WOMEN'S COMMISSION
for refugee women & children

Still in Need:

Reproductive Health Care for Afghan Refugees in Pakistan

Women's Commission for Refugee Women and Children

October 2003

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Mission Statement

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 levels 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.

Acknowledgments

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Photographs by Dr. Ouahiba Sakani Afzal.

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CONTENTS

ACRONYMS

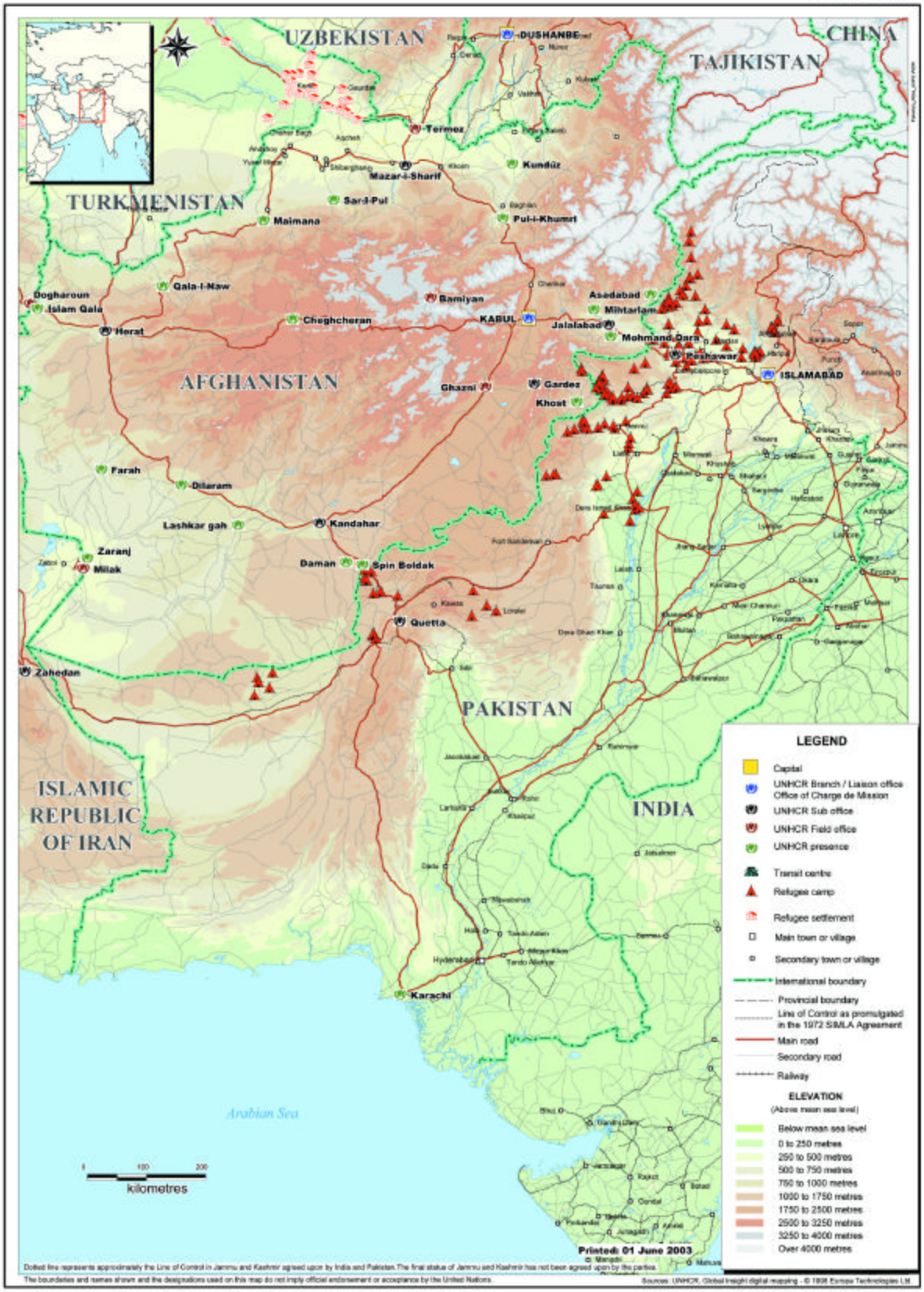
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
BHUs	Basic Health Units
CAR	Commissionerate for Afghan Refugees
CDC	Centers for Disease Control and Prevention
CLRs	Community Labor Rooms
COCs	Combined Oral Contraceptives
EC	Emergency Contraception
EmOC	Emergency Obstetric Care
FP	Family Planning
GBV	Gender-based Violence
IPs	Implementing Partners
IDPs	Internally Displaced Persons
IRC	International Rescue Committee
IUD	Intrauterine Device
HIV	Human Immunodeficiency Virus
JSI	JSI Research and Training Institute
LHVs	Lady Health Visitors
MCH	Maternal and Child Health
MISP	Minimum Initial Service Package
MOH	Ministry of Health
MMR	Maternal Mortality Ratio
NGO	Nongovernmental Organization
NWF	Northwestern Frontier
PDH	Project Directorate Health
PNC	Postnatal Care
PHC	Primary Health Care
PAC	Post-Abortion Care
RH	Reproductive Health
RHR	Reproductive Health for Refugees
RHRC	Reproductive Health Response in Conflict Consortium
SM	Safe Motherhood
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization
WRA	Women of Reproductive Age

UNHCR
The UN Refugee Agency

Pakistan

As of June 2003

GIMU / PGDS
Geographic Information and Mapping Unit
Population and Geographic Data Section
Email : mapping@unhcr.ch



I. EXECUTIVE SUMMARY

The Women's Commission for Refugee Women and Children (Women's Commission) conducted a reproductive health (RH) assessment focused on the implementation of priority RH activities among Afghan refugees in the Northwest Frontier (NWF), Baluchistan and Punjab provinces of Pakistan from August 2002 through June 2003.

The assessment of these priority RH activities, also known as the Minimum Initial Service Package[1] (MISP), revealed that while isolated efforts have been made to improve the quantity and quality of reproductive health care for Afghan refugees in Pakistan, many programs are limited to traditional maternal and child health care services, and the quality of RH care is a significant concern.

Reproductive health focal points, who support advocacy and outreach for the implementation of the MISP, are available in approximately one-third of organizations implementing health care. There is a critical need to increase the number of RH focal points and complement the administrative duties of existing focal points with technical support responsibilities in order to improve RH services. The overarching gap is a lack of standard protocols, data collection and monitoring and evaluation of reproductive health service delivery. A key recommendation of the assessment is to revitalize the RH working group in Pakistan, comprised of representatives from international and local organizations and the Project Directorate Health (PDH), which is part of the Pakistani Health Ministry, and coordinate their efforts in improving the quality of RH care.

The Women's Commission has monitored conditions for Afghan women and girls since its founding in 1989. In the aftermath of United States attacks on the Taliban authorities and the large refugee influxes in late 2001, a Women's Commission RH focal point conducted a MISP assessment as part of a broader project to provide education and advocacy for critical reproductive health issues identified by Afghan refugee women in Pakistan. Information was collected through key interviews with United Nations and international and local nongovernmental organizations (NGOs) and through health facility assessments, community meetings and reproductive health workshops for health providers and Afghan refugees.

This report focuses on the four technical areas of reproductive health: safe motherhood, including emergency obstetric care; family planning; HIV/AIDS and sexually transmitted infections (STIs); and gender-based violence. Adolescent health is a particular focus in all the areas studied.

Regarding **safe motherhood,** the assessment found that maternal and child health (MCH) programs address antenatal (ANC) and postnatal care (PNC) with the exception of routine syphilis screening and blood typing. Most Afghan women deliver at home with the assistance of traditional birth attendants (TBAs); pregnant women and TBAs routinely receive clean delivery kits. Midwife delivery kits supplied by the United Nations Population Fund (UNFPA) are also widely available in basic health units (BHUs).

The United Nations High Commissioner for Refugees (UNHCR) and its implementing partners recently agreed to reduce fees at community labor rooms (CLRs) for emergency obstetric care (EmOC) to address this barrier to life-saving services. However, some CLRs designed to provide basic EmOC are unable to provide services due to inadequate numbers of qualified female staff, equipment and supplies. Several international organizations have undertaken programs to improve EmOC at CLRs and the lessons identified from recent EmOC pilot projects should be shared and utilized to improve the quality of EmOC for Afghan women.

Family planning (FP) supplies are generally available, yet service registers indicate that current users are low and the number of those who discontinue use is high. Post-abortion care (PAC) often does not include FP, and emergency contraception (EC) is rarely known. Service providers need refresher training in contraceptive technology, counseling skills, comprehensive follow-up of FP defaulters and male involvement in child spacing.

Health providers do not routinely practice univer-

sal precautions, the set of safety measures designed to prevent the transmission of Human Immunodeficiency Virus (HIV) and other infections that are spread from patient to patient. Health providers report that they are practicing syndromic management — treatment based on standardized patient signs and symptoms — of STIs, but protocols and patient service registers are not utilized. While condoms are generally available at basic health units, promotion of safe sex is not evident.

While **gender-based violence** (GBV) is a problem, it is not widely recognized as such and reporting is not likely to occur. Domestic violence and early marriage of girls as young as 8 to 10 years old were reported to the RH focal point by refugee women, representatives of international organizations, local health care providers and a UNHCR protection officer. The RH focal point also heard isolated reports of allegations of sexual harassment and sexual exploitation of female health professionals by male staff. UNHCR recently established a GBV working group that meets in Peshawar comprised of representatives of local and international organizations to address the prevention and management of GBV. A strong commitment and a sense of urgency were noted among members of the group, which is facilitating community awareness raising and mobilization to prevent GBV and to ensure survivors receive care.

The focus on maternal and child health services at BHUs leaves unmarried adolescent girls and boys without access to reproductive health care. Only one agency was noted to support RH education and programs for youth and they reported that the needs far exceed their capacity to meet them. The RH focal point noted that men rarely seek RH services and male involvement in RH programming is also lacking.

RECOMMENDATIONS

Recommendations for United Nations agencies and the government of Pakistan

- Revitalize the RH working group with representatives from UNHCR, UNFPA, PDH and international and local organizations in order to establish RH protocols and monitoring mechanisms, and to provide technical assistance to improve the quantity and quality of RH services.
- Identify RH focal points within United Nations (UN) organizations and the PDH and encourage all implementing partners (IPs) and others providing health services to identify an RH focal point to provide technical assistance and to facilitate the coordination of comprehensive quality RH services.

International and local nongovernmental organizations providing health care for Afghan refugees

- Identify an organizational RH focal point to collaborate with UN agencies and the PDH to establish RH protocols and monitoring mechanisms and to provide technical support, including refresher training, to health care providers for the delivery of comprehensive quality RH services.
- Establish comprehensive community RH education including the development of education materials and peer-to-peer education models, with and for refugee women, adolescents and men, to promote reproductive health seeking behavior.
- Provide technical assistance and funding to local women's organizations with the capacity to provide RH services.
- Establish and support youth and male groups to address GBV, child spacing and other RH issues.

Donors

- Provide funding for RH focal points for technical support and monitoring of RH service delivery.
- Provide support for the delivery of comprehensive RH services to women, adolescents and men.
- Provide support for cross-border RH advocacy and education to create linkages and share information about refugee RH services and resource materials inside Pakistan with internally displaced persons (IDPs) and returnees in Afghanistan.

II. AFGHANISTAN/PAKISTAN BACKGROUND

Approximately 1.5 million[2] Afghan refugees, primarily ethnic Pashtuns who have fled armed conflict, inter-ethnic rivalries, severe drought, food shortages and economic destitution since 1978, remain within Pakistan's borders. In addition, almost 200,000 refugees fled Afghanistan in the weeks preceding, and following, United States attacks on the Taliban authorities in the aftermath of the September 11, 2001 terrorist attacks in the United States.[3]

The government of Pakistan officially closed its borders with Afghanistan in November 2000 and refused to open them despite international pressure. Throughout 2001, when the number of Afghan refugees in Pakistan was estimated to peak at 3 million following the events of September 11, refugees endured extreme hardship to find their way across Pakistan's borders, where the majority sought refuge among relatives and friends in urban areas or were forced to settle in designated refugee camps such as Jalozai camp in the Northwest Frontier (NWF) province. Residents of Jalozai were later transferred to new camps in the NWF, Punjab and Baluchistan provinces.[4]

Training conducted by RH focal point, 2002

AGENCIES ASSISTING REFUGEES

UNHCR and the Pakistan Commissionerate for Afghan Refugees (CAR) coordinate refugee assistance, security and protection within refugee camps. While attention in recent years has focused on the return and reintegration of Afghan refugees, resulting in a decline in overall funding and support to refugees in Pakistan, numerous international[5] and local[6] organizations support at reduced levels the Pakistan Ministry of Health (MOH) through the Project Directorate Health to implement primary health care services, including RH.

GENERAL CONDITIONS IN AFGHANISTAN

Afghan refugees come from a country where access to survival needs is an ongoing struggle, basic infrastructure and systems have been destroyed and life expectancy is only 43 years.[7] In the former Taliban-controlled areas, Afghans, particularly women, endured some of the worst human rights abuses in the world.[8] Women's rights remain seriously constrained, affecting women's access to already extremely limited health services, as well as social and economic opportunities.[9]

REPRODUCTIVE HEALTH CONDITIONS IN AFGHANISTAN

The entire health system in Afghanistan has been devastated for more than two decades and key health and RH indicators are among the worst in the world, especially in rural areas. In a recent study conducted by the U.S. Centers for Disease Control and Prevention (CDC) and the United Nations Children's Fund (UNICEF), the maternal mortality ratio (MMR) was estimated at 1,600 deaths per 100,000 live births, with significant differences between urban and rural areas.[10] For example, in the remote

area of Badakhshan, the MMR was reported at 6,500 per 100,000, a ratio that exceeds any previously recorded in the world.[11] The overwhelming majority of deaths, primarily caused by hemorrhage and obstructed labor, were due to lack of access to health services (70%) and deemed preventable (87%). In addition, only 7% of women had the benefit of a skilled health worker at delivery. [12] Further, the total fertility rate for women in Afghanistan is 6.8 children and the use of modern contraceptives is 4%.[13]

Patriarchal cultural traditions support gender discrimination and other forms of GBV in Afghanistan. While data on GBV in Afghanistan is limited, human rights groups have reported abduction, rape and forced early marriages carried out by the Taliban and other armed actors. Under the Taliban, women who survived sexual violence were saddled with an unrealistic burden of proof for non-complicity and faced accusations of adultery with subsequent forced marriage to perpetrators and, in extreme cases, murder. Reports from NGOs and investigators also indicate a high prevalence of domestic violence, as well as sex trafficking, in Afghanistan.[14]

GENERAL CONDITIONS IN PAKISTAN

Support for Afghan refugee programs in Pakistan began waning in the mid-1990s. Food aid was cut in 1995 and international assistance dwindled throughout the late 1990s as humanitarian assistance providers shifted their attention to facilitate the repatriation and reintegration of Afghan refugees. UNHCR reports that 1.5 million refugees were repatriated from Pakistan to Afghanistan in 2002.[15] At the same time international organizations reduced funding, staffing and program activities in Pakistan.

Primary health care services, including RH, are provided through basic health units, community labor rooms for basic EmOC and hospitals. Among the local population, selected indicators of mortality reveal a life expectancy of 61 years and a MMR of 200 deaths per 100,000 live births. The total fertility rate is 5.0 and contraceptive prevalence for modern methods of FP is 20%. The prevalence of HIV in Pakistan is estimated at 0.1% and the majority (67%) of infections are the result of heterosexual transmission.[16]

REPRODUCTIVE HEALTH CONDITIONS AND SERVICES IN PAKISTAN

Recent studies reflect the precarious RH status of Afghan refugees in Pakistan. A study conducted by the CDC in 12 Afghan refugee settlements receiving international assistance from January 20, 1999 to August 31, 2000, indicated 41% of deaths among women of reproductive age were due to maternal causes and 60% of their infants were either born dead or died after birth. Moreover, the study reveals the critical need for women's access to good quality EmOC services.[17] A further CDC study among Afghan refugees in Pakistan in 2000 showed that 48% of women have an unmet need for FP.[18]

A multi-agency[19] study was undertaken in 1999 and 2000 among Afghan refugees in Pakistan to improve the ongoing use of FP. Findings showed that of the two most commonly used modern methods of FP, continued use was significantly higher for injectable contraception than for pills. Use by younger women was also higher than by older women. Researchers concluded that the quality of FP counseling, particularly with regard to pills, should be improved.[20] JSI Research and Training Institute conducted an assessment on contraceptive logistics supply and a workshop for health workers and procurement officers on contraceptive logistics management.

The Reproductive Health Response in Conflict Consortium (RHRC) GBV research officer documented alarming levels of GBV and a dearth of programs to address it during a site visit to Pakistan in April 2001. NGOs, human rights organizations and the UN Special Rapporteur on Violence against Women have reported GBV, including domestic violence, with a rise in case fatalities, sex trafficking, sexual assault, forced early marriages, child sexual abuse, prostitution, abduction and rape of women without consequence for perpetrators.[21]

Under severe socio-cultural, security, political and judicial constraints, several local Pakistani NGOs[22] have successful model projects that could provide local and international organizations assisting Afghan refugees with guidance on GBV programming. Lack of international commitment and donor support has been a primary barrier to GBV prevention and management programs for

Afghan refugees in Pakistan.[23]

A Women's Commission protection partner, based in Peshawar since early 2000, monitors women's protection issues and serves as a key resource for the local humanitarian and refugee community on gender and human rights issues. Some local women's organizations also receive funding to promote protection of refugee women and capacity building.

Although little is known about adolescents living in refugee camps in Pakistan, adolescent refugees in urban areas of Pakistan are particularly neglected and exploited without the protection and care afforded through UN-administered camps. Among the problems youth endure are harmful child labor to support survival needs, sexual violence, sex trafficking and early marriage, which expose prepubescent girls to physical injuries and high-risk pregnancies.[24]

III. METHODOLOGY

In the context of new Afghan refugee influxes, and the massive repatriation in late 2001 and throughout 2002, the Women's Commission conducted an assessment from August 2002 through June 2003 on the availability and accessibility of the MISP of priority RH services as well as comprehensive RH services for refugees in the Northwest Frontier, Baluchistan and Punjab provinces of Pakistan. A data collection instrument was developed based on the RHRC Needs Assessment Field Tool and utilized to assess services in select facilities with the highest refugee beneficiary populations. The assessment covered 35% of basic health units (BHUs) and 100% of basic EmOC clinics and referral hospitals in the urban and peri-urban areas of these provinces (attachments 1-3).

The assessment, intricately linked with practical advocacy and education on RH with humanitarian relief organizations and the Pakistan government, includes extensive identification, development, procurement and distribution of resource materials. Existing materials such as the Women's Commission's synopsis of the UNHCR *Guidelines on the Protection of Refugee Women* and the *Guidelines on the Prevention and Response to Sexual Violence* were translated into the local languages, Pashto and Dari. In addition, a synopsis of the MISP chapter in the *Reproductive Health in Refugee Situations Inter-agency Field Manual* (Field Manual) was developed, translated and widely distributed. A clear indication of the need for resource materials in local languages was apparent when the RH focal point came across a local physician who had started translating the entire Field Manual into Pashto. Most of these resources are available on the Reproductive Health Response in Conflict Consortium (RHRC) website at www.rhrc.org.

The project also includes support and technical assistance to five local women's organizations[25] to improve and strengthen reproductive health care for Afghan refugees. The local NGOs are undertaking a variety of education and service delivery projects to:

- provide refresher training on infection prevention and contraceptive technology;
- introduce and strengthen syphilis testing for pregnant women in clinics;
- educate women and adolescent girls on safe motherhood, including timely recognition of the danger signs of pregnancy and delivery and the prevention of GBV;
- provide clinical care for GBV, including EC, STIs/HIV/AIDS prevention and child spacing;
- strengthen mobile teams to provide good quality RH services;
- develop locally and distribute clean delivery kits;
- identify and educate a core group of adolescent male peer educators on family planning and the prevention of GBV and STIs.

IV. REPRODUCTIVE HEALTH ASSESSMENT FINDINGS

Although some refugees have been in Pakistan for more than 22 years, the focus of implementing partners' (IPs) RH services was limited to maternal and child health (MCH) programs integrated into primary health care (PHC) services until the late 1990s, at which time child spacing and STI programs were initiated. These additional services are generally of poor quality and require strengthening. Most IPs working with refugees who arrived in 2001 and reside in the new camps provide traditional relief assistance and limited PHC to control communicable and infectious diseases. Some of the IPs working in these now stable settings explained that they do not intend to expand maternal and child health care to broader RH services because of funding constraints. While some basic reproductive care is available, substantial gaps remain.

An RH working group, which met in Peshawar, was established in 1999 by UNHCR and UNFPA, but stopped one year later for unknown reasons. At the UNHCR provincial offices in Quetta and Peshawar, a health program officer is designated to coordinate, supervise and monitor RH services provided by IPs. However, their activities in BHUs are focused on the administrative management of the PHC/RH program rather than technical assistance and monitoring of RH services. Basic EmOC in community labor rooms and the Pakistani PDH provincial offices that have either an identified RH coordinator or MCH deputy director with broad RH responsibilities also lack technical oversight.

Of the 18 IPs of UNHCR/PDH in refugee camps in Baluchistan and the Northwest Frontier provinces, only six have an RH coordinator. The other partners have medical coordinators, but RH is not a particular focus of their programs. In addition, four urban-based NGOs providing health services through clinics established in Peshawar and Quetta are not under UNHCR/PDH supervision and also lack qualified staff and technical assistance.

Many Afghan women suffer from a lack of basic knowledge about their bodies and information to support appropriate health seeking behavior. The lack of knowledge is compounded by socio cultural constraints that limit decision-making about their health problems, resulting in significant barriers to their RH.

SAFE MOTHERHOOD

At the BHU level, pregnant women are generally provided with antenatal (ANC) and postnatal care (PNC) and most deliveries take place in the home. Lady Health Visitors (LHVs) monitor pregnant women through three to four antenatal visits, as per the World Health Organization (WHO) standards. During ANC, pregnant women usually undergo some basic laboratory tests, including blood grouping and hemoglobin testing. However, blood grouping and syphilis testing are not always carried out for pregnant women. Most IPs only conduct syphilis tests for women with high-risk pregnancies.

In the third trimester of pregnancy, most pregnant women or TBAs receive clean home delivery kits. In 1998, UNFPA provided RH kits directly to UNHCR which distributed them to the International Rescue Committee, Save the Children/United States, Médecins Sans Frontières and other IPs. In December 2001, UNHCR and the Pakistani PDH received an additional 118 RH kits for new camps and repatriation centers. Throughout 2003, all UNHCR IPs that work in both old and new camps and provide health services to the refugee population were provided with funds to prepare locally procured and assembled clean delivery kits for distribution to pregnant women. LHVs provide ANC and PNC in homes; most LHVs working inside camps have complete midwife delivery kits provided by UNFPA Islamabad. In refugee camps, where access to a CLR is not possible, the LHVs frequently conduct normal deliveries at home.

Although emergency obstetric referral systems have been established, refugee women are often unable to access them due to a lack of transportation or the ability to pay the service fees. The change to a

system of cost recovery is based on both short-term funding problems and a desire to make the services financially sustainable. UNHCR-established service delivery fees for cost-recovery at CLRs are high for a normal delivery for most refugee women. UNHCR and implementing partners recently agreed to reduce fees for emergency obstetric care to make services affordable to Afghan women.

Some CLRs established to provide basic EmOC are not functioning in this capacity because they are inadequately equipped or lack a trained female medical officer to ensure 24-hour services. Hospital staff complain that women arrive at the obstetric out-patient department in critical condition, indicating that health education on pregnancy-related complications for refugee women and health workers may be inadequate or BHU/CLR staff are ineffectually trained in basic EmOC to stabilize patients before referring them to the hospital for comprehensive EmOC, or both.

Through the RHRC Averting Maternal Death and Disability Among War-affected Populations program funded by the Center for Population and Family Health at Columbia University, the American Refugee Committee and IRC recently initiated projects to establish and improve EmOC services in Pakistan. ARC will improve EmOC services for approximately 90,000 refugees in two camps in Baluchistan and IRC will work with the provincial MOH in Peshawar to improve EmOC at Thall civil hospital in Kohat District where IRC provides care for 136,658 Afghan refugees in 12 camps.

FAMILY PLANNING

Family Planning services are generally available, although a complete lack of contraceptive supplies was noted in a few settings. The most widely available methods are oral pills and injectable contraception. Only a few BHUs provide intra-uterine devices (IUDs). Staff require refresher training in modern contraception technology, communication and counseling skills. Overall service point registers indicate the number of current users is very low and the rate of discontinuation of use is very high. Only a few LHVs and medical officers are knowledgeable about EC.

All CLRs have some post-abortion care services but little attention is given to post-abortion counseling for FP. BHU frontline staff and community health workers, particularly males, are rarely involved in promoting child spacing among the male population.

SEXUALLY TRANSMITTED INFECTIONS AND HIV/AIDS

Most staff have not received refresher training and lack proper equipment and supervision to adhere to universal precautions to prevent the spread of HIV/AIDS and other infections through blood and bodily fluids. Many of the outlets visited do not perform proper decontamination of instruments and medical waste disposal. Often water and soap were not available for hand-washing between clients in maternal and child health or patient exam rooms. Condoms were often available at all BHUs and urban clinics visited. However, supplies are not always free and safe sex behavior is not promoted. Frequently, women refuse to take condoms home as they are unable to negotiate condom use with their partners.

Health providers state that they are following syndromic management of STIs, and some are conducting partner notification and treatment, as well as free condom distribution. However, separate registers for STIs are not maintained and protocols and guidelines for syndromic approach and counseling services are not readily available. Information, education and communication materials on STI/HIV/AIDS prevention are also unavailable.

GENDER-BASED VIOLENCE

In the religious and conservative Afghan milieu, GBV has largely not been addressed. Incidents of GBV are not reported or recorded at health facilities. It is clear, however, that traditions and customs are driving harmful practices, such as early marriage among girls as young as 8 to 10 years old and domestic violence. The Women's Commission RH focal point heard about allegations of sexual harassment and exploitation by physicians, including one incident against a female doctor, and another incident where an international NGO's "temporary supervisor" was allegedly abusing patients. The latter incident resulted in the closure of the clinic for one week due to community pressure. An international NGO representative also reported knowledge of sexual

exploitation against the "lowest classes of some tribes of refugees settled in Chaman camp where men send their women to prostitute" and that some girls in the camp, located in southwestern Pakistan, were reported missing and subsequently returned to camp pregnant and seeking abortions. LHVs and female doctors reported that domestic violence is a problem but that women do not report it. The UNHCR protection officer reported 12 GBV cases in Chaman camps in the previous six months, including early marriage, exploitation and rape of young girls by older men.

While guidelines were developed by UNHCR and UNFPA to manage GBV in 1999, training and monitoring mechanisms were not established to promulgate the guidelines and to provide assistance to survivors. However, in December 2002, UNHCR launched an initiative to establish programs to address the prevention and management of GBV occurring inside the camps. UNHCR facilitated a working group among IPs, collaborating agencies and advocacy NGOs to discuss and endorse a plan of action to establish GBV services. Local Afghan NGOs working in the camps and urban areas of the provincial capitals of Quetta and Peshawar have also joined the working group. Local NGOs are key to community mobilization, awareness raising, identification and referral of victims to appropriate services and have successful model projects to build upon. There is both goodwill and a sense of urgency among working group participants to establish a system to address GBV, and individual partners are now preparing proposals for action.

ADOLESCENT REPRODUCTIVE HEALTH

Most basic health units only provide maternal and child health care; unmarried young girls who face RH problems do not receive services. Moreover, these young women are unlikely to seek services, fearing stigmatization and poor treatment by service providers. Only one organization was found to be working with adolescent RH peer educators.

The health risks of Afghan youth in urban areas of Pakistan are both fueled and compounded by a lack of access to shelter, food, education and health services. The Afghan NGO Shuhada, funded through a Women's Commission small grant in 2001-2002, provides social, economic and health services, including RH, to Afghans in Afghanistan and Pakistan. Shuhada staff report that the needs far exceed their capacity to provide services to youth in Pakistan, especially child workers.[26]

MALE INVOLVEMENT

For the most part, men and young boys appeared to have access only to curative care; health promotion campaigns or disease prevention services aimed at them are very limited. Men rarely seek medical help for RH problems such as sexual disorders and STIs, or to request condoms. Although there are male BHU staff, only clinical outpatient services are provided to men. There are no RH counseling or education services provided to men on family planning or safer sex. Service providers are not comfortable working with the male population on RH issues.

V. CONCLUSION

It is clear that although some basic RH components are being implemented to varying degrees, substantial gaps remain. Generally, there is a lack of RH protocols and guidelines, technical assistance, monitoring and supervision of RH programming.

- Maternal and child health promotion services are generally available, but syphilis testing is not routine. A referral system for EmOC is in place; however transportation for women to a referral site is frequently not available. Costs of services are also a key barrier to access for many refugee women.
- GBV against women and girls is not addressed and reporting by victims is unlikely to occur. Many service providers are not trained in preventing and addressing the consequences of

GBV and do not believe that GBV is a problem.

- STI/HIV/AIDS services are inadequate and require improvement particularly in the identification and use of protocols and guidelines for the syndromic management of STIs and data collection systems. Staff do not conduct proper decontamination of equipment and supplies or adhere to universal precautions to prevent the spread of infectious diseases, including HIV/AIDS. Condoms are available at all basic health units and clinics visited; however, supplies are not always free and safe sex behavior is not promoted.
- Male involvement and adolescent RH are not addressed.
- FP services are available but counseling, communication skills and contraception knowledge are lacking. All community labor rooms have post-abortion care but no special attention is given to post-abortion counseling for FP methods.
- Community education for women, men and adolescents is inadequate.

While UNHCR plans to assist up to 1.2 million Afghans to return home in 2003, continued civil strife, particularly in northern Afghanistan, devastation of basic infrastructure and inadequate living conditions are obstacles that must be addressed before all refugees are able to repatriate.[27] While efforts are underway by UNHCR, the government of Afghanistan and many local and international organizations to improve these conditions in Afghanistan, humanitarian aid workers must continue to address the needs, including RH needs, of Afghan refugees in camps and urban areas of Pakistan.

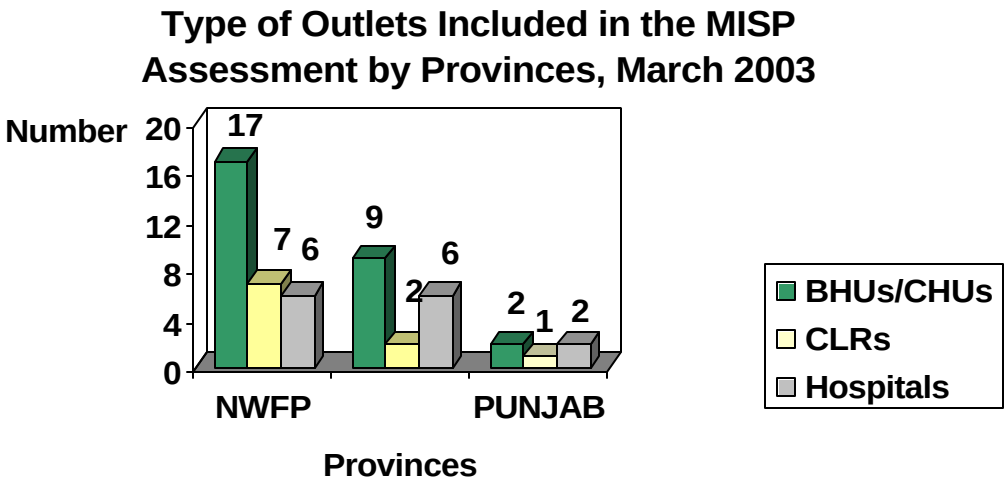
Reproductive health is a vital component of basic health care and must be integrated into all assistance programs for Afghan refugees. Without comprehensive quality reproductive health care, the basic rights of these refugees cannot be met.

OUTLETS INCLUDED IN THE MISP ASSESSMENT UP TO DATE March 2003

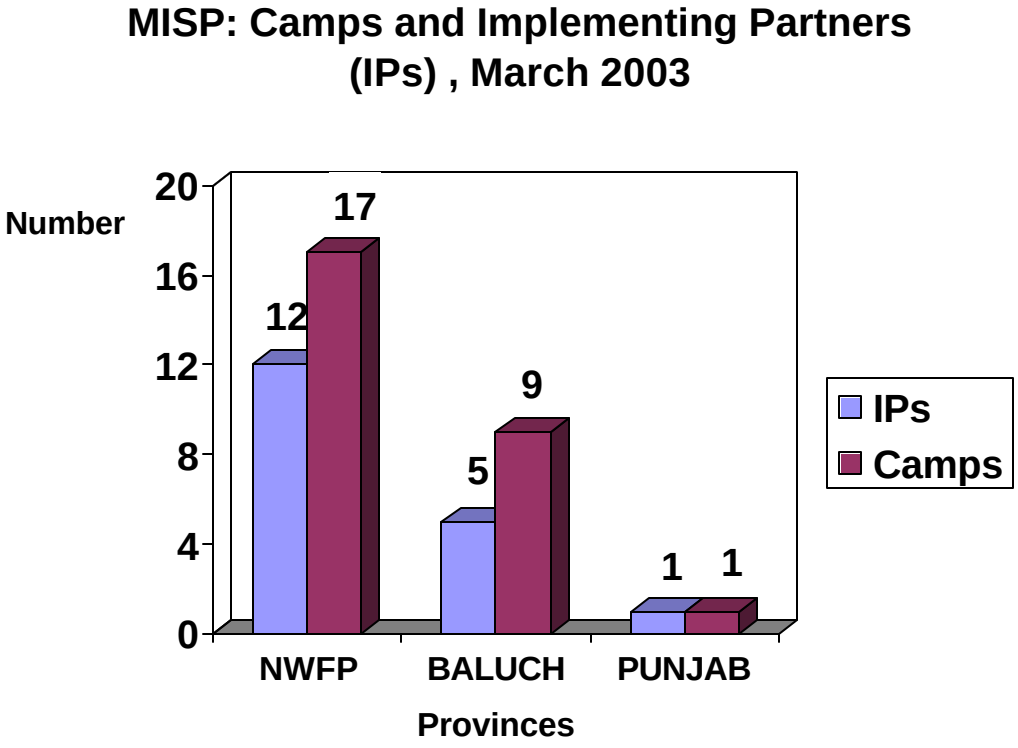
Province	BHUs	BHUs Assessed	BEOC Clinics	BEOC Assessed	Referral Hospitals	Referral Hosp. Assessed	Clinics	Clinics Assessed
NWFP	86	17	7	7	10	6	5	4
Baluchistan	25	9	3	2	5	5	3	3
Punjab	2	2	1	1	1	1	1	1
Total	**113**	**28**	**10**	**10**	**16**	**12**	**9**	**8**

Outlets included in MISP assessment:
25% Basic Health Units (BHU), 100% Basic Emergency Obstetric Care Clinics (BEOC)
75% Referral Hospitals, 89% clinics in urban & suburban areas

Attachment 2



Note: BHU-Basic Health Unit
CLR-Community Labor Room (BEOC)
Hospitals (Comprehensive EmOC)



BEOC CLINICS (CLR) & REFERRAL HOSPITALS BY LOCATION AND PROVINCES

MARCH 2003

NWFP			**BALUCHISTAN**		
Location	**BEOC Clinic/ Referral Hosp.**	**Organization**	**Location**	**BEOC Clinic/ Referral Hosp.**	**Organization**
Akkora Khattak	Community Labor Room (BEOC)	Kuwait Joint Relief Committee	Mohd. Khel	Community Labor Room (BEOC)	American Refugee Committee
Azakhel 1&2	Community Labor Room (BEOC)	Union Aid for Afghan Refugees	Loralai	Community Labor Room (BEOC)	Project Directorate Health
Mardan	Community Labor Room (BEOC)	Frontier Primary Health Care	Loralai	DHQ Hospital	Ministry of Health
Jallala	Community Labor Room (BEOC)	Kuwait Joint Relief Committee	Pishin	Civil Hospital	Ministry of Health
Katcha Garhi	Community Labor Room (BEOC)*	Humanitarian Medical Relief Body	Quetta	Christian Hospital	Christian Hopitals Association of Pak.
Haripur	Community Labor Room (BEOC)	Save the Children USA	Quetta	Hospital	Shuhada Organization
Hangu	Community Labor Room (BEOC)	International Rescue Committee	Quetta	Civil Hospital	Ministry of Health
New Shamshatoo	Community Labor Room (BEOC)*	Lajnat-El dawa Islamia	Quetta	Community Labor Room (BEOC)	Jame-e-Shifa Organization
New Shamshatoo	Community Labor Room (BEOC)	Project Driectorate Health	**Total: 4**	**Total: 3 CLRs 5 Hospitals**	**Total: 6**
Jalozai	Hospital	EL Jihad			
Mansehra	DHQ Hospital	Ministry of Health	**PUNJAB**		
			Location	**BEOC Clinic Referral Hosp.**	**Organization**
Swabi	Civil Hospital	Ministry of Health	Kot Chandna	Community Labor Room (BEOC)	CAR/UNHCR
Peshawar	Hospital	Medical Refresher Courses for Afghans	Kot Chandna	DHQ Hospital Mianl Wali	Ministry of Health
Peshawar	Hayatbad Medical Complex	Ministry of Health	Rawalpindi Katcha Abadi	Malalai Hospital	Rawa Organization
Peshawar	Kuwait Hospital	Kuwait Joint Relief Committee	**Total: 2**	**Total: 1 CLRs 2 Hospitals**	**Total: 3**
Total: 12	**Total : 9 CLR 6 Hospitals**	**Total : 11**			
Note: * Not fully operational					

NOTES

1 The Minimum Initial Service Package (MISP) is a series of actions needed to respond to the reproductive health needs of populations in the early phase of a refugee situation (which may or may not be an emergency). The MISP is not just a kit of equipment and supplies: it is a set of priority activities that must be implemented in a coordinated manner by appropriately trained staff. It can be implemented without any new needs assessment since documented evidence already justifies its use. The MISP prevents excess neonatal and maternal morbidity and mortality, reduces HIV transmission, prevents and manages the consequences of violence, and includes planning for the provision of comprehensive reproductive health services integrated into the primary health program in place.

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