WOMEN'S COMMISSION
for refugee women & children

REPRODUCTIVE HEALTH COORDINATION GAP, SERVICES AD HOC:

Minimum Initial Service Package (MISP) Assessment in Kenya

This Report to Contributors aims to inform the women, men and young people who contributed to this study of the findings on how the Women's Commission is using the information to advocate on behalf of those affected by the post-election violence in Kenya.

WHO ARE WE?

The Women's Commission for Refugee Women and Children is a nongovernmental organization (NGO) based in the United States. We are an advocacy organization: we work with governments, United Nations (UN) agencies and international relief organizations to make sure they consider the rights, safety and well-being of displaced communities when they develop programs. We do not implement or provide funding directly to programs that support women, children or young people. Instead, our work contributes to long-term solutions to the problems facing displaced persons.

WHY DID WE COME TO KENYA?

We visited Kenya to see what sexual and reproductive health services were available to displaced women, men and young people after the post-election violence. There are basic reproductive health services that should be available in every emergency, and we wished to meet with the providers of these services and those receiving them. We wanted to see what was in place, what was not, and what displaced people wanted in order to improve their reproductive health.

WHAT DID WE DO DURING OUR VISIT?

Two members of the Women's Commission visited Kenya for two weeks in April 2008. We visited camps and hospitals in Nairobi, Kisumu, Kitale, Eldoret and Nakuru. We met with 139 women, men and young people in eight focus group discussions. We interviewed representatives of local and international NGOs, UN agencies, the Kenya Red Cross and the Ministry of Health.

Listening to people in Kenya was very important because we learned directly about their experiences in the post-election violence. We are very grateful to have met with them and for their permission to let us share the information in a responsible way.

WHAT DID WE LEARN DURING OUT VISIT?

Countless women, men and young people with whom we met noted the harsh challenges of displacement, including strained living circumstances, fear of returning home, the arrival of the rainy season and an uncertain future. Illnesses such as pneumonia, diarrhea and malaria were reported in the camps, but a common concern was the effects of displacement on children's education, especially older children of secondary school age and above. Young people themselves were requesting educational and job opportunities from aid agencies, but this seemed unlikely as many agencies had begun pulling out of Kenya at the time of the assessment.

We tried to answer five questions regarding reproductive health services provided to displaced people:

1. Were agencies coordinating reproductive health services to ensure these life-saving services were available?

2. What was being done to prevent sexual violence and provide care to survivors?

3. What was being done to minimize the transmission of HIV?

4. What was being done to reduce unnecessary death and disability of pregnant women and their newborn babies?

5. What was being done to plan for more comprehensive reproductive health services and address other related needs?

KEY FINDINGS

"My children are supposed to join secondary school. My husband was a driver but was killed. Now I am earning nothing."
Female focus group discussion participant, Kisumu

Another issue concerning young people was the increase in sexual activity, as self-reported by young people themselves. Young people in focus group discussions noted that boys and girls were meeting each other more regularly in camp settings, whereas in the past, such encounters were limited to church, ceremonies or weddings. Idleness and lack of space in the tents and camp overall also contributed to this development. The increase in sexual activity was a concern for some as it represented a major and sudden shift in cultural practices.

1. WERE REPRODUCTIVE HEALTH SERVICES BEING COORDINATED?

While both international and Kenyan organizations working to prevent sexual violence and provide care to survivors were meeting on a regular basis at the Nairobi level, no coordination was in place for reproductive health. This produced many challenges as reflected below.

2. WHAT WAS BEING DONE TO PREVENT SEXUAL VIOLENCE AND PROVIDE CARE TO SURVIVORS?

Sexual violence, including sexual exploitation and abuse, were found to be significant issues especially for displaced women and girls. Some people in positions of power were demanding sexual favors in exchange for goods, even from younger girls. Bribery was also widespread. A common response from focus group participants was that it was not so much food, firewood or water that prompted women and girls to sleep with men, but personal items including oil, undergarments, soap, lotion and perfume. Those that perpetrated the violence included police, businessmen, camp leaders and humanitarian workers.

Violence against women takes different forms, but the priority at the beginning of an emergency is to address sexual violence, which can increase during conflict and chaos. Many agencies were working together under the leadership of the UN Population Fund (UNFPA) and the Kenya Red Cross to implement international standards and guidelines on preventing and responding to sexual violence in camps. UN agencies were holding various trainings for international and local organization staff, as well as those from relevant government ministries. Issues that posed as security threats included the lack of overall camp security, latrines that would not lock from the inside, and the pitch black darkness of night. In Noigam Camp in Kitale, torches had been distributed to families, but they were not available to everyone. In Nakuru Showground, lighting was not established even though electricity had been paid for. A system to prevent perpetrators of sexual violence from returning to the camps or be employed by another humanitarian organization was not in place, although agencies were working on a set of rules to prevent and handle sexual violence and mechanisms for people to report offenses.

A survivor of sexual assault is entitled to medical care, which, if sought early enough, can reduce the risk of HIV infection and unwanted pregnancy. There is a drug that can reduce the risk of contracting HIV if taken within 72 hours after the assault. In addition, emergency contraception is a medicine that, if taken within 120 hours, can reduce the risk of unwanted pregnancy, but it will not affect someone if she is already pregnant. Other drugs are available to prevent sexually transmitted infections. Most medicines that people need after they have been assaulted were available in larger facilities. Not many survivors were coming for immediate care, possibly because they were ashamed and did not know how important it was to seek care. Cases were slowly emerging months after the height of the violence. Emotional support, on the other hand, was widely sought and provided, although the quality of care varied by the organization and individual offering the counseling.

3. WHAT WAS BEING DONE TO MINIMIZE HIV TRANSMISSION?

Many activities can be undertaken to prevent HIV transmission, but select activities are priorities, one of which is to make condoms available for free. The Kenyan Government, service providers and displaced persons saw HIV as a real risk, and male condoms were provided in camps and condom dispensers. While this was one commodity that appeared to be readily available, some displaced persons noted that they were too far away to access in the camp. The real impact of the post-election violence on whether or not there was an increase in the number of people becoming HIV positive is not yet clear.

The Kenyan government and international and local institutions were also making sure that those on anti-retroviral medication would not miss their doses; otherwise they may become resistant to the drugs they were taking. The assessment team learned of creative ways that organizations such as the Academic Model for the Prevention and Treatment of HIV (AMPATH) reached out to displaced people through creating telephone hotlines and using cell phone networks.

Condom dispenser in Eldoret Showground IDP camp

4. WHAT WAS BEING DONE TO REDUCE UNNECESSARY DEATH AND DISABILITY OF PREGNANT WOMEN AND THEIR NEWBORNS?

In emergencies, agencies such as UNFPA distribute "clean delivery kits" to pregnant women through their partners working in the camps. The kits provide some means for a clean delivery when pregnant women could be forced to deliver outside, on a bus on their way to a camp, in their tents, or if health centers do not have the supplies. The kits contain plastic sheeting, gloves, soap, a razor blade, string to tie the umbilical cord, a sealed bag for disposal, picture instructions and cloth. These kits were distributed by international and local organizations working in the camps, but were in short supply. None of the women interviewed through the focus group discussions had seen or were aware of the kits.

Another important activity that can reduce unnecessary death and disability is to establish a way of providing care to women who have problems with their pregnancy and need to be taken to a hospital or fully equipped clinic. To do this, community members must be aware of the danger signs in pregnancy that require immediate attention. A system of transporting the woman must be available once she is known to require more care, and the facility to where she is taken must have trained staff and supplies at all times. The Women's Commission discovered that the issue of transport was a significant issue, especially in Kitale where curfew posed additional challenges. Other problems included the need to obtain a letter from the Kenya Red Cross, a lack of a vehicle, fuel and driver and locked gates at night. Focus group discussion participants in one camp in Kitale noted that the Kenya Red Cross representative was only present during the day, and at night when there was an emergency, little could be done except to remain with the patient until morning.

"There were no means of transport and so they [neighbors] prepared a bicycle. She lost a lot of blood and when she arrived at the district hospital, she wasn't paid much attention. Around 6 am, both the mother and baby died. I witnessed it. The woman was 38 years old."
Male focus group discussion participant, Kisumu

Ambulance in front of the camp clinic, Eldoret Showground IDP camp

One organization, the International Medical Corps, in Eldoret Showground had a working referral system. It had teamed with the district ministry of health to have an ambulance that was fueled and available at all times for anyone that needed to be taken to the hospital. The organization had also provided cell phone numbers to its volunteer health workers from the camp so that they could call a doctor in an emergency.

5. WHAT WAS BEING DONE TO PLAN FOR MORE COMPREHENSIVE REPRODUCTIVE HEALTH SERVICES AND ADDRESS OTHER RELATED NEEDS?

Other reproductive health issues that people mentioned included family planning and managing menstruation. While agencies reported a lack of family planning supplies in the initial weeks due to insecurity, by the time this assessment was undertaken, government and international NGO clinics for the most part had some contraceptives available. Marie Stopes Kenya also had mobile outreach teams and coordinated with other agencies working in the camps so that people could access long-term and permanent methods of contraception, such as vasectomies and tubal ligation. Focus group discussion participants noted that many women wanted contraceptives because of sexual abuse and exploitation, and that pregnancies were increasing after the post-election violence. While this has not been verified, the demand for contraception was apparent. Unsafe abortion had also been reported in the Nakuru Showground clinic.

"The demand for family planning is increasing because people do not know their fate."
Female focus group discussion participant, Noigam Camp, Kitale

WHAT WILL THE WOMEN'S COMMISSION DO NOW?

The Women's Commission will share these findings and recommendations with governments, donors, the UN and international and local aid agencies. Some of the recommendations include advocating for:

- UNFPA and the Ministry of Health's Division of Reproductive Health to coordinate a response for reproductive health-related issues, which is still timely, since people continue to be displaced in camps, transit camps and communities, and those returning can also benefit from such services.
- All agencies working to prevent sexual violence and provide care to survivors to enforce rules and procedures to prevent and manage sexual violence; address the issue of impunity; and inform communities of where and how to report incidents and why it is important to seek medical care.
- All agencies working in or funding the health sector to strengthen the health care system to manage pregnancies and provide care for pregnancy-related problems, especially as international agencies hand over their projects to the government and local organizations.
- All organizations to ensure that young people are better engaged in the recovery process and their educational and job opportunities are enhanced.

WHAT CAN YOU DO IF YOU WANT TO LEARN MORE ABOUT OUR WORK?

For a copy of the complete report, please visit:
http://www.womenscommission.org/pdf/ken_misp.pdf

If you would like to learn more about the Women's Commission's advocacy on behalf of displaced women, children and youth, visit our website at: www.womenscommission.org or contact us at: info@womenscommission.org

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The Women's Commission thanks Jedidah Mwawingwa, who was the translator for the focus group discussions. This project would not have been possible without the participation of the internally displaced women, men and young people in Kenya whose insights, stories, time and advice are invaluable.

This assessment was made possible by the generous support of the William and Flora Hewlett Foundation.

All photographs: Women's Commission for Refugee Women and Children/Sandra Krause

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September 2008