

INTER-AGENCY GLOBAL EVALUATION OF REPRODUCTIVE HEALTH SERVICES FOR REFUGEES AND INTERNALLY DISPLACED PERSONS

SUMMARY OF EVALUATION COMPONENTS

BACKGROUND

Since its formation in 1995, the Inter-agency Working Group on Reproductive Health in Refugee Situations (IAWG) has worked relentlessly toward the institutionalisation of reproductive health (RH) care for refugees and the internally displaced. In 2002, the IAWG endorsed a plan presented by the United Nations High Commissioner for Refugees (UNHCR) to evaluate efforts made thus far. The aim was to evaluate the provision of RH services to refugees and internally displaced persons (IDPs), based on the framework for implementation outlined in the *Inter-agency Field Manual*¹ on reproductive health in refugee situations. Specifically, the objectives for the evaluation were to take stock of the range and quality of the RH services provided to refugees and IDPs and identify factors that facilitate or hinder the provision of these services; identify factors that facilitate or hinder access to, use of, and satisfaction with the RH services, from the perspective of the beneficiaries of these services; and explicate the lessons-learned since 1995 and recommend ways in which RH services for refugees and IDPs can be strengthened and/or expanded.

The IAWG established a Steering Committee² to guide the evaluation process, and UNHCR hired a part-time consultant, in October 2002, to coordinate the evaluation activities. The evaluation covered seven components, the first four of which focused on the field level, including a review of literature related to RH services for refugees and IDPs (Component 1), evaluation of coverage of RH services (Component 2), evaluation of quality, access to, and use of RH services (Component 3), and evaluation of the use of the Minimum Initial Service Package (MISP) and RH Kits (Component 4). Component 5 focused on the agency/institutional level and involved assessment of changes over time within agencies/institutions involved in RH for refugees and IDPs, and Component 6 entailed a review of resource availability over time at the global level. The seventh component focused on dissemination of the evaluation results.

Many agencies and individuals were involved in the implementation of Components 1 through 6 and various evaluation methods were used. These included questionnaire surveys, administered electronically, (Components 2, 4 Part A, and 5), telephone interviews (Component 6), and focus group discussions with refugees and IDPs, interviews with field staff, and health facility observations/checks (Components 3 and 4 Part B). The latter methods were used during evaluation activities undertaken in Uganda, Republic of Congo (RoC), Yemen (Component 3), and Chad (Component 4 Part B).

¹ The components of RH which formed the basis of the evaluation are those described in the *Inter-agency Field Manual*: Minimum Initial Service Package (MISP), Safe Motherhood, Sexual and Gender-based Violence, Sexually Transmitted Diseases, including HIV/AIDS, Family Planning, Other Reproductive Health Concerns (managing complications of spontaneous and unsafe abortion, and eliminating the practice of female genital mutilation and caring for women who have undergone this procedure), and Reproductive Health of Young People.

Note that the term post abortion care refers to the strategy to reduce death and suffering from the complications of spontaneous and unsafe abortion, as described in the *Inter-agency Field Manual*. The elements of post abortion care are emergency management of incomplete abortion and potentially life-threatening complications; post abortion family planning counselling and services; and making links between post abortion emergency services and other RH services.

² The IAWG Steering Committee consists of the following agencies/organizations/institutions: CDC, Columbia University, ICMH, IFRC, Population Council, UNFPA, UNHCR, WHO, and Women's Commission for Refugee Women and Children.

EVALUATION COMPONENTS

Component 1: Review of Literature¹ A brief review of literature describing the RH needs of refugees and war-affected populations is provided as a backdrop to an extensive review of assessment and/or evaluation reports that focus primarily on RH services for refugees and IDPs. Other reports and documents were also included, such as the global overview on gender-based violence and the gender-based violence prevalence studies because they relate to refugee, internally displaced, and post-conflict settings. Several assessments and/or evaluations on the quality of refugee health services as a whole were also included, as they contain findings that are relevant to RH services for refugees.

On the whole, the findings of the literature review suggest that the RH needs of refugees and IDPs living in stable post-conflict settings are generally the same as for people living in settled populations. The services required to meet these needs include those for family planning, safe motherhood, the prevention and management of sexually transmitted infections (STIs), including HIV/AIDS, and the prevention and response to gender-based violence (GBV). A generally favourable impression was found with respect to RH services for refugees, although some gaps were noted in family planning services, particularly in relation to the availability of methods and the skills and abilities of service providers. In terms of safe motherhood, the services at most sites for refugees were comprehensive, with better indicators and outcomes than in the host or home countries of the refugees. Nonetheless, improvements required at some sites included those for antenatal and postnatal care, as well as for emergency obstetric care and post-abortion care. Notwithstanding these positive findings, services for STIs/HIV/AIDS and, to an even greater extent, those for GBV in refugee settings, were found to be generally less comprehensive and in some instances considerably limited. However, in contrast to the RH services provided for refugees, those for IDPs appeared, in general, to be severely lacking, requiring much more attention if the RH needs of these persons are to be met.

Component 2: Evaluation of Coverage of Reproductive Health Services for Refugees and Internally Displaced Persons² The purpose of the evaluation was to establish a baseline of RH services available to conflict-affected populations and to identify the gaps in service provision. Countries with a minimum of 10,000 refugees or IDPs were identified and a questionnaire, posing questions about the RH services available to the refugee and IDP populations in a single settlement, was emailed to key informants in 73 countries in March 2003. The questions referred only to the availability of services, as quality of care and usage were beyond the scope of this component. Key informants were followed up through email, phone and fax to collect completed forms and to clarify any missing or questionable information.

One-hundred-and-eighty-eight questionnaires were received from refugee and IDP settings in 33 countries in Africa, Asia and Latin America, covering approximately 8.5 million displaced people (82 percent refugees, 18 percent IDPs), three-quarters (76%) of whom lived in camps, 6 percent in urban areas, and the remainder in non-camp settings. More than two-thirds of sites (68%) had 2-4 elements of antenatal care (ANC), while 32 percent offered comprehensive ANC. Basic emergency obstetric care (EmOC) was available in 45 percent of the sites, while comprehensive EmOC was available directly or through referral in 39 percent of sites. Nearly all sites reported offering at least one method of family planning with oral contraceptive pills (96%), condoms (95%) and injectable hormones (89%) the most commonly available methods. Some aspects of HIV prevention were reported to be widely available, such as condoms (94%), the correct practice of universal precautions (90%), and community-based AIDS education (89%), while diagnosis and treatment of STIs were available at 85 percent of sites. In over half of the sites, programmes for the prevention (57%) and the response (59%) to gender-based violence were in place; community education and awareness-raising took place in 79 percent of sites, while psychosocial support and counseling were available in 64 percent. Additionally, in 60 percent of sites,

emergency contraception was available to survivors of rape, and two in three (66%) sites had guidelines for medical personnel's response to incidents of sexual violence, while one in three (33%) had such protocols for security personnel and protection officers (39%).

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

Component 3: Evaluation of Quality, Access to, and Use of Reproductive Health Services for Refugees and Internally Displaced Persons³ The purpose of this evaluation, conducted in Uganda, Republic of Congo (RoC), and Yemen, from February to April 2004, was to identify factors that facilitate or hinder access to, use of, and satisfaction with RH services, from the perspective of the beneficiaries of these services. The three countries in this component were selected from among the 33 countries inventoried in Component 2 of the evaluation, taking into consideration factors such as regional and cultural balance, refugee and IDP populations, contexts (camp, settlements, urban), providers of RH services, and security and access. The sites evaluated in Uganda were Kiryandongo in the west, Nakivale in the south-west, and Moyo-Palorinya in the north; in RoC Loukolela, Ndjoundou and Liranga in the north, Sangolo and IDR in Pool south of Brazzaville, and Brazzaville; in Yemen Sana'a in the north, Basateen, Aden in the south and Al Kharaz camp out of Aden.

The evaluation tools were selected and adapted from the Reproductive Health Response in Conflict (RHRC) Consortium's Health Needs Assessment Field Tools and the Monitoring and Evaluation Toolkit and included the Health Facility Questionnaire and Checklist, Group Discussion Questions, Refugee Leader Questions, and the Client Exit Interview Protocol. It was estimated that the total sample for the three countries would be approximately 90 key informants (health care providers and field staff) and 360 beneficiaries (40 beneficiaries in each site). However, because of the number of refugees who insisted on participating in the group discussions, the total sample of beneficiaries was 816 (379 in Uganda, 287 in RoC, and 150 in Yemen).

The findings from the evaluations conducted in the three study countries were variable, although similar gaps were identified to those outlined for Components 1 and 2 of the evaluation. Services for safe motherhood were, for example, reasonably good, with the exception of those for obstetric emergencies, which need strengthening in all three study countries. Referral for the management of obstetric complications was difficult due to issues with transport, communication, and personnel. In addition, some referral centres were unable to provide the services needed. Family planning services at the evaluation sites in Uganda and Yemen were found to be of good quality in terms of commodities and trained staff, but there was cultural resistance to the use of these services. In contrast, in RoC, health care providers were found to have limited expertise in family planning and there were inadequate supplies of family planning commodities. The supply of drugs for treating STIs was described as variable in Uganda, poor in RoC, and limited in Yemen. In addition, the use of syndromic case management was problematic at some sites. While GBV was common in the three study countries, there appeared to be very little available in terms of programming to address this problem. Although the evaluation was to cover services for both refugees and IDPs, the study team appears to have had limited access to the latter. Hence the evaluation findings apply primarily to refugee populations.

Each site in the study countries had different organizational structures and human resource management styles that were influenced by the organizational culture and philosophy of the

particular NGO. For example, there were differing approaches to practising medicine from highly interventionist to more primary health care oriented. Referral to various specialists was sometimes over-used and the use of some diagnostic procedures seemed excessive in some cases (e.g. ultrasonography, Xray, spinal taps, antibiotic sensitivity tests, etc.), thus misusing resources.

NGOs had different views on the level of staff incentives given, what categories of staff were eligible (e.g. nurses were said not to have received any “incentive payments” but doctors did), and whether refugee CHWs or TBAs were given incentives or benefits. In one site, CHWs received incentives and TBAs did not. The official policy is that allowances are paid to CHWs but not to TBAs, who are remunerated as per tradition when they attend births; however, some TBAs work in clinics or transport women to hospitals when there are complications.

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

In addition to these findings, the following factors were thought to have hindered access to RH services: poor or no roads (in particular in RoC), insufficient transport, limited communication systems, lack of water and poor sanitation in rural areas, and poor security (e.g. at some sites refugees had to pass through unsafe territory to reach services). Other factors that had an impact on the use of services included distance to health facilities, hours of operation, cost of services, perceived competence of health staff, and perceived quality of services. The health-seeking behaviours of refugees was also thought to affect their RH outcomes because of factors such as cultural and religious barriers to family planning, preference for using TBAs, lack of time (e.g. busy at home or at work) to attend health facilities for antenatal care, and dislike of the lithotomy position and fear of having an episiotomy during childbirth. While many refugees expressed gratitude for high quality services and caring staff, they held strong views on the quality of RH services and satisfaction with those services. Concerns were expressed by some refugees about the quality and availability of appropriate drugs and their use, poor communication between staff and patients, and the attitudes and behaviours of health workers.

The general recommendations, applicable to all three countries, include, but are not limited to, formalising referral networks and strengthening referral systems through strategic planning; ensuring the availability of essential drugs for treating STIs and for obstetric emergencies; ensuring the availability of the equipment needed for post abortion care; providing GBV awareness raising activities in all refugee camps and with all staff working in the camps; building on the capacity of Traditional Birth Attendants (TBAs); and improving data collection methods relevant to RH.

Component 4 Part A: Evaluation of the Use of the Minimum Initial Service Package (MISP) and RH Kits in Post Emergency Situations⁴ The purpose of Part A of this component was to conduct a retrospective evaluation of the use of the MISP and the distribution and use of RH Kits in post emergency situations. A two-part questionnaire was used to collect information on general issues, including implementation of the MISP components, logistics for ordering, packaging, storage, distribution of the kits, and usefulness of the IEC materials distributed with the kits (part one), and feedback on the contents of the RH Kits (part two). Forty-eight questionnaires were distributed via e-mail in April 2003 to UNFPA, UNICEF and WHO field offices and to IRC and IFRC, in 39 countries.

Thirty-three (68%) of the 48 questionnaires were returned, 28 of which were completed fully. Sixty-eight percent of respondents reported having implemented all of the MISP components at some point during an emergency, whereas 78 percent indicated that they had implemented at least one component. Of these, 81 percent had appointed an RH coordinator; 90 percent

implemented prevention and medical management of the consequences of sexual and gender violence; 90 percent addressed reduction of HIV transmission by distributing condoms (90%) and introducing universal precautions (65%); 100 percent implemented the prevention of neonatal and maternal morbidity and mortality through clean delivery kits and/or clean and safe deliveries; 72 percent planned for the provision of comprehensive RH services; and 72 percent established a data collection system for monitoring RH services. However, none of the 10 respondents indicating that they worked in the acute phase of an emergency reported putting in place all components of and supplies for the MISP within a month after the onset of the emergency.

Of the total number of RH Kits ordered in 2000, 2001 and 2002, Kits 2 (clean delivery kit), 6 (professional midwifery delivery kit) and 5 (STI kit) were the most frequently ordered. Most of the organizations that completed a questionnaire indicated that they were satisfied with the usefulness of the RH Kits and with the materials included in the kits, although suggestions were made to add and/or change some items, and the need for more training on the correct use of the kits was highlighted. In addition, 40 percent of respondents indicated that they had encountered problems with in-country transport and storage of the kits.

In conclusion, while the evaluation findings suggest that the MISP was better used than in the past, there is still room for improvement. In addition, while the RH Kits were, in general, found to be useful, some helpful suggestions have been made for improvements. However, in some countries, poor road conditions, irregular flights, extreme heat and humidity, and other factors may continue to pose a serious challenge to the distribution of the kits and, therefore, delay or prevent their use.

Component 4 Part B: Assessment of the Minimum Initial Service Package (MISP) of Reproductive Health for Sudanese Refugees in Chad⁵ The purpose of Part B of this component was to determine the availability and quality of emergency response to RH needs of refugees and IDPs by evaluating implementation of the MISP and use of the RH Kits in an acute emergency. Whereas the methodology in Part A of Component 4 consisted of eliciting retrospective feedback through a questionnaire from experienced users of the RH Kits, who were aware of the MISP, Part B was undertaken on site during the acute phase of the refugee crisis in Chad, in April 2004. The evaluation team 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. Four evaluation instruments were used: a semi-structured field staff interview questionnaire; a focus group discussion guide for refugees; an observational resource and services checklist; and an assessment site basic information form. 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 to another three sites, for which no checklist was completed due to an obvious lack of supplies or staff.

The 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 objectives and priority activities. There was no overall RH coordinator and only one agency had an identified RH focal point. Moreover, there was limited overall coordination of the humanitarian situation and no routine coordination of health or RH 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.

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 in 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 supplies for the practice of universal precautions, including blood screening, to prevent the transmission of HIV/AIDS and other infections. While international NGOs were adequately supplied to practice 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.

None of the three priority interventions to prevent excess neonatal and maternal morbidity and mortality 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 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 RH 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 RH services was not evident. A notable gap in planning for comprehensive RH care was family planning. Agencies were implementing or planning to implement commonly known components of comprehensive RH 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 RH 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 UN awareness and support, as well as delays in

funding, hindered timely implementation of the MISP in this emergency. Standard supplies of RH Kits available from UNFPA were not in country until six weeks into the start of the emergency. In addition, humanitarian workers were generally unfamiliar with the contents of the RH 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.

Based on these findings, many recommendations, focusing on the gaps identified, were made to address RH needs during the emergency in Chad. In addition, the following recommendations, which are applicable to any emergency setting, were made: 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 assure that health coordination is in place and appoint an RH focal point early in the emergency; and 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.

Component 5: Assessment of Changes over Time Within Agencies/Institutions Involved in Reproductive Health for Refugees and Internally Displaced Persons⁶ The assessment methodology involved a questionnaire survey of key informants working in organizations with known involvement in reproductive health for refugees (RHR) within the last decade. A sample of 46 organizations meeting this criterion was generated, including 18 international NGO's, four with RH as their primary mission; 13 academic/research institutions; eight multi-lateral/UN affiliated agencies; and seven governmental agencies, including three U.S., two European, one Canadian and one Japanese. A key informant at each organization was identified and sent the survey questionnaire by email in December 2003. The survey topics included policies; budget and finance; programming components; technical assistance; RH training; technical resources; and collaboration among agencies. Key informants were requested to confer and consult with their RHR colleagues in their organization, when completing the questionnaire, so as to obtain the most complete history and representative perspective possible in their answers, and to make use of their organization's documentation wherever possible. Completed survey questionnaires were received from 30 organizations.

Seventy-three percent of the organizations reported significant changes in their RHR programming and/or operational working areas since 1995. Eighty-two percent of these organizations described RHR growth in their organization while 18 percent described either stagnation or reduction of growth. Expansion of information and new developments in technical areas were seen to have stimulated more programmes that address a wider scope of RHR components. Other changes included the introduction of a rights-based approach integrated into the organization and programming, and an increasing emphasis on integrating RH into primary health care programmes at the outset of emergencies, including the use of the MISP and provision of RH Kits. An increasing programme focus on HIV/AIDS and STIs was noted by some respondents who felt that this drew effort away from other components.

Approximately half of the organizations reporting significant growth indicated that RHR had reached the point of integration into the formal structure of their organization. Providers of direct services reported that integration had also occurred within health care delivery and multi-sectoral service delivery approaches. Respondent ratings of 'perceived value of RHR to the mission of your organization' indicated that there had been an appreciable rise in institutional endorsement of RHR since 1995. Yet simultaneous concern was expressed that RHR would only be sustained organizationally if funding remained available and new donors were identified. Half of the organizations surveyed reported that recent political/policy changes had seriously affected their RHR action agenda and/or implementation. While the continuing viability of RHR was seen to depend heavily on a positive external policy environment, endorsement by internal policy seemed

of lower priority, with only 43 percent of organizations having written internal policies that specifically validate RHR in their respective institutions. This is, however, a significant positive change, since prior to 1995 only one organization in the sample had written RHR policy guidelines.

Programming in RHR components was seen to be fairly evenly distributed across organizations, although intensity of effort varied among organizations. Operational working areas were also spread fairly evenly across organizations, with two thirds or more being engaged in training and research, and 43 percent in policy development. In terms of “work effort,” the area of service delivery received the greatest relative ranking with nearly three-quarters of engaged organizations ranking it as “high.” In contrast, while more organizations engaged in monitoring and evaluation and research, the “work effort” allocated was much lower.

To address the greater demand for more comprehensive and technically focused programming, respondents indicated the need for more frequent and specific training to build skills and capacity among staff members. In addition, there was universal agreement about the need for more data based evidence to improve programme management and demonstrate effectiveness, especially for funding purposes. While 57 percent of organizations reported involvement in research, only a minority of these furnished expenditure information of any kind. In the small amount of data furnished, RHR research expenditure showed quite large increases between 1995 and 2000, although between 2000 and 2003 there was more variability.

Examination of changes in budget and staffing data over time indicated that only one-third of organizations were able to provide data that tracked RHR expenditure specifically. Overall organizational expenditure showed strong increases between 1995 and 2003, with the strongest growth between 1995 and 2000. However, between 2000 and 2003, there was more variability, with 40 percent of organizations reporting a downward trend in RHR expenditure.

Sixty-eight percent of respondents reported significant increases in collaboration/linkages in their programming initiatives since 1995. Collaboration, assessed for programmes between 2001 and 2003, was found to occur across a wide variety of different types of organizations, most frequently between international NGO's and local NGOs, with the most common form of collaboration being the sharing of resources such as office space, equipment and materials. Additionally, many respondents credit working groups, especially the IAWG and the RHRC Consortium, as primary facilitators of interaction, partnerships, sharing of resources, and designation of responsibility across members. On a rating scale of one to five with five being the highest, the “Positive impact of the IAWG on the RHR programme activities of this organization” was rated 3.1 for 1995, and 3.9 at the time of the survey. These ratings indicate that the perceived positive impact of the IAWG on organizations had grown over this time period. Collaboration, whether formally planned or as a response to field contingencies, was viewed as a mechanism that enhances both learning opportunities and programmatic effectiveness. Partnership and linkages improve efficiency, reduce duplication and amplify individual strengths through joint efforts. The growing collaboration reported by the majority of organizations is therefore direct evidence of the IAWG achieving one of its main objectives. Growing collaboration is also indicative of stronger inter-institutional support and higher quantity and quality of RHR work.

Although improvements have occurred in all RHR programming working areas, technical support, and RH strategy since 1995, the most important concerns voiced include the lack of all forms of data, surveillance, monitoring and evaluation. Despite emphasis on tool development and expert efforts, collection of data in the field is poor and requires further simplification of systems and formats, and better technical support. The related need for more in-depth research on the elements of RHR was also widely expressed, especially more information about successful models and best practices. Another broad concern is the need for more capacity building with local NGOs and organizations' own staff, in all areas – especially those areas requiring highly technical skills – it continues to prove a challenge to identify and to develop competent staff. However, despite these concerns, the demonstrated trends of growth in technical expertise,

collaboration, programme activities and institutionalization will, in all likelihood, continue. Possibilities to ensure that growth continues include formation of an IAWG Outreach Committee to seek out and engage peripherally involved organization and raise awareness in the larger community; revitalization of the **refugeerh** listserv to encourage networking, dissemination of information, and ongoing discussion; simplification of systems and formats and better technical support for data collection in the field; and capacity building within local NGOs and organizations already involved in RHR aimed at increasing the pool of competent technical staff.

Component 6: Review of Resource Availability Over Time at the Global Level in Support of Reproductive Health for Refugees and Internally Displaced Persons⁷

The purpose of this component was to identify changes over time in resource availability, at the global level, for RH services for refugees and IDPs. A series of open-ended questions was used during interviews, conducted from August to October 2003, with nine senior level staff members and experts who had been, or were still, involved in the mobilization of resources for RH for refugees and IDPs. The interview questions covered trends in funding, advocacy activities and/or strategies, changes in policies and practices affecting the availability of resources, and resources provided through the IAWG. Seven of the key informants were present, and two were former, staff members of UNFPA, UNHCR, WHO, IOM, the Women's Commission for Refugee Women and Children, CDC, IFRC, and ICMH. Seven interviews were conducted by phone and two were conducted face-to-face. Additional information was gathered through a review of publications on financing of humanitarian assistance and RH, from UNFPA, ODI and OCHA.

The findings indicate that major sources of funding include government agencies such as USAID, DFID, and SIDA and, more recently, ECHO. Other sources include private foundations such as the Mellon and Turner Foundations, and UN agencies such as UNHCR and UNFPA. A steady upward trend in funding was described following the ICPD in 1994, with a plateau in 1999-2000, followed by a continuing downward trend, possibly due to factors such as media and political influence, global economic recession, and increased competition in the area of humanitarian aid. On the other hand, factors thought to have had a positive effect on the availability of funds include international conferences (e.g ICPD), humanitarian emergencies such as those in former Yugoslavia and Rwanda, and the work of the IAWG. In addition, support for initiatives under the leadership of UNHCR and UNFPA, aimed at providing RH services in refugee situations in the mid-90s, was felt to have been critical to the successful integration of RH into the UN humanitarian response.

The most effective advocacy activities/strategies, which helped draw attention to the RH needs of refugees and IDPS, include the ICPD, the report, *Refugee Women and Reproductive Health: Reassessing Priorities*, released by the Women's Commission for Refugee Women and Children in 1994, the symposium organized in 1995 by UNHCR, UNFPA and WHO, the formation of IAWG following the symposium, the provision of research-based evidence relevant to RH in refugee situations, and the involvement of senior members of organizations in the drive to address the RH needs of refugees and IDPs. Nonetheless, it was agreed that more aggressive advocacy activities are needed if the IAWG members want to keep RH on the humanitarian agenda. Advocacy efforts must be revitalized, better packaged and better targeted. Engaging senior management in advocacy and strategic planning activities was frequently recommended to increase donor and humanitarian partners' awareness. It was also recommended that more research be undertaken to provide solid evidence of RH needs; efforts should concentrate, for example, on demonstrating the consequences of not providing RH care to refugees and IDPs. Similarly, it was recommended that cost effectiveness estimates be developed for RH interventions in emergencies, to help demonstrate to donors the potential benefits of investing in RH of refugees and IDPs. Moreover, it was felt that advocacy workshops for policy makers could help to reverse the downward trend in funding.

With regard to changes in policies and practices, the most significant policy improvement relevant to RH during the past decade involved a change in direction from a demographically driven agenda to a human rights-based approach. This change was thought to help underscore the RH

needs of various populations, including refugees and IDPs. Additionally, creation of the IAWG was considered critical to triggering policy changes; the IAWG, together with the RHRC Consortium, provided fora that facilitated collective conceptualization of RH in emergency situations. Other important activities of the IAWG were seen to include the provision of guidelines/standards (e.g. the *Inter-agency Field Manual*), the MISP and RH Kits, and RH training courses. However, it was concluded that the IAWG should strive to improve its coordination, information flow and planning, and also allow more involvement of local NGOs from the field. Moreover, it was suggested that the IAWG must accelerate its work, particularly since funding to support RH services for refugees and IDPs is decreasing.

CONCLUSIONS AND FUTURE DIRECTIONS

The findings presented for Components 1 through 6 of the Inter-agency Global Evaluation of Reproductive Health Services for Refugees and IDPs attest to the progress made since 1995 with respect to the institutionalisation of RH programmes. The evaluation findings also indicate particular aspects of RH services that need to be strengthened and/or expanded. It should be noted here, however, that the findings from the field (with the exception of the MISP evaluation in Chad) relate primarily to stable camp settings and therefore do not necessarily reflect the situation in acute complex emergency settings where information is particularly difficult to collect due to security constraints.

At the field level, Components 1 through 4 of the evaluation indicate that the services being provided are consistent with those outlined in the *Inter-agency Field Manual*. For example, past assessments and/or evaluations, such as those included in the literature review (Component 1), report the availability of services for safe motherhood, sexual and gender-based violence, sexually transmitted infections, including HIV/AIDS, and family planning. These services were found to be generally favourable for refugees living in stable settings, although there were gaps noted in most areas, as outlined above. Moreover, the services for IDPs were, in general, extremely poor.

The findings from the coverage study (Component 2) reinforce those from previous assessments and/or evaluations. For example, the findings by technical area suggest that coverage is fairly good. However, as noted above, services for the prevention and response to GBV were weak and other services such as those for HIV/AIDS prevention and obstetric emergencies could (and should) be stronger.

The findings from the evaluations conducted in Uganda, RoC and Yemen (Component 3) were variable, although similar gaps were identified to those noted in Components 1 and 2 of the evaluation, particularly with respect to safe motherhood, including EmOC, family planning, and GBV.

The findings from the evaluation of the MISP and RH Kits in post-emergency situations (Component 4 Part A), suggest that, based on retrospective data from more than 40 countries covering the years 2000-2002, the MISP was better used than in the past and the RH sub-kits were found to be generally useful. However, in contrast to these findings, those from the assessment of the MISP during the Sudanese refugee emergency in Chad (Component 4 Part B) indicate that most of the humanitarian actors in Chad were not familiar with the MISP and did not know its overall goal, key objectives and priority activities. Consequently, services were not in place to prevent and respond to sexual violence or to prevent the transmission of HIV/AIDS. In addition, services to prevent excess maternal and neonatal mortality and morbidity were not fully established, and there was no evidence of planning for comprehensive RH services integrated with primary health care as the situation stabilizes.

These findings point to the need for increased awareness and understanding of the MISP amongst donors and humanitarian actors and better health coordination and the appointment of

an RH coordinator early in an emergency, the allocation of funds to support the use of the MISIP, and the need for a network of experienced RH coordinators.

At the agency/institutional level, the findings of the assessment of changes over time within agencies/institutions involved with RH services for refugees and IDPs (Component 5) were generally positive. For example, since 1995, improvements were noted in all areas of RHR, technical support, and RH strategy. Moreover, there was overwhelming evidence that collaboration and exchange amongst organisations involved in RHR had increased since 1995, due in large part to the vital roles played by the IAWG and the RHRC Consortium, as well as other key groups. While these achievements are impressive, the majority of organizations involved in RHR also feel that inadequate funding and, frequently, too few technical staff to support all of their functions hampers their work. Notwithstanding these concerns, the growth in collaboration through a variety of exchange mechanisms among RHR organizations over the past decade was seen to provide momentum for extensive activities to promote future connections.

At the global level, the review of resource availability over time in support of RH services for refugees and IDPs (Component 6) raises important questions regarding RH programmes in conflict situations and suggests some useful lessons for the future. While the funding sources for these programmes remain unchanged, funding has actually declined since 2000 and seems unlikely to increase in the near future. The major reasons suggested for this are weakening political support for RH programmes in general, the continuing perception at some levels that RH is not an essential part of emergency response, and the absence of a strategic advocacy plan on behalf of the IAWG. It was further suggested that the IAWG's advocacy strategy should focus on providing evidence to donors and the public of RH needs in conflict settings; integrating RH into the UN system's humanitarian response mechanism; involving senior staff in advocacy and fundraising; and working with media to increase the visibility of the problem. The review concluded that better coordination, exchange of information and experience and joint operational planning are required if the IAWG is to influence resource mobilization in a competitive humanitarian environment.

In conclusion, the findings of the evaluation present a comprehensive picture at field, agency/institution, and global levels with respect to providing RH services for refugees and IDPs, highlighting the progress made since 1995 and emphasizing the gaps that need to be filled. Based on the findings, the main challenges for the future include: implementing the MISIP in new emergencies; establishing GBV programming in all situations where it is required; ensuring access for IDPs to the full range of RH services; and improving access to and quality of EmOC, family planning services, and services for the prevention and management of STIs, including HIV/AIDS, for refugee and other displaced populations, male and female adolescents included. Additional challenges include improving the collection and appropriate use of data, nurturing the growth of inter-agency collaboration, and the development of an advocacy strategy aimed at ensuring that RH for refugees and IDPs remains securely on the agendas of donors and relevant international agencies and organizations. Collectively, these challenges will provide direction for the future work of the IAWG.

INDIVIDUALS, AGENCIES AND INSTITUTIONS INVOLVED IN THE EVALUATION

- ¹ O'Heir J (UNHCR) *Review of Literature: Evaluation of Reproductive Health Services for Refugees and Internally Displaced Persons.*
- ² Casey S, Purdin S, McGinn T (Heilbrunn Department of Population and Family Health, Mailman School of Public Health, Columbia University) *Evaluation of Coverage of Reproductive Health Services for Refugees and Internally Displaced Persons.*
- ³ Bloggs J, Hickling C, Marceau-Pitts L, Rapheal D, Wheelan A, Zwi A. (School of Public Health and Community Medicine, University of New South Wales). *Evaluation of Quality, Access to, and Use of Reproductive Health Services for Refugees and Internally Displaced Persons.*
- ⁴ Common N (UNFPA). *Evaluation of the Use of the Minimal Initial Services Package (MISP) and RH Kits in Post Emergency Situations.*
- ⁵ Doedens W (UNFPA), Krause S, Mathews J (Women's Commission for Refugee Women and Children). *Assessment of the Minimum Initial Service Package (MISP) of Reproductive Health for Sudanese Refugees in Chad.*
- ⁶ White C (Women's Commission for Refugee Women and Children). *Assessment of Changes Over Time Within Agencies/Institutions Involved in Reproductive Health for Refugees and Internally Displaced Persons.*
- ⁷ Buzurukov A (UNFPA). *Review of Resource Availability Over Time at the Global Level in Support of Reproductive Health for Refugees and Internally Displaced Persons.*