

**Part III.M**

**Reproductive  
Health in  
Emergency  
Situations**

- Number of incidents of sexual violence reported per 10,000 population
- Percent of health facilities with adequate supplies for universal precautions
- Number of condoms distributed per 1,000 population
- Number of clean delivery kits distributed

## INDICATORS TO MEASURE REPRODUCTIVE HEALTH IN EMERGENCY SITUATIONS

Historically, humanitarian agencies responding to emergencies – war, civil strife, famine, environmental disasters – did not think about the reproductive health needs of the people they were serving. They focused on providing shelter, food, water, and health care to prevent deaths due to infectious diseases.

Recognition of the importance of reproductive rights and needs of persons affected by armed conflict has, however, evolved rapidly since 1993. Several events highlighted the lack of attention: a 1993 *Lancet* editorial argued for reproductive freedom for refugees; a 1994 survey of refugee settings by the Women's Commission for Refugee Women and Children exposed the virtual lack of reproductive health services; in 1994, Rwandan women refugees in Tanzania and Zaire (now the Democratic Republic of Congo) demanded access to, at least, the services they had used before their flight (*The Lancet*, 1993 & Wulf, 1994). The November 1994 International Conference on Population and Development in Cairo, which specifically articulated refugees' right to reproductive health services, provided a major impetus to this evolution (United Nations, 1995).

In many important respects, refugees are no different from the people in stable settings who have been the focus of development efforts and reproductive health programs for decades. Indeed, before flight from their homes and villages, they may have been the very individuals who participated in such programs. Thus, sound principles of program design, monitoring, and evaluation developed in stable settings may also apply to refugee settings.

However, refugees' experiences of conflict, flight, and displacement introduce factors that program planners must consider as they establish reproductive health services. The poverty, powerlessness, family dissolution, and social instability characteristic of refugees' lives may affect their reproductive health desires, their exposure to risk – of STIs and violence particularly – and their capacity to act (McGinn, 2000). Reproductive health programs must consider the living situations of all those affected by the conflict, not only the displaced themselves. The displaced may stay in segregated refugee camps or live intermingled with the local population – who are often materially little better off than are the refugees – in villages, towns or cities. In either case, the refugees and the humanitarian organizations that come to serve them change the social, political, economic, and physical environment. Programs must address the issue of equity and the potential for inter-group tension as they determine the services they will offer, and to whom.

The acknowledgment of reproductive rights for refugees places a burden of responsibility upon humanitarian actors to provide the health services refugees need to exercise these rights.

### Definition of Terms and Phases of Conflict

The term “refugee,” in legal language, refers to a person who has fled his or her home, has crossed an international border, and is unable or unwilling to return because of persecution based on race, religion, nationality, membership in a particular social group, or political opinion. The term also informally includes persons fleeing war, civil strife, famine, and environmental disasters. “Internally displaced persons” (IDPs)

have been forced from their homes but remain within the borders of their own countries. Because countries in conflict are often unable or unwilling to provide needed health and social services to IDPs and because the international community may be averse to overstepping the sovereign rights of states, IDPs may receive little international attention, and victims may go unprotected and unassisted.

All those affected by armed conflict are persons of concern: these include refugees, internally displaced persons, and the host populations residing in the locations of asylum. In general, the terms used here – “refugees,” “displaced,” and “war-affected” – refer to all these affected groups unless otherwise noted.

### **Phases of Conflict**

Complex humanitarian emergencies often fall into phases for guidance in determining program needs and setting priorities. The diagram below (Busza and Lush, 1999) is a useful description of commonly discussed phases. However, conflict is rarely a linear process. A region in conflict often exhibits characteristics of more than one phase at a time as it moves back and forth through the phases.

Conflict Phase	Description
Exodus / Emergency	The event (such as outbreak of war or escalation of violence) that causes flight, followed by loss of infrastructure, essential services, and the breakdown of political and social organization. At this stage, mortality, morbidity, and malnutrition are at their highest, and people may lack access to supplies for basic needs.
Post-Emergency	National and international aid responses have begun to have impact, and most basic subsistence needs are being met regularly. Some informal infrastructure and routine have been established, although political and social stability may still be precarious.
Stabilization	More services have been restored and people have adjusted to life in displacement. This phase can continue for many years.
Settlement /Repatriation	Although permanent settlement in a host country or repatriation results in very different experiences for the people involved, both signal a degree of resolution to the conflict, and frequently an end to dependence on aid agencies. New lifestyles are forged or old ones re-established, and the needs of the community become ones of long-term development.

In the exodus/emergency and post-emergency phases, assessment is typically limited to measuring inputs and functional outputs, specifically logistics. Ironically, evaluators also routinely collect good data on mortality – a long-term outcome measure – at least in closed camp settings, though data are often not age, sex-, or cause-specific. As the population moves into the stabilization and later phases, the data collection system may expand to cover other aspects of the supply or demand environment. In these phases, the programs and monitoring systems may resemble those in development settings and may face many of the same data collection challenges.

## **Methodological Challenges of Evaluating Reproductive Health Programs in Emergency Settings**

- **The destruction of infrastructure and systems in war limits providers' ability to deliver services and evaluate programs.**

By its very nature, armed conflict is destructive. Indeed, a strategy of war is to destroy infrastructure – roads, communication, utilities, health facilities. Agencies working in conflict settings must therefore start from scratch to establish service delivery systems and systems to evaluate the effectiveness of services. Delivery of services receives priority over evaluation.

- **Refugee populations move, and thus measurement becomes difficult.**

Refugees often move more than once. In the early phases of a conflict, large-scale movement can occur in stages as individuals and families make their way to safe havens. Once in a “stable” setting, however, influxes and egresses are common as some family members leave to find work, to return home to harvest their fields, or to test other relocation sites. The ever-shifting denominator complicates measurement.

- **Refugees may view data collection as coercive, and thus data quality may be compromised.**

Although a danger of courtesy bias and intimidation in data collection exist in any population, refugees and the displaced depend for their very lives on the agencies seeking information from them. They may perceive that their participation and their responses will determine access to services that are fundamental to survival.

- **Data collection is limited to accessible populations.**

The published and unpublished literature is biased towards refugees living in stable camp settings, simply because access to other groups – the displaced, those living in scattered sites, those living in insecure areas – is often difficult or impossible. Safety concerns, such as land mines and contact with armed combatants, and practical concerns, such as the inadvisability of traveling at night and the lack of accommodations, limit the ability of staff to travel to deliver services or to collect data. Program staff must guard against generalizing their findings to all refugees and displaced.

- **Agencies may not coordinate monitoring efforts among themselves.**

The office of the United Nations High Commissioner for Refugees (UNHCR) is the intergovernmental agency responsible for the well-being of refugees (except for internally displaced persons, for whom their own government is responsible). UNHCR, and other coordinating agencies, such as OCHA (UN Office for the Coordination of Humanitarian Affairs), work through many reputable humanitarian and governmental organizations, each of which has its own mission and donors, and finance, personnel, logistics, and record-keeping systems. Efforts to create a common monitoring system or to coordinate data collection at the field level may be made by these coordinating bodies or by the organizations themselves in a particular setting, but the task is complex. International, interagency minimum standards for disaster response, developed through the Sphere Project, have facilitated this task. First articulated in 1998, the standards are voluntarily adopted by humanitarian agencies, and their use is spreading gradually (The Sphere Project, 2000).

- **Technically competent staff are in short supply.**

International response at the onset of emergencies includes well-trained medical staff to provide some services. However, it is always necessary to engage staff or volunteers from

among the refugee population for many tasks; these are the majority of workers, especially as the situation stabilizes and the emergency agencies phase out. Frequently, however, refugees with education and technical skill are *not* the ones who remain in refugee camps; their social networks provide them with more attractive and safer alternatives. This exodus applies in particular for trained health workers and persons with research or data analysis experience.

- **Humanitarian agencies and donors plan for the short term.**

Humanitarian agencies are expert in immediate response to emergencies. This is their mission; most are not long-term development agencies. Yet, most of the refugees and displaced in the world are in the stabilization phase, and long-term program objectives are appropriate. Donors and relief agencies typically plan in 6- and 12-month cycles, making measurement of intermediate and long-term outcomes impractical. Ironically, a program is often funded for 3 or more years, but in 6-month increments, with only the most basic functional outputs measured.

However, several agencies have both an immediate relief as well as a longer-term program function. Many agencies have also worked to ensure that their immediate response is consistent with longer-term program needs to ease the transition in services and data collection and use.

- **We have limited program and research experience on reproductive health in forced migration situations to guide us.**

We are only beginning to understand the effects of forced migration on reproductive health knowledge, attitudes, practice and, ultimately, on reproductive health status. We have limited experience with how to gather information related to movement, mental health, family dissolution, and social change, yet these factors may be key to understanding the needs, desires, resources, and concerns of populations affected

by war. Many people debate the ethics of asking questions of traumatized people for whom services may still be unavailable.

We expect that as we gain experience and find answers, this information will be useful to improve services to both refugee and stable populations.

## **The Indicators**

The indicators included in this section are those developed by a community of agencies\* – multilateral organizations, governmental agencies, non-governmental organizations, universities – in a guide entitled, *Reproductive Health in Refugee Situations: An Inter-Agency Field Manual* (UNHCR, 1999). The manual recognizes the classic construct of stages of conflict and recommends implementing a **Minimum Initial Service Package** during the emergency phase – i.e., the period of days or weeks at the beginning of a refugee crisis.

The indicators described in detail here are those recommended for monitoring implementation of this **Minimum Initial Service Package** only. The *Field Manual* also recommends that comprehensive reproductive health services be put in place as soon as possible after the emergency phase and includes indicators for monitoring these more extensive services. A summary list of these indicators is included here with reference to parallel indicators elsewhere in this manual.

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\* The Inter-Agency Working Group on Reproductive Health in Refugee Situations comprises over 30 humanitarian and reproductive health groups who meet regularly to discuss progress and needs in the field. The group was instrumental in developing and revising *Reproductive Health in Refugee Situations: An Inter-Agency Field Manual*.

## Indicator

### NUMBER OF INCIDENTS OF SEXUAL VIOLENCE REPORTED PER 10,000 POPULATION

#### Definition

This indicator is calculated as:

$$\frac{\text{\# of incidents of sexual violence reported in specified reference period}}{\text{Total camp population}} \times 10,000$$

In the emergency phase, sexual violence incidents are most commonly defined as rape.

#### Data Requirements

Information on the number of incidents of sexual violence reported within a specified period of time (e.g., 6 months) and information on the total number of people in the refugee camp

#### Data Source(s)

Reports of sexual violence incidents filed with any authority, such as UNHCR protection or other staff, police, local authorities, or health facility staff

#### Purpose and Issues

The term “sexual violence” covers “all forms of sexual threat, assault, domestic violence, interference and exploitation including involuntary prostitution, statutory rape and molestation without physical harm or penetration” (UNHCR, 1995). In the emergency phase, rape is the form of sexual violence that receives most attention. Note, however, that reproductive health programs should include prevention and response to other forms of sexual violence, as well as gender-based violence, after the emergency phase.

Sexual violence is strongly associated with situations of forced population movement. In

this context, all actors in the emergency response must be aware of this issue and preventive measures must be put in place. The UNHCR’s *Guidelines for Prevention and Response to Sexual Violence Against Refugees* (1995) should be adhered to in the emergency response. Measures for assisting refugees who have experienced sexual violence, including rape, must also be established in the early phase of an emergency.

Women who have experienced sexual violence should be referred for health services as soon as possible after the incident. Protection staff should also be involved in providing protection and legal support to survivors of sexual violence.

Key actions to reduce the risk of sexual violence and respond to survivors during the emergency, include the following:

- Design and locate refugee camps, in consultation with refugees, to enhance physical security;
- Ensure the presence of female protection, health staff, and interpreters;
- Include the issues of sexual violence in the health coordination meetings;
- Ensure refugees are informed of the availability of services for survivors of sexual violence;
- Provide medical response to survivors of sexual violence, including emergency contraception as appropriate; and
- Identify individual or groups who may be particularly at risk to sexual violence (single female heads of households, unaccompanied minors, among others), and address their protection and assistance needs.

Where possible, the evaluator should obtain data

on age and sex-specific incidence rates.

### **Gender Implications of this Indicator**

Reported sexual violence in emergency settings almost always involves female victims and male assailants. Sexual violence against women occurs during all phases of an emergency:

*(1) Emergency*

Sexual violence has been an instrument to persecute, humiliate, torture, and dominate women and their families. Systematic and politically motivated sexual violence has led many communities and individuals to seek asylum in other areas or countries.

(UNHCR, 1993).

*(2) Exodus*

Women are particularly vulnerable during the process of relocation while crossing military lines, areas of civil conflict, and borders. Perpetrators at this stage are most likely to include bandits, smugglers, border guards, police, members of military forces, and civilians from the host population.

*(3) Post-Emergency/Stabilization/Settlement*

Refugee or internally displaced women have been subjected to many forms of sexual violence: rape, sexual extortion, sexual molestation and threats, and forced prostitution. Women in emergency situations are vulnerable when regarded as sexual property by male refugees and camp guards, when coerced to have sex in return for basic needs, and when subjected to attackers while traveling long distances to ration distribution points. (UNHCR 1999).

Many acts of sexual violence against women in emergency settings go unreported because women fear acts of retribution, are ashamed, fear rejection by a spouse or by the community, feel powerless, lack support, or distrust public/refugee services. A gender appropriate response to sexual violence includes the presence of female medical staff to attend women who have been exposed to sexual violence, a safe environment for reporting sexual violence that respects confidentiality, and integrated care for women exposed to sexual violence (including medical care, psychosocial care, and protection). [UNHCR, 1999]

## PERCENT OF HEALTH FACILITIES WITH ADEQUATE SUPPLIES FOR UNIVERSAL PRECAUTIONS

### Definition

The number of facilities equipped for universal precautions

This indicator is calculated as:

$$\frac{\text{\# of health facilities with adequate supplies to carry out universal precautions}}{\text{\# of camp service delivery points}} \times 100$$

Each service-delivery point must define adequate supplies based on the number of potential exposures.

Universal precautions refer to the measures (outlined below) to prevent the transmission of HIV.

### Data Requirements

Information on number of health facilities within the refugee camp that have adequate supplies for universal precautions, and information on the total number of camp service-delivery points

### Data Source(s)

Inventory and commodities report of camp service-delivery points

### Purpose and Issues

Those in charge must emphasize universal precautions against the spread of HIV/AIDS within the health care setting during the first meeting of health coordinators of the refugee camp. Under the pressure of an emergency situation, the field staff may be tempted to take short cuts in procedures and thus to jeopardize the safety of patients and staff. Staff must respect universal precautions. This indicator

measures the effectiveness of distribution systems for supplies related to universal precautions.

The guiding principle behind universal precautions to prevent transmission of HIV within the health care setting is that one should assume that all blood, blood products, and bodily fluids are potentially infectious.

The minimum requirements for universal precautions are:

- Facilities for frequent hand-washing;
- Availability of gloves for all procedures involving contact with blood and other bodily fluids;
- Availability of protective clothing;
- Safe handling of sharp objects;
- Safe disposal of waste materials;
- Appropriate cleaning, disinfecting, and sterilizing of medical instruments;
- Proper handling of corpses; and
- Appropriate handling of workplace injuries (UNHCR, 1999).

**Indicator****NUMBER OF CONDOMS DISTRIBUTED PER 1,000 POPULATION****Definition**

The volume of condoms distributed in relation to the population of the camp

pregnancy and disease prevention, this indicator is potentially useful, especially since data are readily available.

This indicator is calculated as:

$$\frac{\text{\# of condoms distributed in a reference period}}{\text{Total population of the camp}} \times 1000$$

**Data Requirements**

Total number of condoms distributed in the refugee camp within a specified period of time (i.e., one month), the total population in the refugee camp

**Data Source(s)**

Condom distribution lists

**Purpose and Issues**

Availability of condoms should be ensured from the beginning of the emergency so that they can be provided to anyone who requests them. Sufficient supplies should be ordered to cover potential need.

As well as providing condoms on request, field staff should make sure that refugees are aware that condoms are available and where they can be obtained. Condoms should be made available in health facilities, especially when treating cases of STIs. Other distribution points should be established so that those requesting condoms can obtain them in privacy.

One limitation of this indicator is that distribution does not necessarily equate to use, especially where the product is given away free of charge. A second caveat is that in refugee populations with a high proportion of children, the number of condoms per 1,000 would decrease, making comparisons across refugee settings invalid. Nonetheless, as a crude measure of protection against unwanted

**Indicator**

**NUMBER OF CLEAN DELIVERY KITS DISTRIBUTED**

**Definition**

This indicator is calculated as:

$\frac{\text{\# of clean delivery kits distributed}}{\text{Estimated \# of pregnant women in the refugee camp}} \times 100$
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Delivery kits can be those for use by mothers or birth attendants as well as those for use by midwives.

**Data Requirements**

Information on the total number of clean delivery kits distributed within the refugee camp and information on the estimated number of pregnant women within the camp (estimated to be 75-125 in a three-month period in a population of 10,000)

**Data Source(s)**

Distribution or inventory lists of delivery kits and health facility data on the number of pregnant women within the camp

**Purpose and Issues**

A refugee population will include women in the later stages of pregnancy who will deliver within the initial phase of the emergency. Camp personnel should provide simple delivery kits for home use to women in the late stages of pregnancy. Women

themselves or traditional birth attendants (TBAs) can use these very simple kits. Staff can assemble kits on site, which should include: one sheet of plastic, two pieces of string, one clean razor blade, one bar of soap, and a cotton cloth to prevent hypothermia in the newborn.

Evaluators can use a formula based upon the crude birth rate (CBR) to calculate the supplies and services required. With a crude birth rate CBR of 3 to 5 percent per year, some 75-125 births will likely occur in a 3-month period in a population of 10,000. Using this estimate, staff can calculate the number of kits they should order.

In the early phases of an emergency, births will often take place outside the health facility without the assistance of trained health personnel. Approximately 15 percent of births will involve some complications. Those assisting in the birth should refer complicated births to the health center. The supplementary unit of the New Emergency Health Kit (NEHK-98) has all the materials needed to ensure safe and clean normal deliveries. The health center can manage many obstetric emergencies with the equipment, supplies, and drugs contained in the NEHK-98. When the centers cannot manage obstetric complications, they should stabilize the patients before transferring them to the referral hospital.

## Reproductive Health in Refugee Situations Indicators and Compendium of Reproductive Health Indicators

**Note:** Many of the indicators for the post-emergency and later phases of refugee crises correspond to the areas of reproductive health outlined in this *Compendium*. The full list of indicators for these later stages included in *Reproductive Health in Refugee Situations, An Inter-Agency Field Manual*, is presented in the first column. Each one is then cross-referenced with the indicators described elsewhere in the *Compendium*. In some cases, they are exactly the same; in others, they are similar. Column 3 gives the section in which each indicator appears in this manual.

Indicators in Reproductive Health in Refugee Situations, An Inter-Agency Field Manual	Parallel Indicator in this Compendium	Section in this Compendium
<b>Newborn Health</b>		
1. Neonatal mortality rate	Neonatal mortality rate (NMR)	III.E
2. Percent of births which are of low birth weight (<2500 g)	Percent of live births with low birth weight	III.E
3. Percent of births which are of very low birth weight (<1500 g)	Percent of live births with low birth weight	III.E
4. Stillbirth ratio		
<b>Safe Motherhood</b>		
1. Percent of reported maternal deaths investigated according to established guidelines and results of which are disseminated to health staff	Percent of facilities that conduct case review/audits into maternal death/near misses	III.D
2. Percent of women attending antenatal services at least once	Percent of women attended at least once during pregnancy for reasons related to the pregnancy	III.D
3. Percent of women delivering tested for syphilis during pregnancy	Percent of pregnant women attending antenatal clinics screened for syphilis	III.D
4. Percent of pregnant women screened for syphilis who test positive	Percent of pregnant women attending antenatal clinics screened for syphilis	III.D
5. Incidence of unsafe and spontaneous abortions	Abortion rate (AR) and total abortion rate (TAR)	III.I
6. Percent of women delivering adequately vaccinated with tetanus toxoid	Percent of pregnant women with at least two doses of tetanus toxoid immunization	III.E
7. Percent of women with obstetric complications		
8. Percent of women with obstetric emergencies treated in timely and appropriate manner	Percent of women with obstetrical complications treated within two hours at a health facility	III.D
9. Percent of women delivering attended by trained health worker	Percent of births attended by skilled health personnel	III.D
10. Percent of WRA who can name at least 2 danger signs of obstetric complications	Percent of audience that know three primary warning/danger signs of obstetric complications	III.D
11. Percent of women delivering by Caesarean section	Cesarean sections as a percent of all live births	III.D
12. Percent of women with abortion complications treated in timely and appropriate manner		
13. Percent of women delivering who receive at least 1 postpartum care visit	Percent of women attended during the postpartum period by skilled personnel	III.D
14. Percent of newborns receiving BCG and polio by 1-month birthday		

<b>Indicators IN Reproductive Health in Refugee Situations, An Inter-Agency Field Manual</b>	<b>Parallel Indicator in this Compendium</b>	<b>Section in this Compendium</b>
<b>Sexual Violence (SV)</b>		
1. Percent of SV survivors who receive basic set of psychosocial and medical services	Number of VAW service visits provided, by type of service, in a reference period	III.K
2. Percent of SV survivors who present for care within 3 days of event		
3. Percent of identified SV offenders prosecuted to the full extent of the law		
4. Percent of designated health workers trained within past 2 years to provide services to SV survivors	Number of trainees by type of personnel and topic of training	II.D
<b>STI/HIV/AIDS</b>		
1. Percent of blood samples for transfusion tested for HIV	Percent of transfused blood units screened	III.C
2. Incidence of STIs		
3. Percent of STI patients assessed and treated according to protocol	Percent of STI patients appropriately diagnosed and treated	III.C
4. Percent of designated health workers trained to manage STI cases according to protocol	Number of trainees by type of personnel and topic of training	II.D
5. Percent of health workers who demonstrate use of universal precautions		
6. Percent of potential condom outlets with condoms available	Condoms available for distribution nationwide	III.C
7. Percent of persons in target population who recognize a condom, know its preventive effects, and can describe how to use it properly	Percent of population who know HIV prevention methods	III.C
8. Percent of persons in target population reporting using condom at last intercourse with non-regular partner	<ul style="list-style-type: none"> <li>• Condom use at last higher risk sex</li> <li>• Young people using a condom at last higher risk sex</li> <li>• Percent of sexually initiated adolescents who used a condom at first/last sex</li> <li>• Percent of sexually active, unmarried adolescents who consistently use condoms</li> </ul>	III.C III.C III.H III.H
<b>Family Planning</b>		
1. Contraceptive prevalence rate (CPR)	Contraceptive prevalence rate (CPR)	III.B
2. Percent of health workers who provide family planning services trained in the past 2 years	Number of trainees by type of personnel and topic of training	II.D
3. Percent of sexually active refugees able to cite major messages about family planning	Percent of audience who recall hearing or seeing a specific message	II.F
4. Percent of service-delivery points maintaining minimum of 3-months supply of each of combined oral contraceptive pills, progestin-only pills, and injectables	Percent of facilities whose stock levels ensure near-term product availability	II.E

Indicators in Reproductive Health in Refugee Situations, An Inter-Agency Field Manual	Parallel Indicator in this Compendium	Section in this Compendium
<b>RH of Young People</b>		
1. Incidence of STIs in young people	<ul style="list-style-type: none"> <li>• Percent of adolescents who were ever diagnosed with an STI</li> </ul>	III.H
2. Percent of births to young women		
3. Contraceptive prevalence rate among young people	Contraceptive prevalence rate (CPR)	III.B
4. Percent of sexually active young people reporting condom use at last intercourse	<ul style="list-style-type: none"> <li>• Percent of sexually initiated adolescents who used a condom at first/last sex</li> <li>• Percent of sexually active, unmarried adolescents who consistently use condoms</li> </ul>	III.H III.H
5. Percent of young people assessed, treated, and counseled according to protocol		