changing gender-roles in society.

In many cultures the deployment of male health staff often constitutes a main obstacle for women to attend the SRH facilities and the deployment of international staff may be the cause of serious language and communication problems.

Active involvement of the displaced community, with special emphasis on the active participation of women, in the needs assessment and the design of SRH services is important to ensure that these services are gender sensitive and culturally acceptable, and that they respond to women's real needs and can rely on community support.

The following topics should be considered:

SRH of displaced women	- SRH knowledge, beliefs, attitudes and practices among the displaced. - Prevailing attitudes towards women's sexuality. - Taboos. - Impact of the community. - Impact of the family. - Impact of prevailing gender-relationships: man-women, boy-girl, elderly-young. - Impact of changing gender-relationships. - Impact of religion. - Empowerment programmes (including economic empowerment).
Harmful traditional	- Kind of harmful traditional practices (e.g. early marriage,

practices	female genital mutilation, widow marrying, dowry brides, honour killing). - Prevalence of harmful traditional practices.
Health staff	- Origin (international, national, local, members of the displaced community). - Knowledge of the language of the displaced. - Knowledge, belief and attitudes towards prevailing SRH practices. - Efforts to employ and train female health staff. - Efforts to employ and train members of the displaced community. - Training in cross-cultural skills. - Gender-training.
Information-Education-Communication (IEC)	- Participative approach (involving women, community leaders, religious leaders). - On prevailing taboos concerning SRH. - On harmful traditional practices.

5. PROVISION OF COMPREHENSIVE AND HIGH QUALITY SEXUAL AND REPRODUCTIVE HEALTH SERVICES

5.1. EMERGENCY PHASE OF CONFLICT

In emergencies only a limited range of SRH care services can be offered. Often these services are limited to the reduction of maternal mortality and morbidity, but other aspects of SRH such as the provision of modern contraceptives, prevention and care of sexually transmitted infections (STI), including HIV/AIDS, and violence against women (VAW) should not be neglected.

The Interagency-Working Group on Reproductive Health in Refugee Situations(IAWG)[3] developed a *"Minimum Initial Service Package"* (MISP) for rapid interventions in emergencies. This package has been designed as a set of activities that can be implemented for:

1. the identification of organizations and individuals to facilitate co-ordination and implementation of the MISP
2. the prevention and management of the consequences of sexual and gender-based violence
3. the reduction of HIV
4. the prevention of excess neonatal and maternal morbidity and mortality
5. the planning of provisions for the development of comprehensive SRH services integrated into primary health care as the situation permits.

For the launching of the MISP UNFPA developed a *"Reproductive Health Kit of Emergency Situations"* (RH Kit). The kit consists of several sub-kits which can be ordered separately for use at different levels (primary health care, health centre or referral level, referral level).[4]

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[3] The IAWG was established as an outcome of the Inter-agency Symposium on Reproductive Health in Refugee Situations that took place in Geneva in 1995. The group was initially comprised of UNHCR, UNFPA and the Reproductive Health for Refugees Consortium (RHRC) members and has been expanding ever since along with the growing recognition for the importance of SRH issues in conflict situations. The IAWG was created to ensure a better coordination and information sharing for various aspects of refugee reproductive health related programming, monitoring and evaluation, as well as a tool development and research.

[4] UNHCR, *Reproductive Health in Refugee Situations. An Inter-agency Field Manual.*, 1999. The UNFPA Reproductive Health Kit contains:

- For use at primary health care/health centre level: 10.000 population for three months:
  0. Training and administration.
  1. Condoms.
  2. Clean delivery sets.
  3. Post-rape management.
  4. Oral and injectable contraceptives.
  5. STD drugs.
- For use at health centre or referral level: 30.000 population for three months:
  6. Professional midwifery delivery kit.
  7. IUD insertion.
  8. Management of the complication of unsafe abortion.
  9. Suture of cervical and vaginal tears.

In emergencies the following topics in the provision of SRH services should be considered:

Coordination	- Identification and employment of a SRH coordinator. - Planning for the provision of comprehensive SRH services. -
Tools	- MISP: knowledge, use and training. - RH Kit: knowledge, use and training.
Basic SRH services	- Prevention of excess neonatal and maternal morbidity and mortality. - Minimal supply of modern contraceptives. - Free condom supply. - Prevention of HIV/AIDS. - Prevention of VAW. - Assistance to victims of VAW. -

5.2. STABILIZED PHASE OF CONFLICT

Once a refugee situation stabilizes it is important to expand SRH services beyond the basic provisions. More comprehensive health care services can be provided and due attention can be given to needs assessment, community participation, quality of care, integration of services, information-education-communication activities (IEC), advocacy and coordination among relief agencies.

A thorough needs assessment is basic for the further planning, implementation, monitoring and evaluation of the services to be provided. This needs assessment should not only include quantitative data, but also qualitative data on the displaced population's SRH. When doing the needs assessment the active participation of the displaced community, and more particularly of the displaced women, is paramount.

Ideally refugees' and IDPs SRH needs should be met as an integrated part of primary health care and community services. Where refugees and IDPs live in camps, clinics and outreach programmes should be established within the camps and a reliable referral system should be organized and supported where necessary. When refugees and IDPs live dispersed throughout the community the capacity of the local health system should be supported and supplemented with additional

10. Vacuum extraction.

? For use at the referral level: 150.000 population for three months:

11. A – Referral-Level Surgical (reusable equipment).
11. B – Referral-Level Surgical (consumable items and drugs).
12. Transfusion (HIV testing for blood).

services such as counselling for post-traumatic stress disorder. [5] The SRH needs of the host population should not be neglected neither and humanitarian SRH should include them in their programmes where necessary.

Over the past years several guidelines, manuals and tools have been developed for the implementation, monitoring and evaluation of SRH programmes for refugees and IDPs. Serious efforts have been made to make these tools widely available but there is still a huge need for having the development of comprehensive SRH programmes to be accepted as a standard policy and practice in humanitarian aid operations.

In stabilized conflicts the following topics should be considered:

Needs assessment	- Quantitative needs assessment. - Qualitative needs assessment. - Participatory approach: active participation of o the displaced community o the displaced women o "less visible" women (such as widows, sole female heads of household, elderly women).
SRH services	- Participatory approach: active participation of the displaced community and the women in the design. - Efforts to strengthen the capacity of the local health system. - Economical affordability (cheap, free of charge). - Accessibility to the hosting community. - Integration in primary health care centres (within the camp in case of camp settlements) - Outreach programmes. - Referral system for emergency obstetric care. - Transportation system to reach the referral centres (organization, availability, efficiency). - Continuous monitoring and evaluation.

[5] *Meeting the Reproductive Health Needs of Refugees. Outlook. Volume 17 Number 4*,, UNFPA-PATH, December 1999, http://www.path.org/Files/eol17_4.pdf, 01/09/2001.

Equipment	- Material equipment. - Basic laboratory equipment. - Regular and reliable drug supply (including condoms and modern contraceptives).
Staff	- Qualified and skilled staff (trained traditional birth attendants, nurses, midwives, general practitioners, obstetricians, gynaecologists). - Regular training. - Monitoring. - Supervision
Safe Motherhood	- Antenatal care. - Postnatal care. - Breastfeeding. - Skilled attendance of deliveries. - Emergency obstetric care. - Abortion (where legally permitted). - Post-abortion care. - IEC activities.
Family Planning	- Counselling. - Availability of modern contraceptives (condoms, oral contraceptives, injectables, IUD). - Accessibility of modern contraceptives. - Regular and reliable supply of modern contraceptives.
STI/HIV/AIDS	- Counselling. - Treatment. - Care. - Support to HIV/AIDS infected. - Voluntary Counselling and Testing (VCT). - Safe blood supplies. - IEC activities.

Violence against women	- Prevention. - Clinical assistance. - Abortion services (where legally permitted) - Psychosocial support. - Legal aid. - IEC activities. -
Data collection and recording	- Recording system. - Systematic data collection (age and sex disaggregated).

6. CONCLUSIONS AND RECOMMENDATIONS

On basis of the outcome of the outcome of the literature review, the interviews, the focus group discussions and the visits to the camps and settlements conclusions and formulations can be formulated with the aim to improve the number and quality of the SRH services provided and to contribute to the development of a more comprehensive approach.

6.1. CONCLUSIONS

The conclusions should give an overview of the key issues to be taken into account for a better understanding of the impact of the conflict on the SRH rights and needs of women displaced by war and armed conflict. They should also give an overview of the different stakeholders involved in the field of SRH, their specific mandate and of the coordinating mechanisms which may have been created.

In the formulation of the conclusions the following topics should be considered:

Overall SRH related issues	- Identification of the main characteristics of conflict and displacement that affect the displaced women's SRH status. - Identification of the main stakeholders in SRH humanitarian aid. - Information about the mandate, the efficiency and the effectiveness of the SRH coordinating mechanisms. - Identification of the main environmental factors that may hamper the development of comprehensive SRH programmes (political, legal, economical, socio-cultural).

SRH counterpart	- Information about the specific role and contribution of the counterpart to the SRH coordinating mechanisms.
	- Identification of needs and gaps in the provision of SRH services considering:
	  - the kind of services provided
	  - the quality of the services provided
	  - the accessibility (geographical, cultural)
	  - the affordability.

6.2. RECOMMENDATIONS

The recommendations should be aimed at the development of long term strategies for reaching a more comprehensive approach of SRH in conflict situations. They should consider the development of a supportive environment for improved SRH services as well, but equally focus on improved complementarity of the respective SRH initiatives in the field.

In the formulation of the recommendations resulting the following topics should be considered:

Overall SRH related issues	- How to address conflict and displacement specific characteristics that affect the displaced women's SRH status. - How to involve other stakeholders in SRH humanitarian aid. - How to develop and reinforce SRH coordinating mechanisms. - How to improve the efficiency and effectiveness of SRH coordinating mechanisms.
SRH counterpart	- How to improve the complimentarity of the counterpart's SRH initiative within the context of the overall SRH humanitarian aid programme. - How to ensure a comprehensive approach of the SRH initiative concerned at the political, legal, social, cultural and economical level. - How to provide a broad range of SRH services. - How to ensure high quality of the SRH services provided. - How to ensure accessibility of the SRH services provided. - How to ensure affordability of the SRH services provided.

ANNEX 1

GLOSSARY OF TERMS

Abortion: The termination of pregnancy from whatever cause before the fetus is capable of extrauterine life.

Abortion death: The death of a woman from any cause occurring within 42 days after spontaneous abortion or initiation of induced abortion. If the death occurred after 42 days, the fatal complication must have begun within this interval.

Anaemia: A reduction in the number of red blood cells or in the amount of haemoglobin present in them. Anaemia can be caused by excessive blood loss, or by not eating enough foods rich in iron and folic acid. Some diseases can also cause anaemia by destroying the red blood cells.

Anaemia in pregnancy: Anaemia in pregnancy is defined as a haemoglobin concentration of less than 110 g/l. Degree of anaemia—classified as moderate (70-109 g/l), severe (40-69 g/l) and very severe (<40 g/l). Corresponding haematocrit (PCV) values are 24-37%, 13-23% and <13% respectively.

Antepartum haemorrhage: Bleeding from the genital tract occurring after the 20th week of pregnancy but before delivery of the baby.

Assessment: The process of identifying and understanding a problem and planning a series of actions to deal with it. There are usually a number of different stages in the process, but the end result is always to have a clear and realistic plan of activities designed to achieve a set of clear aims and objectives.

Case: A person in the population or study group identified as having a disease or health problem of interest.

Case-fatality rate: The probability of death among diagnosed cases of a specific health problem:

> number of persons dying of a specific problem during a specified period: total number of persons with the problem during the specified period

Cause-specific death rate: A mortality rate indicating the number of deaths attributable to a specific health problem or disease in a given population in a given time period (usually expressed per 100,000 population per year).

Clean delivery: A delivery that follows three basic principles of cleanliness (clean hands, clean surface, clean cutting of the cord).

Contraceptive prevalence rate (CPR): The percentage of women of reproductive age who are using (or whose partner is using) a contraceptive method at a given point in time.

Crude birth rate (CBR): The number of live births in a given period per 1000 people in the same period. Usually expressed per year.

Crude death rate: The number of deaths from all causes per 1000 population in a given year or per 10,000 per day in an emergency situation.

Deliveries attended by skilled health personnel: Percentage of deliveries attended by skilled health personnel irrespective of outcome.

- **Skilled health personnel or skilled attendant**: Doctors (specialist/non-specialist) and/or persons with midwifery skills who can diagnose and manage obstetrical complications as well as normal deliveries**.**

- **Person with midwifery skills**: A person who has successfully completed the prescribed course in midwifery and is able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries alone, to provide lifesaving obstetric care, and to care for the newborn and the infant.

Disaggregate: Analyse data according to different groupings to show differences between certain groups (by gender, age, ethnic group etc.) and therefore to reflect the true variations within the sample.

Eclampsia: A condition peculiar to pregnancy or a newly delivered woman, characterized by fits followed by more or less prolonged coma. The woman usually has hypertension and proteinuria. The fits may occur in the antepartum, intrapartum and postpartum periods.

Essential obstetric care: The minimal health care interventions needed to manage complications of pregnancy and delivery.

Evaluation: An assessment at one point in time that concentrates specifically on whether the objectives of a piece of work have been achieved and what impact has been made.

Fertility rate: The number of live births per 1000 women of childbearing age, usually taken as 15-44 years, in a given year.

Fetal death (deadborn fetus): Death prior to the complete explusion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy. The death is indicated by the fact that after separation, the fetus does not breathe or show any other evidence of life.

First-in/First-out (FIFO): A method of managing supplies in a storage facility to ensure that stock with the earliest expiry date that has been stored for the longer period is issued before stock which has been stored at a later date and has a later expiry date.

Focus group discussions: A small group of people (6-12) with specialist knowledge or interest in a particular topic are invited to discuss specific topics in detail. A facilitator is chosen to keep the discussion on or around the original topic, and to stop individuals dominating the discussion. It can bring together people who have a particular problem, those who cannot speak up at large meetings (such as women or minority groups), or those who are peripherally involved in a community, such as nomadic herders.

Hypertensive disorders of pregnancy: A diagnosis of hypertension in a pregnant woman is made when the diastolic blood pressure is 90 mmHg or greater. A differentiation should be made between pregnancy-induced hypertension (which occurs without a previous history of hypertension) and that associated with pre-existing hypertension.

Incidence rate: The rate at which people without a health problem develop the problem during a specific time, i.e. the number of new cases developing in a population over a period of time.

In-depth interviews: Semi-structured interviews with no formal questionnaire but with a checklist of topics to be covered. They are useful both for gathering detailed information about a community from key informants and also for discussing subjects which are too complex or too sensitive to be discussed in a group.

KABP survey: Survey of knowledge, attitudes, beliefs and practice through structured face-to-face interviews (or self-administered questionnaires) with a representative sample of the target population. Provides quantifiable data on what people know, believe, want and do.

Live birth: Complete expulsion or extraction from its mother of a baby, irrespective of the duration of the pregnancy, which after such separation breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached.

Logistics: The science of forecasting, procuring, storing, transporting and distributing supplies.

Low birth weight: Birth weight less than 2500 g.

Maternal mortality: A maternal death is the death of a woman while pregnant or within 42 days of termination of the pregnancy, irrespective of the duration and the site of pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

Maternal mortality rate: The maternal mortality rate is the number of maternal deaths per 100,000 women of reproductive age (15-49).

Maternal mortality ratio: The number of maternal deaths per 100,000 live births during the same period.

Monitoring: The systematic and continuous collecting and analysing of information about the progress of a piece of work over time.

Neonatal death: A death of a liveborn infant during the period which commences at birth and ends 28 completed days after birth. It may be subdivided into early neonatal deaths, occurring during the first seven days of life, and late neonatal deaths, occurring after the seventh day but before 28 completed days of life.

Neonatal mortality rate: Number of deaths among live births during the first 28 completed days of life per 1000 live births.

Neonatal period: The neonatal period commences at birth and ends 28 completed days after birth.

Objectives: Specific, time-bound and measurable goals for particular aspects of a piece of work which contribute to achieving the longer-term aims.

Obstructed labour: A labour in which progress is arrested by mechanical factors and delivery is impossible without operative intervention.

Perinatal mortality: The perinatal period commences at 22 completed weeks of gestation (154 days) when birth weight is normally at least 500 g and ends seven completed days after birth.

Perinatal mortality rate: Number of deaths in the perinatal period during a specified period of time, per 1000 total births (live births plus fetal deaths) during the same time period.

Postpartum haemorrhage: The loss of 500 ml or more of blood from the genital tract after delivery of the baby. In anaemic mothers, a lower level of blood loss should be the cut-off point for starting therapeutic action.

Pre-eclampsia: A condition peculiar to pregnancy manifested by hypertension, oedema and/or proteinuria.

Pre-term: Less than 37 completed weeks of gestation.

Prevalence rate (PR): A measure of the total number of people (old and new cases) in a population who have a health problem at a specified point in time (usually used for chronic conditions like AIDS).

Prolonged labour: Active labour with regular uterine contractions for more than 12 hours.

Prolonged rupture of the membranes (regardless of labour status): Rupture of the membranes for more than 12 hours.

Puerperal sepsis: Infection of the genital tract occurring at any time between the onset of rupture of membranes or labour and the 42-day postpartum period in which, apart from fever, one or more of the following are present: pelvic pain, abnormal vaginal discharge (e.g. presence of pus), abnormal smell/foul odour of discharge, delay in the rate of reduction of size of uterus.

Qualitative assessment methods such as in-depth interviews, observation and focus group discussions provide detailed information about behaviour and beliefs, and about the spectrum of beliefs in the community, but do not provide information on the incidence of these behaviours and beliefs.

Quantitative assessment methods such as probability sampling surveys, KABP surveys, routine surveillance and record review provide answers to the questions *who, what, when, where, how much, how many, how often.* They can give statistically accurate information about an entire community, but little information on the reasons why people behave as they do.

Random sampling: A method of selecting a sample whereby each element in the population has an equal chance (probability) of being selected for the sample.

Rate: A measure of the frequency of some event in a defined population at a specified time. In a rate, the numerator is a subset of the denominator.

Ratio: A measure of the frequency of one group of events relative to the frequency of a different group of events (e.g. the number of abortions per 1000 live births—abortion ratio).

Safe/atraumatic delivery: A safe delivery is one where the birth attendant monitors progress to avoid prolonged, obstructed labour or other complications which can lead to haemorrhage, infection and shock in the mother and birth asphyxia and brain damage in the infant.

Spontaneous abortion or miscarriage: A fetal death in early pregnancy. At what gestational age a miscarriage becomes a stillbirth for reporting purposes depends on the policy of the country.

Stillbirth: A fetal death late in pregnancy. At what gestational age a miscarriage becomes a stillbirth for reporting purposes depends on the policy of the country.

Surveillance: A dynamic process in which data on the occurrence and distribution of health or disease in a population are collected, collated, analysed, and disseminated.

Traditional birth attendant (TBA): A trained or untrained birth attendant who traditionally assists women at community level.

Trained TBA: A TBA or a family TBA who has received a short course of training through the modern health care sector to upgrade her skills.

Unsafe abortion: A procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking minimal medical standards or both.

Source: WHO, *Reproductive Health During Conflict and Displacement. A guide for programme managers,* WHO Department of Reproductive Health and Research, Geneva, 2000.

ANNEX 2

ICPD AND ICPD +5 REPRODUCTIVE HEALTH INDICATORS

Terminology	Definition	International Goals
Total fertility rate	Total number of children a women would have by the end of her reproductive period if she expereienced the currently prevailing age-specific fertility rates throughout her childbearing life.	Stabilize world population.
Contraceptive prevalence	Percentage of women of reproductive age* who are using (or whose partner is using) a contraceptive method** at a particular point in time.	By 2005: 60% of PHC and FP facilities should offer widest range of safe and effective FP methods.
Maternal mortality ratio	The number of maternal deaths per 100.000 live births.	By 2005: rate below 125 per 100.000 live births and by 2015 below 75 for the countries with highest maternal mortality.
Antenatal care coverage	Percentage of women attended, at least once during pregnancy, by skilled health personnel*** (excluding trained or untrained traditional birth attendants) for reasons related to pregnancy.	Expand maternal health services in the context of PHC.
Births attended by skilled health personnel	Percentage of women attended by skilled health personnel*** (excluding trained or untrained traditional birth attendants).	By 2005: at least 40% of all births should be assisted by skilled attendants for the countries with highest maternal mortality.
Availability of basic essential obstetric care	Number of facilities with functioning basic essential obstetric care**** per 500.000 population.	Expand adequate delivery assistance and provision for obstetric emergencies in the context of PHC.
Availability of comprehensive essential obstetric care	Number of facilities with functioning comprehensive essential obstetric care***** per 500.000 population.	By 2005: 60% of PHC and FP facilities should offer directly or through referral EOC.
Perinatal mortality rate	Number of perinatal deaths****** per 1000 total births.	Extend integrated reproductive health care and child health services.
Low birth weight prevalence	Percentage of live births that weigh less than 2500g.	Improve health and nutritional status of women, especially pregnant, and of infants and children.
Positive syphillis serology prevalence in pregnant women	Percentage of pregnant women (15-24 years) attending antenatal clinics, whose blood has been screened for syphillis, with positive serology for syphillis.	By 2005: 60% of PHC and FP facilities should offer prevention and management of reproductive tract infections.

Prevalence of anaemia in women	Percentage of women of reproductive age (15-49 years) screened for haemoglobin levels with levels below 110g/l for pregnant women and below 120g/l for non-pregnant women.	Countries should implement special programmes on the nutritional needs of women of childbearing age, and give particular attention to the prevention and management of nutritional anaemia.
% of obstetrics and gynaecological admissions owing to abortion	Percentage of all cases admitted to service delivery points proiding in-patient obstetric and gynaecological services, which are due to abortion (spontaneous + induced, but excluding planned termination).	Women should have access to quality services for the management of complications from abortions.
Reported prevalence of women with female genital mutilation	Percentage of women interviewed in a community survey, reporting to have undergone female genital mutilation.	Countries should take steps to eliminate violence against women.
Prevalence of infertility in women	Percentage of women of reproductive age (15-49 yeaars) at risk of pregnancy (not pregnant, sexually active, non-contracepting and non-lactating) who report trying for a pregnancy for two years or more.	By 2005: 60% of PHC and FP facilities should offer prevention and management of reproductive tract infections.
Reported incidence of urethritits in men	Percentage of men (15-49 years) interviewed in a community survey, reporting at least one episode of urethritis over the last 12 months.	By 2005: 60% of PHC and FP facilities should offer prevention and management of reproductive tract infections.
HIV prevalence in pregnant women	Percentage of pregnant women (15-24 years) attending antenatal clinics, whose blood has been screened for HIV and who are sero-positive for HIV.	By 2005: HIV infection rates should be reduced by 25% in the most affected countries.
Knowledge of HIV-related prevention practices	The percentage of all respondents who correctly identify all three major ways of preventing the sexual transmission of HIV and who reject three major misconceptions about HIV transmission of prevention.	By 2005: 90% of young persons, 15-24, should have access to the information, education and services needed to reduce risk on HIV-infection.

*

Reproductive age — *Women of reproductive age refers to all women aged 15-49, who are at risk of pregnancy i.e. sexually active women who are not infecund, pregnant of amenorrhoeic.*

**

Contraceptive methods — *Include female and male sterilization, injectable and oral hormones, intra-uterin device, diaphragms, spermicides and condoms, natural family planning and lactational amenorroea.*

***

Skilled health personnel — *Refers to doctor (specialist and non-specialist), and/or persons with midwifery skills who can manage normal deliveries and diagnose or refer obstetric complications. Both trained and untraind traditional birth attendants are excluded.*

****

Basic essential obstetric care — *Should include the capabilities for adminitration fo parenteral antibiotics, oxytocics and sedatives for eclampsia; the manual removal of placenta and reained products; assissted vaginal delivery with forceps or vacuum extractor.*

*****

Comprehensive essential obstetric care — *Should include basic essential obstetric care plus surgery, anaesthesia and safe blood transfusion.*

******

Perinatal deaths	*Deaths occurring during late pregnancy (at 22 completed weeks gestation and over), during childbirth and up to 7 completed days of life.*

Source: WHO, *Reproductive Health Indicators for Global Monitoring. Report of the second interagency meeting 2001 Reference WHO/RHR/01.19*, http://www.who.int/reproductive-health/publications/RHR_01_19_abstract, 29/07/2002.

ANNEX 3

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ANNEX 4

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