

Lifesaving Reproductive Health Care: Ignored and Neglected Assessment of the Minimum Initial Service Package (MISP) of Reproductive Health for Sudanese Refugees in Chad



Women's Commission for Refugee Women and Children
and
United Nations Population Fund

*On behalf of the Inter-agency Global Evaluation of
Reproductive Health Services for Refugees and Internally Displaced Persons*

August 2004



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ACRONYMS

AAH	Action Against Hunger
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
CAP	United Nations Consolidated Appeals Process
CDW	Community Development Worker
CHW	Community Health Worker
CNAR	Commission Nationale tchadienne d'Accueil et de Réinsertion des Réfugiés (Chad National Commission for Refugee Assistance)
CRS	Catholic Relief Services
CSB	Corn Soy Blend
EmOC	Emergency Obstetric Care
FP	Family Planning
GBV	Gender-based Violence
GOS	Government of Sudan
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit (German Agency for Technical Cooperation)
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HRU	Humanitarian Response Unit
IAWG	Inter-agency Working Group
ICRC	International Committee of the Red Cross
IDP	Internally Displaced Person
IMC	International Medical Corps
IP	Implementing Partner
IRC	International Rescue Committee
JEM	Justice and Equality Movement
MCH	Maternal and Child Health
MISP	Minimum Initial Service Package
MOH	Ministry of Health
MSF	Médecins Sans Frontières (Doctors Without Borders)
NCA	Norwegian Church Aid
NEHK	New Emergency Health Kits
NGO	Nongovernmental Organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PEP	Post-exposure Prophylaxis
PHC	Primary Health Care
RH	Reproductive Health
RHR	Reproductive Health for Refugees
SECADEV	Secours Catholique et Développement (Catholic Relief Fund)
SLM/A	Sudanese Liberation Movement/Army
SM	Safe Motherhood
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
THW	Technisches Hilfswerk
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNCT	United Nations Country Teams
UNCTAD	United Nations Conference on Trade and Development
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WHO	World Health Organization

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Photographs by Sandra Krause and Julia Matthews.

ASSESSMENT TEAM

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MISSION STATEMENTS

THE WOMEN'S COMMISSION FOR REFUGEE WOMEN AND CHILDREN

The Women's Commission for Refugee Women and Children works to improve the lives and defend the rights of refugee and internally displaced women, children and adolescents. We advocate for their inclusion and participation in programs of humanitarian assistance and protection. We provide technical expertise and policy advice to donors and organizations that work with refugees and the displaced. We make recommendations to policy makers based on rigorous research and information gathered on fact-finding missions. We join with refugee women, children and adolescents to ensure that their voices are heard from the community level to the highest councils of governments and international organizations. We do this in the conviction that their empowerment is the surest route to the greater well-being of all forcibly displaced people. Founded in 1989, the Women's Commission for Refugee Women and Children is an independent affiliate of the International Rescue Committee.

THE UNITED NATIONS POPULATION FUND

UNFPA is the world's largest multilateral source of population assistance. Since it became operational in 1969, UNFPA has provided close to \$6 billion to developing countries to meet reproductive health needs and support sustainable development issues. The Fund helps ensure that women displaced by natural disasters or armed conflicts have life-saving services such as assisted delivery, and prenatal and post-partum care. It also works to reduce their vulnerability to HIV infection, sexual exploitation and violence.

MAP OF CHAD



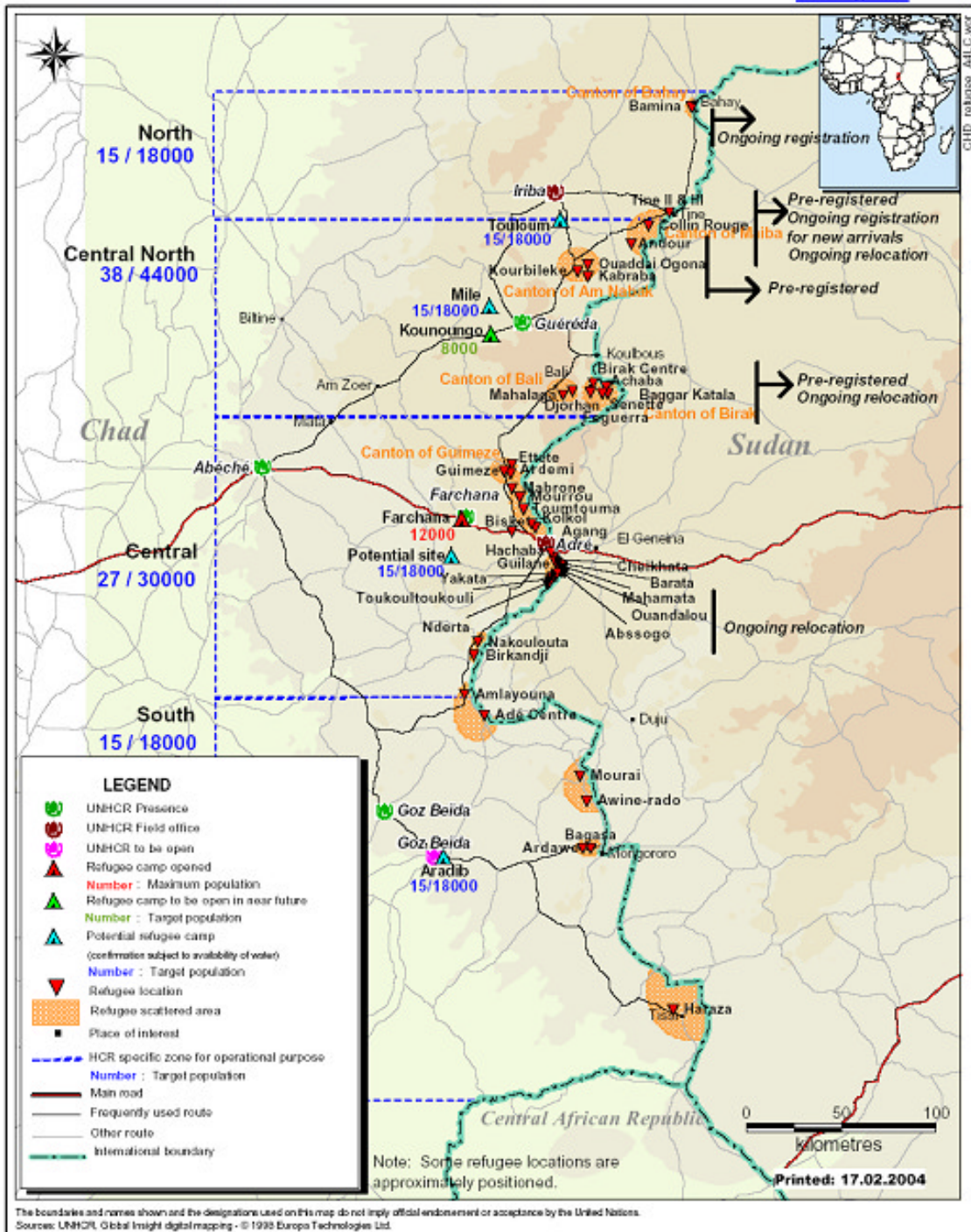
SUDANESE REFUGEES IN EASTERN CHAD

GIMU / PGDS

17.02.2004

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EXECUTIVE SUMMARY

The United Nations Population Fund (UNFPA) and the Women's Commission for Refugee Women and Children (Women's Commission) conducted an assessment of the Minimum Initial Service Package (MISP) of reproductive health services among Sudanese refugees in eastern Chad from April 5-14, 2004. The MISP¹ was first developed in 1995 as part of the *Inter-agency Field Manual on Reproductive Health in Refugee Settings*, and established as a guideline for priority reproductive health services required in the initial acute phase of an emergency. The objectives of the MISP are to:

- identify organization(s) and individual(s) to facilitate and coordinate the implementation of the MISP;
- prevent and manage the consequences of sexual violence by supporting the protection needs of refugees and ensuring clinical care for survivors of violence;
- reduce HIV transmission through the practice of universal precautions and guaranteeing the availability of free condoms;
- prevent excess maternal and neonatal mortality and morbidity by providing clean delivery kits for mothers and/or birth attendants to use for home deliveries and midwife delivery kits for clean and safe deliveries at health facilities and by initiating a referral system to manage obstetric emergencies; and
- plan for the provision of comprehensive reproductive services, integrated into primary health care, when the situation permits.²

The purpose of this assessment was to determine the availability and quality of emergency response to reproductive health needs of refugees, which represents one of seven components of the *Inter-agency Global Evaluation of Reproductive Health Services for Refugees and Internally Displaced Persons*.³ The global evaluation, based on the guidelines established in the *Inter-agency Field Manual on Reproductive Health in Refugee Settings*, was undertaken by the Inter-agency Working Group (IAWG) on Reproductive Health

for Refugees under the auspices of an evaluation steering committee led by UNHCR, from October 2002 to May 2004.

The IAWG Evaluation Steering Committee determined that the Sudanese refugee emergency in Chad met the criteria for an assessment of the MISP in an acute emergency based on the total number of refugees; tens of thousand of refugees with a lack of access to their basic survival needs; persistent conflict in Sudan with hundreds of new Sudanese refugee arrivals per day; and an established UN coordinated humanitarian response. Attacks by the Government of Sudan (GOS) and the Janjaweed, a government-backed militia, on Sudanese civilians in the western border area of Darfur, Sudan, for over a year which escalated in December 2003, resulted in approximately 700,000 internally displaced Sudanese in Darfur and 110,000 Sudanese refugees fleeing to eastern Chad by March 2004. Ongoing cross-border attacks by the Janjaweed and aerial bombardments on the border area prompted UNHCR to initiate its emergency response to relocate refugees from the dangerous border area in Chad to refugee camps a safe distance from the border in mid-January 2004. UNHCR divides its emergency response operations on Chad's eastern border into north, central north, central and south and aims to relocate the refugees to camps further inland before the rainy season obstructs access to both new arrivals and refugees. The refugees have been on the border, some for more than a year, without humanitarian assistance and their health and living conditions are rapidly deteriorating.

Using four instruments reviewed and approved by the IAWG Evaluation Steering Committee, the assessment team collected basic site information, conducted semi-structured interviews with 53 field staff, facilitated ten focus group discussions with 108 refugee women, men and adolescents and observed resources and services in twelve health facilities. Activities were carried out in four refugee camps (Kounoungo, Toulum, Iridimi, Farachana), and four spontaneous refugee settlements (Bahai, Tine, Birak, Adré), in the north, north central and

central border areas of eastern Chad. Due to the geographic spread of refugees on the 600 km border, difficult road travel and time constraints, the team was unable to visit refugee sites in the south but did speak with two of the major agencies assisting refugees in this region.

MISP assessment findings revealed that most humanitarian actors in Chad were not familiar with the MISP and subsequently did not know the MISP's overall goal, key objectives and priority activities. There was no overall reproductive health (RH) focal point and only one agency with an identified RH focal point. Moreover, there was limited overall coordination of the humanitarian situation and no routine coordination of health or reproductive health activities in this acute refugee emergency setting.

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

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

seeking firewood and water, particularly those living in spontaneous settlements along the border or who cross the border 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 adequate 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 to provide informal training on universal precautions to local staff, they did not have written protocols or established guidelines with staff monitoring and supervisory systems.

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

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

None of the three priority interventions to prevent excess maternal and neonatal mortality and morbidity were fully established in this emergency setting. Visibly pregnant women were not provided clean delivery kits. International NGOs reported that they provided clean delivery kits to traditional birth attendants (TBAs) and midwives; however, focus group participants, including some midwives and TBAs, noted a lack of supplies revealing a gap in coverage. National health facilities lacked adequate equipment, supplies and skilled staff to ensure basic emergency obstetric care (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 centers supported by international NGOs

did provide comprehensive EmOC, now was this care available at the two national hospitals that lacked international support.

The final MISP objective—to begin planning for comprehensive reproductive health services integrated with primary health care as the situation stabilizes—was partially implemented through the establishment of general health services, but specific planning for comprehensive reproductive health services was not evident. A notable gap in planning for comprehensive reproductive health care was family planning. Agencies were implementing or planning to implement commonly known components of comprehensive reproductive health services, bypassing the MISP interventions designed for the emergency phase. Examples include: establishing antenatal care for pregnant women before ensuring pregnant women have access to life-saving emergency obstetric care; planning HIV/AIDS community awareness campaigns before ensuring condoms are 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 emergency obstetric care, as well as meeting their clean delivery supply needs. Taking the time and resources to implement comprehensive reproductive health services without first establishing the priority MISP objectives and activities wastes scarce energy and resources in a difficult emergency setting.

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

In this context, as well as in all emergency settings, the implementation of the MISP, a

SPHERE standard of care, is essential to prevent morbidity and mortality, particularly among women.

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

AWARENESS AND UNDERSTANDING OF THE MISP

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

IDENTIFY ORGANIZATION/INDIVIDUAL TO FACILITATE COORDINATION AND IMPLEMENTATION OF THE MISP

- UN agencies and implementing partners should maintain a network of experienced RH health coordinators and an adequate budget to release staff to work in emergencies to initiate RH coordination, when needed.
- UNFPA should receive emergency response funding to second a staff member to UNHCR for the first few weeks of the emergency to facilitate ordering and distribution of the RH kits.

PREVENT AND MANAGE THE CONSEQUENCES OF SEXUAL VIOLENCE

- UNHCR, the Chadian government and international donors should immediately increase its capacity to open more camps in Chad and relocate refugees living in spontaneous settlements on the dangerous borders areas to established camps

to address the protection needs of refugees.

- UNHCR and implementing partners should assure that female protection officers are available in all camp and non-camp settings and all humanitarian actors should be informed about the responsibilities of these individuals.
- All agencies should seek gender balance in staffing for the emergency.
- All agencies should identify an individual whose job description includes agency or sector-relevant activities that support the systematic protection and participation of refugees, particularly women and children.
- All agencies should consult all refugee women and women's groups in camp and non-camp settings about their safe access to water, firewood, latrines, health care and other issues, such as registration and food distribution.
- UNHCR should issue all women—not only female-headed households—their own registration cards.
- All agencies working in the health sector should make adapted protocols and supplies for the clinical management of rape survivors available to humanitarian actors and national health providers as early as possible in all clinic settings. Specific documents include: *Clinical Management of Rape Survivors* (WHO/UNHCR, 2002) and *Guidelines for Prevention and Response: Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons* (UNHCR, 2003).
- UNHCR should inform all agencies and the refugee community of where to report incidences of sexual violence and access available services.
- Humanitarian actors should undertake an information campaign to inform the community, e.g., refugee leaders, women's groups, health workers (CHWs, TBAs, midwives) about the urgency of and the procedure for referring survivors of sexual violence.
- All agencies should develop a code of conduct, covering, among other issues, sexual abuse, inform staff and potential staff, and include the code in all the contracts to be signed by both expatriate and local staff. UNHCR's code of conduct can be used as a model. A trained focal point

for reporting should be appointed in each setting.

REDUCE THE TRANSMISSION OF HIV

- Agencies working in the health sector should support national referral level structures early in the emergency, including provision of sufficient supplies, protocols and equipment to ensure adherence to universal precautions.
- All agencies should make condoms available to humanitarian staff and refugees, even when working with “conservative” populations. Condoms can be made available at registration and distribution of food and non-food items, at clinics, from community health/outreach workers, traditional birth attendants, camp managers, etc.
- All humanitarian actors should be reminded of the difference between “making condoms available” and “condom distribution and awareness raising campaigns” in early coordination meetings to ensure that scarce time and resources are used most efficiently on priority activities during the early days of an emergency.

PREVENT EXCESS NEONATAL AND MATERNAL MORBIDITY AND MORTALITY

- IAWG member agencies should undertake widespread awareness raising among all humanitarian actors to ensure the distribution of clean delivery kits to all visibly pregnant women as early as at pre-registration or screening. Also, agencies should encourage actors to consider local procurement of kit supplies and involving women to assemble and distribute the kits.
- Agencies working in the health sector should identify TBAs and local midwives in camp and non-camp settings and nurses/midwives at the clinic level to assess and address their supply needs while informing them about the emergency obstetric referral system.
- Agencies working in the health sector should assess and support the equipment, supply and staffing needs of the referral hospital to ensure the provision of comprehensive emergency obstetric care services for both the refugee and host population.
- All humanitarian agencies responding to the emergency, including national authorities, should work together to improve the referral

level and ambulance systems ensuring that emergency transport to the referral hospital is available 24 hours per day seven days per week.

PLANNING FOR THE PROVISION OF COMPREHENSIVE REPRODUCTIVE HEALTH SERVICES

- All agencies working in the health and community services sectors should plan for comprehensive RH services with the involvement of refugee women, men and youth to include the management of sexually transmitted infections, family planning and gender-based violence programming.
- The RH focal point should collaborate with the health coordinator to assure that reproductive health data is collected in a standardized manner, collated, analyzed and shared at regular health/reproductive health coordination meetings to ensure coordinated planning and appropriate response.

The assessment team also asked all of the agency staff interviewed for their recommendations in improving implementation of the MISP. Here is a short summary:

- UNHCR field offices should facilitate communication with UNFPA for RH kits and WHO for the New Emergency Health Kits (NEHK)
- Establish communication between UNHCR and UNFPA country offices on how to prepare for emergencies to ensure RH kits are readily available.
- Due to the 600-kilometer border area, RH coordination meetings should be organized geographically to facilitate communication among agencies.
- Appoint a UN RH coordinator in the earliest days of the emergency and ensure a stock of MISP supplies is on the ground as soon as possible in an emergency.
- Recruit Chadian personnel to improve and maintain staff skills in the host country and conduct more training on RH in emergencies in national training curriculum.
- Provide information on sexual violence and emergency obstetric referral care to all refugees at registration.
- Provide each camp manager a supply of condoms to make available to refugees and agency staff wherever feasible.

I. INTRODUCTION

As part of the IAWG global evaluation’s first objective: “to take stock of the range and quality of the reproductive health (RH) services provided to refugees and internally displaced persons (IDPs) and identify factors that facilitate or hinder the provision of these services,” the Humanitarian Response Unit (HRU) of the United Nations Population Fund (UNFPA), in collaboration with the Women’s Commission for Refugee Women, and Children undertook completion of Component 4 of the Evaluation Framework. Component 4 aims to determine the availability and the quality of emergency response to the RH needs of refugees and IDPs. This evaluation encompasses two elements:

1. Conduct a retrospective evaluation of the distribution and use of the MISP and the RH Kits in past emergencies.
2. Evaluate implementation of the MISP and the

use of RH Kits in acute emergency situations which involve refugees or internally displaced persons.

The first prong was completed in 2003 and a report completed. The current report addresses the second element of the evaluation for Component 4.



Mother and child in Amnabak.

II. METHODOLOGY

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

EVALUATION TOOLS

The evaluation was undertaken with the use of four evaluation instruments (listed below), which were developed by the study team and reviewed by the Steering Committee prior to the mission (see Appendix 3, p.33).

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

Semi-structured field staff interviews were conducted with 53 staff members (medical coordinators, health care staff, program 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. (See Appendix 4 for the list of

field staff interviewed and sites visited, p. 65.)

Because of the different groups targeted in the two prongs of Component 4 (experienced users of the RH kit with assumed knowledge of the MISP versus humanitarian workers implementing a response in an acute emergency) and the different methodologies used (retrospective desk study versus direct observations and interviews in an acute emergency), the findings of the two studies are reported separately.

CRITERIA FOR SELECTING EMERGENCY SETTING

The site for the evaluation (the refugee crisis in eastern Chad) was selected and agreed upon by the IAWG on Reproductive Health in Refugee Settings global evaluation steering committee, according to the following pre-determined criteria:

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



Midwives at Adré.

III. HOST COUNTRY BACKGROUND

GEOGRAPHY AND RECENT HISTORY

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

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

Saharan mountains make up the hot, arid regions of northern Chad, while the south enjoys a more tropical climate. Although droughts and floods are common in southern areas, this region is Chad's most fertile and contains the only two rivers in the country. Lake Chad lies to the west and provides the country with its only permanent fresh water source.

POLITICAL AND ECONOMIC CONTEXT

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

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

Chad is one of the least developed countries in the world. It ranks 165th on the United Nations Development Program (UNDP) Human Development Index, which takes into account health, life expectancy, knowledge and standard of living. Based on United Nations Conference on Trade and Development (UNCTAD) Least Developed Country Report, 82 percent of Chad's population lives on less than US\$1 a day and over 64 percent live below the national poverty line.⁴ According to the World Bank, Chad's GNP per capita is \$230, which is poor even relative to other sub-Saharan countries. Although poverty is endemic to the entire country, the severity differs by region. The central Sahel region suffers from frequent famines and the rate of poverty for women in this area is exceptionally high, which may be because of the lack of male income-generators due to prolonged conflict. However, women in every region are poor, especially in areas such as education, health and land ownership. Gender inequality is strongly linked with human poverty: only five percent of girls attend secondary school, compared with 17 percent of boys, and men earn nearly twice as much as their female counterparts.⁵

DEMOGRAPHICS

The population of Chad was estimated at 8.3 million in 2002, with women representing 52 percent of the total.⁶ The annual population growth rate is 3.15 percent.⁷ According to UNFPA, only 20 percent of the total population lives in urban areas. The population distribution is uneven, with 59 persons per square kilometer in the southwestern regions compared to the northern Sahara region, which makes up 50 percent of the total land, with an estimated population density of 0.1 inhabitants per square kilometer. The life expectancy at birth is estimated at 46 and 49 years for men and women, respectively.⁸

The people of Chad divide themselves into over 200 distinct ethnic groups. Chadian society is highly traditional, and patriarchal norms are deeply rooted. Women and girls experience discrimination in a variety of areas, including access to knowledge, economic and political opportunities and health services. Gender inequali-

ties are reflected in the literacy rate: 66 percent of women aged 15 and above are illiterate as compared to 48 percent of men.⁹

French and Arabic are the two official languages, although more than 120 different languages and dialects are spoken. Muslims currently make up half the population, and 35 percent of Chadians identify themselves as Christian. The remaining practice animist or local tribal religions.

REFUGEE POPULATION

Years of internal strife have caused an exodus of the population into neighboring countries. More than 35,000 Chadians had fled the country by the end of 2002.¹⁰ Despite its own political instability, Chad has consistently hosted refugees from other countries. Refugees have come primarily from Sudan, and approximately 1,000 refugees from the Central African Republic were living in Chad and another 500 urban refugees of various nationalities lived in the capital, N'Djamena at the end of 2002.¹¹

Twenty years of civil war in neighboring Sudan has created a steady flow of refugees into Chad. In the late 1990s, more than 20,000 Sudanese refugees escaping internal conflict entered Chad. Approximately 5,000 had repatriated back to Sudan by the end of 2001. However, fighting between the Sudanese government-backed militias and rebel groups intensified in the western Darfur region in February 2003. Two new rebel factions, the Sudan Liberation Movement/Army (SLM/A) and the Justice and Equality Movement (JEM), joined forces at this time and demanded an end to the terrorization of their communities by the militias, known as the Janjaweed. The Sudanese government responded by greatly increasing support to the militias, which subsequently began a brutal campaign of systematic rape, looting, mass killing, and other atrocities against both rebel and civilian populations. Senior UN officials have characterized the emergency as “the world’s worst humanitarian crisis.”¹²

The Janjaweed’s policy of ethnic cleansing and scorched-earth tactics have led to the displacement of over one million Sudanese.¹³ In May 2004, UNHCR approximated that over 110,000 Sudanese had fled into Chad and another 1 million were estimated to be internally displaced. Access to the IDPs in Sudan by humanitarian

actors has been extremely limited.

Women and girls have been directly targeted for violence in Sudan. Attacks by the Janjaweed have resulted in widespread sexual violence towards women and girls searching for water, food and firewood in Darfur. Thousands of these displaced women are pregnant and nursing, with little access to health care services.¹⁴



New arrivals from Darfur at Bahai, Chad.



Women gave birth on the roadside, such as this woman near Tine.

IV. REFUGEE AND HOST COUNTRY HEALTH CONTEXT

Table 1: Health Indicators

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

Source: *State of World Population 2003*, UNFPA

NATIONAL GENERAL HEALTH SERVICES/CONDITIONS—CHAD

Due to years of civil unrest and political instability, Chad's current health care system remains exceedingly deficient. In 2001, the government of Chad spent only 2.6 percent of its GDP on health care.¹⁵ Primary health care services suffer from an extreme lack of health care workers. Indeed, approximately 200 physicians are currently working in Chad and half are based in the capital. Access to services also remains severely limited. Certain areas, particularly in the northern region, do not have any functioning medical structures. Lack of transportation, civil strife and long distances hinder people in rural areas from seeking medical help. Medical equipment and supplies are also scarce, and doctors frequently pay for equipment themselves.¹⁶

Reproductive health services in Chad remain particularly problematic due an exceptionally low rate of modern contraceptive use, high fertility rates and a great cultural emphasis on early marriage and polygamy. As a result, Chad has one of the highest maternal mortality rates in the world.

Female health care workers are rare and women

are often disinclined to seek out medical help from men. Despite a high rate of vaginal fistula, only two physicians in the country have been trained in advanced fistula repair.¹⁷

NATIONAL GENERAL HEALTH SERVICES/CONDITIONS—SUDAN

Over 20 years of civil war has hobbled Sudan's health care system. High population growth rates, extreme poverty and a weakened economy have further compounded the decline in health care. Lack of access, scarce medical resources, few qualified health workers and high costs plague the crumbling medical infrastructure. In the 1970s and early 1980s, medicine and medical consultations were free. However, the subsequent privatization of the health care sector caused a great increase in the cost of services. In an effort to combat Sudan's large debt, Structural Adjustments Programs, advocated by the World Bank and International Monetary Fund, were introduced in the 1980s, resulting in further cutbacks to government health care expenditures. By 1991 Sudan's health care system had virtually disintegrated due to the ongoing civil unrest and

economic decline. Many facilities have closed or have been destroyed and military factions often control the few remaining clinics.

Reproductive health care services in Sudan are poor and, in some areas, non-existent. Maternal and child mortality rates are exceptionally high and approximately 90 percent of women and girls in Sudan have undergone some type of female genital mutilation.¹⁸ Despite limited awareness of modern contraception combined with high-risk sexual activity among the general population, Sudan has a relatively low HIV/AIDS prevalence rate. Although the government has funded reproductive health initiatives, few of these projects are developed in the conflict-affected western and southern regions.

REFUGEE CRISIS RESPONSE AND CONTEXT

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

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

The German agency GTZ is managing overall logistics in all regions and in conjunction with Norwegian Church Aid (NCA) and THW (Technisches Hilfswerk—another German agency) is also responsible for camp infrastructure. Camp management was undertaken by Intersos in the south and SECADEV, the local counterpart of Catholic Relief Services (CRS), CARE and Africare in the remaining camps. Oxfam and CRS are providing technical support and capacity building to SECADEV.

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

(See Appendix 5 for a matrix illustrating camps sites and activities by implementing partners, UNHCR March 25, 2004, p. 68).

To provide a picture of the circumstances in which the Sudanese refugees are living in Chad, the following are descriptions of two different border areas to which refugees were fleeing during the assessment team's visit.

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

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

Approximately 40,000 refugees are living on the border of Chad and Sudan near the town of **Adré**. The Women's Commission spoke with a group of 17 Masalit men who had arrived in November 2003 after their villages were attacked and burned by the Janjaweed. The refugees reported that sometimes planes reinforce attacks on villages with aerial bombing. They had fled their villages in Sudan: Krenik, Konkoniya, Shoyou, Modoine, Koukoumanda, Sheden, Binediya, Daltaing, Kounti and Dongete—all areas south of El Geneina. They reported that a group of approximately 100 Janjaweed divided themselves into two groups to attack the area they were living in just three days before the assessment team's interview to steal cattle and sheep from the refugees. One group stormed the area in the middle of the day to steal the animals while the other waited behind the border to support the assault from the Sudan side. One man in the focus group had lost most of one of his fingers during an attack by the Janjaweed two months ago during which all the other men with him were killed.

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

V. FINDINGS

GENERAL ASSESSMENT FINDINGS

The primary concerns of the non-camp refugees in April 2004 were food, water and shelter, with an overriding concern for their security. All refugees the assessment team spoke to living in spontaneous settlements, most for several months without humanitarian assistance for food, water and shelter, were eager to be moved anywhere to access their basic survival needs. A UNHCR senior program officer reported that malnutrition¹⁹ was increasing. To survive, some refugees did menial labor for local Chadians, such as supplying them with wood and water.

While it was clear that refugees had received generous support from their Chadian neighbors over the past year, there was also evidence of the struggle between the refugees and their hosts for vital resources such as water and firewood. In Bahai, refugee women had a well-founded fear of being harmed by Chadian women while collecting water at the public well. They reported that six refugee women were beaten at the public well owned by the local people. An international NGO representative working in the area confirmed that there were seven incidents requiring medical intervention from beatings involving local and refugee women at the public well. Women reported that they went at night to collect water from the well to prevent incidents of violence. In Bahai, the refugee women also reported that women and children made dangerous treks to collect wood from the Sudan side of the border because the local people did not allow them to cut trees.

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

Although one UNHCR field office reported its overall goal was to relocate people from the border, the transport of these populations—whose precise numbers are unknown—was severely

hampered by the lack of UNHCR capacity to provide transport to existing camps and the slow process of identifying sites to establish new camps with adequate water sources. UNHCR field offices and their implementing partners decried the lack of vehicles. There were six vehicles and they required 60 to move the refugees on schedule before the rainy season, which will severely restrict transport and access to refugees. Furthermore, many of the limited number of vehicles available sat idle due to a lack of petrol.

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

The situation is very, very bad here—people are in desperate condition. People are calling me from everywhere [for help].

There are no tents in Chad and they take one month to arrive from Pakistan; the rainy season is applying pressure.

The main problem is to maximize the number of people under tents before the rainy season.

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

MISP ASSESSMENT FINDINGS

IDENTIFY ORGANIZATION/INDIVIDUAL TO FACILITATE COORDINATION AND IMPLEMENTATION OF THE MISP

- There was no coordination of health activities among humanitarian actors and the assessment team did not identify an organization or individual facilitating coordination and implementation of the MISP. A UNFPA representative stated, “There is no RH focal point; it happened so suddenly that no one was appointed and the country program officer stepped in to coordinate the ordering and distribution of kits.”
- There were no regular official health coordination meetings or reproductive health meetings at any level from N’Djamena to Abéché or the camps and border areas where refugees were living. Organizations appeared to expect another agency to undertake organization of this activity. In response to whether there is a lead agency addressing RH, one humanitarian assistance worker stated that they would probably go to UNFPA if they had questions.
- Another representative of an international organization reported that there were general coordination meetings in N’Djamena every two weeks; however, only a couple of international organizations that the assessment team spoke with were aware of regular meetings in N’Djamena. General weekly coordination meetings were established in most camps and UNHCR regional areas.
- One agency referenced its internal RH coordination activities in a spontaneous refugee settlement, explaining that it initiated coordination with the local administration and ministry of health to begin working with local midwives and nurses. Another agency indicated that there was informal coordination at the camp level with the involved agencies and that they reviewed vulnerable people together and would hold meetings when important issues arose. They also report the number of births and provide clothes for infants and children.

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

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

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

PREVENT AND MANAGE THE CONSEQUENCES OF SEXUAL VIOLENCE

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

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

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

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

- Access to firewood is not surprisingly a problem in this desert terrain. One woman from Iridimi transit center was attacked collecting firewood in the wadi 1.5 kilometers away and her registration card was stolen. Protection problems related to the collection of firewood are likely to escalate in all settings over the next six months to one year as women and children are forced to walk farther and farther to collect this necessity.
- Most respondents were aware of the composition of different ethnic groups in the camps and considered their representation on camp committees and in work with refugee women's groups. In one camp, however, the ethnic group with the smallest numbers in the camp did not have a representative in community service activities.
- The national community service organization in one camp stated that its activities are specifically targeted to women and that they work with refugee women to reach the men. This organization also works with a provisional male committee comprised of community elders or chiefs.
- One camp offered a women's center in each sector that could be used for training, micro-enterprise activities and community health education. Women's groups in this setting were also involved in disseminating community health messages, e.g., hygiene, efficient cooking, water, etc.
- Many, though not all, international agencies had a code of conduct signed by contracted expatriate staff. For example, UNHCR staff must sign the code of conduct²⁰ upon employment and are trained on the code of conduct before coming to the field. UNHCR also requires its local staff and implementing partners to sign a contract that includes the code of conduct. However, the majority of the agencies did not include the code of conduct in local staff contracts. Some agencies were working to adapt the code of conduct from the international NGO to the local NGO partners. One international agency representative reported they had a code of conduct that all staff, including drivers, guards and cooks, must sign, but the representative's understanding of the code of conduct was that it involved no alcohol and no prostitution. The representative did not seem to understand the concept of preventing and responding to sexual abuse and exploitation. In addition, most agencies did not have reporting focal points or mechanisms for survivors of sexual exploitation and abuse; however, most said they would bring a case to the attention of UNHCR and one respondent indicated they would bring the case to the attention of their regional director and headquarters.
- UNHCR reported that its community services implementing partners (IPs) addressed women's participation and protection through women's equal representation on camp refugee committees. The camp refugee committees were involved in camp management and according to UNHCR the concept of addressing the needs of the most vulnerable was well known to their IPs.
- There had been a UNHCR protection officer in Abéché but there was currently a gap and there were also no protection officers in Iriba or Adré. A UNHCR community services assistant was based in Iriba and had done some work in organizing women and addressing women's issues but had recently left. Some NGOs said they were not sure to whom they would report incidents of sexual violence or exploitation. Humanitarian actors also reported a lack of female protection personnel.
- Refugee women were rarely employed compared to men in camp construction and community services. A small but noteworthy effort was made to hire female refugees in camp construction in Iridimi camp. Four refugee women out of 60 refugees employed in camp construction were hired to carry construction materials on a donkey—creating a small stir among the men.
- The lead community service agency had recruited and employed staff from the south because it had been difficult to find qualified people to fill positions from the area.
- Refugees and humanitarian staff both reported that there were many children without their fathers, but reports on the number of unaccompanied minors varied. Some children were absorbed into extended families and the assessment team met three women in Bahai responsible for the care of their grandchildren because the children's parents were missing or had died,

while some children may live with families unknown to them. Also in Bahai, twelve orphaned children ranging in age from 4 to 13 were reportedly cared for by a “kind” Sudanese man according to refugee women focus group participants. Adolescent focus group participants in Farachana camp said there were many children without parents and no one responsible for protecting them, while there were many more with only one parent. They also said that relatives such as brothers and uncles supported children without parents.

- One community service agency respondent said they work in close collaboration with UNICEF on children’s issues. Another said, “I think it’s a problem, especially unaccompanied minors—there are a lot of them and there are difficulties with spontaneous arrivals.” The respondent reported that there was only one unaccompanied minor in Farachana camp and the child was reunited with its family in two days. The respondent also indicated that there was a female protection officer working with UNHCR who accompanied convoys and did some reunification of spontaneous arrivals. However, a family reunification system was not known to the refugees or to field workers with whom the assessment team spoke. In some settings agencies were using various methods to identify and follow up on vulnerable people, including children, handicapped, pregnant women, etc., and one agency was centralizing the data between the camps in which they were working. However, there was not a consistent way in which vulnerable populations were identified and provided with services.
- Reports from UNHCR, implementing agencies and refugees themselves stated that an untold number of women were raped in Sudan by the Janjaweed before they fled to Chad. Refugees fled to Chad after they were attacked by the Janjaweed and GOS soldiers and their villages were bombed and burned and their cattle, sheep and goats stolen. Almost everyone had heard of the Janjaweed raping women and girls in Sudan, though not all groups of focus group participants had experienced rape of women and girls in their villages. Refugees in Iridimi camp said that the Janjaweed took young girls, ages 10-17 years, from villages in Sudan such as Abougambrah, Amborou, Jirjira and Maun, to big towns such as

Fasher and El Geinena, where the GOS held them. Some of these girls had returned while others had not. In Toulum camp, focus group participants said that in Sudan the men were tied up and the women and girls were taken by the Janjaweed, sometimes for one month.

- There were varying reports among different focus groups about the incidence of sexual violence. Focus groups were quite clear and outspoken on the issue of sexual violence, expressing that it either happened or it did not. Focus group participants in some settings, such as spontaneously settled refugees in Adré and refugees in the Farachana camp (where refugees from Adré would be transported) and the spontaneous settlement in Tine, as well as in Touloum and Iridimi camps, reported extensive rape of women and girls by the GOS soldiers and the Janjaweed in Sudan. However, focus group participants in other areas along the border, such as Bahai and Birak, said that while they had heard of this happening it had not occurred in their village or to anyone they knew. It is possible that the groups in these areas may have fled their villages earlier, having been warned of the impending violence.
- There were rare reports of incidents of sexual violence in Chad. While most focus group participants reported that they felt safe in camp settings there were two incidents reported in focus groups and field staff interviews involving at least one assault while collecting firewood outside of refugee camps. A focus group participant reported that a woman was attacked outside of Touloum camp while collecting firewood. It is unclear whether the incident involved sexual violence, but according to the respondent, the incident was reported to the local police. An international NGO representative from Norwegian Church Aid (NCA) reported that a refugee woman was attacked and her registration card stolen while she was collecting firewood outside of Iridimi camp. In addition, one international NGO representative had heard that a refugee woman living in a village was raped and subsequently taken to Kariari. Many women in spontaneous non-camp refugee settings reported fearfully walking up to or across the border into Sudan to obtain firewood and water and encountering the Janjaweed, though there were no reported incidents of rape.

- The one currently functioning health-implementing NGO said that in most of their clinics they could clinically manage rape survivors, including post-exposure prophylaxis (PEP). On observation however, clear protocols for the clinical management of rape survivors were not available in the clinics themselves. On the other hand there were very clear instructions on the provision of medical certificates to rape survivors and referring the case to UNHCR or ICRC for protection.
- In Abéché public hospital rape cases were seen on a regular basis (not refugees). The survivor undergoes a forensic examination, but receives no treatment. None of the national health structures visited had the supplies or protocols needed for clinical management of rape survivors.
- UNHCR reported that sexual violence services were included in the proposals of their IPs.
- The community service agency in Farachana camp stated that sexual violence services were in place and that survivors would be referred to MSF and the main hospital.
- No clinic had visible protocols on universal precautions. Local staff of one international health NGO were trained “on the job,” but staff working at national structures needed urgent support to be able to implement and maintain injection safety, sterilization protocols and safe waste disposal.
- Safe blood transfusions were only available from the international NGOs that had established referral-level services. The national health structures did not have HIV tests available and one staff member admitted that untested blood was transfused in emergencies.
- Condoms were not made available to refugees in this emergency because the majority of humanitarian actors spoken with believed that the refugees were members of a very traditional society who were not familiar with condoms and would not use them.
- The refugee population had very little knowledge regarding HIV, with many focus groups reporting that they had never seen anyone infected with HIV, never heard of condoms and did not know how to prevent HIV transmission. Almost all focus groups reported that HIV is very dangerous and they are worried about becoming infected with HIV. Some focus group participants identified HIV transmission routes including through blood, unclean shaving instruments, mother-to-child and sexual relations.

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

If a woman is raped we may report to the head of the camp sector—it depends. We would also go to the camp manager and agency director.

I think it's cultural—even with positive discrimination, it's difficult to recruit women.

I haven't heard the words gender, protection, GBV survivor since I've been here.

We focus on food, water and shelter and then six months later you hear about all the rapes.

REDUCE THE TRANSMISSION OF HIV

- Most of the functioning international health NGOs had effective and sufficient supplies to adhere to universal precautions. However, national structures typically lacked the necessary supplies and resources to implement universal precautions unless they were supported by an international NGO, which provided them.
- There was also misinformation about the transmission of HIV. In one focus group, participants said they heard that refugees could get HIV from the clothing of an infected person and the group confirmed that they believed this. They also reported it was possible to get HIV from a toothbrush and drinking water from the same cup.
- In response to questions about how HIV could be prevented, focus group participants said they must avoid sexual relations, not take blood from others and not use instruments that have been used before. There was some awareness about getting tested for HIV in two focus groups, with one participant stating, “If you want to get married you should go to get tested for HIV.”
- Focus group participants frequently offered that they did not know how to protect themselves and requested information on how to prevent HIV. In some areas, focus group participants had heard messages about HIV on the radio but

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

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

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

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

responses indicate that the information provided was not comprehensive. In one focus group that included trained CHWs and TBAs, a participant said they learned that condoms prevent HIV/AIDS and they believed this. However, one

respondent interjected that condoms do not prevent against HIV/AIDS every time.

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

themselves against HIV.

- Despite a demand for condoms, condoms are not available to local Chadian staff. After discussions about reproductive health issues, local Chadian staff in several sites asked spontaneously for a supply of condoms from the assessment team. When an assessment team member provided condoms to someone and advised him to inquire in the clinic for more supplies, the nurse in this site later received several requests from male staff members and from refugee women for condoms. When asked, young refugee men said that condoms were not available to them anywhere, not even from the market. When asked what they did in this case they said, “We just take the risk.”
- Many partners still confuse “making condoms available” with “condom distribution and awareness raising campaigns.” One international organization received a request from local authorities to provide information on how to prevent HIV/AIDS. Instead of instituting MISP activities to prevent transmission of HIV/AIDS this organization was preparing for more comprehensive HIV/AIDS programming.

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

Condoms would probably melt here.

We need to concentrate on basic activities— not complicated activities like HIV.

Up until now we’re in an emergency situation ... and focused on the relocation process ... so we have not addressed the HIV issue.

We have asked questions about HIV several times and they really don’t know HIV/AIDS



Refugee woman and children at the Iridimi refugee camp.

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

Iridimi Camp Iridimi camp is located 7 kilometers northwest of the town of Iriba, which is inland from the northern Chadian border. Iridimi started as a transit center for refugees but with a population of over 5,000 refugees was being reconfigured as a permanent site during the assessment team’s visit. Adolescent boys participating in a focus group reported (while laughing) that when someone dies of AIDS, their body must be burned because it could infect others in the village. They said that they are worried about getting HIV/AIDS. To prevent HIV, they suggested not eating with someone who has HIV, not taking the infected person’s blood, not drinking the water or being near an infected person, not using their blanket. They do not know what a condom is and don’t know if people in this setting would use condoms. Sex education consists of teachers advising them not to have sex.

except that HIV is related to shaving, injections and sexual activity. We are at the point of doing the basic services now but we will do HIV at some point.

This issue of condoms has not been addressed yet. The population is very conservative.

PREVENT EXCESS NEONATAL AND MATERNAL MORBIDITY AND MORTALITY

- Most women reported delivering in their makeshift shelters or tents. However, in one camp setting, deliveries were reportedly taking place at the health facility. Clean birthing kits for pregnant women were not available in this setting, although many humanitarian actors stated their support and willingness to make the kits available. Focus group participants in Touloum camp explained that most women deliver babies in their tents and that there were seven midwives in the camp to assist them. The midwives had not received supplies. The partici-

pants further explained that if women suffer from complications of pregnancy or delivery the health agency's ambulance will transport them. However, the health agency's ambulance was not available in the evenings or at night so women may have to wait or go by donkey. Generally a mother or sister will accompany them.

- Refugee focus group participants and health agency staff reported that no supplies were provided to pregnant women; however, in two camp settings the community services organization provided a small gift package to mothers after they deliver that included a blanket, soap and infant clothing. Focus group participants, including some midwives, stated that TBAs and midwives did not receive any supplies to facilitate safe deliveries, although one health agency recruited two to four TBAs in the settings in which it worked and provided them with delivery kits. One agency, which had recently undertaken an assessment, identified clean delivery and TBA kits as a need and planned to seek a donation of RH kits from UNFPA. Another health agency was also seeking to order kits from UNFPA.
- Although the assessment team did not document any reports of maternal or neonatal deaths in camp settings, in spontaneous settlements in border areas both agencies and refugees reported a number of maternal and infant deaths. For example in Tine, women often delivered in their makeshift shelters with the assistance of TBAs and midwives who had no supplies, although some women accessed the clinic managed by an international NGO. If women suffered from complications of pregnancy or delivery, they sometimes went to the clinic or they may not have left the tent at all. Sometimes refugees in Tine hired a car to go to Iriba hospital. "You have to pay money for the car, if there is no money; women will stay here and die." Focus group participants said that four women had died over the past several months and that many babies had died. The refugees in Tine estimated 50 and not fewer than 30 children had died in the past three to four months, primarily from diarrhea. In Senette, there had been one maternal and one infant death. A 25-year-old woman and her infant had died four months earlier. The focus group participants did not know the cause but said that she had been seen at the clinic in

Birak and sent home afterward. She had four other children. In addition, focus group participants in Farachana said that two infants among ten families over a period of three months died while on the border and the mothers were not referred to Adré hospital.

- The "pregnancy risk-assessment" principle for preventing maternal deaths was still clearly followed by health providers interviewed. It was hard to convince clinicians that current expert consensus is that "every pregnancy is at risk," that most maternal mortality occurs at delivery, and that safe delivery care must have priority over antenatal care (ANC) in the acute phase of an emergency.
- Three of the five referral centers supported by international NGOs did provide comprehensive emergency obstetric care, while comprehensive emergency obstetric care was not available at the two national hospitals that lacked international support resulting in insufficient supplies and, sometimes, skills. Normal deliveries and some stabilization of patients can be done in national primary health care (PHC) settings. Only one of the NGOs so far had been effective in providing basic EmOC at the primary health care level, but often only during the day. Other NGOs had had difficulties locating and ordering appropriate supplies. UNFPA also was providing supplies to Iriba, Guerreda and Adré hospitals and would extend services to other referral centers (Abéché and Biltin) if additional supplies were available.
- Setting up an effective system for the transport of pregnant women with complicated deliveries to a referral facility was not systematic and was



Donkeys are sometimes used to transport women who are experiencing problems in childbirth.

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

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

In the same setting, one focus group participant made the following comment:

The baby who is breastfeeding is the only one who has what she needs.

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

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

The following comments from field staff underline the problems associated with providing timely EmOC to refugee women in Chad:

We have a presence every day, the main problem is that we have no presence at night

after 4:30 P.M.

The majority of our referrals are for emergency obstetric care.

A sensitization campaign [on the importance of referring women early for emergency obstetric complications] cannot begin until relocation to the camp is complete.

However...already there are five to six newborns. Women are delivering in their tents.

PLANNING FOR THE PROVISION OF COMPREHENSIVE REPRODUCTIVE HEALTH SERVICES

- Most agencies were planning for more comprehensive RH services, including doing more outreach activities to the refugee community, developing awareness campaigns and identifying and training health workers and staff.
- Some elements of more comprehensive services were put in place before the MISP. In particular, a number of health actors still believe that it is more important to have functioning antenatal care services, with pregnancy risk screening, in place before basic emergency obstetric care services.
- In particular, family planning (FP) services, STI management and planning for comprehensive HIV programming had not been addressed. However, one international NGO was treating STIs using the syndromic approach, according to the national protocol, which was developed in 1998 with the help of MSF-Belgium. Both international NGO and national clinic staff reported seeing regular cases of STI syndromes (mainly urethral discharge, occasionally genital ulcers). The rate at which these cases were seen varied from three cases per month to two cases per week. In the national health centers, treatment protocols were not available and knowledge of staff on treating STIs was limited.
- One humanitarian assistance provider inquired, “I would like to know if anyone is planning to address female genital mutilation in this setting.”
- Overall, there were a number of efforts to collect RH data but there was a lack of coordination among all humanitarian actors to facilitate standardized collection and reporting. For example, one international health NGO had its own data collection system, which included information on RH issues, and was revising its monthly data collection sheets to improve data collection coordination with the government’s health information system (HIS). Another international health NGO was also implementing an HIS. UNHCR was collecting some health statistics and was informed of births and deaths. In one spontaneous refugee settlement, data collection was initiated through CHWs on the number of live births, deaths and pregnant

women. A community services agency maintained a database and had collected population information including an overall census, skills, education level, health problems, vulnerability, conditions in Sudan compared to Chad, etc.

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

OTHER MISP-RELATED FINDINGS

General awareness and understanding of the MISP

- Of the 35 field staff queried from nine agencies, eight (22.8 percent) had heard of the MISP. Only two staff (six percent) from one agency could correctly define all or most of the objectives and activities of the MISP correctly and were aware that the MISP is a SPHERE standard.
- After the purpose and the components of the MISP were explained, some humanitarian actors agreed that the MISP is a necessary and feasible set of activities and that they were willing to contribute to facilitating its implementation. Others believed that MISP activities should not be implemented until the situation had advanced to a more stable phase.
- Many agencies believed that reproductive health activities must wait until the emergency situation became more stable.
- One agency coordinator thought that the MISP was feasible in closed camps, but not in a population in flux like in Tine.

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

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

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

MISP SUPPLIES

- Obtaining supplies to support the MISP early in the emergency was reported as a major problem by one international organization. According to this organization, RH kits were requested in November 2003 without a response. According to the UNFPA representative, in response to an order by the Special Representative of the Secretary General in January 2004, UNFPA secured RH kits which arrived by the end of February 2004. UNFPA began distribution of kits to one agency on March 10, 2004 and initiated discussions with at least one additional agency at that time. At the time of the delegation, UNFPA had kits 1-6 available in-country.
- The contents of the various kits with medical supplies (WHO NEHK-98, UNFPA RH Kits, UNICEF kits) and the differences among them were not clear to most humanitarian actors.
- One international NGO did understand that supplies to implement the MISP could be obtained from UNFPA and representing insightful creativity in securing essential materials noted, “You can make up your own supplies for example, obtaining condoms from the ministry of health or the United Nations Office for

Project Services (UNOPS).”

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

FUNDING ISSUES

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



Girl collecting wood in Touloum.

VI. LIMITATIONS

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

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

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

Given the urgency to undertake the assessment in the early days of an emergency, there was no opportunity to fully pre-test all of the assessment

tools. However, all of the tools were based on the Reproductive Health Response in Conflict (RHRC) Consortium's *Refugee Reproductive Health Needs Assessment Field Tools*, which have been widely used in refugee settings to conduct RH assessments, and were modified to focus on the priority RH activities outlined in the MISP and reviewed by the IAWG steering committee.

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

A limitation of the refugee community focus group discussions was that translation was initially challenged by the limited reproductive health knowledge of the interpreter and at times the need for discussions to be carried on through two interpreters. Furthermore, the discussion of sensitive issues with either women's or men's groups may have been hindered at various times by female interviewers and a male interpreter.

VII. CONCLUSIONS AND RECOMMENDATIONS

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

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

An RH focal point to coordinate a MISP response was not on the ground in this emergency and there

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

Reports of widespread rape in Sudan had not resulted in any concerted community outreach to identify and address the clinical management of women who had survived rape in Sudan and were new refugee arrivals in Chad. Although the assessment team only heard indirectly of two incidents of rape in Chad, there were clear risks for sexual violence, particularly for refugee women and girls living close to the border and others walking long distances from a camp and/or crossing the border back to Sudan for water and firewood. Although one international agency had reportedly established a comprehensive clinical management of sexual violence protocol, fully described at its base office

in N'Djamena, it was not available in the field at the agency-supported clinics. However, the agency field staff reported that they had clear guidelines for the medical documentation of incidents and would refer rape survivors to UNHCR and ICRC for related protection issues. Apart from this agency, there were no efforts to manage the consequences of sexual violence for women and girls.

With the exception of facilities supported by international organizations, national health facilities lacked adequate supplies and materials to practice universal precautions including blood transfusion screening. International NGOs appeared adequately supplied to practice universal precautions and provided on-the-job training for local staff. However, protocols, guidelines and monitoring mechanisms to ensure the practice of universal precautions were not available.

All focus groups included participants who reported significant fears about contracting HIV/AIDS and could cite some basic methods of HIV/AIDS prevention but also shared incorrect information about HIV/AIDS. Focus group participants readily offered their lack of knowledge about HIV/AIDS and expressed a desire to learn more and to protect themselves.

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

National health facilities lacked adequate equipment, supplies and skilled staff to ensure basic emergency obstetric care 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 centers supported by international NGOs did provide comprehensive emergency obstetric care while comprehensive emergency

obstetric care was not available at the two national hospitals that lacked international support.

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

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

The MISP objective to plan for the provision of comprehensive reproductive health services, integrated into primary health care, when the situation permits did not appear to be systematically approached. The two most active international organizations working in the health sector in this setting were providing commonly known components of comprehensive reproductive health care such as antenatal care, basic data collection and treatment of sexually transmitted infections. However, the agencies did not appear to be providing, or planning to provide, comprehensive reproductive care such as family planning or HIV/AIDS programming. Two additional international organizations preparing to provide an emergency response in this setting, shared program plans that were also more focused on incomplete comprehensive services integrated with primary health care than priority activities to prevent and respond to sexual violence, prevent the transmission of HIV/AIDS and to prevent excess maternal and neonatal morbidity and mortality in the early phase of the emergency.

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

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

AWARENESS AND UNDERSTANDING OF THE MISP

- An IAWG member agency should develop a distance-learning module on the MISP to be made available on the Internet and CD-ROM to UNFPA staff, humanitarian actors and donor representatives. All should be encouraged to complete the module, including training on the RH Kits, and receive a certificate of completion.
- IAWG member agencies should conduct short training sessions among existing UNFPA and humanitarian staff, including information on where to obtain supplies and the differences and similarities among the various kits: UNFPA RH Kits, WHO New Emergency Health Kits (NEHK) and UNICEF Kits. All kits should refer to other kits with a description of each kit's objectives and how each kit is complementary to the others. Kit contents and ordering information should be available on UNFPA and other agency websites.
- Humanitarian agencies should develop generic emergency response proposals that include the MISP SPHERE standard so proposals can be quickly generated when an emergency occurs. (See Appendix 8 for an example.)
- UN country teams (UNCT) should assure that proposals included in the Consolidated Appeal Document (CAP) for their country address all components of the MISP in a coordinated manner.

- Donors should evaluate all proposals for multi-sectoral (site-planning, community services, water and sanitation, health sectors) activities ensuring MISP interventions, including the protection of women from sexual violence, and compliance with SPHERE standards.
- Donors should integrate MISP SPHERE standard in donor field operations manuals and in the curriculum of emergency preparedness training courses.
- International nongovernmental organizations should identify an RH Focal Point in each site for coordination of the MISP and allocate funds to support MISP activities in all settings and ensure coordination with national governments.
- When time permits, agencies should undertake contingency planning to implement reproductive health by training and placing staff and pre-positioning supplies in the region.

IDENTIFY ORGANIZATION/INDIVIDUAL TO FACILITATE COORDINATION AND IMPLEMENTATION OF THE MISP

- UNHCR or other lead agency where UNHCR is not present, should ensure that health coordination is in place and appoint an RH focal point (an agency or person, can be combined with the overall focal point role to provide overall coordination) early in the emergency. This role could be delegated to one of the health-implementing partners.
- UNFPA should receive emergency response funding to second a staff member to UNHCR for the first few weeks of the emergency to facilitate ordering and distribution of the RH kits.
- UN agencies and implementing partners should maintain a network of experienced RH health coordinators and an adequate budget to release staff to work in emergencies to initiate RH coordination, when needed.

PREVENT AND MANAGE THE CONSEQUENCES OF SEXUAL VIOLENCE

- UNHCR, the Chadian government and international donors should immediately increase their capacity to open more camps in Chad and relocate refugees living in spontaneous settle-

ments on the dangerous borders areas to established camps to address the protection needs of refugees.

- UNHCR and implementing partners should assure that female protection officers are available in all camp and non-camp settings and all humanitarian actors should be informed about the responsibilities of this individual.
- All agencies should seek gender balance in staffing for the emergency.
- All agencies should identify an individual whose job description includes agency- or sector-relevant activities that support the systematic protection and participation of refugees, particularly women and children.
- All agencies should consult refugee women and women's groups in camp and non-camp settings about their safe access to water, firewood, latrines, health care and other issues such as registration and food distribution.
- UNHCR should issue all women—not only female-headed households—their own registration cards.
- All agencies working in the health sector should make adapted protocols and supplies for the clinical management of rape survivors available to humanitarian actors and national health providers as early as possible in all clinic settings. Specific documents include: *Clinical Management of Rape Survivors* (WHO/ UNHCR, 2002) and *Guidelines for Prevention and Response: Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons* (UNHCR, 2003). Post-rape management supplies and resources include emergency contraception, HIV/AIDS post-exposure prophylaxis and STI drugs.
- UNHCR should inform all agencies and the refugee community where to report incidences of sexual violence and access available services.
- Humanitarian actors should undertake an information campaign to inform the community, e.g., refugee leaders, women's groups, health workers (CHWs, TBAs, midwives) about the urgency of and the procedure for referring survivors of sexual violence.
- All agencies should develop a code of conduct, including on issues of sexual abuse, inform staff

and potential staff, and include the code in all the contracts to be signed by both expatriate and local staff. UNHCR's code of conduct can be used as a model. A trained focal point for reporting should be appointed in each setting.

REDUCE THE TRANSMISSION OF HIV

- Agencies working in the health sector should support national referral level structures early in the emergency, including provision of sufficient supplies, protocols and equipment to ensure adherence to universal precautions.
- All agencies working in the health sector should regularly monitor the use of protocols and availability of supplies.
- All agencies should make condoms available to humanitarian staff and refugees, even when working with “conservative” populations. Condoms can be made available at registration and distribution of food and non-food items, at clinics, from community health/outreach workers, traditional birth attendants, camp managers, etc.
- All humanitarian actors should be reminded of the difference between “making condoms available” and “condom distribution and awareness raising campaigns” in early coordination meetings to ensure that scarce time and resources are used most efficiently on priority activities during the early days of an emergency.

PREVENT EXCESS NEONATAL AND MATERNAL MORBIDITY AND MORTALITY

- IAWG member agencies should undertake widespread awareness raising among all humanitarian actors to ensure the distribution of clean delivery kits to all visibly pregnant women as early as at pre-registration or screening. Also, encourage actors to consider local procurement of kit supplies and involving women to assemble and distribute the kits.
- Agencies working in the health sector should identify TBAs and local midwives in camp and non-camp settings and nurses/midwives at the clinic level to assess and address their supply needs while informing them about the emergency obstetric referral system.
- Agencies working in the health sector should

assess and support the equipment, supply and staffing needs of the referral hospital to ensure the provision of comprehensive emergency obstetric care services for both the refugee and host population.

- All humanitarian agencies responding to the emergency, including national authorities, should work together to improve the referral level and ambulance systems ensuring that emergency transport to the referral hospital is available 24 hours per day, seven days per week.
- Agencies working in health and community services sectors should undertake an information campaign to inform the community, e.g., refugee leaders, women's groups, health workers (CHWs, TBAs, midwives) about the urgency of and the procedure for referring women who suffer from complications of pregnancy or delivery.

PLANNING FOR THE PROVISION OF COMPREHENSIVE REPRODUCTIVE HEALTH SERVICES

- All agencies working in health and community services sectors should plan for comprehensive RH services with the involvement of refugee women, men and youth to include management of sexually transmitted infections, family planning and gender-based violence programming.
- The RH focal point should collaborate with the health coordinator to assure that reproductive health data is collected in a standardized manner, collated, analyzed and shared at regular health/reproductive health coordination meetings to ensure coordinated planning and appropriate response.
- The RH focal point should organize training of staff to implement comprehensive reproductive health services as soon as possible.
- In planning for comprehensive RH services, STI management should be a priority and national STI treatment protocols should be assessed and upgraded if necessary.
- Agencies working in health should integrate comprehensive family planning services into the primary health care level as soon as routine supply management is functional and needs and staff skills have been assessed and upgraded if necessary.
- All agencies should collaborate to implement

comprehensive gender-based violence programming that addresses the protection needs of refugees, particularly with regard to safe access to water and firewood for women and girls, as well as plans to assess and respond to female genital mutilation.

- All agencies should engage youth in community protection issues, awareness campaigns and planning for services in the community.

SUGGESTIONS FROM AGENCIES WORKING IN CHAD FOR IMPROVING IMPLEMENTATION OF THE MISP

- Agencies ordering supplies should combine orders for WHO and UNFPA kits to facilitate logistics of ordering and delivery.
- UNHCR field offices should facilitate communication with UNFPA for RH kits and WHO for the NEHK. Establish communication between UNHCR and UNFPA country offices on how to prepare for emergencies to ensure RH kits are readily available.
- Due to the 600-kilometer border area, RH coordination meetings should be organized geographically to facilitate communication among agencies.
- Appoint a UN RH coordinator in the earliest days of the emergency and ensure a stock of MISP supplies are on the ground as soon as possible in an emergency.
- Recruit Chadian personnel to maintain and improve staff skills in the host country and conduct more training on RH in emergencies in national training curriculum.
- Provide information on sexual violence and emergency obstetric referral care to all refugees at registration.
- Organize training sessions on basic RH issues and HIV awareness for all staff.
- Provide each camp manager a supply of condoms to make available to refugees and agency staff wherever feasible.
- Tetanus vaccination for pregnant mothers should be one of the first things to be implemented once the situation moves from the emergency to a more stable phase.

VIII. ENDNOTES

1. MISP Fact Sheets in English and French are available on the RHRC Consortium website www.rhrc.org.
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7. United Nations Population Fund, *Country Profile - Chad*, 2004, <http://www.unfpa.org/profile/chad.cfm>
8. World Health Organization, *Chad - Statistics*, 2004, <http://www.who.int/country/tcd/en/>
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10. US Committee for Refugees, *World Refugee Survey 2003 Country Report*, 2003.
11. *Ibid.*
12. UNFPA, *Women Suffer Brunt of Conflict in Western Sudan*, UNFPA Warns, May 6, 2004, <http://www.unfpa.org/news/news.cfm?ID=447>
13. United Nations High Commissioner for Human Rights, *Situation of human rights in the Darfur region of the Sudan*, May 7, 2004.
14. UNFPA, *Women Suffer Brunt of Conflict in Western Sudan*, UNFPA Warns. May 6, 2004. <http://www.unfpa.org/news/news.cfm?ID=447>
15. World Health Organization. *Chad: Core Health Indicators*. 2001. <http://www3.who.int/whosis/country/indicators.cfm?country=tcd>
16. UNFPA. *Recognizing the needs in Chad*, nd. http://www.unfpa.org/fistula/docs/eng_chad.pdf
17. *Ibid.*
18. UNFPA, *Proposed Projects and Programmes - Sudan*, 2001, <http://www.unfpa.org/arabstates/sudan/2sud0206.doc>
19. A January 2004 exploratory mission by Action Against Hunger (AAH) noted that at the time of their visit nutritional issues were not a pressing issue but food security was a major concern despite a good harvest year in Chad. Based on a lack of transport capacity and that the area could not cope with a large influx of refugees, AAH predicted a hunger gap would start in May.
20. The purpose of a code of conduct is to prevent sexual exploitation and abuse in humanitarian crises. A code of conduct is intended to serve as an illustrative guide for staff to make ethical decisions in their professional lives, and at times in their private lives. Humanitarian staff are responsible for promoting respect for fundamental human rights, social justice, human dignity and respect for the equal rights of men, women and children. While acknowledging that local laws and customs differ from one country to another, a code of conduct is based on international legal standards.

IX. APPENDICES

APPENDIX I: ASSESSMENT TEAM CONTACT INFORMATION

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APPENDIX 3: MISP ASSESSMENT TOOLS:

- A) SEMI-STRUCTURED FIELD STAFF INTERVIEW QUESTIONNAIRE
- B) FOCUS GROUP DISCUSSION GUIDE FOR REFUGEE COMMUNITY INTERVIEWS
- C) OBSERVATIONAL RESOURCE AND SERVICES CHECKLIST
- D) ASSESSMENT SITE BASIC INFORMATION FORM

APPENDIX 3: MISP ASSESSMENT TOOLS:

A) SEMI-STRUCTURED FIELD STAFF INTERVIEW QUESTIONNAIRE

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

COMPONENT 4:

DETERMINE AVAILABILITY AND QUALITY OF THE EMERGENCY RESPONSE (MISP) TO RH NEEDS

FIELD STAFF INTERVIEWS

- Regional and Country Directors, Health and RH Program Coordinators and Managers -

Site information

Date: _____

Interviewer: _____

Interviewee Name: _____

Position: _____

Organization: _____

Contact information: _____

Date began working with this organization: _____

Major Responsibilities: _____

Other Staff

Job title	Female or Male	International or National	Training

MISP Objectives, Activities, Supplies and Funding

- 1) Have you ever heard of the Minimum Initial Service Package (MISP) for reproductive health (RH)?

How did you learn about it?

- 2) What is your understanding of the objectives of the MISP?
- 3) What are the priority activities of the MISP?
- 4) Where would you obtain supplies to support implementation of the MISP?
- 5) Have you sought funding to implement the MISP? If so, from what source? Results? If not, why not? e.g., sought funding for any components of RH? Which donors/own organization? Results?

Identify organization/individual to facilitate coordination & implementation of MISP

- 6) Are there RH coordination activities in this setting? When did these activities begin, i.e., how soon after the first influx of refugees to this setting?
- 7) Is there a focal point in your organization for RH? How soon after the first influx of refugees to this setting was a RH focal point in place?

Title:

Is there a lead agency addressing RH?

Name of Organization:

Is there an RH focal point in this lead agency?

Name:

Is there an RH focal point in each camp? How soon after the first influx of refugees/IDPs was the focal point in place?

- 8) Are there RH coordination meetings in this setting? When did they start?
How often do they meet?

Is there a TOR for the meetings and/or meeting minutes?

- 9) Are there health coordination meetings in this setting? How often?

Other RH-related coordination meetings, e.g., GBV? HIV/AIDS?

Is there a TOR for the meetings or minutes from the meetings?

Prevent and manage the consequences of sexual violence

- 10) What sexual violence protection measures are in place? How soon after the first influx of refugees/IDPs were the measures put in place and were any problems encountered?

- 11) Is there a staff Code of Conduct in place? Reporting focal point and mechanisms?

- 12) Have refugee women and women's groups been consulted in site planning (water, latrines, access to health care) and other camp management, e.g., registration, food distribution?

- 13) Are women issued their own registration cards?

- 14) Are there special protection measures in place for female-headed household, widows, and unaccompanied children in the camp?

- 15) Are there female protection officers and guards?

16)

Sexual violence services, resources and protocols	Yes	No	Notes (when were services started?)
Are services in place to provide clinical care and psychosocial support for survivors of sexual violence? - detailed history - general physical exam - assessment of psychological trauma - gynae exam - tests/investigations (e.g., vaginal swab, pregnancy test) - treatment (e.g., STI treatment, emergency contraception)			
Is there a standard protocol for clinical care of survivors of sexual violence?			
Resources available?			
Staff aware of importance of early referral of survivors? Are TBAs aware?			
Female health workers to provide exam?			
Is PEP available?			
STI care - diagnosis? prophylaxis?			
Care for injuries?			
Psychosocial services?			
Are staff aware of relevant local laws regarding emergency contraception and abortion (what circumstances, e.g., only in cases of rape, etc.)?			

Reduce HIV Transmission

17) Are services in place to reduce the transmission of HIV/AIDS? If so, what are they?

Are condoms freely available and visible? Where are they (clinics, bars, latrines, NGO offices)?

Current supply?

Stock-outs or other supply issues?

How soon after the first influx of refugees/IDPs were the services put in place and were any problems encountered?

Are universal precautions practiced, e.g., protocols and monitoring mechanism for disinfection and sterilization of equipment; convenient hand washing facilities and safe waste disposal systems/availability and use of gloves?

How soon after the first influx of refugees/IDPs were the services put in place and were any problems encountered?

Is blood screened for HIV? How soon after the first influx of refugees/IDPs were the services put in place and were any problems encountered?

What is your system for obtaining and testing blood? Do you have access to sufficient IV fluid for patients?

Prevent excess neonatal and maternal morbidity and mortality

18) Are services in place to prevent excess neonatal and maternal morbidity and mortality?

19) Are clean delivery kits available? Stock - stock issues? What supplies are included in the kits?

Where did they come from, e.g., locally procured/assembled or ordered from?

Are they provided to all pregnant women? TBAs? How are they provided?

(Note: Condoms and clean delivery should be available at the intake point/transit center where people register for their ration cards.)

How many have been distributed?

20) Have midwives been identified representing all ethnic groups? How many?

Are midwife delivery kits available? Stock - stock issues?

Where did they come from?

Have the supply needs of the midwives been assessed and addressed?

Have midwives been provided with information about the urgency of referring women who have survived sexual violence or are in need of emergency obstetric care?

How soon after the first influx of refugees/IDPs were the services put in place and were any problems encountered?

21) Is basic emergency obstetric care (EmOC) available? Location and distance?

Services Available	Yes	No	Notes (when were services started?)
Basic EmOC			
1. Administer parenteral antibiotics			
2. Administer parenteral oxytocic drugs			
3. Administer parenteral anticonvulsants for pre-eclampsia and eclampsia			
4. Perform manual removal of placenta			
5. Perform removal of retained products			
6. Perform assisted vaginal delivery			
Comprehensive EmOC (Basic plus)			
7. Perform surgery (Caesarean section)			
8. Perform blood transfusion			

22) Is comprehensive emergency obstetric care (EmOC) available?

Location and distance? Transport vehicles 24/7? Communication? Drivers 24/7?

Problems with emergency transport?

23) Have the needs of the referral hospital to ensure the provision of EmOC services been assessed? (Staff including MD and Anesthesiologist 24-hour coverage, running water, electricity, equipment, supplies, data collection) Addressed?

What follow-up is conducted of women referred?

What data is collected on women referred for complications of pregnancy and delivery?

What is the site-specific emergency referral system? Is there 24/7 coverage?

24) Has an information campaign been undertaken to inform the community, e.g., refugee leaders, women's groups, health workers (CHWs, TBAs, midwives) about early referral of women who have survived sexual violence or who suffer from complications of pregnancy or delivery about how to access the system?

Plan for the provision of comprehensive RH services

- 25) What steps have been taken to plan for the provision of comprehensive RH services integrated with primary health care services?
- Data Collection
 - Sustainable equipment and supplies
 - Staffing
 - Training
 - Family Planning
 - STI including or and HIV/AIDS prevention and care
 - GBV prevention and care (Ask specifically about plans to address FGM)
 - Safe Motherhood
 - Reproductive health for young people

Participation, Recommendations and Awareness

- 26) Are there any activities to involve refugee women, men and adolescents to implement the MISP?
- 27) What are your recommendations to improve timely implementation of the MISP in new emergency settings?
- 28) Are you aware that the MISP is now a SPHERE minimum standard in health care? Are you aware that some donors such as the Bureau for Population, Refugees and Migration have included language in their cooperative agreements that encourages NGOs to use SPHERE Standards as a basis for design, implementation and evaluation in proposals, including proposed objectives and indicators?

APPENDIX 3: MISP ASSESSMENT TOOLS:

**B) FOCUS GROUP DISCUSSION GUIDE FOR REFUGEE
COMMUNITY INTERVIEWS**

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

COMPONENT 4:

DETERMINE AVAILABILITY AND QUALITY OF THE EMERGENCY RESPONSE (MISP) TO RH NEEDS

REFUGEE COMMUNITY INTERVIEWS

- women, men, youth - leaders, TBAs, CHWs -

Date: _____

Facilitator: _____

Translator: _____

Note Taker: _____

Participants: _____

Introduction

I am interested in learning about your views on health services in this camp/village. I would like to ask your permission to interview you and other people in your community about health care and other issues that may be related to health care, especially reproductive health. If you prefer not to answer certain questions, please feel free to keep silent. This information will be used in evaluating reproductive health services, and shared publicly with the aim to educate others about reproductive health service needs. It is important that you understand that the information that we gather in this discussion will be treated with the utmost confidentiality. This means that your name will not appear in any documents. I expect our talk to last about an hour. Do I have your permission to begin?

Living conditions and health services

First, I would like to ask you some general questions about your living conditions and about health services.

1. What are the most important concerns about the situation of the people (men, women, youth) in the camp at this time? (security, food, water, shelter, health care) What do you think should be done to help the situation?

2. What health services are available in this camp/area? Where are they located? How did you learn about these health services?

3. Were the services available when you arrived in this camp/area? If no, how soon after your arrival in this camp/area were the services made available?

4. What times are the services open?

5. Who provides the services? (doctors, nurses, midwives, refugee workers, others, etc.)

6. Do you have to pay for the services? If yes, what do you have to pay for and how much? (e.g., consultation/visit, medicines, etc.)

7. Do you use the services you have mentioned? If yes, are you satisfied with the services? If no, why don't you use them? (e.g., not open at right time, don't like the service providers, don't have money to pay for the services, no privacy/confidentiality, no medicines, cultural reasons, etc.)

Prevent excess neonatal and maternal morbidity and mortality

Now, I'd like to ask questions about women having babies in this camp.

8. Where do women generally have their babies in this camp? Who stays with them while they are in labor?

9. What do they do if a woman is having a problem with the delivery where does she go and who goes with her? What happens if a woman must go to the hospital? How does she get there and who goes with her?

10. Do pregnant women and/or TBAs get any supplies for a clean delivery? What supplies do they get and from where? How do women learn about these supplies?

Are the supplies available to women when they arrive in the camp/area? If no, how soon after arrival in the camp/area are the supplies available? Do the supplies ever run out?

11. What kind of health workers do pregnant women see? (doctor, nurse, midwife, TBA, traditional healer)

12. Since coming to this camp/area, do you know women who have died while having a baby? or their babies died? Do you know why they died?

Reduce transmission of HIV

Now I'd like to talk about HIV/AIDS for a few minutes.

13. Have you heard of HIV/AIDS? What do you know about HIV/AIDS? Do you know of people who have AIDS?

14. Are people in this setting worried about getting AIDS? What do they do to prevent it?

15. Are there places to get condoms in this camp? Where? Do you have to pay for them? How did you learn about where to get condoms? Were they available when you arrived in this camp/area?

If no, how soon after your arrival in this camp/area were condoms made available? Are there always enough condoms? Is everyone (married, unmarried, women, men, adolescent girls, adolescent boys) allowed to access condoms?

Prevent and manage the consequences of sexual violence

We have heard that sometimes women, girls and boys are at risk of sexual violence.

16. Have you heard of this happening? Who do you think may be at most risk for this? Where does it happen?

17. Who collects water for the household and where do they go to get water? How far is it? Is it safe? Is there enough food? Is it difficult for women to get food?

Who collects firewood and where do they go to get it? Are women and children safe from physical attack (including rape) when they go to get water, firewood, food, use latrines, or go to a health service?

18. What has been done (e.g., what safety measures have been put in place, what measures have been taken against perpetrators of sexual violence, if any) in this camp/area to help keep women and children safe from physical attack including sexual violence? How soon after your arrival in this camp/area were these safety measures put in place? Are there some people who are particularly at risk of sexual violence? ?

19. Are there many women and young girls here without their partners or that are heads of household? Who protects them? Are there many children and adolescents here without their parents? Who takes care of them?

20. Are men and/or adolescent boys in the camp/area violent toward women and/or adolescent girls?

Are there health services in the camp/area that women and or adolescents who have been raped can use? What are they? (e.g., physical care, counseling, medicines, emergency contraception) If yes, who provides the services? (male or female health care workers)

How did you learn about these health services? Were the services available when you arrived in this camp/area? If no, how soon after your arrival in this camp/area were the services made available?

One last question...

21. Are you satisfied with the services that we have talked about? If not, how could they be improved? Are there other health services that you would like to have in this camp? What are they? Which are the most important?

Thank you for your time. I have learned quite a bit about your health concerns and views on health services. This information will be helpful in our work in evaluating the services. Your contribution is greatly appreciated.

APPENDIX 3: MISP ASSESSMENT TOOLS:

C) OBSERVATIONAL RESOURCE AND SERVICES CHECKLIST

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

**COMPONENT 4:
OBSERVATIONAL AND RESOURCE CHECKLIST**

SITE:

POPULATION NUMBER:

FACILITIES VISITED:

DATE:

COMPLETED BY:

Site:

Date:

A. Identify an organization(s) and individual(s) to facilitate the MISP

- o An organization(s) and individual(s) to facilitate the coordination and implementation of the MISP is in place
- o Resources available at coordination level
 - Reproductive Health in Refugee Situations: An Inter Agency Field Manual, UNHCR/UNFPA/WHO.
 - Reproductive Health During Conflict and Displacement: A Guide for Program Managers. WHO, 2000.
 - Refugee Reproductive Health Needs Assessment Field Tools, RHR Consortium, 1997.
 - Sexual Violence against Refugees: Guidelines on Prevention and Response, UNHCR, year:.....
 - Guidelines for HIV in Emergency Situations, UNAIDS, 1996.
 - Guidelines on HIV/AIDS Interventions in Emergency Settings, IASC 2003.
 - The Reproductive Health Kit for Emergency Situations, UNFPA/IAWG, year:
 - The Reproductive Health Kit (CD-ROM), UNFPA, version:
 - Others, please list: _____

Notes:

Site:

Date:

B. Prevent and manage the consequences of sexual violence

- o Systems to prevent sexual violence are in place
 - Secure location of water points, average distance to communities:
 - Secure location of latrines, number of latrines/population:.....
 - Health posts, schools and clinics are in secure locations
 - Fire wood collection arrangements are safe
- o Health service able to manage cases of sexual violence

1. Protocol	Available
Written medical protocol in language of provider	
2. Personnel	Available
24-hour (on-call) service available	
List staff working in SV care, function, gender, speaks local language	

3. Furniture/setting	Available
Room (private, quiet, accessible, with access to a toilet or latrine)	
Examination table	
Light, preferably fixed (a torch may be threatening for children)	
Access to an autoclave to sterilize equipment	
4. Supplies	Available
Speculum	
Tape measure for measuring the size of bruises, lacerations, etc.	
Supplies for universal precautions (gloves, box for safe disposal of contaminated and sharp materials, soap)	
Sterile medical instruments (kit) for repair of tears, and suture material	
Needles, syringes	
Cover (gown, cloth, sheet) to cover the survivor during the examination	
Sanitary supplies (pads or local cloths)	
5. Drugs	Available
For prophylactic treatment of STIs as per protocol	
For post-exposure prophylaxis of HIV transmission (PEP)	
Emergency contraceptive pills	
Emergency intrauterine device (IUD)	
Access to tetanus vaccination	
Access to Hepatitis B vaccine	

5. Drugs (continued)	Available
Pain relief (e.g., paracetamol)	
Local anaesthetic for suturing	
Antibiotics for wound care	
6. Administrative supplies	Available
Medical chart with pictograms	
Forms for recording post-rape care	
Consent forms	
Information pamphlets for post-rape care (for survivor)	
Safe, locked filing space to keep confidential records	

Notes:

C. Reduce HIV transmission:

- o Condoms are available Male Female
 - For free at registration
 - For free at food distribution
 - For free at clinics
 - For sale on markets or in shops
 - Condom use leaflets are supplied
 - Other, please list: _____

- o All health services have sufficient supplies for universal precautions against HIV (fill this out for each health setting and for vaccination activities)
 - Disposable needles and syringes
 - Single-use syringes
 - Sterile surgical gloves, disposable
 - Examination gloves
 - Face masks, glasses and aprons in the Operation Theatre
 - Hand soap
 - Antiseptic fluid to wipe work surfaces
 - Protocols for universal precautions are in place
- o Staff is complying with universal precautions
- o Safe waste disposal systems are available and functioning
 - Functioning and used autoclave or “pressure cooker” sterilizer
 - Instructions for sterilizing by pressure cooker and autoclave
 - Reliable supply of electricity or fuel
 - Timer
 - Indicator strips
 - Safety boxes/burn-boxes for sharps disposal
 - Functioning and used incinerator
 - Waste pit, fenced off
- o Blood transfusion is safe
 - Blood transfusion services are available 24 hours
 - Protocols for the safe and appropriate use of blood are in place
 - Referral level has sufficient supply of IV fluids, giving sets and IV needles

Blood transfusion supplies	Available
Blood-group Test, anti A	
Blood-group Test, anti A + B	
Blood-group Test, anti B	
Rhesus Test, anti D	
HIV Test 1 + 2, test kits	
HBsAg rapid test	
HCV rapid test	
RPR test	
Microcentrifuge, hematocrit (Battery/mainstream) + Transformer	
Capillary Tube for hematocrit per microcentiliter (9 microliter)	
Cuff for pressure, for bag 500/1,000ml	
Battery, R14, C, alkaline, 1.5V, 26 x 50 mm	
Blood-bag + CPD, (citrate de sodium, phosphorus hydrogen, dextrose), 250ml	
Blood IV-set	

Notes:

C1: Not in MISIP

- o Syndromic STI treatment is prescribed
 - Genital ulcers
 - Urethral discharge
 - Vaginitis/Cervicitis
 - Syndromic treatment protocols are in place

D. Prevent excess neonatal and maternal morbidity and mortality

- o Clean delivery kits are provided to all pregnant women
 - At registration
 - At non-food distribution
 - At clinics
 - Other, please describe

- o Clean delivery kits are provided to birth attendants
- o Basic Emergency Obstetric Care is available

Level at which BEOC is available	health centre/referral hospital
IV/IM antibiotics	
IV/IM oxytocics	
IV/IM anticonvulsants for pre-eclampsia and eclampsia	
Manual removal of placenta	
Assisted vaginal delivery	
Removal of retained products	
List staff who provides BEOC 24/7	Available
Protocols	Available
Partographs	
Labor and delivery records	
Newborn records	
Referral forms	
Guidelines for Management of women with pre-eclampsia and eclampsia	
Leaflet on treatment of incomplete abortion	
Manual vacuum aspiration Guide for Clinicians	
Clinical Management of Abortion complications: a practical guide, WHO, 1997	
Protocol for Reusing MVA IPAS Instruments	
Information leaflets for women	
General equipment	Available
Sphygmomanometer, Aneroid 300mm with cuff	
Stethoscope, Binaural Complete	
Stethoscope, foetal, pinard	
Basin Kidney, 825ml Stainless steel	
Thermometer, Clinic Oral/Rectal Celsius/Fahrenheit (easily readable)	
Surgeon's Hand Brush, white nylon Bristles	

Utility Aprons, 900 mm x 1m, opaque Plastic	
Sheeting Plastic Clear PVC 90 cm x 180 cm	
Tourniquet, latex rubber, 75 cm	
Drugs (estimated amount for 30 000 population for 3 months)	Available
Atropine sulphate injectable (100)	
Paracetamol (oral) or acetylsalicylic acid (oral) or other oral pain relief (500)	
Amoxicillin oral (5000)	
Doxycycline (1000) or tetracycline (2000) oral	
Metronidazole oral (4100)	
Ampicillin injectable (10)	
Gentamycin injectable (10)	
Metronidazole injectable (10)	
Tetracycline eye ointment (6)	
Oxytocin, 10 IU/ml (150, kept in cold-chain)	
Ergometrine injectable	
Ergometrine, oral	
Diazepam, injectable (10)	
Magnesium Sulfate, injectable (10)	
Calcium Gluconate, injectable (5)	
Xylocaine or lidocaine injectable (70)	
Crystalloid IV fluids + IV infusion set (350 l)	
Plasma-expander + IV infusion set (10 l)	
Water for injection (50)	
Bleach Solution or NaDCC tabs (200 l)	
Chlorhexidine Solution (Hibiscrub) (3 l)	
Chlorhexidine solution 5% (25 l)	
Povidone iodine sol 10% (2l)	
Urinary Protein Test Strips (150)	
Disposable equipment	
Tape, Umbilical non-sterile 3mm wide x 100mm spool	
Catheter, Female Urethral, disposable 12FR	
Extractor, mucus, 20 ml, sterile, disposable	
Suction catheter CH10-12, sterile, disposable, conical tip	
Syringe 50ml, plastic, conical tip	
Gauze-pads, sterile (2000)	
Canula IV 20G (25)	

Tape, adhesive tape, 10 rolls, 2 cm x 5m	
Envelope, plastic (for drugs/tabs distribution)	
Delivery set	
Scissors, cord cutting, Busch, curved or flat, 160mm (baby)	
Scissors dissect Curved Mayo 170mm B/B SS (mother)	
Forceps, tissue, spring type 1 x 2 teeth, 150mm	
Instrument Box, stainless steel, 18 x 8 x 4 cm	
Assisted vaginal delivery	
Vacuum extractor, complete	
Spare bottle	
Suture set	
Scissors dissect Straight Mayo 170mm B/B SS	
Holder Needle straight Mayo HGR 160mm	
Tissue Forceps, spring-type 1 x 2 teeth, 150mm	
Retractor vaginal Doyen medium blade	
Speculum, vaginal, bivalve, Graves, small SS	
Speculum, vaginal, bivalve, Graves, medium SS	
Speculum, vaginal, bivalve, Graves, large SS	
Forceps sponge-holding straight 200mm	
Instrument Box, stainless steel, 20 x 10 x 3 cm	
Suture material	
Suture, synth, absorb, DEC4 (1), needle 1 /2 , 36 mm, tri (70)	
Suture, synth, absorb, DEC3 (2/0), needle semi-circled 3/8, 30 mm, round (70)	
Suture Chromic absorbable 0/0 , needle semi -circled - (70)	
Vaginal lubricant jelly/exploration gel	
Lighting	
Frontal lamp, with adapter for 4 batteries R6	
Battery, dry cell, R6, Alkaline, 1.5V, (14 x 50mm)	
Kerosene Storm-lamp + extra socks	
Equipment for removal of retained products of conception	
Double valve syringes	
Replacement double valve set	
Canula Flexible 6mm sterile disposable	
Canula Flexible 7mm sterile disposable	
Canula Flexible 8mm sterile disposable	
Canula Flexible 9mm sterile disposable	
Canula Flexible 10mm sterile disposable	

Canula Flexible 12mm sterile disposable	
Set of adapters	
15ml bottles of silicone	
Denniston dilators, set of 5, IPAS double-ended, tapered, 3 mm-14mm range	
and/or	
Curette Gordet, 12 cm, blunt, MED 7812	
Curette Simon, 6 mm, blunt, MED 7807	
Curette Cuzzi, 17 mm, blunt, MED 7813	
Dilator, Hegar, simple, set of 8, covering a range of 4 mm - 18 mm	
General equipment	Available
Forceps, Cheron dressing, 25 cm, straight, MED 7317	
Forceps, Muzeux, 24 cm, jaw 10 mm, MED 7459	
Gallipot, 8 cm, stainless steel, 100ml	
Probe, uterine, Sims, MED 7105	
Retractor, Doyen, 85 x 45 mm, straight, MED 7065	
Speculum Collin, 35 mm, 100 mm MED 7034	
Speculum, Jayle, with detachable weight	
Box instrument, stainless steel, 40 x 20 x 10 cm	

Notes:

D1: Not in MISP

- o Family Planning methods are available
 - Combined oral contraceptives
 - Progestin-only oral contraceptives
 - Injectable contraceptives
 - Condoms
 - IUD/implants

- o Comprehensive Emergency Obstetric Care is available, supply checklist for referral level

Box, abdominal instruments (MSF: KSURBABD42-)	Available
Box, instrument, stainless steel, 40 x 20 x 10 cm	
Clamp, towel, Backhaus, 10,5 cm	
Forceps, artery, Bengolea, 20 cm, curved cross serr.	
Forceps, artery & tissue, Chaput, 14 cm, 2 x 3 teeth	
Forceps, artery, Crafoord (Coller), 24cm, curved	
Forceps, artery Kelly, 14cm, curved	
Forceps, artery, Halsted-Mosquito, 12,5cm, curved	
Forceps, artery Kocher, 14cm, straight, 1 x 2 teeth	
Forceps, artery, Mixer, 23cm, delicate	
Forceps, dressing, standard, 14,5 cm, straight	
Forceps, dressing, standard, 25 cm, straight	
Forceps, intestinal, Doyen, 23 cm, curved	
Forceps, peritoneal, Faure, 21 cm, slightly curved	
Forceps, tissue grasping, Duval, 23 cm, jaws 20mm	
Forceps, tissue, standard 14,5cm, 1 x 2 teeth, straight	
Forceps, tissue, standard 25 cm, 1 x 2 teeth, straight	
Gallipot, 500ml, 12cm, stainless steel	
Needle holder, Mayo-Hegar, 18cm, standard pattern	
Retractor, abdominal Collin, 110mm bla., 80 x 38 65 x 55mm	
Retractor, abdominal Gosset, 2 blades 55mm, op.115mm	
Retractor, abdominal Rochard Fixation unit 19cm foldable	
Retractor, abdominal Rochard, 115 x 65 mm, 28 cm	
Retractor Farabeuf, double ended, 15 cm, pair	
Scalpel handle, n°4, standard	
Scissors, Metzemaum, curved, 18 cm	
Scissors, Nelson (Mezemaum), curved, 23 cm	

Scissors, Mayo, 17 cm, curved	
Scissors, Mayo, 23 cm, curved	
Spatula, Ribbon retractor, malleable, 27 x 25 cm	
Nozzle suction, 28 cm, Yankauer, chrome plated	
Suction tube, 22,5 cm, 23 French Gauge	
Round-bodied needles n°12, size 6 (packed of 12)	
Triangular point suture needles, 7,3 cm, size 6 (packed of 20)	
Embryotomy set	
Cranioclast, Braun, 42 cm	
Hook, decapitation, Braun, 31 cm	
Perforator, Smellie, straight, 27 cm	
Scissors, gyneco, curved, blunt/blunt, 27 cm	
Disinfecting equipment	
Gallipot 180ml	
Sponge forceps, 22,5 cm	
Suction apparatus	
Suction apparatus foot operated for adults	
Suction apparatus pediatric foot-operated	
Resuscitation equipment	
Resuscitator “Laerdal,” neonate , hand operated with mask n° 0/1	
Resuscitator for adults, hand operated with mask	
Set of airways (Cannula Mayo)	
Drugs	Available
Ampicillin Powder	
Gentamycin, injectable	
Water for injection	
Metronidazole, injectable	
Methylergometrine, injectable	
Oxytocin, injectable, kept in cold-chain	
Xylocaine 1%	
Calcium Gluconate, injectable	
Magnesium sulfate, injectable	
Hydralazine, injectable	
Quinine di-chlorhydrate, injectable	
Metronidazole oral	
Amoxicillin oral	
Paracetamol oral	
Quinine sulfate oral	
Doxycycline oral	

Pregnancy test, temperature stable	
Tetracycline eye ointment	
Dextrose 5% + IV infusion set	
Saline Solution 0,9% + IV infusion set	
Haemacell 500ml	
Chlorhexidine soap (Hibiscrub)	
NaDCC tabs -	
Chlorhexidine sol. 5%	
Lidocaine 2%, vial	
Lidocaine heavy, 5%	
Ketamine injectable	
Renewable supplies	Available
Suction catheters for babies Ch 10	
Suction catheters for babies Ch 12	
Catheter IV 20 G, disposable	
Catheter IV 18 G, disposable	
Needle 23G long	
Syringe hypo, 1ml, 0,1 graduated	
Plaster, adhesive, 2 cm x 20 m	
IV-set	
Surgical brush	
Gloves, Surgical, latex, pairs of different sizes	
Gloves, examination, latex, disposable	
Suture, Synthetic, absorbable, DEC4 (1), needle 36 mm, 4/8, tri	
Suture, Synthetic, non-absorbable DEC3 (2/0),needle 3/8, 30mm, tri	
Suture, Synthetic, absorbable, DEC3 (2/0) , spool	
Suture, Synthetic, absorbable, Dec 3 (2/0) needle 4/8, 30mm, round	
Catheter, Urethral Foley, sterile, with balloon, ch14	
Plastic urine bag for catheter Urethral Foley with outlet	
Drapes	
Spinal Needles 22G (0.7x90mm), sterile, disposable	
Syringes different sizes	
Needles 21G	
Gauze-Pads, sterile	
Tape, adhesive 2 cm x 5 m	
Surgical knife blades n°10	
Safety box	
Envelope, plastic (for drugs/tabs distribution)	

Notes:

- o A referral system to manage obstetrics emergencies is in place

Notes:

E. Plan for the provision of comprehensive reproductive health (RH) services, integrated into Primary Health Care (PHC), as the situation permits.

- o Collection of background data on maternal, infant and child mortality, STI/HIV/AIDS prevalence, and contraceptive prevalence
- o Suitable sites for future services delivery of comprehensive RH services identified
- o Staff assessment of capacity to provide comprehensive RH services planned
- o Training/retaining curriculum for RH staff planned
- o Sustainable equipment and supplies ordering system for comprehensive TRH services designed or planned

Notes:

Site:

Date:

MONTHLY DATA COLLECTION

Is the following information collected monthly and monitored?

Basic demographic information (disaggregated by age/sex where relevant)

- o Total population
- o Number of women of reproductive age
- o Number of births
- o Number of maternal deaths
- o Number of pregnant women
- o STI prevalence
- o Number of Family Planning Visits
- o Contraceptive methods

Prevent and manage the consequences of sexual violence

- o Number of cases of sexual violence reported to health services, protection and security officers (disaggregated by age/sex)

Prevent HIV transmission

- o Numbers of syringes, needles, gloves, burn boxes, etc., per health facility.
- o Number of condoms distributed

Prevent excess neonatal and maternal morbidity and mortality

- o Number of clean delivery kits distributed
- o Number of women delivering in health facilities
- o Number of women referred to a higher health facility level for complications of delivery

Notes:

APPENDIX 3: MISP ASSESSMENT TOOLS:

D) ASSESSMENT SITE BASIC INFORMATION FORM

Inter-Agency Global Evaluation of Reproductive Health Services for Refugees and Internally Displaced Persons

COMPONENT 4: DETERMINE AVAILABILITY AND QUALITY OF THE EMERGENCY RESPONSE (MISP) TO RH NEEDS

Assessment Site Basic Information Form

DATES INFORMATION COLLECTED:

From (month/year) _____ to (month/year) _____

Location of Situational Analysis

Camp/Community Name	Nearby Village/Town	District/Zone

Current Population Data:

	Female	Male	TOTAL
Total Population			
<5			
5-14			
15-45			
>45			

General information about population:

Primary Language Spoken	
Other languages	
Ethnic/tribal groups represented	
Religions (approximate % of population)	
Home Country Lifestyle / Economic Information (urban, rural, nomadic, farming, business, etc.)	

When did the refugee/IDP population first arrive in this location?

Date	Size of Population (first influx)	Place of Origin	Ethnicity

Describe major population movements in the past 1 year beginning with the most recent:

Month	Size of Population	Influx/Egress	Origin / Ethnicity
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

International Organizations/Institutions Providing Services/Funding/Technical Support

Organization	Role	Contact Name/Title	Contact Information	Comments

APPENDIX 4: LIST OF FIELD STAFF INTERVIEWS, HEALTH FACILITIES OBSERVED, AND FOCUS GROUPS CONDUCTED

1. Abéché Referral Hospital, Director
2. Abéché Referral Hospital, Gynecologist
3. Abéché Referral Hospital, Manager
4. Abéché Referral Hospital, Senior Midwife
5. Abéché Referral Hospital, Statatician
6. CNAR, Registration, Farchana Camp
7. COOPI, Resident Representative, N'Djamena
8. CRS/SECADEV, Technical Advisor, Farchana Camp
9. CRS/SECADEV, Technical Advisor, Kounoungo Camp
10. CRS/SECADEV, Technical Advisor, Abéché
11. CRT, Assistant Coordinator, Farchana Camp
12. CRT, Coordinator, Farchana Camp
13. GTZ, Construction Assistant, Farchana
14. GTZ, Construction Supervisor, Abéché
15. GTZ, Head of Office, Abéché
16. International Medical Corps, Acting Country Director, N'Djamena
17. International Medical Corps, Nurse/Midwife, Abéché
18. International Medical Corps, Nurse/Midwife/Roving Operations Team, Abéché
19. International Medical Corps, Logistician, Abéché
20. International Medical Corps, Nurse/Nutritionist, Guereda
21. International Medical Corps, Medical Coordinator, Guereda
22. International Medical Corps, Doctor, Abéché
23. International Rescue Committee, Emergency Response Team Health Coordinator, Bahai
24. International Rescue Committee, Emergency Response Team Leader/Coordinator, Chad
25. Intersos, Logistician
26. Ministry of Health Staff Nurse, Mahameta village (Adré)
27. MSF- Belgium, Medical Doctor, Birak
28. MSF-Belgium, Field Coordinator, Birak
29. MSF-Belgium, Medical Coordinator, Abéché
30. MSF-Belgium, Medical Coordinator, N'Djamena
31. MSF-Belgium, Water/Sanitation Engineer, Birak
32. MSF-France, Anesthetist, Adré

33. MSF-France, Logistician, Adré
34. MSF-France, Medical Doctor, Adré
35. MSF-France, Nurse, Adré
36. MSF-France, Surgeon, Adré
37. MSF-Holland, Financial Controller, N'Djamena
38. MSF-Holland, Medical Doctor, Adré
39. MSF-Holland, Team Leader, Adré
40. MSF-Holland, Team Leader, Adré
41. MSF-Holland, Water/Sanitation Engineer, Adré
42. Norwegian Church Aid, Field Manager, Iridimi Camp
43. SECADEV, Camp Manager, Kounoungo Camp
44. SECADEV, Community Services Manager, Kounoungo Camp
45. SECADEV, Sanitation Supervisor, Touloum Camp
46. SECADEV, Water Supervisor, Touloum Camp
47. UNFPA, National Program Officer, Chad
48. UNHCR, Protection Assistant, Touloum Camp
49. UNHCR, Senior Program Officer, N'Djamena
50. UNHCR, Site Planner, Abéché
51. UNHCR, Head of Field Office, Adré
52. UNHCR, Head of Field Office, Iriba
53. UNHCR, Protection Assistant, Farchana Camp

LIST OF HEALTH FACILITIES OBSERVED

1. Abéché Referral Hospital
2. MSF-Belgium Birak Referral Hospital
3. Mahameta Health Post (Adré)
4. MSF-Holland Health Clinic, Farchana Camp
5. MSF-Belgium Mobile Clinic, Kounoungo Camp
6. MSF-Belgium Mobile Clinic, Touloum Camp
7. MSF-Belgium Mobile Clinic, Iridimi Camp
8. MSF-Belgium, Referral Hospital, Tine
9. Ministry of Health Clinic, Bahai

LIST OF FOCUS GROUPS CONDUCTED

1. Adré border, 17 men, Masalit ethnic group
2. Bahai, 9 midwives, Zaghawa
3. Farachana camp, 11 girls, ages 12-19
4. Iridimi camp, 12 boys, ages 13-17
5. Kounoungo Camp, 14 women, ages 16-42
6. Kounoungo Camp, 9 adolescent girls, ages 10-18
7. Senette, 12 women, Tama ethnic group, ages 14-32
8. Tine, 11 women
9. Tine, 7 men
10. Touloum camp, 6 community workers with SECADEV (4 Chadian, 2 refugees)

APPENDIX 5: UNHCR CAMPS SITES AND ACTIVITIES BY IMPLEMENTING PARTNERS

UNHCR OPERATION IN EASTERN CHAD 2004 - CAMP SITES AND ACTIVITIES BY IMPLEMENTING PARTNERS AS AT 25 MARCH 2004

	S Goz Amer (permanent)	C Farchana (permanent)	CN Kounoungo (permanent)	CN Touloum (permanent)	N Mile (permanent)	N Iridimi (transit)	C Touroungesh to be confirmed	N Aminabak to be confirmed
Camp infrastructure, incl. water supply system, shelter, sanitary facilities, reception area, mosques, schools	THW	GTZ	GTZ	NCA	NCA	NCA	THW	NCA
Camp management, incl. community services, NFI and food distribution, public health education, education, maintenance of infrastructure, stock keeping	InterSOS	SECADEV	SECADEV	SECADEV	CARE	CARE	Africare	CARE
Medical and Nutrition, incl. medical screening upon arrival, health care in general	COOPI	MSF-H	IMC	IMC	IMC	MSF-B	MSF-H	MSF-B
Registration before departure and upon arrival in camp	CNAR	CNAR	CNAR	CNAR	CNAR	CNAR	CNAR	CNAR
Reception and information in new camp, assistance of transports to the camps	CRT	CRT	CRT	CRT	CRT	CRT	CRT	CRT
Overall logistics, incl. management of the vehicles fleet, maintenance of technical equipment and vehicles, fuel supply, NFI and food transport into camps	GTZ	GTZ	GTZ	GTZ	GTZ	GTZ	GTZ	GTZ
Capacity building SECADEV		CRS/OXFAM	CRS/OXFAM	CRS/OXFAM				

APPENDIX 6: POPULATION OF CAMPS

	Farchana	Kounoun.	Toloum	Goz Amer	Iridemi	Total
Individuals	6,429	6,190	5,804	3,536	5,118	27,077
Families	1,651	1,795	1,209	1,205	1,440	7,300
Men	2,758	2,384	2,494	1,480	1,853	10,969
Women	3,671	3,806	3,310	2,056	3,265	16,108

Source: UNHCR-Abéché, April 14, 2004.

APPENDIX 7: GENERIC MISP PROPOSAL FOR INCLUSION IN THE CAP

INGO SAMPLE PROJECT PROPOSAL

I. PROJECT SUMMARIES

Appealing Agency	UNFPA
Project Title:	Implementing the Minimum Initial Service Package of Reproductive Health interventions (MISP) in the refugee crisis.
Project Code:	(number assigned by OCHA’s Financial Tracking Unit)
Sector:	Health
Themes:	Safe Motherhood, Sexual Violence—prevention and management. HIV/AIDS, Refugees
Objective:	To reduce reproductive health-related morbidity and mortality, through making a minimum set of reproductive health interventions available as early as possible and through planning for the provision of more comprehensive RH services as the situation permits.
Targeted Beneficiaries:	110,000 refugees, of whom 22,000 are women 15 - 49 yrs old
Implementing Partners:	XXXXXX
Project Duration:	6 months
Total Project Budget:	XXXXXX
Funds Requested:	250,000 US\$

2. THE PROJECT DESCRIPTION

In the early phase of a refugee crisis morbidity and mortality related to reproductive health (RH) continue and, in fact, are often increased: The risk for complications of pregnancy and delivery and maternal and neonatal mortality is increased through the lack of access to emergency obstetric care, the increased risk of malnutrition and epidemics, and the increased incidence of childbirth under unhygienic circumstances. Furthermore, the risk of sexual violence may increase during social instability and population movement and STI and HIV transmission are more likely in areas of high population density. The lack of family planning methods increases risks associated with unwanted pregnancy. Some aspects of reproductive health must therefore be addressed in the early phase of an emergency to reduce reproductive morbidity and mortality, particularly among women. This is best done through the widely accepted Inter-Agency standard of the Minimum Initial Service Package of Reproductive Health Interventions in Crisis Situations (MISP). This strategy assures that basic, limited reproductive health services are delivered to the population as soon as possible, without spending time on a site-specific needs assessment. The strategy includes reproductive health supplies and medication, and coordination and future planning activities.

UNFPA will work together with implementing partner [XXXXXX]. The project will provide for a Reproductive Health Coordinator to work in collaboration with the Health Coordination team. RH supplies and medicines will be delivered in the form of RH kits. The RH coordinator will be responsible for identifying health centers and health staff that can implement the objectives of the MISP; distribution of the RH materials; and monitoring and evaluating the activities. The activities will focus on:

- 1) Preventing and managing the consequences of sexual violence through including the community in secure planning of the camp design, assuring a medical response for survivors of rape, and protection of at risk groups.
- 2) Reducing HIV transmission through collaborating with the other health sector partners to enforce respect for universal precautions, making safe blood transfusions available and assuring the availability of free condoms.
- 3) Preventing excess neonatal and maternal morbidity and mortality through providing all pregnant women in the last trimester with clean birthing materials, assuring clean and safe deliveries at health facility, and initiating the establishment of a referral system for obstetric emergencies. Furthermore, the RH coordinator, in collaboration with all partners and beneficiaries will plan for the provision of comprehensive RH services, integrated into Primary Health Care, as soon as the situation permits.

3. FINANCIAL SUMMARY:

Budget items	Amount
Salary RH Coordinator	50,000 US\$
RH Supplies and infrastructure support	120,000 US\$
Hardware (vehicle, computer, etc.)	50,000 US\$
Software (admin, office hiring, etc.)	30,000 US\$
Total	250,000 US\$

APPENDIX 8: GENERIC MISP PROPOSAL FOR SUBMISSION TO DONORS

Project Title:	Implementing the Minimum Initial Service Package (MISP) of Reproductive Health
Organization:	Description of the organization and its work, including reproductive health activities, in the region.
Brief background and reason for project or problem to be addressed:	The MISP for reproductive health activities will save lives if implemented at the onset of an emergency. Neglecting reproductive health in emergencies has serious consequences: preventable maternal and infant deaths; unwanted pregnancies and subsequent unsafe abortions; and the spread of sexually transmitted infections, including HIV/AIDS. The (MISP) is a set of priority activities designed to: prevent excess neonatal and maternal morbidity and mortality; reduce HIV transmission; prevent and manage the consequences of sexual violence; and plan for comprehensive reproductive health services. The MISP includes a kit of equipment and supplies to complement a set of priority activities that must be implemented in the early days and weeks of an emergency in a coordinated manner by trained staff. The MISP can be implemented without a new needs assessment because documented evidence already justifies its use. The components of the MISP form a minimum requirement and it is expected that comprehensive reproductive health services will be provided as soon as the situation allows. The MISP is a minimum standard in the SPHERE 2004 guidelines. An RH Coordinator is essential to ensuring coordination of MISP activities among all health implementing agencies. Under the auspices of the overall health coordination framework, the RH Coordinator should: be the focal point for RH services and provide technical advice and assistance on RH; liaise with national and regional authorities of the host country; liaise with other sectors to ensure a multi-sectoral approach to RH; introduce standardized strategies for RH which are fully integrated with PHC, standardized protocols, and simple forms for monitoring RH activities; and report regularly to the health coordination team. Provide brief background on emergency situation.
Objectives:	<ul style="list-style-type: none"> ■ Identify an organization(s) and individual(s) to facilitate the coordination and implementation of the MISP. ■ Prevent and manage the consequences of sexual violence. ■ Reduce HIV transmission by: enforcing respect for universal precautions against HIV/AIDS, guaranteeing the availability of free condoms. ■ Prevent excess neonatal and maternal morbidity and mortality by: providing clean delivery kits for use by mothers or birth attendants to promote clean home deliveries, providing midwife delivery kits (UNICEF or equivalent) to facilitate clean and safe deliveries at the health facility and initiating the establishment of a referral system to manage obstetric emergencies. ■ Plan for the provision of comprehensive reproductive health (RH) services, integrated into Primary Health Care (PHC), as the situation permits.
Activities:	<p>Collect or estimate basic demographic information:</p> <ul style="list-style-type: none"> ■ Total population ■ Number of women of reproductive age ■ Number of men of reproductive age ■ Crude birth rate ■ Age-specific mortality rate ■ Sex-specific mortality rate ■ Number of pregnant women ■ Number of lactating women <p>Prevent and manage the consequences of sexual violence:</p> <ul style="list-style-type: none"> ■ Systems to prevent sexual violence are in place ■ Health service able to manage cases of sexual violence ■ Staff trained (retrained) in prevention (protection measures) and response systems for cases of sexual violence <p>Prevent HIV transmission:</p> <ul style="list-style-type: none"> ■ Materials in place for adequate practice of universal precautions ■ Condoms procured and visibly available to displaced population ■ Health workers trained/retrained in practice of universal precautions <p>Prevent excess neonatal and maternal morbidity and mortality:</p> <ul style="list-style-type: none"> ■ Clean delivery kits available and distributed ■ UNICEF midwife kits (or equivalent) available at the health center ■ Staff competency assessed and retraining undertaken ■ Referral system for obstetric emergencies functioning

	<p>Plan for provision of comprehensive RH services</p> <ul style="list-style-type: none"> ■ Basic information collected (mortality, HIV prevalence, CPR) ■ Sites identified for future delivery of comprehensive RH services <p>Identify as organization(s) and individual(s) to facilitate the MISP:</p> <ul style="list-style-type: none"> ■ Overall RH Coordinator in place and functioning under the health coordination team—RH focal points in camps and implementing agencies in place ■ Staff trained and sensitized on technical, cultural, ethical, religious and legal aspects of RH and gender awareness ■ Material for the implementing of the MISP available and used
Indicators:	<ul style="list-style-type: none"> ■ Incidence of sexual violence: Monitor the number of cases of sexual violence reported to health services, protection and security officers. ■ Supplies for universal precautions: Monitor the availability of supplies for universal precautions, such as gloves, protective clothing and disposal of sharp objects. ■ Estimate condom coverage: Calculate the number of condoms available to make visibly available in various settings (clinical exam rooms, latrines, etc.) to the population. ■ Estimate of coverage of clean delivery kits: Calculate the number of clean delivery kits available to cover the estimated births in a given period of time.
Targeted Beneficiaries:	(total number of) refugees/IDPs, of whom (XXXXXX) are women 15 - 49 yrs old
Project Duration:	6 months to one year
Project Budget:	<ul style="list-style-type: none"> ■ salary for RH Coordinator ■ RH supplies and infrastructure support (coordinate with UNFPA to obtain supplies) ■ Travel ■ Indirect Costs (XXXXXX %)

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