How To Guide

Reproductive Health in Refugee Situations
Kakuma & Dadaab, Kenya

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HEALTH AND COMMUNITY DEVELOPMENT SECTION

UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES

This is the ninth in a planned series of HOW TO GUIDES that document how Reproductive Health (RH) activities were implemented in the field. It was compiled by Judith o'Heir (UNHCR RH Consultant) who provided technical assistance from 31 May – 30 June 2001. Her assessment of RH services in Kakuma and Dadaab refugee camps was undertaken with the aim of presenting recommendations for an efficient and adapted organization of services through a harmonized and coordinated distribution of tasks between implementing partners.

Each How To Guide documents one field experience and illustrates and innovative approach to a particular area of RH. The Guide is not meant to present a definitive solution to a problem. Rather, its recommendations should be used and adapted to suit particular needs and conditions of each refugee setting.

Should you have any questions about this Guide, please contact UNHCR Kenya or the Health and Community Development Section at UNHCR Geneva (e-mail: HQTS00@unhcr.org).

Other HOW TO GUIDES:

❶ Crisis Intervention Teams: Responding to Sexual Violence in Ngara, Tanzania (January 1997)

❷ From Awareness to Action: Eradicating Female Genital Mutilation with Somali Refugees in Eastern Ethiopia (May 1998)

❸ Reproductive Health Education for Adolescents – Prepared by the IRC, Guinea (February 1998)

❹ Building a Team Approach to Prevent and Respond to Sexual Violence in Kigoma, Tanzania (December 1998)

❺ Strengthening Safe Motherhood Services, Tanzania (November 1998)

❻ Monitoring and Evaluation of Sexual Gender Violence Programmes, Tanzania (April 2000)

❼ Sexual and Gender-based Violence Programme in Guinea (January 2001)

❽ Sexual and Gender-based Violence Programme in Liberia (January 2001)

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1. INTRODUCTION

WHAT IS THE PURPOSE OF THIS HOW TO GUIDE?

This How to Guide describes the process used to assess the reproductive health (RH) services provided in the refugee camps in Kakuma and Dadaab, Kenya. Information is provided about RH services in refugee settings and the activities undertaken during the assessment process. The main findings of the assessment are presented, together with conclusions and recommendations for strengthening the capacity of the agencies involved in RH activities.

WHO IS THIS HOW TO GUIDE FOR?

This How To Guide is intended for supervisors and coordinators of RH services in refugee settings. The guide covers the main components of reproductive health services (safe motherhood, family planning, sexually transmitted diseases (including HIV/AIDS), and sexual and gender-based violence) and describes how to undertake an assessment of these services.

WHAT IS UNHCR'S POLICY ON REPRODUCTIVE HEALTH?

UNHCR acknowledges RH as a right that, like all other human rights, applies to refugees. To exercise this right, populations experiencing conflict and/or emergency situations must be provided access to comprehensive RH information and services, thus enabling free and informed choices about RH.

Quality RH services must be based on the needs of refugees, with particular attention to the needs of women refugees. The services must also respect the religious and ethical values and cultural backgrounds of refugees, while conforming to universally recognized international human rights standards. Therefore, comprehensive information on options and access to RH services should be made available, leaving the choice to the individual.

The range of RH services, as defined in the ICPD Programme of Action, includes: family planning counselling, information and education; education and services for antenatal care, safe delivery and postpartum care for mother and baby, prevention of abortion and post-abortion care; treatment of reproductive tract infections and STIs (including HIV/AIDS); prevention and appropriate treatment of infertility; detection and management of breast cancer and cancers of the reproductive system; and other RH conditions. UNHCR believes that providing comprehensive and high-quality RH services requires a multi-sectoral integrated approach; protection, health, nutrition, education and community services personnel all have a part to play in planning and providing RH services.

2. BACKGROUND

WHAT IS THE REFUGEE SETTING?

Kakuma, in the northwest of Kenya, is the location of one refugee camp, with a population of 74,112 (May 2001). The camp is situated 1 km from the Kakuma town centre. The region's climate is hot and dry, with occasional dust storms. While the rivers surrounding the camp are dry most of the year, rains in Uganda can cause sudden, massive flooding.

The camp was established in July 1992 for Sudanese refugees. Since then, however, with the closure of thirteen refugee camps across Kenya and the government-mandated transfer of Coast Province's refugees, Kakuma has become a multi-national community providing a home for refugees from eight countries. While the vast majority are Sudanese, there are also large numbers of Somali and Ethiopian nationals and smaller numbers from the DR of Congo, Rwanda, Burundi, Uganda, Liberia and Eritrea. Since 1997, two new sites – Kakuma II and Kakuma III – have been constructed to accommodate new arrivals and refugees transferred from the now closed camps.

Dadaab, in the northeast of Kenya, is the location of three refugee camps: Ifo, Dagahaley and Hagadera. The camps, with a combined total refugee population of 130,051 persons (May 2001), are within an 18 km radius of Dadaab town. The region surrounding Dadaab is an arid area with sparse semi-desert vegetation.

The refugee population consists largely of Somali nomadic pastoralists, but also includes farmers, former civil servants and traders. The small non-Somali population in the camps includes Ethiopians, Sudanese, Ugandans and Eritreans.

Ifo camp (population 47, 700 as of May 2001) was established in September 1991. Prior to that time, the Somali refugee influx was accommodated in Liboi, 15 km from the Somali border. Dagahaley camp (population 35,562 as of May 2001) was established in March 1992 when it became impossible to accommodate more refugees in Ifo camp. Hagadera camp (population 46,789 as of May 2001) was established in June 1992, initially to accommodate refugees from Liboi. However, the influx of new arrivals was so high following the opening of Hagadera camp that the transfer of Liboi camp only took place in late 1994.

The Dadaab-Garissa region has been plagued with security problems and banditry for decades; violent crimes, including rape and armed banditry occur in and around the camps, requiring all movement to and from the camps to take place under armed police escort. UNHCR has supported the local authorities with the construction of a Police Post in each camp and a Police Station in Dadaab town, and has provided vehicles, radios and incentives to police officers based in the area. With UNHCR funding, refugees in the Dadaab camps have constructed live thorn fencing around their compounds to protect themselves from violence and banditry, contributing to a modest reduction in armed banditry and the incidence of rape.

HOW ARE HEALTH SERVICES ADMINISTERED?

In Kakuma the camp hospital provides both inpatient and outpatient services, including maternity inpatient services and outpatient services for, amongst others, RH problems such as STDs. There are also five outreach clinics located throughout the camp, where a range of preventive and curative outpatient services are provided, including antenatal, family planning and child health services, and treatment services for STDs. In Dadaab there is a hospital and three health posts in each of the three camps. The hospitals provide much the same services as those provided in Kakuma, and the health posts provide a similar range of preventive and curative services to those provided at the outreach clinics in Kakuma.

The administration of health services is the responsibility of the designated implementing agencies, including the hiring and supervision of staff, provision and maintenance of infrastructure, supplies, equipment and drugs, and planning, implementing and monitoring a range of preventive and curative health services, including those for RH.

IRC is the implementing partner for health in Kakuma. In addition, the National Council of Churches Kenya (NCCK) and Jesuit Refugee Services (JRS), although not UNHCR implementing partners, are involved in RH activities in Kakuma camp; NCCK is involved in community education for RH, and JRS in counselling for victims of SGV. MSF/B is the implementing partner for health Dadaab and NCCK is responsible for community education for RH. Healthcare providers in both Kakuma and Dadaab are predominately refugees, although there are some expatriate and Kenyan staff in both locations.

WHAT ARE THE REPRODUCTIVE HEALTH NEEDS OF REFUGEES?

Providing adequate food, clean water, shelter, sanitation, and primary health care (PHC) are priorities in order to combat the major killers in refugee settings: malnutrition, diarrhoeal diseases, measles, acute respiratory infections (ARI) and malaria (where prevalent). However, RH care is also essential for the physical, mental and social well being of any individual. In refugee settings, it is important that RH interventions are timely, appropriate and consistent with national laws and development priorities. Because RH programmes affect highly personal aspects of

life, they must be particularly sensitive to the religious, ethical and cultural backgrounds of refugee populations.

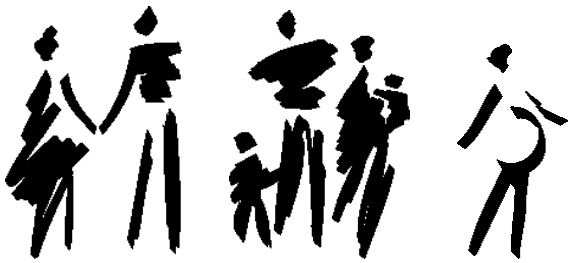
As an integral part of PHC, RH care is important in overcoming problems such as:

- complications of pregnancy and childbirth, which are leading causes of death among refugee women of childbearing age;
- malnutrition, which can further diminish the physiological reserves of pregnant or lactating women; and
- absence of law and order, commonly seen in refugee emergencies, which may lead to an increased risk of sexual violence; for example, violence against refugee women, rape and sexual abuse are far more widespread than previously acknowledged.

WHAT ARE SOME OF THE BARRIERS TO REPRODUCTIVE HEALTH IN REFUGEE SETTINGS?

Some of the barriers to RH, in both refugee and non-refugee settings, include inappropriate or poor-quality RH information and services; insufficient knowledge about human sexuality; high-risk sexual behaviour; and discriminatory social practices and negative attitudes toward women and girls. In addition to these barriers, refugees may face additional difficulties, such as:

- the breakdown of family support networks leading to loss of traditional sources of information, assistance and protection for young people, but women in particular;
- loss of income leading to a reduction of the ability to make free choices;
- an increase in the emotional and physical burden for women with respect to the welfare of their families; and
- the tendency to focus attention on immediate life-saving measures and view reproductive health as a low priority.



3. ASSESSING REPRODUCTIVE HEALTH SERVICES

WHAT IS THE AIM OF THE ASSESSMENT?

The assessment of RH services in the camps in Kakuma and Dadaab was undertaken with the aim of presenting recommendations for an efficient and adapted organization of services through a harmonized and coordinated distribution of tasks between implementing partners.

The anticipated outcome of the assessment was a strengthening of the capacities of the agencies in their RH activities through:

- Outlining clearly the concept of the different components of RH activities in order to identify achievable goals.
- Planning concrete and feasible programs adapted to the different refugee caseloads, taking into consideration their cultural and religious profiles.
- Setting up a range of practical and measurable indicators that will be utilized for monitoring the outcome of the activities and to assess the impact in terms of achieving agreed objectives.
- Organizing a workable implementation strategy for the delivery of RH activities taking into consideration the capacity of various health agencies.

The anticipated tasks of the assessment included the following:

- Briefing by the Senior Health Coordinator and other Heads of Section involved in RH.
- Assessment of activities as currently implemented by RH partners, with particular attention to identifying the gaps/shortfalls and overlap in the delivery of activities. The assessment will also determine the possible areas of confusion within the different agencies concerning their respective responsibilities.
- Review, during the camp visits, the objectives of the activities implemented and assist in revising these, where applicable.
- Propose a new approach to the scope of activities to be delivered in relation to clear objectives.
- Standardize RH reporting for all RH component areas with identification of indicators measuring the impact of RH activities on refugee welfare.
- Finalize a written report and organize a workshop at the end of camp visits for all partners and sectors dealing with RH where the consultant will present her recommendations and plan of action.

HOW SHOULD THE ASSESSMENT BE CONDUCTED?

Kakuma camp was visited between 31 May and 5 June 2001, and Dadaab between 6-13 June 2001. In Kakuma, the camp hospital and three of the five outpatient clinics were visited, as well as the mission hospital in Kakuma town. However, time spent at the camp clinics was limited because of their closure over a long weekend (1-3 June). In Dadaab, the hospital and at least one of the three health posts at each of the camps were visited.

The assessment of RH services in the camps covered two areas: the clinical services for RH provided at camp health facilities; and the community education activities conducted to raise awareness/change behaviour relevant to RH (Appendix 1). Assessment of the clinical services for RH involved the following activities:

- Observation of the organization and delivery of RH services at clinics, health posts and hospitals.
- Discussions with staff about the clinical care provided for RH clients/patients.
- Review of client records and registers pertaining to RH services.
- Observation of physical facilities, supplies, equipment and drugs relevant to RH services.
- Discussions with staff about the collection and use of RH data.
- Group discussions with the users of RH services.

Assessment of community education activities for RH focused on discussions with community members who had participated in an NCCK training activity, as well as those who had not, as follows:

- Group discussions with men, women, adolescent boys, and adolescent girls to determine what they know about RH, where they obtained their information, how they use it, and what they know about RH services in the camps.
- Group discussions with RH motivators, CHWs and teachers to determine what RH messages they provide and to whom, where and how they provide the messages, and their perceptions of how the messages are used.

In addition to these activities, discussions were held with relevant UNHCR field staff and the medical coordinators for IRC in Kakuma and MSF/B in Dadaab. The discussions focused primarily on issues related to coordination and collaboration of RH services.

WHAT WERE THE FINDINGS OF THE ASSESSMENT?

The findings of the assessment are presented and discussed, jointly for Kakuma and Dadaab, under the following headings: safe motherhood; family planning; sexually transmitted diseases (including HIV/AIDS); sexual and gender-based violence; coordination and collaboration; and monitoring and surveillance. Under each of the technical headings, RH services and community education for RH are covered.

SAFE MOTHERHOOD

Antenatal Care

In Kakuma, antenatal care is provided at camp clinics, six days a week. The schedule of visits is as follows: first visit at approximately 16 weeks gestation; monthly visits until the end of the seventh month of pregnancy; bi-weekly visits during the eight month; and weekly visits during the ninth month. An examination room is designated at each clinic for antenatal care and has running water and the basic furniture, equipment and supplies required to facilitate the provision of care.[1] Refugee workers, who have been trained on the job, provide antenatal care at the clinics. There is one worker per antenatal clinic, who takes the woman's history, records her weight, completes a physical examination, including abdominal examination and blood pressure, and provides the necessary care.

Although there are no written guidelines for antenatal care, the basic package of care provided at the clinics includes the following: history and physical examination, haemoglobin and urinalysis (at clinic laboratory, with same-day results), syphilis testing (VDRL at hospital laboratory, with next-day result) tetanus toxoid immunization, and iron and folic acid supplementation (three times daily). In addition, all antenatal women are given a supply of paracetamol to be used when necessary for common complaints such as backache, headache or fever, and vitamin C. Some women are also given multivitamin pills, although it was not clear why either vitamin C or multivitamins are being used for antenatal women, particularly since there does not appear to be evidence to support this practice.

Malaria prophylaxis/treatment is not included as a routine component of antenatal care, although women who present at antenatal clinic with symptoms of malaria (and many appear to), are sent to the clinic laboratory for a blood smear and, if necessary, treated. Treatment of intestinal parasites is not included as a routine component of antenatal care, either, which may be a factor related to anaemia in pregnant women (see below).

While group health education is provided before antenatal clinics, covering topics such as hygiene, rest, breast-feeding, and family planning, there is very little

[1] Basic requirements for antenatal clinics include a small table and chair or stool, an examination table with a sheet or cloth to cover the woman, sphygmomanometer and stethoscope, foetal stethoscope, and water and soap for hand washing.

individual health promotion and/or counselling provided during the clinic visit. An individualized birth plan, which should include anticipated place of birth, recognition of and response to emergencies, family and social support, etc., did not appear to be a standard part of antenatal care; although, for first pregnancies and previous obstetric complications, the woman was advised to deliver at the camp hospital.

A review of the antenatal register and individual records, which in most cases contain the necessary information, revealed that many of the women attending antenatal clinic are anaemic; however, regardless of their haemoglobin results, it appeared that they are given iron and folic acid three times daily. In other words, a woman who has a haemoglobin >10 gm (not anaemic) appeared to receive the same dose of iron and folic acid as one who has a haemoglobin < 7 gm (severely anaemic).[2]

Although antenatal care at the Kakuma camp health facilities compares favourably with the WHO recommended standards,[3] there are some gaps and/or problem areas. The first is that the providers of antenatal care are refugee workers who are trained on the job and have approximately the same level of knowledge and skill that TBAs working in the community have. Traditionally, TBAs would be expected to identify pregnant women living in their respective communities and refer them for antenatal care, to a health care provider more knowledgeable and skilled than themselves. While, it was obvious during the observations made at antenatal clinics that the providers of care have learned to follow established procedures (e.g., taking a history, doing a physical examination, providing iron and folic acid), they lack the skills necessary to recognize and respond effectively to problems. For example, they fail to question why so many of the women attending antenatal clinic continue to be anaemic, despite being given three times the recommended dose of iron and folic acid. Is there a problem with iron and folic acid compliance? Is there a problem with accuracy of haemoglobin tests? Is there a problem with food availability and/or diet? Are the women who continue to be anaemic those who have suffered recent acute episodes of malaria? Is there a problem with intestinal parasite infestation? These are some of the questions that a more knowledgeable and skilled health care provider, such as an experienced midwife, would be expected to pursue.

In addition to having the skill to identify problems, staff at antenatal clinics should be able to respond appropriately by providing treatment, referring the woman to a higher level of care when necessary or, simply, by providing individual health education or counselling geared to meeting the particular needs of antenatal women.

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[2] The recommended preventive supplementary dose during pregnancy is 60 mg of iron and 400 μg of folic acid (1 tablet) once daily, whereas the recommended dose for women with moderate (Hb 7 to 10 gm) and severe (Hb <7 gm) anaemia is 120 mg of iron and 400 μg of folic acid (two tablets once daily) for three months, followed by resumption of the preventive supplementary dose.

[3] WHO recommends inclusion of the following components in antenatal care: history, and physical examination; syphilis screening (RPR test); haemoglobin and urinalysis, where possible; tetanus toxoid immunization; iron and folic acid supplementation (60 mg iron + 400μg folic acid once daily), malaria prophylaxis/treatment (one dose of sulphadoxine-pyrithamine at the beginning of the first and second trimesters); treatment of intestinal parasites (mebendazole if the woman is not in first trimester and has not had a dose in the previous six months); Vitamin A supplementation (in Vitamin A deficient areas); development of an individual birth plan; health education about nutrition and rest, safer sex, breastfeeding, newborn care; recognition and management of antenatal complications, including referral to a higher level of care, when necessary; and treatment of complications such as haemorrhage, pre-eclampsia, anaemia, malaria, urinary tract infection, and STDs.

Although antenatal clinics are well attended, data for March, April and May indicate that only approximately one third of women attend during the first trimester of pregnancy. Women should be encouraged to attend antenatal clinic as early in the pregnancy as possible, and certainly by the fourth month.[4]

In Dadaab, antenatal care is provided at camp health posts, two days a week; one day is reserved for first visits and the other for revisits. The schedule of visits is the same as that followed in Kakuma. Two small rooms are designated for antenatal care at the four health posts visited; one serves as the examination room and the other is used for family planning consultations and meetings. The examination rooms have no source of water for hand washing and are equipped only with an examination table. Other supplies, equipment and drugs (e.g., sphygmomanometer, stethoscope, foetal stethoscope, iron and folic acid, etc.,) are carried to the health post by the staff on clinic days.

Three refugee workers, who have been trained on the job, provide antenatal care at each health post. The three workers share the antenatal consultation in that one weighs the woman and takes her history, another takes her blood pressure and perhaps dispenses iron and folic acid and vitamin C, and yet another examines her. The sharing of responsibilities varies somewhat from health post to health post, although the general impression was that the process contributes to fragmentation of care. In addition, observation of the abilities of these workers suggests limitations with respect to history taking and physical examination; particular areas of weakness appear to be obstetric history, abdominal palpation, and estimation of fundal height.

The basic package of antenatal care provided in the Dadaab camps is limited to history and physical examination, tetanus toxoid immunization, iron and folic acid supplementation (once daily), and the provision of vitamin C (daily). Although the camp hospitals have laboratory facilities, syphilis testing, haemoglobin estimates and urinalyses are not routinely available to antenatal women. Malaria prophylaxis/treatment and treatment of intestinal parasites are not provided on a routine basis for antenatal women, either. Group health education is provided before antenatal clinic begins, although very little individual health promotion and/or counselling were observed during the clinic visits.

The antenatal records reviewed at the health posts lacked much of the required information; for example, obstetric history and findings on physical examination were often not recorded. This may be because the record card being used in Dadaab lacks the space and headings needed to include the information usually found on an antenatal record. Poor record keeping may also explain the observation that all of the antenatal records reviewed indicated that TT1 had been given during the present pregnancy. This seemed peculiar, since many of the women had attended antenatal clinic for previous pregnancies and had quite probably been given at least

[4] WHO recommends a minimum of four antenatal visits: the first visit by the fourth month; the second visit in the sixth or seventh month; the third visit in the eighth month; and the fourth visit in the ninth month.

TT1, if not TT2 and TT3, then. However, in the absence of records to indicate this, immunization begins with TT1, it seems, for each pregnancy.

When compared to the WHO recommendations for antenatal care, there are some serious gaps and/or problems in the Dadaab camps. For instance, the skills of the refugee workers appear to be limited and the actual provision of antenatal care lacks focus because the three workers share the tasks involved. In addition, the basic package of antenatal care lacks essential components such as syphilis screening and haemoglobin tests, even though both are possible at the camp's hospital laboratories. These omissions have particular implications in an environment where the prevalence of STDs is thought to be high, where the number of stillbirths is known to be high, and where many women present during pregnancy with clinical signs of anaemia.

In common with antenatal care in Kakuma, other missing components in Dadaab include malaria prophylaxis/treatment, treatment of intestinal parasites, and individual health education and/or counselling.

Labour and Delivery Care

In both Kakuma and Dadaab, the majority of deliveries are conducted by trained TBAs; in 2000 67 percent of the deliveries in Kakuma camp were conducted by TBAs. In general, the TBAs in the camps are authorized to do more than one would normally expect.[5] For example, they do vaginal examinations to assess cervical dilatation, although because many of them are illiterate, they do not record their findings. Accurate assessment of cervical dilatation is an advanced skill, normally expected of facility-based workers who monitor labour by graphic representation of cervical dilatation on a partograph. For these reasons it seems neither appropriate nor necessary for TBAs working in the community to do vaginal examinations during labour.

TBAs also do episiotomies because many of the women delivered by them have undergone circumcision; however, they are not permitted to suture the episiotomy and must bring the woman to the camp hospital to have this done. In view of this practice, it would seem more appropriate for them to learn to suture an episiotomy than to continue doing vaginal examinations during labour.

Hospital deliveries are available in Kakuma camp and in the three camps in Dadaab, for first pregnancies, for women who are considered at risk (e.g., poor obstetric history), and for women who experience a problem or complication during labour at home. In Kakuma and Dadaab, there is one Kenyan midwife per maternity ward, who works only during day shift. The remaining workers are refugees, who may have had experience as a health worker in their home country, and who have had additional on-the-job training in the maternity ward. Most of the refugee workers on the maternity ward in Kakuma camp are TBAs, while in the Dadaab camps they tend to be auxiliary nurses. Despite this, discussions with staff about clinical care suggest that

[5] The generally accepted role of a trained TBA is to identify pregnant women in the community; refer them to a health facility for antenatal care and provide simple follow-up between antenatal visits; provide health education messages about pregnancy, labour, delivery and newborn care; conduct normal deliveries using clean delivery practices; and identify problems and refer women immediately to a health care facility for management.

they know how to deal with obstetric complications, although opportunities to observe their level of skill were not available. While the Kenyan midwives working in the camps would certainly qualify as "skilled attendants"[6] it is doubtful that the refugee workers on the maternity wards and TBAs working in the community would, which has implications for preventing maternal deaths and morbidity.

In Kakuma, the partograph is not used to monitor labour, although findings on assessment during labour are recorded on a ruled sheet of paper. In Dadaab, the partograph is used, although not always properly. For example, many of the partographs reviewed had cervical dilatation plotted on admission only, while other sections contained no information at all, suggesting that the staff do not understand how to use the partograph or simply do not bother to complete it properly. A most curious observation was that on almost all of the partographs reviewed, the foetal heart was recorded as 140. This suggests that the foetal heart is not being monitored accurately, or possibly not at all, and the worker responsible simply completes this particular section of the partograph as a matter of routine, always plotting at 140.

At present, TBAs who work in the community in Kakuma camp rotate through the maternity ward for one week as a means of providing refresher training. While in principle this is a good idea, it was not clear that the midwife on the maternity ward, rather than another TBA, was providing the refresher training.

With few exceptions, the maternity wards in Kakuma and Dadaab camps have the basic equipment, supplies and drugs needed to provide normal delivery care and respond to common obstetric emergencies. The delivery rooms have a good supply of running water and electric lighting, although the only delivery room with a spotlight is in Kakuma. At Ifo camp, the maternity ward is in an old building that does not have fly screens; as a result, swarms of flies were observed on and around the perineum during a delivery at this facility.

Women in Kakuma camp who require obstetric surgery such as caesarean section are referred to Kakuma Mission Hospital, which is less than ten minutes by road from the camp hospital. The Mission Hospital has one surgeon and the necessary supplies, equipment and drugs to facilitate obstetric surgery. In Dadaab, obstetric surgery is available at Hagadare camp but, because of the security situation in the camps, only between the hours of 8:30 am and 4:30 pm. When an obstetric complication occurs between 4:30 pm and 8:30 am, the refugee worker on the maternity ward is provided support and guidance through radio contact. This situation undoubtedly places the lives of women who experience an obstetric emergency and their babies at risk.

Maternal Deaths

There were four maternal deaths reported in Kakuma camp during 2000 (maternal mortality ratio 216 per 100,000 live births). Twenty-two maternal deaths were

[6]With respect to reducing maternal mortality and morbidity, the long term aim is to have "skilled attendants" in place (midwives, doctors, nurses with midwifery and life-saving skills) who possess the knowledge and skills necessary to give safe and effective care during childbirth to women and their newborn, in a variety of settings (e.g., home, health centre and hospital). Safe and effective care requires that the skilled attendant is able to: manage normal labour and delivery; recognize the onset of complications; perform essential emergency interventions; and safely refer the mother and/or her baby, when necessary.

reported in the Dadaab camps during 2000 (maternal mortality ratio 460 per 100,000 live births): there were 10 deaths in Dagahaley, seven in Ifo, and five in Hagadare. Some of these deaths were related to either malaria and/or anaemia, which reinforces the need to review and revise, in particular, the content and process of antenatal care. Although the maternal mortality ratios in Kakuma and Dadaab camps are lower than for Kenya as a whole (650 per 100,000 live births (Source: World Development Indicators 1999)), it is alarming to note that the ratio for the Dadaab camps is more than double that for Kakuma. This suggests an urgent need to introduce a formal process, in both Dadaab and Kakuma, to review thoroughly each maternal death, to identify avoidable factors, determine interventions (e.g., staff training, strengthening the referral system), and prevent deaths in the future.

Newborn Care

Observations of newborn care suggest the need for refresher training with respect to thermal protection, basic newborn resuscitation procedures and the provision of support and encouragement for early breastfeeding. Even in hot climates such as in Kakuma and Dadaab, babies need to be dried immediately following birth and then wrapped in a clean dry, cloth. On the other hand, they do not need to be hung upside down by their ankles and have their feet pounded if they do not cry vigorously following birth, as was observed in the delivery room at one camp.

Delivery rooms at all of the camps have newborn resuscitation equipment available, although at Dagahaley camp, this was kept in a locked cupboard, instead of on the newborn resuscitation table where it should be. Tetracycline eye ointment is available for newborn eye care but was not observed in use. With respect to newborn immunization, in Kakuma OPV-0 and BCG immunizations are given within the first 24-36 hours of birth; babies born at the hospital are immunized before discharge, and those born at home when they are brought to the maternity ward for registration, usually the day after birth. In Dadaab, mothers are advised that OPV-0 immunization is available at the camp health posts and that BCG vaccination will be given on registration day at the end of the month. This means, of course, that some, if not most, babies are not vaccinated within two weeks of birth, as recommended by WHO, placing them at risk for polio and TB; the paediatric ward at Dagahaley, in fact, has a six month old baby with TB, at present.

Preterm and low birth weight babies are cared for in the maternity ward by their mothers. Three such babies were observed during visits to the wards, none had additional thermal protection and two had cold hands and feet. It was difficult to

determine during the limited time spent at the maternity wards how much support is provided for mothers to breast feed their small babies; in at least one instance; however, giving glucose water via a syringe appeared to be the practice of choice, suggesting the need for refresher training on feeding, and general care, of preterm and low birth weight newborns.

Neonatal Deaths and Stillbirths

There were 15 neonatal deaths and 32 stillbirths reported in Kakuma camp during 2000 (neonatal mortality rate 8 per 1,000 live births; stillbirth rate 17 per 1,000 total births). The total number of neonatal deaths and stillbirths reported in Dadaab camps during 2000 was 81 and 187, respectively (neonatal mortality rate 17 per 1,000 live births; stillbirth rate 37 per 1,000 total births): there were 22 neonatal deaths and 58 stillbirths in Dagahaley, 27 neonatal deaths and 41 stillbirths in Ifo, and 32 neonatal deaths and 88 stillbirths in Hagadare.

The neonatal mortality and stillbirth rates in Dadaab are more than double those in Kakuma. Neonatal deaths and stillbirths should be investigated, in both Dadaab and Kakuma, for the same reasons indicated above with respect to the investigation of maternal deaths. In the Dadaab camps, for example, lack of antenatal syphilis screening may be a contributing factor to stillbirths. Similarly, anaemia and malaria during pregnancy may also be contributing factors for both neonatal deaths and stillbirths. Additional contributing factors, in Dadaab and Kakuma, may include the labour and delivery skills of the maternity ward staff and the TBAs in the community.

Management of Incomplete Abortion

Incomplete abortion is managed at the Kakuma camp hospital and each of the three camp hospitals in Dadaab, using manual vacuum aspiration (MVA). Each of the hospitals has an MVA room containing the necessary equipment, supplies and drugs, and designated staff members have had training in the procedure of MVA. Since January 2001, 45 cases of incomplete spontaneous abortion have been treated using MVA in Kakuma and 20 in Dadaab.

It was difficult to ascertain the extent to which post-abortion family planning counselling is provided, although the general impression is that it is not a particularly strong component of post-abortion care, suggesting the need for refresher training for those involved in this care.

Postpartum Care

There is no formal system of postpartum care at the clinics in Kakuma camp or the health posts in the camps in Dadaab. Women do, however, receive immediate postpartum care, which includes a dose of vitamin A, whether they deliver in the hospital or at home. Beyond this, if a postpartum woman has a problem, she can report to a health facility for care.

Postpartum care is a typically neglected area of maternal and newborn care in many developing countries; however, WHO recommends that a skilled provider should see the postpartum woman at least once in the week following delivery and again at six weeks postpartum. Care should include, at a minimum, examination of mother and baby, provision of iron and folic acid supplementation for three months postpartum,

treatment for complications and/or problems, and health education related to: the recognition of dangers signs and what to do should these occur; breastfeeding and newborn care; hygiene, rest and nutrition; family planning; and prevention of STD/HIV/AIDS. While each of these components is important, it seems particularly relevant to continue iron and folic acid supplementation during the postpartum period because of the prevalence of anaemia among refugee women in Kakuma and Dadaab.

In both Kakuma and Dadaab, the worker providing antenatal care would be the most appropriate worker to provide clinic-based postpartum care, but only if she/he is adequately trained to do so.

Community Education for Safe Motherhood

The discussions held with community members (including women attending antenatal clinic) about community education for reproductive health, suggest that the main messages relating to safe motherhood are about antenatal care and breast-feeding. There was little evidence to indicate that women (or men) learn, for example, about danger signs (during pregnancy, labour and delivery, and postpartum) and what to do if this occur, preparing for a clean home delivery, and avoidance of harmful traditional practices. This suggests the need to include a broader range of messages for safe motherhood, for women in particular, but also for men and adolescent girls and boys.

FAMILY PLANNING

Family planning services are provided through the camp clinics in Kakuma and through health posts at the camps in Dadaab. The methods available are limited to oral and injectable contraceptives and condoms. Intrauterine devices are also available at Kakuma camp hospital.

In Kakuma, each clinic has a refugee family planning worker, specifically trained for this role, who works from a small examination room in the clinic. Counselling about available methods is provided, a history is taken, a physical examination performed, and the woman provided with her method of choice. During the short time spent at the clinics, however, it was not possible to determine the skill level of family planning workers. The Ministry of Health, Kenya family planning record card is used to record details of the first and subsequent visits, and pertinent details are also recorded in a family planning register. In addition a small follow-up card is issued to the woman, reminding her when to return to the clinic.

In Dadaab, the same refugee workers who provide antenatal care provide family planning services, thereby integrating these two important components of reproductive health care. While integration is an excellent idea, the disorganization at the clinics (see above under Antenatal Care) and a lack of privacy for consultations would quite possibly discourage women from using family planning services. Family planning record cards, although less comprehensive than the MOH

card used in Kakuma, and a register are written up, and a small scrap of paper is given to the women with a return date written on it. The general impression was that these services would not attract potential users.

Community education about FP, focusing on child spacing, is provided in Kakuma and Dadaab, through NCCK, for community groups and workers attached to the health system. For example, RH Motivators and CHWs serve as a link between the community and facilities where FP services are available, by providing information about family planning and following up on family planning defaulters, although it was not clear how successfully this latter activity was implemented. RH Motivators at some of the camps seemed also to provide counselling for FP acceptors, when their role should in fact be limited to providing information and linking interested persons to the appropriate health care facility, where counselling should be provided as an integral part of FP services.

Despite the availability of family planning services and the provision of community education about this component of reproductive health, the use of modern FP methods remains low. In Kakuma, for example, there were 554 new FP acceptors in 2000. Contraceptive prevalence rates in Kakuma and Dadaab in 2000 were XXX% and XXX%, respectively. Reasons cited for low contraceptive prevalence, in both Kakuma and Dadaab, include cultural and religious beliefs and practices and the performance of family planning providers. The observations described above certainly suggest the need to determine possible ways of improving the performance of FP workers and, hence, the quality of the services they provide. It would no doubt also be helpful to better understand how socio-cultural and religious factors affect contraceptive prevalence in the camps.

SEXUALLY TRANSMITTED DISEASES (INCLUDING HIV/AIDS)

Treatment of STDs is available in camp clinics and at the camp hospital in Kakuma. Syndromic case management is used, although laboratory tests are resorted to in cases of urethral and vaginal discharge. Each of the clinics visited in Kakuma, as well as the hospital OPD, had a wall poster of syndromic management flow charts, provided by the Ministry of Health. Although the drugs of first choice on the poster are sometimes not available, alternative drugs are. IRC has developed a handbook of clinical guidelines (soon to be made available at the camp health facilities), which includes information about syndromic case management.

In Dadaab, treatment for STDs is available at the camp health posts and hospitals. Discussions with refugee workers at the health posts indicated that their understanding of STD syndromic case management is limited. Both men and women presenting with dysuria, lower abdominal pain and/or back pain, for example, are treated for urinary tract infection, and cases of urethral and vaginal discharge are referred to the hospital OPD, although there is no mechanism in place to ensure that the patient actually goes to the hospital. Nor is there a mechanism in place to facilitate the treatment of sexual partners; patients are asked to advise their

partner(s) to seek treatment, but if they fail to do so, nothing is done about it (also the case in Kakuma). Clinical officers at hospital OPDs expressed concern about the lack of partner treatment but had no suggestions for overcoming the problem. Although they appeared more knowledgeable about syndromic case management than the refugee workers at the health posts, clinical officers also indicated reliance on laboratory tests for cases of urethral discharge and vaginal discharge. Systematic application of a syndromic approach to STD case management allows effective care for symptomatic cases without the need for laboratory support; however this requires that health workers have the knowledge and skills relevant to using a syndromic approach and suggests the need to provide refresher training for those workers involved in treatment services for STDs.

Prevention of STD/HIV/AIDS was often the first topic mentioned during the discussions with women, men, and adolescent girls and boys about community education for RH, indicating their awareness of this particular topic. Nonetheless, although people in the discussion groups were able to describe how to protect themselves from STDs, it was not clear that they would actually do so. Some women, for example, said that it was not possible to refuse unprotected sex with their husband, even if he was suspected of having an STD. The numbers of patients reporting symptoms of STDs at the camp health facilities suggests further that unprotected sex is practiced, and indicates the need to focus community education activities on behaviour change (practicing safer sex), rather than simply on raising awareness (knowing what safer sex entails).

While community education activities on STD/HIV/AIDS include information about the availability and correct use of condoms, distribution in the camps makes it almost impossible for potential users to obtain them anonymously. For example, the main distribution points are at clinic pharmacies (Kakuma), health post pharmacies (Dadaab) and hospital pharmacies (Kakuma and Dadaab), requiring community members to either ask for a supply or be observed, by both the dispenser and patients waiting for drugs, reaching through the window and into the box of condoms kept on the counter. Condoms are also available through RH motivators but this, too, requires potential users to be identified. These observations suggest the need to consider how and where condoms could be made widely available and easily accessible.

SEXUAL AND GENDER-BASED VIOLENCE

In Kakuma, there is no formal mechanism in place for the referral of SGV victims (e.g., victims of rape), either from the community to the camp hospital or the reverse. The usual scenario is for the victim to go to the police, then to the hospital where physical examination and care are provided, together with counselling, which is provided by social workers and counsellors. On return to the community, the victim has access to the services provided by JRS, at day care centres and/or the "safe haven." While day care centres are open to all "traumatized persons," the "safe haven" is for victims of rape only.

These findings suggest that the recommendations made following the April 2000 assessment of the SGV programmes in Kakuma and Dadaab have not, in general, been implemented. The recommendations focused primarily on the development of tools and systems, based on those used in the refugee camps in Tanzania, to facilitate appropriate monitoring and evaluation of the programmes.

In Dadaab, there is a protocol in place for managing victims of rape, and individual incident forms are completed at the hospital following examination and treatment of victims. In terms of coordination of services, an interagency meeting is held weekly, which is chaired by the UNHCR Protection Officer, and attended by the SGV focal person from MSF/B, NCCK, CARE, and the police force. The main items on the agenda for these meetings appear to be the number of victims, the circumstances surrounding each incident of rape, and the response of the various organizations involved. However, it was not clear whether these meetings were in place before, or were introduced following, the April 2000 assessment of the SGV programme. In addition, it was not clear whether the monitoring and evaluation procedures used in Dadaab are based on the recommendations made after the assessment.

An intervention in Dadaab aimed at reducing the incidence of rape involves the provision of firewood for women, through GTZ. The impact of this intervention is not clear, however, possibly because monitoring and evaluation of the SGV programme is inadequate. Nonetheless, there is a widespread perception that the firewood distribution project is the main reason for a decline in the number of reported rape cases, despite the fact that the project provides only approximately 30 percent of household fuel needs.

Another intervention in the Dadaab camps involves the work of anti-violence committees (formerly called anti-rape committees). Committee members (male and female refugees) are involved in activities such as awareness raising and community-based problem identification and resolution.

One of the issues raised with respect to clinical care for rape victims, in Kakuma and Dadaab, was the availability of female health care providers to examine the woman and provide treatment. Observations made during visits to the camp clinics, health posts and hospitals in Kakuma and Dadaab suggest that many workers providing treatment services are male.

With respect to FGM, in Dadaab (Hagadare and Ifo camps), a study is underway to compare IEC/BCC activities targeting girls and their parents and the use of advocacy and BCC activities targeting community leaders. CARE conducted a baseline study along these lines in 2000, and a sociologist employed by CARE and seconded to NCCK is coordinating the present study. The results of the baseline study were, however, not available.

Both FGM and SGV are topics included in general community education activities for RH, in Kakuma and Dadaab, although the group discussions held in the camps suggest that the messages about these topics are oriented to awareness raising, rather than behaviour change.

COORDINATION AND COLLABORATION

In Kakuma, IRC is UNHCR's implementing partner for health and, as such, is responsible for providing preventive and treatment services for RH through the camp health facilities. In addition, NCCK, although not a UNHCR implementing partner, is responsible, principally, for providing community education for RH and, to a lesser extent, counselling for victims of rape. JRS, contracted through LWF, also provides counselling for victims of rape and other forms of violence. There is no formal mechanism in place, however, to facilitate coordination and collaboration between these organizations, with respect to RH activities. Regular meetings, initially chaired by IRC, were apparently once held for this purpose; however, for reasons that were not disclosed, the meetings were disbanded more than a year ago.

Observations made during the assessment of RH services in Kakuma camp provided little evidence that IRC and NCCK work together with respect to RH activities. While the role of each of these organizations is different, it is essential that they work collaboratively to ensure consistency in their assumptions about RH services, to prevent role confusion and/or duplication of activities, and to maintain a strong link between the community and the camp health facilities and services for RH. NCCK, for example, appears to be involved in counselling activities to a far greater extent than expected, particularly since the organization's major focus is community education for RH.

In Dadaab, MSF/B is UNHCR's implementing partner for health, providing preventive and treatment services for RH in Ifo, Dagahaley and Hagadare. NCCK plays the same role as in Kakuma, by providing community education for RH and some counselling services, while CARE is involved in community education about FGM. There is no formal mechanism in place in Dadaab, either, for collaboration and coordination; however, in contrast to the situation in Kakuma, the staff from these organizations work together on a daily basis. To some extent this is related to the security situation in Dadaab, which requires the staff from various organizations to move together, to and from, and to a lesser extent within, the camps. This provides ongoing opportunities to discuss and observe their respective activities, ensure consistency, avoid duplication of effort, and maintain a link between the community and health facilities and services. Apart from this, however, there is no formal mechanism for collaboration and coordination, such as regular interagency meetings at which issues and/or problems and progress with respect to RH services are discussed.

Although there may be opportunities at the monthly meetings of the Interagency Health and Nutrition Coordination Committee, to discuss issues relevant to RH services, it may be worthwhile to consider the possibility of forming a RH Coordination Committee. Membership should include all organizations involved, in

Kakuma and Dadaab, and meetings of the committee should be held on a regular basis, possibly every two months, focusing on issues related to planning, implementing, monitoring and evaluating RH activities.

MONITORING AND SURVEILLANCE

Both IRC in Kakuma and MSF/B in Dadaab, submit monthly reports containing health status and health facility data. However, NCCK, in Kakuma and Dadaab, is responsible for completion and submission of the monthly RH reporting form, even though most of the data to be included on the form is obtained from health facility records and/or registers. It was unclear why NCCK, as the organization principally responsible for community education for RH, is required to do this. While all of the organizations involved in RH activities need to understand and use the information compiled in these reports, it would seem more appropriate for IRC and MSF/B to complete and submit the forms.

Nonetheless, regardless of who collects the information, time and effort will be wasted if it is not used for planning, monitoring and evaluating activities. At present, there is no evidence to suggest that the information in the monthly RH reports is used for these reasons; rather, it is simply collected and submitted month after month. If an RH Coordination Committee were to be established, as suggested above, the monthly RH reports could be used to identify issues of concern and facilitate planning, monitoring and evaluation of RH activities.

WHAT WERE THE CONCLUSIONS OF THE ASSESSMENT?

Safe Motherhood

- In both Kakuma and Dadaab, there are services in place covering the main components of maternal and newborn health, as follows: antenatal care; care during labour and delivery, including management of obstetric emergencies; newborn care; and postpartum care.

- Many of the recommended interventions for antenatal care are in place, although in both Kakuma and Dadaab, intermittent preventive treatment for malaria and treatment of intestinal parasites are missing, and birth planning and individual health education are poorly implemented. In Dadaab, syphilis screening and haemoglobin tests are not available for antenatal women. In addition, the skills and abilities of refugee workers who are trained on the job to provide antenatal care are below the level of the skills and abilities of, for example, trained midwives, particularly with respect to problem identification, response and resolution. These areas of deficiency may have a negative effect on the health of pregnant women and on pregnancy outcomes and suggest the need to revise interventions and upgrade the skills and abilities of workers to fill gaps in antenatal care.

- The majority of deliveries, in Kakuma and Dadaab, are attended by TBAs, who work in the community and are also used to staff maternity wards. While they appear to know more and do more than normally expected of a TBA, their level of skill is unlikely to be comparable to that of a midwife.

- The maternity wards in the camp have, in general, the basic supplies, equipment and drugs for conducting normal deliveries and for responding to the major obstetric emergencies, with the exception in Kakuma of caesarean section. However, this service is available at Kakuma Mission Hospital, a short distance from the camp. The problem in Dadaab with respect to obstetric surgical interventions is that they are available only during the day, because security measures allow non-refugee workers to be present in the camps only between 8:30 am and 4:30 pm.

- As with antenatal care, the skills and abilities of the workers involved in labour and delivery care are not at the level of a trained midwife and suggest the need for refresher training on normal labour and delivery care and management of complications, together with closer supervision to ensure that standards are maintained. The same holds true for essential newborn care, especially related to thermal protection, basic resuscitations measures, and breast-feeding. In addition, there is a need in Dadaab to ensure that newborns receive OPV-0 and BCG within the first two weeks of life.

- In terms of postnatal care, there is a need to formalize clinic-based follow up postpartum care to ensure the provision of basic interventions aimed at preventing postpartum problems and/or detecting and responding to them early, with a view to reducing maternal and newborn mortality and morbidity.

- Although there are reproductive health community education activities in place, focus on safe motherhood seems to be lacking, implying that women (and men) are less well informed than they could and should be about this topic. This has implications for preventing maternal and neonatal mortality and morbidity and suggests the need to include a broader range of safe motherhood messages in community education activities.

Family Planning

- Despite the provision of family planning services over a period of many years, the number of new users and the contraceptive prevalence rate remain low. Factors contributing to this situation may include the skills and abilities of workers, the availability of methods, the knowledge and understanding of the women (and men) in the camps, with respect to family planning, and their socio-cultural and religious beliefs, attitudes and practices. Better understanding of these factors is needed in order to improve family planning services and community education, with a view to increasing contraceptive prevalence.

Sexually Transmitted Diseases, Including HIV/AIDS

- The skills and abilities of workers involved in the treatment of STDs, and poor use of syndromic case management, affect the quality of care and may contribute to under-reporting of STDs. In addition, the availability of drugs of first choice may contribute to inappropriate and/or inadequate treatment of

STDs. Moreover, treatment of sexual partners is poorly implemented and seems hardly to take place at all, placing those who do seek treatment at risk of reinfection.

- Condom distribution is limited, primarily to health care facilities, indicating the need to make them more widely available and accessible, and to ensure that community education about the prevention of STDs is geared toward behaviour change, rather than awareness raising alone.

Sexual and Gender-based Violence

- While there are services in place for victims of SGV (e.g., victims of rape), there is a need, particularly in Kakuma, to formalize the process for referral and treatment, as the lack of coordination between the agencies involved may affect the outcome for victims and have implications for preventing incidents of rape. An additional area that needs to be addressed includes the availability of female health workers, as the presence of male health workers at treatment facilities may represent a barrier to accessing these services.

- In terms of monitoring and evaluating interventions for victims of rape, there is a need to standardize procedures in both Kakuma and Dadaab, with a view to identifying and resolving problems and improving the response to and services for victims.

Coordination and Collaboration and Monitoring and Surveillance

- The lack of formal mechanisms for coordination and collaboration in Kakuma and Dadaab has the potential for undermining the organization, implementation and quality of the reproductive health programme. There is a distinct need to be clear about roles and responsibilities and to establish mechanisms to support better communication, coordination and collaboration between actors involved in clinical services and community education for reproductive health. Similarly, there is a need to improve the collection, analysis and use of reproductive health data, aimed at improving services and community education and strengthening the reproductive health programme as a whole.

WHAT RECOMMENDATIONS WERE MADE ON THE BASIS OF THE ASSESSMENT FINDINGS?

Safe Motherhood

- In Kakuma and Dadaab, the schedule of antenatal visits should be revised, in keeping with WHO recommendations, to encourage the first visit early in pregnancy and provide fewer subsequent visits of higher quality.

- In Dadaab, the provision of antenatal care should be reorganized so that antenatal women are seen by one health care provider, instead of three; the ANC examination room should be improved in terms of basic privacy and comfort; and consideration should be given to providing antenatal care, at least five days a week, at health posts (1st visit on any day).

- Additional recommended interventions should be included in antenatal care, as follows: preventive intermittent treatment for malaria, treatment of intestinal parasites, birth planning, and individual health education (Kakuma and Dadaab); and syphilis testing and haemoglobin screening (Dadaab).

- Refresher training for refugee workers, aimed at improving clinical skills and the ability to recognize and respond to problems, should be provided for refugee workers involved in antenatal care.

- Written guidelines should be provided for workers at antenatal clinics, based on WHO guidelines and including the recommendations above.

- The scope of work of TBAs should be reviewed and revised with a view to excluding vaginal examination and including the suturing of episiotomies.

- Refresher training for TBAs working in the community and staff on maternity wards, focusing on normal labour, delivery and newborn care, including use of the partograph (maternity wards) and universal precautions, should be provided.

- The supervision and support procedures for TBAs, in the community and hospital, should be revised to ensure that standards are maintained (this should include supervision and support by a "skilled" worker).

- Consideration should be given to making more than one "skilled" worker (i.e. midwife) for maternity wards.

- Written guidelines should be provided for maternity wards for normal labour and delivery care and the management of complications, based on WHO guidelines.

- Review procedures for maternal deaths, based on WHO guidelines, should be introduced.

- Refresher training should be provided for workers on essential newborn care, including care of preterm and low birth weight babies, based on WHO guidelines.

- Written guidelines on essential newborn care, based on WHO guidelines, should be provided on maternity wards.

- Procedures for newborn immunization in Dadaab should be revised, based on procedures in Kakuma, to ensure that all newborns receive OPV-0 and BCG in the first two weeks of life.

- Review procedures for perinatal deaths should be introduced, along the same lines as those for reviewing maternal deaths.

- Postpartum care at clinics and health posts should be formalized, based on WHO guidelines, and training provided for workers who will provide postpartum care (same workers who provide ANC).

- Written guidelines for postpartum care should be provided at clinics and health posts, based on WHO guidelines.

- A broader range of messages on "safe motherhood", covering all components of maternal and newborn care, and emphasizing antenatal care, birth planning, danger signs, emergency response, etc., should be included in community education activities. In relation to this, the content of messages should be revised and refresher training provided for workers involved in community education activities for safe motherhood.

Family Planning

- A comprehensive review of family planning services should be conducted in Kakuma and Dadaab, covering the skills and abilities of the workers involved; the organization and delivery of services, with particular emphasis on accessibility and convenience to clients; the range of methods available vis-à-vis the needs of potential clients; and IEC/BCC/advocacy activities vis-à-vis the socio-cultural profile of camp populations. The results of the review should then be used to revise and improve family planning services and community education related to family planning.

Sexually Transmitted Diseases, Including HIV/AIDS

- Refresher training should be provided on syndromic case management for workers involved in the provision of treatment services for STDs.

- Written guidelines should be provided at health posts and OPDs (Dadaab) on syndromic case management (e.g., similar to or the same as the wall posters used in Kakuma). In addition written guidelines about treatment of sexual partners should be provided in both Kakuma and Dadaab.

- Implementation of guidelines, through appropriate supervision and support, especially for refugee health workers in clinics and health posts, should be provided.

- Availability of recommended drugs of first choice should be ensured for the treatment of STDs.

- Condom distribution should be reviewed and revised to ensure greater availability and access, and community education provided to ensure that community members know where to obtain them and how to use them properly.

- Community education activities related to STD/HIV/AIDS, should be reviewed and revised, considering the need for behaviour change and the socio-cultural barriers to this.

Sexual and Gender-based Violence

- Clinical care for victims of SGV should be strengthened, based on UNHCR or guidelines. In addition, refresher training should be provided for health workers involved in the care of victims of SGV, and the availability of female health workers should be ensured.

- Monitoring and evaluation procedures for SGV should be implemented, based on UNHCR guidelines (i.e., from Kigoma).

- Community education about SGV should be revised, based on information provided through improved monitoring and evaluation procedures.

Coordination and Collaboration and Monitoring and Surveillance

- The roles and responsibilities of each organization involved in RH activities (clinical services and community education) should be reviewed and agreed to.

- The role and responsibilities of the RH coordinators for IRC and MSF/B should be reviewed and agreed to, using the sample job description in the IAFM as a guide.

- Consideration should be given to establishing an RH coordination committee, representing interests in both Kakuma and Dadaab, to meet on a regular basis for the purpose of discussing issues related to planning, implementation, monitoring and evaluation of RH activities.

- The collection, analysis and use of RH data should be reviewed and revised, based on UNHCR recommendations, including the selection of objectives and indicators for monitoring and evaluation of RH activities in Kakuma and Dadaab.

HOW WERE THE ASSESSMENT FINDINGS AND RECOMMENDATIONS DISSEMINATED?

The assessment findings and recommendations formed the basis of a technical meeting organized by UNHCR BO in Nairobi, on June 20 and 21, 2001. The meeting was attended by relevant UNHCR staff and staff responsible for and/or involved in RH activities in Kakuma and Dadaab camps (Appendix 2). The outcome of the meeting (Appendix 3) included an agreed plan of action covering the various components of reproductive health, the indicators to be used for monitoring the various components, and mechanisms to improve coordination and collaboration between organizations involved in reproductive health services and community education activities. Mechanisms to improve coordination and collaboration include the establishment of an RH Coordination Committee in Kakuma and Dadaab, which would meet on a monthly basis. The overall aim of the Committee will be to clearly define the roles and responsibilities of all actors involved in reproductive health activities, implement the agreed plan of action (see above), and identify and resolve reproductive health issues and problems through careful planning, monitoring and evaluation of activities.

APPENDIX 1
ASSESSMENT TOOLS

Services Checklist
Written Guidelines/Protocols Checklist
Facility Infrastructure Checklist
Consumable Supplies Checklist
Equipment Checklist
Drug Supply Checklist
Discussion Guide: Traditional Birth Attendants
Discussion Guide: Refugee Women and Men
Discussion Guide: Refugee Adolescent Girls and Adolescent Boys
Discussion Guide: Community Health Workers, RH Motivators, and Teachers

Assessment of Reproductive Health Services in Refugee Camps Services Checklist		

Service		Finding
SERV1	◆ antenatal care	• yes • no
SERV2	◆ normal delivery care*	• yes • no
SERV3	◆ vacuum extraction*	• yes • no
SERV4	◆ forceps delivery*	• yes • no
SERV5	◆ caesarean section*	• yes • no
SERV6	◆ blood transfusion (HIV tested blood)*	• yes • no
SERV7	◆ "rooming-in" for baby*	• yes • no
SERV8	◆ family planning counselling and services	• yes • no
SERV9	◆ management of abortion complications*	• yes • no
SERV10	◆ management of anaemia*	• yes • no
SERV11	◆ management of pre-eclampsia*	• yes • no
SERV12	◆ management of eclampsia*	• yes • no
SERV13	◆ management of puerperal sepsis*	• yes • no
SERV14	◆ management of postpartum haemorrhage*	• yes • no
SERV15	◆ postnatal care	• yes • no
SERV15	◆ syndromic management of std	• yes • no
SERV16	◆ voluntary HIV testing and counselling	• yes • no
SERV17	◆ management of SGBV (rape)*	• yes • no
Comments:		
Camp:		
Facility:		

* 24 hours/day

Assessment of Reproductive Health Services in Refugee Camps
Availability of Written Guidelines/Protocols for Reproductive Health Services

Written Clinical Guidelines/Protocols		**Finding**
GUID1	◆ antenatal care	• yes • no
GUID2	◆ postnatal care	• yes • no
GUID3	◆ normal labour/delivery care	• yes • no
GUID4	◆ normal newborn care	• yes • no
GUID5	◆ newborn resuscitation	• yes • no
GUID6	◆ common newborn illnesses	• yes • no
GUID7	◆ care of preterm/low birth weight babies	• yes • no
GUID8	◆ postpartum haemorrhage	• yes • no
GUID9	◆ prolonged/obstructed labour	• yes • no
GUID10	◆ pre-eclampsia/eclampsia	• yes • no
GUID11	◆ puerperal sepsis	• yes • no
GUID12	◆ abortion complications	• yes • no
GUID13	◆ syndromic management of STD	• yes • no
GUID14	◆ voluntary HIV testing and counselling	• yes • no
GUID15	◆ SGBV (rape)	• yes • no
GUID16	◆ family planning	• yes • no
Comments:		
Camp:		
Facility:		

Assessment of Reproductive Health Services in Refugee Camps Facility Infrastructure Checklist		
Item		**Finding**
INFR1	◆ reception room	• yes • no
INFR2	◆ examination room	• yes • no
INFR3	◆ table and stool for obstetric examinations	• yes • no
INFR4	◆ examination light	• yes • no
INFR5	◆ wall clock (delivery room)	• yes • no
INFR6	◆ delivery room with bed and lighting	• yes • no
INFR7	◆ post-delivery room	• yes • no
INFR8	◆ electricity 24 hours/day	• yes • no
INFR9	◆ running water 24 hours/day	• yes • no
INFR10	◆ toilet facilities (functioning)	• yes • no
INFR11	◆ refuse disposal (functioning)	• yes • no
INFR12	◆ laboratory facilities (functioning)	• yes • no
INFR13	◆ storage area for drugs and other supplies	• yes • no
INFR14	◆ telephone 24 hours/day	• yes • no
INFR15	◆ ambulance 24 hours/day	• yes • no
INFR16	◆ operating room with table, lighting, trolley, suction apparatus, anaesthetic equipment	• yes • no
Comments:		
Camp:		
Facility:		

Assessment of Reproductive Health Services in Refugee Camps Consumable Supplies Checklist		
Item		**Finding**
CONS1	**Basic Consumables**	
CONS1.1	◆ gloves	• yes • no
CONS1.2	◆ disposable syringes and needles	• yes • no
CONS1.3	◆ gauze, dressings, adhesive tape	• yes • no
CONS1.4	◆ cord ties/clamps	• yes • no
CONS1.5	◆ IVI sets	• yes • no
CONS1.6	◆ IV solutions (e.g. saline, ringers lactate)	• yes • no
CONS1.7	◆ blood transfusion sets	• yes • no
CONS1.8	◆ pregnancy test kits	• yes • no
CONS1.9	◆ HIV test kits	• yes • no
CONS1.10	◆ syphilis test kits	• yes • no
CONS1.11	◆ disinfectants and antiseptics	• yes • no
CONS1.12	◆ hand soap	• yes • no
CONS2	**Standard Forms/Records**	
CONS2.1	◆ antenatal records	• yes • no
CONS2.2	◆ labour and delivery records	• yes • no
CONS2.3	◆ partographs	• yes • no
CONS2.4	◆ newborn records	• yes • no
CONS2.5	◆ family planning records	• yes • no
CONS2.6	◆ STD records	• yes • no
CONS2.7	◆ SGBV records	• yes • no
CONS2.8	◆ referral forms	• yes • no
CONS3	**Educational Materials (written)**	
CONS3.1	◆ warning signs of complications of pregnancy	• yes • no
CONS3.2	◆ antenatal nutrition	• yes • no
CONS3.3	◆ preparation for birth	• yes • no
CONS3.4	◆ breast feeding	• yes • no
CONS3.5	◆ newborn care (including NB immunization)	• yes • no
CONS3.6	◆ postnatal care	• yes • no
CONS3.7	◆ family planning	• yes • no
CONS3.8	◆ STD/HIV/AIDS	• yes • no
CONS3.9	◆ SGBV	• yes • no
CONS3.10	◆ FGM	• yes • no
Comments:		
Camp:		
Facility:		

Assessment of Reproductive Health Services in Refugee Camps Equipment Checklist		

Item		Finding
EQU1 Basic Equipment		
EQU1.1	◆ sphygmomanometer	• yes • no
EQU1.2	◆ stethoscope	• yes • no
EQU1.3	◆ foetal stethoscope	• yes • no
EQU1.4	◆ infant scale	• yes • no
EQU1.5	◆ clinical thermometer	• yes • no
EQU1.6	◆ sterilizer	• yes • no
EQU1.7	◆ protective clothing (shoes, aprons)	• yes • no
EQU1.8	◆ speculum (different sizes)	• yes • no
EQU1.9	◆ sterilizer	• yes • no
EQU1.10	◆ manual vacuum aspiration or D&C equipment	• yes • no
EQU1.11	◆ adult ventilation bag and mask	• yes • no
EQU2 Delivery Equipment		
EQU2.1	◆ scissors, suture needles, sutures	• yes • no
EQU2.7	◆ vacuum extractor	• yes • no
EQU2.8	◆ obstetric forceps	• yes • no
EQU3 Newborn Equipment		
EQU3.1	◆ cloth or towel to dry baby	• yes • no
EQU3.2	◆ blanket to wrap baby	• yes • no
EQU3.3	◆ bag and mask for newborn resuscitation	• yes • no
EQU3.4	◆ mucous extractor	• yes • no
Comments:		
Camp:		
Facility:		

Assessment of Reproductive Health Services in Refugee Camps
Drug Supply Checklist

Item		Finding
DRUG1	**Anaesthetics: general and pre-operative medication**	
DRUG1.1	◆ nitrous oxide/other general anaesthetic agent	• yes • no
DRUG1.2	◆ diazepam (injection)	• yes • no
DRUG1.3	◆ ketamine (injection)	• yes • no
DRUG2	**Anaesthetic: local**	
DRUG2.1	◆ lidocaine 2% and 5% (injection)	• yes • no
DRUG3	**Analgaesic**	
DRUG3.1	◆ paracetamol (oral)	• yes • no
DRUG3.2	◆ acetylsalicylic acid (oral)	• yes • no
DRUG3.3	◆ pethedine (injection)	• yes • no
DRUG4	**Anti-infective drugs**	
DRUG4.1	◆ ampicillin (oral)	• yes • no
DRUG4.2	◆ ampicillin (injection)	• yes • no
DRUG4.3	◆ benzylpenicillin (injection)	• yes • no
DRUG4.4	◆ procaine penicillin (injection)	• yes • no
DRUG4.5	◆ ceftriaxone (oral)	• yes • no
DRUG4.6	◆ ceftriaxone (injection)	
DRUG4.6	◆ gentamicin (injection)	• yes • no
DRUG4.7	◆ kanamycin (injection)	• yes • no
DRUG4.8	◆ sulfamethoxazole+trimethoprin (oral)	• yes • no
DRUG4.9	◆ tetracycline eye ointment/silver nitrate drops	• yes • no
DRUG4.10	◆ tetracycline (oral)	• yes • no
DRUG4.11	◆ erythromycin (oral)	• yes • no
DRUG4.12	◆ doxycycline (oral)	• yes • no
DRUG4.13	◆ sulphafurazole (oral)	• yes • no
DRUG4.14	◆ chloramphenicol (oral)	• yes • no
DRUG4.15	◆ metronidazole (oral)	• yes • no
DRUG4.16	◆ ciprofloxacin (oral)	• yes • no
DRUG4.17	◆ cefixime	• yes • no
DRUG4.18	◆ spectinomycin (injection)	• yes • no
DRUG4.19	◆ nystatin pessaries	• yes • no
DRUG4.20	◆ clotrimazole pessaries	• yes • no
DRUG4.21	◆ miconazole (vaginal)	• yes • no
DRUG5	**Antianaemia drugs**	
DRUG5.1	◆ ferrous sulpate (oral)	• yes • no

DRUG5.2	◆ folic acid (oral)	• yes • no
DRUG6 Antimalarial drugs		
DRUG6.1	◆ chloroquine (oral)	• yes • no
DRUG6.2	◆ quinine (injection)	• yes • no
DRUG6.3	◆ sulfadoxide+pyrimethamine (oral)	• yes • no
DRUG7 Antihelminthic drugs		
DRUG7.1	◆ mebendazole	• yes • no
DRUG 7 Antihypertensive drugs		
DRUG7.1	◆ methyldopa (oral)	• yes • no
DRUG7.2	◆ hydralazine (injection)	• yes • no
DRUG7.3	◆ propranolol (oral)	• yes • no
DRUG 8 Anticonvulsant drugs		
DRUG8.1	◆ magnesium sulphate (injection) or	• yes • no
DRUG8.2	◆ diazepam (injection)	• yes • no
DRUG 9 Antiretroviral drugs		
DRUG9.1	◆ zidovudine (ZDV)	• yes • no
DRUG10 Contraceptives		
DRUG10.1	◆ oral contraceptives (COC and POP)	• yes • no
DRUG10.2	◆ injectable (Depot medroxy-progesterone acetate)	• yes • no
DRUG10.3	◆ intrauterine devices	• yes • no
DRUG10.4	◆ condoms (male and female)	• yes • no
DRUG10.5	◆ diaphragms	• yes • no
DRUG10.6	◆ spermicides	• yes • no
DRUG10.7	◆ intradermals (norplant)	• yes • no
DRUG10.8	◆ emergency contraceptives	• yes • no
DRUG11 Vaccines		
DRUG11.1	◆ Tetanus vaccine	• yes • no
DRUG11.2	◆ BCG vaccine (for newborn)	• yes • no
DRUG11.3	◆ oral polio vaccine (for newborn)	• yes • no
DRUG12 Oxytocics		
DRUG12.1	◆ ergometrine injection/tablets or	• yes • no
DRUG12.2	◆ oxytocin injection	• yes • no
DRUG13 Vitamins		
DRUG13.1	◆ Vitamin A	• yes • no
Comments:		
Camp:		
Facility:		

Discussion Guide:
Traditional Birth Attendant (TBA)

The following questions, together with possible responses, are provided to facilitate group discussions with TBAs.

1. **What danger signs during pregnancy would prompt you to refer a woman to a nurse or midwife?**
   - poor obstetric history
   - pallor/tiredness/breathlessness
   - vaginal bleeding
   - bad headache/swelling/fits
   - baby in wrong position

2. **What danger signs during delivery would prompt you to refer a woman to a nurse or midwife?**
   - bad headache/swelling/fits
   - heavy bleeding
   - water broken with no contractions
   - long delivery/sun set two times
   - baby in wrong position
   - baby not moving
   - bad smelling vaginal discharge

3. **What danger signs after delivery would prompt you to refer a woman to a nurse or midwife?**
   - heavy bleeding
   - bad smelling vaginal discharge
   - abdominal pain
   - fever

4. **When was the last time you conducted a delivery?**
   - today or in the past week
   - more than one week ago, less than four
   - more than four weeks ago, less than six
   - more than six months ago
   - never

5. **What are the "cleans" which should be observed during a delivery?**
   - clean hands
   - clean cord cutting instrument
   - clean perineum
   - clean delivery surface
   - nothing unclean inserted into the vagina

6. How do you manage the delivery if the mother has been circumcised?

- stretch perineum
- cut perineum with scissors
- stitch perineum after delivery

7. What do you use to cut the cord?

- new razor blade
- used razor blade
- knife
- scissors

8. What do you do to the baby's cord after birth?

- nothing
- put ash on it
- put dung on it
- put herbs on it

9. What traditional treatments do you use during pregnancy, delivery, after delivery?

- none
- herbs

10. What do you use the traditional treatments for?

- to stimulate appetite
- to change sex of baby
- to stop abortion
- to cause abortion
- to stimulate contractions
- to treat fever
- to treat bleeding
- to treat obstructed labour
- to treat vaginal bleeding

11. What advice and information do you provide to mother after delivery?

- possible complications (bleeding, fever, infection, bad head ache)
- personal hygiene
- nutrition for mother
- child spacing/family planning (contraception)
- breast feeding
- cord care
- immunization

12. How soon after a normal delivery do you refer mother and baby to a nurse or midwife for follow-up care?

- never refer
- immediately
- during first week
- during first six weeks
- only if mother or baby are ill

13. When did you complete your training as a TBA?

14. When did you last have refresher training?

15. What would you like to be included in refresher training?

16. Who is your supervisor?

17. When do you meet with your supervisor?

18. What do you talk about with your supervisor?

Camp:
Facility:

Discussion Guide:
Refugee Women and Men

The following questions, together with possible responses, are provided to facilitate group discussions with refugee women and men. Note that separate discussion groups should be held for women and men.

1. **What have you learned about reproductive health through community education?**
   - safer sex (condom use)
   - STD/HIV/AIDS prevention
   - anatomy and physiology of male and female reproductive systems
   - respect for the reproductive rights of girls and women
   - SGBV prevention
   - RH services available in the camp

2. **Who in the community did you learn this from?**
   - TBA
   - CHW
   - RH motivator
   - Friend
   - Nurse-midwife
   - Other

3. **How have you used your new knowledge about reproductive health?**
   - practiced safer sex
   - shared knowledge with spouse, children, others
   - used available health services

4. **What reproductive health services are provided at the camp health facilities?**
   - antenatal
   - labour and delivery
   - postpartum
   - family planning (contraception)
   - STD/HIV/AIDS prevention and management
   - management of SGBV victims

5. **Are there ways in which you think reproductive health services for women/men could be improved?**

6. **Are there ways in which you think community education about reproductive health, for women/men, could be improved?**

Camp:
Facility:

Discussion Guide:
Refugee Adolescent Girls and Boys

The following questions, together with possible responses, are provided to facilitate group discussions with refugee adolescent girls and boys. Note that separate discussion groups should be held for adolescent girls and adolescent boys.

1. **What have you learned about reproductive health through community education?**
   - safer sex (condom use)
   - STD/HIV AIDS prevention
   - anatomy and physiology of male and female reproductive systems
   - respect for the reproductive rights of girls and women
   - delaying early marriage and childbearing
   - complications of teenage pregnancy
   - SGBV prevention
   - RH services available in the camp

2. **Who in the community did you learn this from?**
   - Teacher
   - TBA
   - CHW
   - RH motivator
   - Mother or father
   - Friend
   - Other

3. **How have you used your new knowledge about reproductive health?**
   - practiced safer sex
   - shared knowledge with friends, parents, others
   - delayed marriage and childbearing
   - used health services

4. **What reproductive health services are provided for adolescent girls/boys at the camp health facilities?**
   - antenatal
   - labour and delivery
   - postpartum
   - family planning (contraception)
   - STD/HIV/AIDS prevention and management
   - management of SGBV victims

5. **Are there ways in which you think the reproductive health services for adolescent girls/boys could be improved?**

6. **Are there ways in which you think community education about reproductive health, for adolescent girls/boys, could be improved?**

Camp:
Facility:

Discussion Guide:
Community Health Workers, RH Motivators, and Teachers

The following questions, together with possible responses, are provided to facilitate group discussions with community health workers, RH motivators, and teachers. Note that separate discussion groups should be held for community health workers, RH motivators, and teachers.

1. **What reproductive health messages do you provide in your community?**
   - antenatal
   - labour and delivery
   - postpartum
   - family planning (contraception)
   - STD/HIV/AIDS prevention and management
   - SGBV prevention and management

2. **Who do you provide the messages to?**
   - women
   - men
   - adolescent girls
   - adolescent boys

3. **Where do you provide the messages?**
   - schools
   - health centres
   - homes
   - other

4. **How do you provide the messages?**
   - talks
   - videos
   - printed materials
   - other

5. **How do you think the messages are being used in the community?**

6. **Are there ways in which you think community education for reproductive health can be improved?**

Camp:
Facility:

APPENDIX 2
AGENDA FOR TECHNICAL MEETING ON REPRODUCTIVE HEALTH

Background and Objectives
Timetable Day 1
Timetable Day 2
Working Groups
Working Group Activity 1
Working Group Activity 2

TECHNICAL MEETING ON REPRODUCTIVE HEALTH
UNHCR, Nairobi
June 20-21, 2001

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BACKGROUND

Since 1992, UNHCR, through its implementing partners for health, has been providing various components of reproductive health services to refugees, with varying degrees of success. Emphasis and/or success have greatly depended on the phase of the health programme, the mandate of implementing partners, and the conviction of individual coordinators. There is a need now to review the gains made in reproductive health service provision, determine the way forward, and standardize services in the refugee camps in Kakuma and Dadaab.

The need for close interagency collaboration is increasingly being felt in all areas of health service provision and particularly in reproductive health; there is a need for common understanding and support if all components of reproductive health are to be adequately addressed.

It is against this background that the technical meeting on reproductive health has been organized.

OBJECTIVES

The objectives for the meeting are as follows:

By the end of the meeting, agreement should be reached on a common approach and strategy for reproductive health, as follows:

- Common understanding of the various components of reproductive health should be agreed;
- Clear objectives, together with measurable indicators, for the various components of reproductive health should be agreed;
- Improved mechanisms for coordination and collaboration between sectors and organizations involved in reproductive health activities should be agreed.

Day 1

Date and Time	Activities	Responsible Parties
Wednesday 20 June 2001		**Chairperson (morning): Mr Stephen Maura**
9:00-9:15am	Welcome and Introduction of Participants	Dr Roger Vivarie
9:15-9:30am	Presentation of Agenda and Objectives	Dr Roger Vivarie Ms Judith O'Heir
9:30-10:30am	Results of a Study of Adolescent Sexuality in Kakuma Refugee Camp	Mr Edmond Tadiesse
10:30-11:00am	Tea Break	
11:00-11:45am	Assessment of RH Services in Kakuma and Dadaab Refugee Camps: Summary of Results	Ms Judith O'Heir
11:45-1:00pm	Working Group Activity 1:Filling the Gaps and/or Improving the Quality of RH Services in Kakuma and Dadaab Refugee Camps	**Group A**: Safe Motherhood **Group B**: Family Planning and STD/HIV/AIDS **Group C**: Sexual and Gender-based Violence
1:00-2:00pm	**LUNCH BREAK**	
2:00-3:00pm	Continuation of Working Group Activity 1	Participants & Facilitators
3:00-4:30pm **3:00-3:30pm** **3:30-4:00pm** **4:00-4:30pm**	Plenary Session: Working Group Activity 1 – Group Presentations and Discussion Group A: Safe Motherhood Group B: Family Planning and STD/HIV/AIDS Group C: Sexual and Gender-based Violence	**Chairperson (afternoon): Dr Ibrahim Amira** Participants
4:30-5:00pm	Summary and Wrap-up: Day 1 Reading Assignment for Day 2	

Day 2

Date and Time	Activities	Responsible Parties
Thursday **21 June 2001**		**Chairperson (morning):** **Ms Judith O'Heir**
9:00-10:30am	RH Surveillance and Monitoring	Ms Kate Burns
10:30-11:00am	Tea Break	
11:00-1:00pm	Working Group Activity 2: Selection and Use of Objectives and Indicators for RH services in Kakuma and Dadaab Refugee Camps	**Group A**: Safe Motherhood **Group B**: Family Planning and STD/HIV/AIDS **Group C**: Sexual and Gender-based Violence
1:00-2:00pm	Lunch Break	
2:00-3:30pm **2:00-2:30pm** **2:30-3:00pm** **3:00-3:30pm**	Plenary Session: Working Group Activity 2 – Group Presentations and Discussion **Group A**: Safe Motherhood **Group B**: Family Planning and STD/HIV/AIDS **Group C**: Sexual and Gender-based Violence	**Chairperson (afternoon):** **Ms Kate Burns** Participants
3:30-4:30pm	Plenary Session: Improving Coordination and Collaboration – Discussion of Ways and Means	Participants & Facilitators
4:30-5:00pm	Summary and Wrap-up Day 2 Closing of Meeting	Dr Roger Vivarie

WORKING GROUPS

Group A: Safe Motherhood

Dr Samura - MSF/B, Dadaab
Ms Fatuma Aden - MSF/B, Dadaab
Dr Lucy Wahome - IRC, Kakuma
Dr Jane Ong'ang'o – GOAL, Kenya
Mr Bonventure Barasa – NCCK, Kakuma
Ms Francisca Nzau – UNHCR, Kakuma

Group B: Family Planning and STD/HIV/AIDS

Dr Jagwer – IRC, Kakuma
Ms Fatuma Hussein – NCCK, Dadaab
Ms Alemtsehai Zaleke – UNHCR, Kakuma
Ms Antonina Njau – JRS, Nairobi
Mr Edmond Tadiesse – University Student
Ms Agnes Mutele, UNHCR, Nairobi

Group C: Sexual and Gender-based Violence

Ms Consolata Mwangi – JRS, Kakuma
Mr Michael Ochieng – CARE, Dadaab
Ms Asha Oluoch – GOAL, Kenya
Ms Joyce Riungu – NCCK, Nairobi
Ms Lucy Macharia – IRC, Kakuma
Ms A. Magala – UNHCR, Dadaab
Ms Rita Amukhobu – UNHCR, Nairobi

Faciliators

Dr Roger Vivarie – UNHCR, Nairobi
Dr Ibrahim Amira – Ministry of Health, Kenya
Mr Stephen Mwaura – UNHCR, Nairobi
Ms Kat Burns – UNHCR, Geneva
Ms Judith O'Hier – UNHCR Consultant

Working Group Activity 1:
Filling the Gaps and/or Improving the Quality of RH Services in Kakuma and Dadaab Refugee Camps

Time Frame: 2 ¼ Hours

1. Please appoint a **chairperson** to guide the discussion in your group and a **reporter** who will be responsible for recording the main points of the discussion and reporting at the plenary session.

2. Discuss the particular **component(s) of reproductive** health assigned to your group (i.e., Group A: safe motherhood; Group B: family planning and STD/HIV/AIDS; Group C: sexual and gender-based violence) and determine how to fill the gaps and/or improve the quality of services and community education in the refugee camps in Kakuma and Dadaab.

3. During your discussion, consider (a) the **socio-cultural backgrounds** of the refugees in Kakuma and Dadaab; and (b) the needs of **refugee women, men, and adolescent girls and boys**, with respect to the particular component(s) of reproductive health assigned to your group.

4. By the end of your discussion, you should have answered the following questions:

   - What changes will be made to improve clinical services (suggested changes must reflect evidence-based practice), how will the changes be implemented and who (e.g., organization/agency) will be involved?

   - What changes will be made to improve community education (IEC/BCC) activities, how will the changes be implemented and who (e.g., organization/agency) will be involved?

Working Group Activity 2:
Selection and Use of Objectives and Indicators for RH in Kakuma and Dadaab Refugee Camps

Time Frame: 3 Hours

1. Please appoint a **chairperson** to guide the discussion in your group and a **reporter** who will be responsible for recording the main points of the discussion and reporting at the plenary session.

2. This working group activity relates directly to Working Group Activity 1 in that the **objectives** and **indicators** selected will be used to **monitor** the **process**, **outcome** and **impact** of the reproductive health services discussed and agreed to.

3. Chapter 9 in the Inter-agency Field Manual for Reproductive Health in Refugee Situations should be used as a basis for discussion.

4. By the end of your discussion, you should have answered the following questions:

   - What objectives and indicators will be used to monitor reproductive health services?

   - How and by whom (e.g. organization/agency) will the required data be collected, compiled and used to measure progress toward achievement of objectives?

APPENDIX 3
OUTCOME OF TECHNICAL MEETING ON REPRODUCTIVE HEALTH

Plan of Action for Reproductive Health
Indicators for Reproductive Health
Terms of Reference for RH Coordinator
RH Coordination Committee – Kakuma
RH Coordination Committee – Dadaab
Reproductive Health Activities – Roles and Responsibilities

PLAN OF ACTION FOR REPRODUCTIVE HEALTH – KAKUMA AND DADAAB REFUGEE CAMPS

Safe Motherhood

RH Component/Recommendation	Responsible Org/Comments	Anticipated Implementation	Financial/Other Implications
Antenatal Care • Revise schedule of antenatal visits, in keeping with WHO/IAFM recommendations	IRC/MSF • 1st antenatal visit in first trimester • 8 visits at 16, 20, 24, 28, 32, 34, 36, 38 weeks		
• Include missing interventions and/or revise existing interventions, in keeping with WHO/IAFM recommendations	• Hb for anaemia and RPR for syphilis screening, MSF/B requires to train and/or recruit more lab staff IRC/MSF • Intermittent preventive treatment for malaria in 2nd and third trimester • combined iron/folate prep for daily supplementation		
• Reorganize the provision of antenatal care so that the woman is seen by one health care provider, instead of three • Improve clinic environment (privacy and comfort) • Consider how to provide antenatal care, at least five days a week, at health posts (1st visit on any day)	MSF		

Safe Motherhood (cont'd)

RH Component/Recommendation	Responsible Org/Comments	Anticipated Implementation	Financial/Other Implications
• Provide refresher training for refugee workers, aimed at improving clinical skills and abilities to recognize and respond to problems • Provide written guidelines for workers at antenatal clinics, based on WHO guidelines	IRC/MSF		
Labour and Delivery • Review and revise the scope of work of TBAs (VE; suturing episiotomies)	IRC/MSF Improve skills of TBAs to do VE and encourage universal precautions		
▪ Provide refresher training for TBAs working in the community and staff on maternity wards, focusing on normal labour, delivery and newborn care, including use of the partograph (maternity wards) and universal precautions	IRC/MSF		

Safe Motherhood (cont'd)

RH Component/Recommendation	Responsible Org/Comments	Anticipated Implementation	Financial/Other Implications
• Review and revise supervision and support procedures for TBAs, in the community and hospital, to ensure that standards are maintained – this should include supervision and support by a "skilled" worker	IRC/MSF • upgrade skills of supervisors for better technical supervision at community level		
• Review and revise the availability of "skilled" workers for maternity wards • Provide written guidelines on maternity wards for normal labour and delivery care and the management of complications, based on WHO guidelines • Introduce review procedures for maternal deaths, based on WHO guidelines	IRC/MSF • hold maternal mortality meetings		

Safe Motherhood (cont'd)

RH Component/Recommendation	Responsible Org/Comments	Anticipated Implementation	Financial/Other Implications
Newborn Care • Provide refresher training for workers on essential newborn care, including care of preterm and low birth weight babies, based on WHO guidelines • Provide written guidelines for newborn care on maternity wards, based on WHO guidelines	IRC/MSF		
• Review and revise procedures for newborn immunization in Dadaab, based on procedures in Kakuma	MSF		
• Introduce review procedures for perinatal deaths	IRC/MSF • hold perinatal mortality meetings		

Safe Motherhood (cont'd)

RH Component/Recommendation	Responsible Org/Comments	Anticipated Implementation	Financial/Other Implications
POSTPARTUM CARE • Formalize postpartum care at clinics and health posts, based on WHO guidelines • Provide training on postpartum care for the workers who will provide it (same workers who provide ANC) • Provide written guidelines at clinics and health posts, based on WHO guidelines	IRC/MSF • Increase skills of workers by training • Provide written guidelines for postpartum care in maternity wards, clinics and community		
COMMUNITY EDUCATION FOR SM • include a broader range of messages on "safe motherhood" in community education activities, covering all components of maternal and newborn care, and emphasizing antenatal care, birth planning, danger signs, emergency response, etc.,	NCCK/IRC/MSF		

Safe Motherhood (cont'd)

RH Component/Recommendation	Responsible Org/Comments	Anticipated Implementation	Financial/Other Implications
• Review and revise the content and process of training provided for community education, with respect to safe motherhood, and provide refresher training for workers involved in community education activities	NCCK/IRC/MSF		

Family Planning

RH Component/Recommendation	Responsible Org/Comments	Anticipated Implementation	Financial/Other Implications
• Conduct a comprehensive review of family planning services, covering the skills and abilities of the workers involved; the organization and delivery of services, with particular emphasis on accessibility and convenience to clients; the range of methods available vis-à-vis the needs of potential clients; and IEC/BCC/advocacy activities vis-à-vis the socio-cultural profile of camp populations	IRC/MSF • Conduct assessment of FP clinical services NCCK/UNHCR • Community needs assessment on: (1) why not using FP; (2) acceptability of FP services; (3) message carriers; (4) male involvement		

STD/HIV/AIDS

RH Component/Recommendation	Responsible Org/Comments	Anticipated Implementation	Financial/Other Implications
• Provide refresher training on syndromic case management for workers involved in the provision of treatment services for STDs • Provide written guidelines at health posts and OPDs (Dadaab) on syndromic case management, including treatment of sexual partners • Ensure the implementation of guidelines through appropriate supervision and support, especially for refugee health workers in clinics and health posts • Ensure the availability of recommended drugs or first choice	IRC/MSF • review access to STD care • better partner tracing • female care providers		

STD/HIV/AIDS (cont'd)

RH Component/Recommendation	Responsible Org/Comments	Anticipated Implementation	Financial/Other Implications
• Review and revise condom distribution to provide greater availability and access, and ensure that community members know where to obtain them and how to use them properly	MSF/IRC/NCCK • Plan to be developed		
• Review and revise community education activities related to STD/HIV/AIDS, considering the need for behaviour change and the socio-cultural barriers preventing this	NCCK • Strengthen IEC on STD treatment; privacy; partner tracking • Where do people get care? • Peer education (HIV) IRC/NCCK • Barriers to health services for STD		
	IRC/JRS • VCT/home-based care • Who should provide (STD) drugs, condoms, HIV reagents		

SGBV

RH Component/Recommendation	Responsible Org/Comments	Anticipated Implementation	Financial/Other Implications
• Strengthen clinical care for victims of SGV, based on UNHCR guidelines • Provide refresher training for health workers involved in the care of victims of SGV, based on UNHCR guidelines • Ensure the availability of female health workers for victims of SGV	IRC/MSF JRS – psychosocial support		
• Strengthen monitoring and evaluation procedures for SGV, based on UNHCR guidelines	IRC/MSF/JRS/NCCK/UNHCR		
• Review and revise community education about SGB, based on information provided through improved monitoring and evaluation procedures	NCCK		

Indicators for Reproductive Health
Kakuma and Dadaab Refugee Camps

Safe Motherhood

Indicator	Frequency/Method/Who?
Antenatal coverage (at least four visits)	◆ Monthly ◆ ANC register ◆ IRC/MSF
Antenatal coverage of women attending ANC for 1st visit before 16th week: No. of women at delivery with 1st visit before 16wks / Total number of live births	◆ Birth register ◆ IRC/MSF
Incidence of reported abortions	◆ Monthly ◆ Records office register ◆ IRC/MSF
Coverage of syphilis screening	◆ Monthly ◆ Birth register ◆ IRC
Prevalence of syphilis in pregnant women	◆ One month survey of 1st antenatal visits ◆ MSF
Crude Birth Rate	◆ Monthly ◆ Birth register ◆ IRC/MSF
Neonatal Mortality Rate	◆ Monthly ◆ Birth register ◆ IRC/MSF
Low Birth Weight Rate	◆ Monthly ◆ Birth register ◆ IRC ◆ MSF to procure scales to weigh babies born at home
Stillbirth Rate	◆ Monthly ◆ Birth register ◆ IRC/MSF
Births attended by: ◆ Trained TBAs ◆ Midwives/doctors	◆ Monthly ◆ Birth register ◆ IRC/MSF

Safe Motherhood (cont'd)

Indicator	Frequency/Method/Who?
Incidence of Obstetric Complications	◆ Monthly ◆ Birth register ◆ IRC/MSF
Postnatal Care Rate: No. of women attending PNC/month No, of live births during same month	◆ Monthly ◆ ANC register ◆ IRC/MSF

Family Planning

Indicator	Frequency/Method/Who?
Contraceptive Prevalence Rate	◆ Monthly ◆ FP Register ◆ IRC/MSF
Family planning drop out rate Coverage of follow-up of FP clients	◆ Monthly-quarterly ◆ FP Register ◆ IRC/MSF ◆ Monthly ◆ Interviews with TBAs/records ◆ IRC/MSF
Translation and distribution of common FP messages KAP Survey on RH knowledge	◆ Documentation ◆ NCCK ◆ Annual ◆ Survey/FGD ◆ NCCK

STD/HIV

Indicator	Frequency/Method/Who?
Blood screening for HIV	◆ Monthly ◆ Laboratory records ◆ IRC/MSF
Condom coverage (estimate)	◆ Monthly ◆ Distribution records ◆ IRC/MSF ◆
Incidence of STDs	◆ Monthly ◆ OPD Registers/Laboratory records ◆ IRC/MSF
%of partners of STD patients tracked	◆ monthly-quarterly ◆ records/tracking slips ◆ IRC/MSF
Quality of STD case management: No. of trained workers providing quality care No. of trained workers	◆ 6 months (monthly supervision) ◆ observation/interviews/checking records ◆ IRC/MSF
Condom outlets fully supplied	◆ Quarterly ◆ Observation ◆ IRC/MSF/NCCK

SGV

Indicator	Frequency/Method/Who?
Incidence of Sexual Violence	• Monthly • Record review • IRC/MSF
Coverage of health services: No. of rape cases provided health careX100 No. of reported rape cases	• Monthly • Record review • IRC/MSF
Timely care of survivors within 72 hours: No. of rape cases attended with 72 hoursX100 No. of reported rape cases	• Monthly • Record review • IRC/MSF
Coverage of health workers trained on management of rape cases: No. of health workers trained/re-trainedX100 No. of health workers	• Quarterly • Training records • IRC/MSF/NCCK

Broad Terms of Reference for RH Coordiantor
Kakuma and Dadaab Refugee Camps

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 reproductive health to refugees and all organizations working in health and other sectors, as needed.

- Liase with national and regional authorities of the host country when planning and implementing RH activities in refugee camps and among the surrounding population, where appropriate.

- Liase with other sectors (protection, community services, camp management, education, etc.,) to ensure a multisectoral approach to reproductive health.

- Create/adapt and introduce standardized strategies for reproductive health which are fully integrated within PHC.

- Initiate and coordinate various audience-specific training sessions on reproductive health (for audiences such as health workers, community services officers, the refugee population, security personnel, etc.,).

- Introduce standardized protocols for selected areas (such as syndromic case management of STDs, referral of obstetric emergencies, medical response to survivors of sexual violence, counselling and family planning services. etc.,).

RH Coordination Committee – Kakuma

Membership

- UNHCR – Nairobi (technical); Protection; Community Services
- IRC – Medical/preventive
- LWF – Community Services
- JRS
- MOH, Kakuma
- Community members (representative from Community RH Committee)

Chairperson

- Rotate every six months
- IRC to begin

Timeframe

- Monthly

Date of First Meeting

- First Friday of each month
- First meeting August 3, 2001

Terms of Reference

- Define clear roles and responsibilities of all actors involved in reproductive health activities (health services/community activities).
- Monitor the roles and responsibilities of all actors to prevent overlap and duplication of effort
- Jointly implement Plan of Action for Reproductive Health
- Identify problems related to the implementation of reproductive health services and suggest solutions.
- Share outcome achievements of reproductive health services and plan subsequent activities.
- Jointly develop strategies to improve reproductive health services.
- Enhance sense of teamwork.

RH Coordination Committee – Dadaab

Membership

- MSF/B – RH Coordinator
- CARE – FGM; VWC
- NCCK – RH Coordinator
- WFP - Gender
- GTZ - Gender
- MOH
- UNHCR – Dadaab/Nairobi
- Community members (representative from Community RH Committee)

Chairperson

- Shared between MSF/NCCK

Timeframe

- Monthly

Date of First Meeting

- First Friday of each month
- First meeting 3:30pm July 16, 2001

Terms of Reference

- Define clear roles and responsibilities of all actors involved in reproductive health activities (health services/community activities).
- Monitor the roles and responsibilities of all actors to prevent overlap and duplication of effort.
- Jointly implement Plan of Action for Reproductive Health.
- Analyse the monthly RH data and use it for planning, monitoring and evaluation of the reproductive health programme.
- Discuss and agree on the common approaches for the implementation of community-based activities for reproductive health.
- Identify and resolve reproductive health issues and problems related to implementation of clinical services and community-based activities for reproductive health.

Reproductive Health Activities - Roles and Responsibilities
Kakuma and Dadaab Refugee Camps

Safe Motherhood

Sub-component	Responsible Organization
Antenatal Care	
Labour and Delivery Care and Newborn Care (including management of complications)	
Postpartum Care	
Supervision and Support of Service Providers	
Equipment, Consumable Supplies and Drugs	
Training/retraining of Service Providers	
Community Education	
Other:	

Family Planning

Sub-component	Responsible Organization
Counselling and Services (method provision)	
Supervision and Support of Service Providers	
Procurement of Contraceptives	
Training/retraining of Service Providers	
Community Education	
Other:	

Sexually Transmitted Diseases, Including HIV/AIDS

Sub-component	**Responsible Organization**
Treatment of STDs (including counselling)	
Care for HIV/AIDS patients (facility and community-based care)	
Supervision and Support of Service Providers	
Equipment, Consumable Supplies, Drugs (including those needed for universal precautions and safe blood transfusion)	
Condom Procurement and Distribution	
Training/retraining of Service Providers	
Community Education	
Other:	

Sexual and Gender-based Violence

Sub-component	**Responsible Organization**
Medical care (including counselling)	
Follow up Psychosocial Support	
Supervision and Support of Service Providers	
Equipment, Consumable Supplies, Drugs	
Training/retraining of Service Providers	
Community Education	
Other:	

Important Note: The components of reproductive health indicated above are cross-cutting in terms of <u>adolescent reproductive health</u>; however, the following principles apply: RH services for young people should: be user friendly, have same-gender providers who are competent and understand the needs of young people and who promote trust and confidentiality.