Raising Awareness for Reproductive Health in Complex Emergencies

A Training Manual

Produced by CARE on behalf of the Reproductive Health for Refugees Consortium
Additional copies of this Manual can be ordered from:

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The entire content of this manual and the recommended Resources used in each of the Activities are included as electronic files on the CD ROM accompanying this Training Manual. Insert the disk into any personal computer’s CD ROM drive and instructions for use should appear on your screen.

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CREDITS AND ACKNOWLEDGMENTS

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## LIST OF ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
</tr>
<tr>
<td>BCC</td>
<td>Behavior Change Communication</td>
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<tr>
<td>CARE</td>
<td>Cooperative for Assistance and Relief Everywhere, Inc.</td>
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<tr>
<td>FGC</td>
<td>Female genital cutting</td>
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<td>FGM</td>
<td>Female genital mutilation</td>
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<td>FP</td>
<td>Family planning</td>
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<tr>
<td>GBV</td>
<td>Gender-based violence</td>
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<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<tr>
<td>IAWG</td>
<td>Inter-agency Working Group on Reproductive Health in Refugee Situations</td>
</tr>
<tr>
<td>IDP</td>
<td>Internally displaced person(s)</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, education, and communication</td>
</tr>
<tr>
<td>IRC</td>
<td>International Rescue Committee</td>
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<tr>
<td>LCD</td>
<td>Liquid crystal display</td>
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<tr>
<td>MISP</td>
<td>Minimum Initial Service Package</td>
</tr>
<tr>
<td>MTCT</td>
<td>Mother-to-child transmission [of HIV]</td>
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<tr>
<td>NEHK-98</td>
<td>The New Emergency Health Kit 98</td>
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<tr>
<td>NGO</td>
<td>Nongovernmental organization</td>
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<td>RH</td>
<td>Reproductive health</td>
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<tr>
<td>RHRC</td>
<td>Reproductive Health for Refugees Consortium</td>
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<tr>
<td>SM</td>
<td>Safe Motherhood</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional birth attendant</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
</tr>
<tr>
<td>VCR</td>
<td>Video cassette recorder</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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</table>
INTRODUCTION

The importance of responding to the reproductive health (RH) needs of refugees, internally displaced persons (IDPs), and people living in situations of forced migration and refugee-like circumstances has become evident to development and relief agencies working in emergency and complex political settings over the past decade. As a result of growing awareness, the Reproductive Health for Refugees Consortium (RHRC) was created in early 1995. The Consortium has developed guidelines and manuals for field staff and has assisted the World Health Organization (WHO) and the United Nations High Commission on Refugees (UNHCR) in developing other guidelines for RH program design and implementation, including *Reproductive Health in Refugee Situations: An Inter-agency Field Manual*.

Access to quality RH services is a human right – a right of refugees, IDPs, and people living in situations of forced migration and refugee-like circumstances. An integral part of primary health care, RH care is absolutely essential to ensuring the survival of refugee families. Women and children comprise the majority of the population among refugees in most situations. RH care addresses the leading causes of death and disease among women of childbearing age.

RH involves aspects of life other than disease; it involves normal components of life (such as the transition from childhood to adulthood and pregnancy) and the relationships between men and women, communities, and society. Consequently, there is a wide range of stakeholders in RH. Yet, many relief and development workers have a limited understanding and appreciation of the role of RH programming in saving lives. Effective RH programming also requires coordination and cooperation among all stakeholders, including the refugee community.

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1 The term “refugee” is used throughout this Training Manual broadly, and refers to all people affected by conflict and emergencies, including refugees, internally displaced persons, forced migrants, refugee repatriates and returnees, and people living in refugee-like circumstances, such as “illegal migrants” (who are not refugees by international law).

2 RHRC members are: the American Refugee Committee, CARE, Heilbrunn Department of Population and Family Health at Columbia University's Mailman School of Public Health, International Rescue Committee, JSI Research and Training Institute, Marie Stopes International, and the Women’s Commission for Refugee Women and Children.

3 Materials and guidelines produced by members of the RHRC are available on the World Wide Web at [www.rhrc.org](http://www.rhrc.org), and include *Refugee Reproductive Health: Needs Assessment Tools; Contraceptive Logistics Guidelines for Refugee Settings; Adolescent Reproductive Health in Refugee Settings; and Refugees and AIDS: What Should the Humanitarian Community Do?* among others.
PURPOSE AND ANTICIPATED OUTCOMES

The overall purpose of this Training Manual is to raise awareness of and build support for RH programming in refugee situations.

The Manual covers the following topics:

- Overview of RH.
- RH in emergency situations.
- Minimum Initial Services Package (MISP).
- Overview of comprehensive RH services.
- Key components of RH services for refugees:
  - Safe Motherhood;
  - Prevention of and response to gender-based violence;
  - Prevention and care of sexually transmitted infections, including HIV; and
  - Family Planning.
- Coordination and collaboration in programming.
- Gender and adolescent issues.
- Action planning.

After completing the activities in the Manual, participants should have the knowledge and ability to:

- Perceive themselves as key stakeholders in RH for refugees.
- Work together to apply understanding of refugee RH concerns and programming principles in their specific context, including following up on action plans developed during workshop.
- Identify, obtain and use tools and resources for effective programming in RH for refugees.

The specific output of the Manual is an action plan:

- To raise awareness for the importance of reproductive health programming in the context of situations of forced migration.
- To initiate, improve, or expand RH programming in refugee and forced migration contexts.
TRAINING THE PARTICIPANTS

The priority audience for this training manual is “anyone with a stake in reproductive health” – including people who are already working in complex emergencies and people who are not, but need an awareness of RH issues in situations of forced migration. This includes (but is not limited to) representatives of:

- United Nations agencies.
- Local, national, and international nongovernmental organizations (NGOs).
- Health care services (providers and managers).
- Ministries of Health.
- Local and district government agencies.
- Security and protection services.
- Community organizations.
- Communities affected by complex emergencies.

TRAINERS

This manual, together with the required resource materials, is intended to offer a complete guide for conducting a workshop. Extensive experience in training or RH is not required. However, trainers without familiarity with RH topics and themes should spend substantial time prior to the workshop reviewing the manual and resource materials, and should consult others with expertise in RH and adult learning methodologies for guidance, as needed.

ORGANIZATION OF THE TRAINING MANUAL

Trainers are encouraged to adapt and modify the activities to suit the needs of the participants and the particular circumstances of the training.

The Manual contains several activities. The activities are also included on the enclosed CD-ROM.

Each activity lists:

- The specific learning objectives.
- Training method(s) used.
- Time required.
- Materials needed.
- Preparation.
- Procedure: step-by-step guidance for the trainer(s), including discussion questions and key points to be covered.
Several activities call for presentations (using a lecture format). The presentations are included on the CD-ROM in PowerPoint. Trainers have several options, depending on the resources and technology available:

- Use a computer and a liquid crystal display (LCD) projector to give the presentations.
- Print out the presentations and prepare overhead transparencies of the slides.
- Use the slides and accompanying text as handouts for participants.
- Prepare written flip chart pages of the slides to use in a presentation.

### List of Presentations

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>PRESENTATION TITLE</th>
<th>NUMBER OF SLIDES</th>
</tr>
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<tbody>
<tr>
<td>Reproductive Health: What Is It and Why Is It Important?</td>
<td>Overview of Reproductive Health</td>
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<tr>
<td>What Can You Do? Reproductive Health Services in Humanitarian Response</td>
<td>Reproductive Health Services in Humanitarian Responses</td>
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<tr>
<td>Key Components of Reproductive Health for Refugees</td>
<td>Key Components of Reproductive Health for Refugees</td>
<td>49</td>
</tr>
</tbody>
</table>

### SUGGESTED TRAINING MATERIALS

Minimum materials needed:

- Flip chart paper (newsprint) and markers.
- Writing paper and pens for participants.
- Carrying bag for participants’ resource materials.
- Tape or pins (for hanging flip chart pages).
- Samples of contraceptives.

Optional:

- LCD projector.
- Overhead transparency projector.
- Video cassette recorder (VCR) and television.
- Photocopier.
- Computer with online access (access to the internet); ideally, with a writable CD drive.
- Blank computer diskettes or CDs (so participants can download additional resource materials).
- Printer.
- Highlighter pens (so participants can mark important sections or points in the required resource materials).
REQUIRED RESOURCE MATERIALS (PARTICIPANTS’ “TOOL KIT”)

To carry out the activities in this Manual, each participant needs to have several resource materials, which together make up a “tool kit” for participants to use during the training and on their jobs. The required resource materials are on the enclosed CD-ROM, in Adobe Acrobat format. The resource materials were carefully selected to represent the “state-of-the-art” in RH programming for complex emergencies. It is hoped that participants will consult and refer to the resource materials throughout the training, gaining familiarity with the content and increasing the likelihood that they will continue to be used on the job.

The required resource materials are:

- **Adolescent Reproductive Health in Refugee Settings.** Produced by Marie Stopes International for the RHRC.
RESOURCE MATERIALS FOR TRAINERS

In addition to the materials required for participants, trainers will benefit from the following resource materials:


- Video. What Can You Do? Request from local UNHCR offices or UNHCR, Case Postale 2500, CH 1211 Geneva 2 Depot, Switzerland; Fax: 41-22-739 8591.


These resource materials, with the exception of the video, are also included with the resource materials CD-ROM accompanying this Manual.
BIBLIOGRAPHY: RESOURCES CONSULTED AND/OR USED IN THE DEVELOPMENT OF THIS MANUAL

In addition to the resource materials, the following materials were used in the preparation of the manual:

# ACTIVITIES, LEARNING OBJECTIVES, AND TIME

<table>
<thead>
<tr>
<th>ACTIVITY TITLE</th>
<th>LEARNING OBJECTIVES</th>
<th>ESTIMATED TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>1. Name the learning objectives of the training.</td>
<td>10 – 20 minutes</td>
</tr>
</tbody>
</table>
2. List characteristics of good RH.  
3. Describe importance of good RH and contribution of problems to morbidity and mortality.                                                                                                          | 30 minutes      |
| Refugee Concerns and Reproductive Health in Emergency Situations              | 1. Define disaster, emergency, crisis and application to specific setting.  
2. Describe stages of emergency and stages of response.  
3. List effects of emergency on refugee concerns/issues, including RH.                                                                                                                                       | 30 minutes      |
2. Identify package of minimum RH services to be provided initially in emergency (MISP).  
3. Distinguish between MISP and comprehensive RH services.                                                                          | 30 minutes      |
| Key Components of Reproductive Health for Refugees                            | 1. Gender-based Violence:  
   • Define GBV; name types of GBV;  
   • Describe magnitude of GBV;  
   • List consequences of GBV;  
   • Name specific factors in situations of forced migration contributing to GBV; and  
   • Describe strategies for preventing and responding to GBV.  
2. Safe Motherhood:  
   • Name medical causes of maternal and perinatal morbidity and mortality;  
   • Name specific factors in situations of forced migration contributing to maternal and perinatal morbidity and mortality; and  
   • Name strategies for preventing maternal and perinatal morbidity and mortality.  
3. Sexually Transmitted Infections/HIV:  
   • Name types of STIs;  
   • Describe magnitude and impact of STI/HIV/AIDS; and  
   • Describe strategies for STI/HIV/AIDS prevention and control.  
4. Family Planning:  
   • Describe magnitude and effects of unwanted pregnancy;  
   • List contraceptive methods appropriate/feasible in situations of forced migration; and  
   • Name the elements/principles of quality family planning services.                                                                                                                                   | 2 hours (120 minutes) |
| Key Issue: Coordinating the Response to Reproductive Health Problems         | 1. Identify key stakeholders in RH in specific setting.  
2. Outline mechanisms to facilitate coordination, collaboration, integration.                                                                                                                               | 45 minutes      |
| Applying a Key Principle: Attention to Gender and Adolescent Issues          | 1. Identify different problems men and women may face throughout their lives due to various vulnerabilities.  
2. Describe RH program responses to problems.                                                                                                                                                    | 30 minutes      |
| Action Planning                                                               | 1. Prepare plan for actions to initiate, improve, expand RH programming in specific situation; OR  
2. Prepare plan to incorporate refugee RH issues into ongoing programming (when the Manual is used for training and awareness raising for organizations not currently involved in RH for refugees).  
2. Identify agency and individual contributions, responsibilities, timing, and resources for action plan.                                                                                  | 1½ hours (90 minutes) |
| Conclusion and Evaluation                                                     | 1. Describe if and how the training achieved its objectives.                                                                                                                                                       | 10 – 20 minutes |
| **TOTAL TIME**                                                                |                                                                                                                                                                                                                | 6 hours         |
ACTIVITY
INTRODUCTION

Learning Objectives
1. Name the learning objectives of the training.

Methodology
Presentation and discussion.

Suggested Time
10 – 20 minutes.

Materials
- Flip chart, markers.

Preparation
- Make a flip chart page with the learning objectives of the activities and the anticipated outcomes.
- Select an “Icebreaker and/or Energizer Activity” to use, as appropriate (see page 13).

Procedure
1. Open the workshop with a welcome by organizers, according to local custom.
2. Give a brief overview of the workshop. Present the learning objectives and anticipated outcomes. Ask for questions and comments. Ask participants to propose additional learning objectives or to state their own expectations.
3. Introduce the trainer(s).
4. Review logistical or “housekeeping” issues: accommodations, meals, toilets, childcare, payment of per diems etc.
5. Carry out one of the icebreaker or energizer activities as appropriate, depending on how well participants know each other, etc.
6. Agree on workshop schedule, norms for timeliness, active participation, and how messages will be handled.
SAMPLE ICEBREAKER OR ENGERIZER ACTIVITIES

THE SPIDER WEB

PURPOSE
To help participants to get to know each other (for participants who do not now each other well).

TIME
10 to 15 minutes.

MATERIALS
A ball of yarn, cord, or thin rope.

DIRECTIONS

1. Have participants stand up and form a circle.
2. Give a ball of yarn to one participant and ask him or her to tell the group something about him or herself, such as name, where s/he is from, etc.
3. The participant with the ball of yarn holds onto the end of the yarn and throws the ball to a colleague in the circle, who in turn must introduce her/himself in the same way.
4. Participants continue introducing themselves by tossing the ball around the circle until all participants form part of this spider web.
5. As soon as everyone has introduced her/himself, the person holding the ball (Z) returns it to the person who threw it to her/him (Y), as s/he (Z) repeats the information about the person (Y).
6. Person Y then returns the ball to the person who threw it to her/him (X), repeating his/her information. This continues around the circle, with the ball following its previous path in reverse order until it reaches the participant who first introduced her/himself.
7. Warn participants before hand of the importance of paying attention to each introduction, since they will not know who will be throwing the ball at them.

HIDDEN SQUARES

PURPOSE
To encourage participants to dig deeper into problems and visualize them from a different perspective; to see not only the whole, but also various combinations of parts.

TIME
10 minutes.

MATERIALS
Flip chart, overhead transparency, or copies of the figure below.

DIRECTIONS
1. Provide participants with the drawing of a large, square, divided as shown.
2. Ask them to quickly count the total number of squares seen, and report that number verbally.
3. The correct answer is 30, as follows: 1 whole square, 16 individual squares, 9 squares of 4 units each, and 4 squares of 9 units each.
4. Facilitate a discussion by asking:
   □ What factors prevent us from easily obtaining the correct answer?
   □ How is this task like other problems we often face?
   □ What can we learn from this illustration that can be applied to other problems?

ACTIVITY

REPRODUCTIVE HEALTH: WHAT IS IT AND WHY IS IT IMPORTANT?

Learning Objectives

1. Define reproductive health.
2. List characteristics of good RH.
3. Describe importance of good RH and contribution of problems to morbidity and mortality.

Methodology

Presentation, brainstorming, and discussion.

Suggested Time

30 minutes.

Materials

• Flip chart, markers.
• Reproductive Health in Refugee Situations.
• Adolescent Reproductive Health in Refugee Settings.
• Overhead transparency projector (optional).

Preparation

• If an overhead projector is not available, make flip chart pages based on the slides included in the presentation “Overview of Reproductive Health” (see page 17).

Procedure

1. Give the presentation “Overview Reproductive Health” (page 17) using the overhead transparencies or the flip chart pages prepared in advance.
2. Ask if there are any questions or comments.
3. Summarize the presentation (or, ask participants to summarize).
4. Ask participants to brainstorm the characteristics of a woman, a man, an adolescent girl, and an adolescent boy, from the particular refugee situation, who have good RH. Remind them to consider issues of human rights, protection, gender, and social roles, discrimination against women, the life cycle, as well as disease (or absence of). Note responses on a flip chart.
5. Allow about five minutes. Ask if there are any questions or if any characteristics need further explanation.
6. Facilitate a discussion about good RH and reproductive ill health, by asking the questions below. Note responses on a flip chart.
   □ How do the characteristics we listed relate to the “Cairo” definition of RH?
How do they relate to other human rights? To the principles of protection?

Are the characteristics we listed universal? Which ones? Which ones are specific to this setting? Why?

Which characteristics are unique to women? To men? To adolescents?

Which characteristics do men and women have in common? Adults and adolescents?

Do the women, men, and adolescents in this particular setting have the characteristics we listed? Why or why not?

7. Summarize the discussion (or ask a participant to do so), being sure the Key Points below are covered. Refer participants to Reproductive Health in Refugee Situations and Adolescent Reproductive Health in Refugee Settings, explaining that these resource materials have more information on the definition of and issues in RH in refugee situations. Encourage participants to use them throughout the workshop and in their work.

KEY POINTS

- Reproductive health should be viewed in the context of relationships between men and women, communities, and societies, since sexual and reproductive behaviors are governed by complex biological, cultural, and psychosocial factors.
- Some characteristics of good reproductive health are biological, and therefore, probably fairly universal.
- Many characteristics of good reproductive health are socially and culturally determined, and therefore, specific to the situation.

OVERVIEW OF REPRODUCTIVE HEALTH

SLIDE 1: WHAT IS REPRODUCTIVE HEALTH?

- RH is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes.
- RH implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide, if, when and how often to do so.

This definition of RH represents the consensus of nations participating in the International Conference on Population and Development in Cairo, Egypt in 1994.

SLIDE 2: RH IS A HUMAN RIGHT ARTICULATED IN INTERNATIONAL LAW


SLIDE 3: RH RIGHTS INCLUDE

- The right to health in general.
- The right to reproductive choice.
- The right to RH services.
- The right of men and women to marry and found a family.
- The right of the family to special protection.
- Special rights in relation to motherhood and childhood (antenatal and postpartum care).

SLIDE 4: REPRODUCTIVE MORBIDITY AND MORTALITY ARE SERIOUS HEALTH PROBLEMS

RH problems are the leading cause of healthy life lost among women 15 – 45, accounting for more than 1/3 of healthy life lost. RH problems are also an important cause of healthy life lost among men and children. RH problems can also take a high psychosocial health toll.

A recent study in 12 Afghan refugee settlements in Pakistan found that among women of reproductive age (15 – 49 years old), maternal-related deaths were greater than the deaths from all other causes combined. In addition, compared with women who died of non-maternal causes, women who died of maternal causes had a greater number of barriers to health care, and their deaths were more likely to be preventable.
SLIDE 5: CYCLE OF REPRODUCTIVE ILL HEALTH
[SEE SLIDE 5 FOR GRAPHIC]

There is a cumulative effect across the life span of poor reproductive health. Therefore, RH requires that a continuum of care be provided to meet the health needs of individuals through their life span.

SLIDE 6: GENDER AND RH

- Non-biological differences between men and women.
- Social roles and expectations.

Gender refers to the non-biological differences between men and women. While biological differences are universal, social role differences vary across cultures and societies; and change over time. Gender is learned from childhood forward. Culture, society, religion, and family define gender roles, opportunities, and constraints in any community. Gender affects exposure to risk, access to health care, rights, and responsibilities, and control over one’s life.

SLIDE 7: LIFE SPAN PROFILE OF DISCRIMINATION AGAINST WOMEN
[SEE SLIDE 7 FOR GRAPHIC]

Women bear a heavy burden of RH problems. Biological, social, cultural, and economic factors increase a woman’s vulnerability to reproductive ill health throughout her life.

SLIDE 8: ADOLESCENTS FACE RH RISKS

- Unintended, too-early pregnancy.
- STIs, including HIV.
- Unsafe abortion.
- Sexual violence and exploitation.

More than one of every four persons worldwide is between the ages 10 and 24, that’s 1.7 billion people. RH issues are critical for young people. Young people have high rates of unprotected sexual activity. This leads to unintended and too-early pregnancy, STIs, including HIV/AIDS, and unsafe abortion. Also, young people, particularly women, often face sexual violence or exploitation. These risks can result in serious medical, psychological, social, and economic consequences.
SLIDE 9: WHY ADDRESS RH IN REFUGEE SITUATIONS?

- Human right.
- Significant cause of morbidity and mortality.
- Part of the protection mandate.

ACTIVITY

REFUGEE CONCERNS AND REPRODUCTIVE HEALTH IN EMERGENCY SITUATIONS

Learning Objectives

1. Define disaster, emergency, crisis and application to specific setting.
2. Describe stages of emergency and stages of response.
3. List effects of emergency on refugee concerns/issues, including RH.

Methodology

Large group discussion.

Suggested Time

30 minutes.

Materials

- Flip chart, markers.
- “Refugees and Asylum Seekers Worldwide.”
- “Principle Sources of Internally Displaced Persons.”
- “People in Refugee-Like Situations.”

Preparation

- Make a flip chart page with the terms “refugee”, “internally displaced person”, “person living in refugee-like circumstances”, and “returnee”.
- Make a flip chart page with the terms “emergency”, “crisis”, “complex emergency”, and “disaster”.
- Make a flip chart page with the “Expand/Stretch Model of Crisis Response” (see page 27).
- Print out “Principle Sources of Internally Displaced Persons”; “People in Refugee-Like Situations”; and “Refugee and Asylum Seekers Worldwide” from the enclosed CD-Rom.

Procedure

1. Pointing to the flip chart prepared in advance with the terms “refugee,” “internally displaced person”, “person living in refugee-like circumstances”, and “returnee”, facilitate a discussion on their meaning by asking the questions below. Note responses on a flip chart or ask a participant to do so.
   - What do we mean by each of these terms?
   - How many people fall into each of these categories?
   - What are the international conventions that provide the legal framework for the protection of these people?
   - What do all of these categories of persons have in common?

2. Summarize the discussion (or ask participants to do so), being sure the Key Points on the following page are covered. Refer participants to “Refugees and Asylum Seekers Worldwide”; “Principle Sources of Internally Displaced Persons”; and “People in Refugee-Like Situations” for more data on people affected by conflict and displacement.
KEY POINTS

- Refugee is narrowly defined in international law as a person with a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion, who is outside the country of his or her nationality and is unable or unwilling to return. However, the term is often popularly understood in far broader terms, encompassing persons fleeing war, civil strife, famine, and environmental disasters. Refugees, as legally defined, generally fall within the mandate of the United Nations High Commissioner on Refugees (UNHCR).

- The World Refugee Survey 2001 estimates that there were 14.5 million refugees at the end of 2000, one million more refugees than in 1998.

- The 1951 United Nations Convention Relating to the Status of Refugees and the 1967 Protocol establish the legal standards for refugee protection. As of 2001, the Convention and/or Protocol have been signed by 137 countries, although the rights and protections laid out in these documents are sometimes ignored by countries.

- Internally displaced persons (IDPs) are people who flee for the same reasons as refugees, but who do not cross an international border. By not actually leaving their countries of origin, internally displaced persons are frequently more vulnerable than official refugees who are the beneficiaries of international protection and assistance.

- There are more IDPs than refugees. The World Refugee Survey 2001 estimates that there were 20 to 24 million IDPs in 2000.

- The United Nations Guiding Principles on Internal Displacement, based upon existing international humanitarian law and human rights instruments, serve as an international standard in providing assistance and protection to IDPs.

- Persons living in refugee-like circumstances are the many peoples living in situations similar to those of refugees, but do not meet the narrow refugee definition. Some are regarded by host governments simply as illegal aliens; others are tolerated or ignored. In many such cases, and often in the absence of credible refugee determination procedures, it is difficult to determine who among them might be refugees. Other refugee-like people are stateless, denied the protection afforded by citizenship. Estimates of refugee-like populations are fragmentary.

- A returnee is a refugee or IDP who returns to his or her country or area of origin, either spontaneously or as part of a planned resettlement. Some 1.7 million refugees who have voluntarily repatriated during 2000 – 2001 remain in need of reintegration assistance and protection monitoring.

- All of the people in these categories are affected by conflict and displacement, and their physical and economic security and safety are adversely affected. Between January to December of 2000, more than 5.5 million people around the world – an average of 15,000 new people per day – fled their homes. Some of the newly uprooted fled outside their country to become refugees. Others became internally displaced, remaining within their own country.
3. Pointing to the flip chart prepared in advance with the terms “emergency”, “crisis”, “complex emergency”, and “disaster”, facilitate a discussion on their meaning and application to the specific situation by asking the questions below. Note responses on a flip chart or ask a participant to do so.

- What do we mean by each of these terms? Can we agree on definitions?
- What situations might cause an emergency?
- How would you describe the specific situation in which you are working?
- What is more important than the definition of an emergency?

4. Summarize the discussion (or ask participants to do so), being sure the Key Points below are covered.

**KEY POINTS**

- UNHCR defines “emergency” as “any situation in which the life or well-being of refugees will be threatened unless immediate and appropriate action is taken, and which demands an *extraordinary response and exceptional measures.*”

- UNHCR uses the following indicators to identify an emergency:
  - Mortality rate: more than two deaths per 10,000 per day;
  - Nutrition: More than 10 percent of children with less than 80 percent weight-for-height;
  - Food: less than 2,100 calories/person/day available;
  - Water quantity: less than 10 liters available per person per day;
  - Water quality: more than 25 percent of people with diarrhea;
  - Site space: less than 30 sq. meters per person (this figure does not include any garden space); and
  - Shelter space: less than 3.5 square meters per person.

- UNHCR defines “complex emergency” as “a humanitarian crisis in a country, region or society where there is a total or considerable breakdown of authority resulting from internal or external conflict, and which requires an international response that goes beyond the mandate or capacity of any single agency and/or the ongoing UN country program. Likely characteristics of complex emergencies include: 1) a large number of civilian victims, populations who are besieged or displaced, human suffering on a major scale; 2) substantial international assistance is needed and the response goes beyond the mandate or capacity of any one agency; 3) delivery of humanitarian assistance is impeded or prevented by parties to the conflict; 4) high security risks for relief workers providing humanitarian assistance; 5) relief workers targeted by parties to the conflict.”

- The United Nations Disaster Relief Organization defines a “disaster” as “a serious disruption of the functioning of a society, causing widespread human, material, or environmental losses which exceed the ability of the affected society to cope using its own resources.” A disaster may be the cause of an emergency.

- “Crisis” is a more general term for any sudden and decisive event or series of events that cause widespread human suffering. Both emergencies and disasters are crises.

- Causes of emergencies include a sudden influx of refugees seeking asylum, changes or events in an existing operation that suddenly place in danger refugees who had previously enjoyed asylum in safety, and events during large-scale repatriation that threaten returnees well-being and safety.

- More important than the definition of an emergency is the timely recognition of the development of situations in which an extraordinary response will be required in order to safeguard the life and well-being of refugees.
5. Facilitate a discussion on the stages of a crisis or an emergency, by asking the questions below. Note responses on a flip chart or ask a participant to do so.
   - From the perspective of humanitarian assistance, it is often useful to think of stages or phases of an emergency. How can we describe the stages of an emergency?
   - What are the characteristics of each of these stages?
   - Are these stages rigid and fixed? Give examples of why or why not.
   - Do they always move in a linear (from one to the next) manner? Give examples of why or why not.
   - At which stage is the specific situation in which we work?

6. Summarize the discussion (or, ask participants to summarize), being sure the Key Points below are covered.

   **KEY POINTS**
   - An emergency can be characterized by four or five different stages, depending on the causes and the particular situation.
   - Phases or stages include:
     1. Pre-conflict or pre-emergency, often characterized by deteriorating economic and social circumstances, civil disturbance, and growing instability.
     2. Emergency, beginning with displacement, flight, or mass migration of people fleeing in search of safety in response to a destabilizing event. This stage is characterized by loss of security and essential services and social breakdown. This stage involves the initiation of a humanitarian response to provide a secure environment to meet people's basic needs for shelter, food, water, sanitation, and health care.
     3. Post-emergency, during which chaos is gradually replaced by structure and organization. Essential services are restored, and social structures (families and communities) begin to reestablish.
     4. Stabilization occurs when the initial emergency has passed—life returns to some level of "normality." Stabilization is also defined as having occurred when the mortality rate has fallen to less than one to two per 10,000 population per day.
     5. Post-emergency, when refugees may return to their country of origin. This may be a period of reconstruction and reintegration of communities returning and those who stayed. Returnees often find themselves in a situation similar to the early stages of an emergency, where they are struggling to meet basic survival and security needs.
   - Stages may overlap or occur simultaneously and do not necessarily progress routinely from one to the next. For example, a destabilizing event can occur during "the post-emergency phase," leading to a renewed emergency, rather than resettlement.
   - Regardless of the labels we use to characterize the stages of an emergency, the needs of refugees and different groups within the same refugee community vary considerably.

7. Pointing to the flip chart page prepared in advance with the “Expand/Stretch Model of Crisis Response”, facilitate a discussion on responses to an emergency, by asking the questions on the next page. Note responses on a flip chart or ask a participant to do so.
Perhaps more important than the labels we give to the stages of an emergency, is thinking about how we respond to an emergency, or how we organize and deliver resources.

What do we mean by each of these terms — “prevention and mitigation”, “preparedness”, “relief and response”, and “recovery and rehabilitation”?

What activities or actions characterize each strand?

Why do the strands overlap?

Where would we locate the specific situation in which we work? Explain why by giving examples.

8. Summarize the discussion (or, ask participants to summarize), being sure the key points below are covered.

**KEY POINTS**

- Prevention and mitigation encompass all actions taken prior to the occurrence of an emergency to prevent or reduce suffering from an impending crisis. They include preparedness and long-term risk reduction measures and actions such as:
  - Early warning systems;
  - Strengthening local structures and services;
  - Providing key resources prior to a crisis; and
  - Having the material resources ready for a quick response.

- Prevention also includes action to ensure that aid itself does not contribute to or prolong the crisis or armed conflict that contributes to complex emergencies. Programs can incorporate activities that:
  - Reinforce equitable power and resource distribution; and
  - Promote dialogue among warring parties.

- Although an emergency may start with a sudden large influx of refugees, more often the onset of an emergency is not so dramatic or obvious, and a situation requiring an extraordinary response and exceptional measures may develop over a period of time. Therefore, it is essential to be able to recognize if a situation exists (or is imminent) which requires an emergency response. This calls for preparedness.

- Preparedness consists of activities to minimize loss of life and damage, organize removal of people and property from a threatened location, and facilitate timely and effective rescue, relief, and rehabilitation. UNHCR defines preparedness as: planning and taking action to ensure that the necessary resources will be available, in time, to meet the foreseen emergency needs and that the capacity to use the resources will be in place (UNHCR). Typical activities include:
  - Early warning;
  - Contingency planning;
  - Development of emergency response systems;
  - Generation of support among potential host and donor governments;
  - Provision of stand-by resources;
  - Pre-positioning of supplies; and
  - Training.
Relief and response refers to immediate and appropriate action to save lives, ensure protection, and restore the well-being of refugees. (UNHCR) Typical activities include:
- Problem, needs and resources assessments;
- Resource mobilization;
- Handling donor relations and media interest;
- Operations planning;
- Implementation and coordination;
- Monitoring and evaluation; and
- Transition to the post emergency operation.

Recovery and rehabilitation include longer-term support (care and maintenance) and durable solutions (voluntary repatriation, local integration and resettlement). These must always be kept in mind, starting with the prevention and preparedness strands.

9. Facilitate a discussion on refugee concerns and RH in emergency settings by asking the questions below. Note responses on a flip chart or ask a participant to do so.
   - What percent of refugees are women? Men? Children? Adolescents?
   - What happens when a person becomes a refugee?
   - How does it feel?
   - What is the impact of an emergency on the RH of women, men, and adolescents?
   - If we think of our characterization of good RH in the previous activity, what are some barriers to achieving RH in a refugee situation?
   - What are special concerns that women and children face in refugee situations? How do these relate to RH?
   - How might these conditions change over time, as a refugee situation moves from one stage to another?
   - Is it possible to overcome these barriers, and develop programs to make RH a reality for refugees (in this specific setting)?

10. Summarize the discussion or ask a participant to do so, being sure the Key Points on the following page are covered.
KEY POINTS

- Of the at least 40 million people who are refugees and IDPs, women and children represent about 75%; women of reproductive age (age 15 to 45) make up about 25% of the 40 million; about 20% of these are pregnant. Adolescents (age 10 – 19) are about 30% of the 40 million.
- There is considerable variation from situation to situation; reliable statistics are hard to find. It is important to collect data that is disaggregated (separated) by sex and age group.
- Becoming a refugee may mean someone is forced from an independent human being in control of his/her own life, to a person dependent on others for basic needs.
- Many aspects of life are disrupted:
  - Gender roles and responsibilities;
  - Livelihoods and sources of income;
  - Family composition;
  - Access to resources;
  - Safety and security;
  - Social traditions; and
  - Feelings about life: motivations and hopes for the future.
- An emergency situation has a profound negative impact on RH. Negative effects (or barriers to RH) may include:
  - Violence;
  - Spread of STIs;
  - Increase in unwanted pregnancies and possibly unsafe abortions;
  - Stress and malnutrition;
  - Lack of access to services;
  - Breakdown of traditional support mechanisms may facilitate risk taking behavior among young people; and
  - Loss of decision-making power and choices.
- Special concerns facing refugee women and children include:
  - Separation from spouse or parents;
  - Sudden responsibility for all aspects of household management;
  - Risk of gender-based violence, including sexual violence and exploitation;
  - Pregnancy complications;
  - Inadequate access to family planning; and
  - Lack of sanitary cloths or pads and underclothes, or a private area for washing them.

EXPAND/STRETCH MODEL OF CRISIS RESPONSE

ACTIVITY

WHAT CAN YOU DO?

REPRODUCTIVE HEALTH SERVICES IN HUMANITARIAN RESPONSES

Learning Objectives

2. Identify package of minimum RH services to be provided initially in emergency (MISP).
3. Distinguish between MISP and comprehensive RH services.

Methodology

Video, presentation, and discussion.

Suggested Time

30 minutes.

Materials

• Flip chart, markers.
• Video What Can You Do? (optional).
• Video cassette recorder (VCR) and television/monitor.
• Reproductive Health in Refugee Situations.
• UNHCR. Guidelines for Prevention and Response to Sexual Violence against Refugees.
• The Reproductive Health Kit for Emergency Situations.
• Refugees and AIDS: What Should the Humanitarian Community Do?
• RHRC. Needs Assessment Tools.
• Overhead transparency projector (optional).

Preparation

• If an overhead projector is not available, make flip chart pages based on the slides included in the presentation “Reproductive Health Services in Humanitarian Responses” (see page 30).

Procedure

2. Give the presentation “Reproductive Health Services in Humanitarian Responses” (see page 30).
3. Facilitate a discussion on RH services for refugees, by asking the questions below. Note responses on a flip chart or ask a participant to do so.
   □ What is the minimum package of RH services to provide in an emergency situation?
   □ What do we mean by comprehensive RH services? How are comprehensive RH services different from MISP?
When should comprehensive RH services be developed and introduced in a refugee situation?

Why are comprehensive RH services needed in a stable situation?

Where do comprehensive RH services fit on the “Expand/Stretch Model of Crisis Response?”

What RH health concerns and issues do we anticipate (or find) in this specific setting as the situation shifts from crisis to stabilization?

4. Summarize the discussion (or ask participants to do so), being sure the Key Points below are covered. Refer participants to Reproductive Health in Refugee Situations, Guidelines for Prevention and Response to Sexual Violence against Refugees, The Reproductive Health Kit for Emergency Situations, Needs Assessment Tools, and Refugees and AIDS: What Should the Humanitarian Community Do? for more information on responding to RH problems in refugee situations.

KEY POINTS

- MISP is a range of core RH activities to be carried out from the beginning of an emergency. As the situation gradually stabilizes, a more comprehensive package of RH interventions must be provided.

- Priority activities (MISP) during the early stages of an emergency are:
  - Coordination;
  - Prevention of and response to GBV through protection planning, medical care, and emergency contraception;
  - Reduction of HIV transmission through condom distribution and universal precautions;
  - Prevention of excess neonatal and maternal morbidity and mortality through clean delivery kits, midwifery kits, and a referral system for complications; and
  - Planning for comprehensive RH services.

- Planning for comprehensive RH, as described in the Interagency Field Manual, should include:
  - The collection of information;
  - Identification of suitable delivery sites; and
  - Assessment of needs of training, equipment and supplies.

- The transition from emergency to stabilization may not be clearly defined. As a general rule, a situation is stable when:
  - There are no longer major health problems such as severe malnutrition or epidemics;
  - Mortality rates have declined to less than one to two/10,000 per day; and
  - The population is relatively stable without large influxes of very sick or malnourished people that need special care.
REPRODUCTIVE HEALTH SERVICES IN HUMANITARIAN RESPONSES

SLIDE 1: OBJECTIVES OF RH SERVICES AND INTERVENTIONS

- Prevent and manage the consequences of GBV.
- Reduce transmission of STIs, including HIV.
- Reduce maternal and perinatal morbidity and mortality.
- Prevent unwanted and mistimed pregnancies.

SLIDE 2: COMPONENTS OF RH SERVICES AND INTERVENTIONS

- Prevention of and response to GBV.
- Safe motherhood.
- STI/HIV/AIDS prevention and care.
- Family planning.

These services are essential elements of RH services.

SLIDE 3: MINIMUM INITIAL SERVICES PACKAGE (MISP)

MISP is a set of activities that represent a minimum requirement in the early phase of an emergency or refugee situation. In other words, MISP is a specially designed package of priority interventions for the initial stage of a crisis. It represents the minimum needed.

MISP must be implemented in a coordinated manner by appropriately trained staff. Documented evidence justifies its use; a new needs assessment is not needed to implement it.

SLIDE 4: OBJECTIVES OF MISP

- Identify RH Coordinator.
- Prevent and manage GBV.
- Reduce HIV transmission.
- Prevent excess neonatal and maternal morbidity and mortality.
- Plan for comprehensive RH services.

SLIDE 5: MISP: COORDINATION

- Coordination of activities among relief organizations is essential.
- Coordination is needed among sectors, implementing agencies, and levels of service providers. A RH Coordinator in each refugee situation can assist with overall organization and supervision of RH activities.
SLIDE 6: MISP: PREVENT AND MANAGE GBV

- Protection planning.
- Medical response.
- Emergency contraception.

SLIDE 7: EMERGENCY CONTRACEPTION

- Must be used within 3 – 5 days.
- 2 possible methods: Oral contraceptives and copper-bearing IUDs.

SLIDE 8: MISP: REDUCE HIV TRANSMISSION

- Free condoms.
- Universal precautions.

SLIDE 9: MISP: PREVENT EXCESS NEONATAL AND MATERNAL MORBIDITY AND MORTALITY

- Clean delivery kits to pregnant women.
- Midwifery kits.
- Referral system.

SLIDE 10: THE UNFPA RH KIT FOR REFUGEE SITUATIONS

- 13 self-contained RH subkits which can be ordered quickly.
- Standardized with WHO's NEHK.
- NEHK contains EC, materials for universal precautions, and midwifery kit.

SLIDE 11: MISP: PLAN FOR COMPREHENSIVE RH SERVICES

- Assess needs.
- Design program.
- Implement and monitor.
- Evaluate.

SLIDE 12: STABILIZATION: COMPREHENSIVE RH SERVICES

- Prevention of and response to GBV:
  - Protection;
  - Medical services;
  - Counseling;
  - Policy/Management; and
Legal.

Safe motherhood:
- Antenatal care; and
- Delivery care:
  - Skilled attendance;
  - Basic emergency obstetric care; and
  - Comprehensive emergency obstetric care.


- Postnatal care of the newborn.
- Postnatal care of the mother.
- Support of breastfeeding.
- Postabortion care.
- Prevention of FGC and other harmful traditional practices and care for complications arising from practice.

As the situation gradually stabilizes, a more comprehensive package of RH interventions must be provided.

**SLIDE 14: STABILIZATION: COMPREHENSIVE RH SERVICES (CONTINUED)**

- STI prevention and care:
  - Safe blood transfusion;
  - Universal precautions;
  - STI prevention;
  - STI management;
  - HIV/AIDS counseling and testing; and
  - Care of people with HIV/AIDS.
- Family planning services.

**SLIDE 15: COMPREHENSIVE RH SERVICES**

- Coordination and collaboration;
- Accountability: monitoring and evaluation;
- Community participation;
- Attention to gender and vulnerable groups; and
- Capacity-building.

(Sources: Public Health in Complex Emergencies Training Course: Reproductive Health Module, Minimum Initial Service Package; Reproductive Health during Conflict and Displacement.)
ACTIVITY

KEY COMPONENTS OF REPRODUCTIVE HEALTH FOR REFUGEES

Learning Objectives

SM:
1. Name causes of maternal and perinatal morbidity and mortality.
2. Name specific factors in situations of forced migration contributing to maternal and perinatal morbidity and mortality.
3. Name strategies for preventing maternal and perinatal morbidity and mortality.

GBV:
1. Define GBV; name types of GBV.
2. Describe magnitude of GBV.
3. List consequences of GBV.
4. Name specific factors in situations of forced migration contributing to GBV.
5. Describe strategies for preventing and responding to GBV.

STD/HIV:
1. Name types of STI/HIVs.
2. Describe magnitude and impact of STI/HIV/AIDS.

FP:
1. Describe magnitude and effects of unwanted pregnancy.
2. List contraceptive methods appropriate/feasible in situations of forced migration.
3. Name the elements of quality family planning services.

Methodology

Presentation, small group work, analysis, and discussion.

Suggested Time

2 hours (120 minutes).

Materials

- Flip chart, markers.
- Reproductive Health in Refugee Situations.
- UNHCR. Prevention and Response to Sexual and Gender-Based Violence in Refugee Settings: Inter-Agency Lessons Learned Conference Proceedings.
- The Reproductive Health Kit for Emergency Situations.
- Refugees and AIDS: What Should the Humanitarian Community Do?
- Overhead transparency projector (optional).
- Several copies of the resource materials from page 9.
Preparation

- If an overhead projector is not available, make flip chart pages based on the slides included in the presentation “Key Components of Reproductive Health for Refugees” (see page 41).
- Have available several copies of the “Resource Materials for Trainers” (see page 9) for participants to refer to in their group work.
- Make a flip chart page of the “RH Problem Matrix” (see page 36).
- Make copies of the “Case Studies” (see page 37), for groups to use when workshop participants are not people who work in a situation of forced migration.

Procedure

PART ONE:

1. Give each of the four sections — gender-based violence, safe motherhood, STI/HIV/AIDS, and family planning — of the presentation “Key Components of Reproductive Health”. Pause after each section to ask for and answer questions.

2. Refer participants to the resource materials for more information and to clarify any misunderstandings.

PART TWO (GROUP WORK):

Option 1: When participants work in the context of a specific situation of forced migration.

3. Divide participants into four groups — one for GBV, one for safe motherhood, one for STI/HIV and one for family planning. Give each group flip chart paper, markers and copies of appropriate materials from resources on page 9.

4. Give the instructions:
   - Use the resource materials and your best knowledge of the specific situation.
   - Make a “RH Problem Matrix” for your specific topic area.
   - Determine who (which groups) are affected by problems related to the topic.
   - List the factors that contribute to the problem (for example, the factors that contribute to maternal and perinatal morbidity and mortality among adolescent women in your setting).
   - List the interventions that can address the factors contributing to the problem.
   - Indicate whether this intervention already exists in the specific situation, and if so, who manages it.
   - Select a person to present the group’s work.
Option 2: When participants do NOT work in the context of a specific situation of forced migration

3. Divide participants into four groups — one for GBV, one for safe motherhood, one for STI/HIV and one for family planning. Give each group flip chart paper, markers and copies of appropriate materials from resources on page 9.

4. Give each group one of the “Case Studies.”

5. Give the instructions:
   - Use the resource materials and your best understanding of RH for refugees.
   - Make a “RH Problem Matrix” for your specific topic area (GBV, SM, STIs, FP).
   - Determine who (which groups) are affected by problems related to the topic.
   - List the factors that contribute to the problem (for example, the factors that contribute to maternal and perinatal morbidity and mortality among adolescent women in the situation described in the case study).
   - List the interventions that can address the factors contributing to the problem.
   - Select a person to present the group’s work.

6. Allow 30 minutes for this activity.

7. Allow each group no more than 10 minutes to present its work. Encourage questions and comments. Remind participants to use the resource materials.
### RH PROBLEM MATRIX

**Topic:** Safe Motherhood, GBV, STI/HIV/AIDS, Family Planning (choose one):

<table>
<thead>
<tr>
<th>Who is affected?</th>
<th>Children under 12</th>
<th>Adolescent/ Young Women (12-24)</th>
<th>Adolescent/ Young Men (12-24)</th>
<th>Women Reproductive Age (12-45)</th>
<th>Men of Reproductive Age (12-60)</th>
<th>Older Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factors that contribute to the problem.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interventions to address the problem.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intervention exists in this situation?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CASE STUDIES

Case Study 1: Safe Motherhood

For 10 years, 98,000 refugees have been living in this flat, dusty, desert site in Africa. It is hot in the summer and in the winter when the rains come the roads are impassable. About 85 percent of the refugees are of one ethnic group and the remainder are of three additional minority groups. 80 percent of all the refugees are women and children. Originally the countryside was filled with trees but the trees have all been removed and used as firewood or fencing. The distance to obtain firewood and wood for cooking and fences continues to increase as all the trees within proximity of the camp are removed. Many parts of the camp are without adequate fencing and remain unsafe. The police protection in this camp is sporadic.

An Irish NGO provides social services to vulnerable groups such as single heads of households, unaccompanied minors and adolescents. They also provide non-health related needs such as clothes, non-food items, or services such as assistance with water collection for the elderly or infirm living alone. A German NGO has set up formal primary schools.

A French humanitarian aid agency is providing primary health care, curative and preventive services to the whole camp. Emergency obstetric services are available only by traveling to the hospital in the nearest town, 120 kilometers away. Police escort is required to travel on the road because of the high likelihood of being attacked by bandits. No travel is possible after dark. In the camp in-patient services are available for normal deliveries, however, there are no services for blood transfusions or cesarean sections. Less than half of the deliveries in the camp take place in the inpatient facilities. The remainder of women deliver in their tents with traditional birth attendants (TBAs) present. Approximately 60 percent of the women receive antenatal care prior to delivery. All of the women have experienced Female Genital Cutting (FGC).

Maternal mortality rates are high and the common reasons for maternal deaths are hemorrhage, sepsis, high blood pressure and obstructed labor.
Case Study 2: Gender-based Violence (GBV)

You work in a camp of approximately 45,000 refugees. The refugees walked for three weeks to this desolate, parched location and have been living here for five months. The camp management has set up tents and there are adequate food supplies, health facilities and community outreach workers. As there are no latrines in this camp, people walk a distance from the camp and use the open fields to defecate.

In their country of origin, the male members of the family provided protection for women and children. This was the cultural norm at the village level. A strong sense of morality was maintained and the families generally had lived in their village for decades. As the people fled their country the village and family structure broke apart and for the first time they found themselves living among strangers. Within the camp the cultural norms began to weaken and the stress of leaving their country, walking a great distance and trying to survive in this difficult setting has lessened the protection available from traditional social structures.

In the camp some of the young women and children live alone in groups of five to six and are without the protection of their family members who either died on the walk or remained behind. Others are alone because they were separated from their families during flight. As it is not customary for young women to live alone, many of the people in the camp are suspicious of these young women.

One night the women were returning from the fields and they were accosted by several men who threatened to come to their tent at night for “special favors.” The girls were afraid and ran away, escaping. They reported the incident to one male NGO worker who advised for one of them to stay awake to make sure that nobody surprised them during the night. The young women didn’t know where else to turn for help.

The next evening four men came to their tent with knives and raped two of the women. The other women and children escaped and ran to another tent but instead of getting help were accused of being prostitutes. The women that were raped do not want to go to the health facility because the doctors are all men.
Case Study 3: Family Planning

A population of five million people of various ethnic backgrounds is living in a newly independent country in Eastern Europe. Over half of the population is under the age of 25. The schools are crowded and classes are given in shifts to accommodate the large adolescent population. Ethnic conflict and war has caused extensive destruction of the health infrastructure, with widespread destruction of usable medical buildings, furniture, equipment, medicines. The health care staff provide services to the population in buildings that are partially destroyed, without heat and adequate equipment.

Because of political strife it has been over 15 years since doctors and nurses have had any formal training or been able to practice their profession openly. Their knowledge and information on family planning is limited. Family planning supplies are also limited. Humanitarian agencies have been supplying only condoms and oral contraceptives in the health facilities supported by their agencies, so supplies are not consistently available throughout the country. One ethnic group making up 30 percent of the population is unable to access any of the governmental health services due to continuing political strife and potential violent attacks.

A recent survey was undertaken in the country by the United Nations that indicated only 15 percent of the population were using modern contraceptive methods. Eighty five percent of women of reproductive age interviewed stated that if their husband did not wish to use modern contraceptive methods, they would find it difficult to use them. Forty percent of adolescents interviewed were found to be sexually active, but only one percent of adolescents were using contraceptives. The assessment teams also found that 60 percent of the health care staff interviewed felt that oral contraceptives would cause cancer in patients who used them.
Case Study 4: STIs/HIV/AIDS

A group of 40,000 Asian refugees is living less than two miles from the border of their home country. They are living in small ghetto groupings in villages amidst the host population. The host government does not recognize them officially as refugees or as immigrants, and the host country military prevents any movement within their town, effectively confining them to their ghettos. The population of these enclaves is 90 percent women and children. The men of reproductive age come and go intermittently, staying with relatives for only short periods of time. Approximately three percent of the population are elderly and infirm, living without any social services, surviving only with support they receive from their families.

Since the population is so isolated, there are almost no income-generation activities. A French NGO has started a women’s cooperative for textile production, but there is no outlet for selling the products. No government or humanitarian agencies are distributing food, and most families are surviving from garden plots that are not big enough to provide sufficient food.

Many young girls turn to prostitution to support their families. Rape of women by local militia is common but rarely reported.

The rate of HIV in the host population is about three percent but among the military the rate of HIV has been seen as high as 50 percent. The rate of HIV in the camp population is unknown because no testing is available. A local NGO has set up health services for the population since they are not allowed to travel. The health services include antenatal care, basic delivery services, outpatient curative services including medications for infectious diseases. Condoms are occasionally available through humanitarian aid donations. This NGO has already set into place a training program for community health educators, training them in communicable disease prevention.
KEY COMPONENTS OF REPRODUCTIVE HEALTH FOR REFUGEES

SLIDE 1: KEY COMPONENTS OF REPRODUCTIVE HEALTH IN REFUGEE SETTINGS

- Gender-based Violence prevention and response.
- Safe Motherhood.
- STIs including HIV/AIDS.
- Family Planning.

GENDER-BASED VIOLENCE

SLIDE 2: GENDER-BASED VIOLENCE

- Sexual violence.
- Physical violence.
- Emotional, psychological, and social abuse.
- Harmful traditional practices.

Gender-based violence (GBV) is a term that encompasses a wide variety of abuses. It can be defined as “physical, mental, or social abuse directed against a person because of her or his gender or gender role.” Most reported cases of gender-based violence amongst refugees (and throughout the world) involve women victims or survivors and male perpetrators – in other words acts of aggression addressed toward women on the basis of their gender. GBV is a violation of human rights.

SLIDE 3: TYPES OF GBV

- Rape, attempted rape.
- Sexual coercion.
- Sexual harassment.
- Domestic violence, spouse beating.
- Assault.
- Humiliation.
- Female genital cutting (FGC).
- Early, forced marriage.

GBV takes many forms, including the ones listed above. Perpetrators of GBV are often motivated by a desire for power and domination. GBV is often meant to hurt, control and humiliate, while violating a persons’ physical and mental integrity.
SLIDE 4: CONSEQUENCES OF GBV

- Physical.
- Psychological.
- Social.

GBV can lead to death from murder, suicide, HIV infection, or unsafe abortion, if an unwanted pregnancy results. Survivors may suffer from physical or mental trauma, sexually transmitted infections (STIs), chronic infections, unwanted pregnancy, and possible complications. They often experience depression, terror, guilt, shame, sexual dysfunction, and loss of self-esteem. They may be unable to function in daily life, rejected by spouses and families, ostracized, subjected to further exploitation or to punishment.

SLIDE 5: GBV IS A SERIOUS PROBLEM

- Assume it exists, unless there is conclusive proof that it does not.

The magnitude of GBV is difficult to determine. Incidents of GBV are widely under-reported. The World Bank estimates that less than 10 percent of sexual violence cases in non-refugee situations are reported. The factors contributing to under-reporting – fear of retribution, shame, powerlessness, lack of support, breakdown or unreliability of public services, and the dispersion of families and communities – are all exacerbated in refugee situations.

SLIDE 6: FACTORS CONTRIBUTING TO GBV IN REFUGEE SITUATIONS

- Lack of police protection and lawlessness.
- Coercion around food and other distributed rations.
- Insecure living quarters.
- Distance women have to travel (to latrines, to collect firewood, etc.).
- Political motivation.
- Collapse of traditional societal support (loss of family members, family and community support structures).
- Strains of refugee life (women’s loss of self esteem/status).

GBV can occur during all phases of a refugee situation: prior to flight, during flight, while in the country of asylum, during repatriation and reintegration.

SLIDE 7: PREVENTION AND RESPONSE

- Protection.
- Medical.
- Psychosocial.
- Policy/management.
- Legal.
Humanitarian actors should attempt to prevent GBV, and, when it occurs, respond adequately. At the very least, structure and administration should not worsen the security situation and contribute to GBV. A multisectoral team approach is required to prevent and respond appropriately to GBV. A task force should be empowered to design, implement, and evaluate GBV programming.

SLIDE 8: PREVENTION

- Involve refugee women.
- Public information.
- Camp design, location.
- Food and other distributions.

Community-based groups, often called anti-rape or crisis intervention teams, should be established to help raise awareness of the problem, identify preventive measures, and be at the forefront of providing assistance to survivors.

SLIDE 9: PROTECTION

- Ensure physical safety.

Immediately following an incident of GBV, the physical safety of the survivor must be ensured and guided by the best interests of the survivor and respect for her wishes.

SLIDE 10: MEDICAL CARE RESPONSE TO GBV

- Trauma care.
- Emergency contraception.
- Pregnancy test.
- STI treatment.
- Voluntary testing for HIV.
- Awareness and sensitivity of staff.
- Confidentiality.
- Referral to legal, social and other services.

Health care professionals must be specially trained to undertake post-sexual violence medical care. A protocol should be adopted to guide the medical care provided to survivors (see the WHO Clinical Management of Rape Survivors).
SLIDE 11: PSYCHOSOCIAL RESPONSE

- Counseling.
- Support groups.
- Community education to decrease stigma.
- Legal.

Psychosocial support should begin from the very first encounter with the survivor. A protocol to guide care is needed, and providers must be trained to provide counseling and support. Community-based activities can be effective in helping support survivors to overcome the trauma of sexual violence. National and local or traditional laws against GBV should be enforced, including prosecution of offenders and measures to protect the survivor.

SLIDE 12: POLICY AND MANAGEMENT

- Train and monitor authorities and staff to reduce sexual exploitation.
- Ensure proper documentation for women.
- Increase women protection officers.
- Increase visibility of problem and seriousness of response.
- Document cases, care, and other responses.

(Sources: Public Health in Complex Emergencies Training Course: Reproductive Health Module; Introduction to Reproductive Health Issues in Refugee Settings: An Awareness Building Module; Reproductive Health in Refugee Situations.)

SAFE MOTHERHOOD

SLIDE 13: TITLE

SLIDE 14: MATERNAL MORTALITY

- Maternal death = pregnancy-related death (within 42 days of termination of pregnancy).
- Leading cause of death among women of reproductive age = more than 586,000 deaths a year, almost all in developing countries.
SLIDE 15: LIFETIME RISK OF MATERNAL DEATH

<table>
<thead>
<tr>
<th>Region</th>
<th>Lifetime Risk of Maternal Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>1 in 15</td>
</tr>
<tr>
<td>Asia</td>
<td>1 in 105</td>
</tr>
<tr>
<td>Latin American and Caribbean</td>
<td>1 in 150</td>
</tr>
<tr>
<td>Europe</td>
<td>1 in 1,895</td>
</tr>
<tr>
<td>North America</td>
<td>1 in 3,750</td>
</tr>
</tbody>
</table>

SLIDE 16: CAUSES OF MATERNAL DEATH

<table>
<thead>
<tr>
<th>Causes of Maternal Death</th>
<th>% of Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bleeding after delivery (postpartum hemorrhage)</td>
<td>25</td>
</tr>
<tr>
<td>Infection after delivery</td>
<td>15</td>
</tr>
<tr>
<td>Unsafe abortion</td>
<td>13</td>
</tr>
<tr>
<td>High blood pressure (hypertension) during pregnancy: most dangerous when severe (eclampsia)</td>
<td>12</td>
</tr>
<tr>
<td>Prolonged/obstructed labor</td>
<td>8</td>
</tr>
<tr>
<td>Other direct obstetric causes</td>
<td>8</td>
</tr>
<tr>
<td>Indirect causes (malaria, anemia, other pre-existing conditions)</td>
<td>19</td>
</tr>
</tbody>
</table>

The causes of maternal death are consistent across countries.

SLIDE 17: MATERNAL MORBIDITY (ILL HEALTH)

- For every maternal death, 16 to 25 women experience short or long-term illness.
- Fistulas.
- Laceration.
- Uterine prolapse.
- Infections.
- Anemia.
SLIDE 18: MATERNAL MORBIDITY AND MORTALITY

A “near miss” represents a woman who nearly died. Although maternal death is a relatively rare event, many women come very close to death from pregnancy-related conditions.

SLIDE 19: COMPLICATIONS ARE UNPREDICTABLE

- At least 15 percent of pregnant women in any population can be expected to have life-threatening complications.
- Cannot predict or prevent complications: any delivery can become a complicated one requiring emergency intervention.

SLIDE 20: PERINATAL DEATHS

- 28 weeks gestation through seven days after birth.
- 7.6 million perinatal deaths/year.
- (4.3 million stillbirths; 3.3 early neonatal deaths).
- Syphilis.
- Infection (malaria, sepsis).
- Asphyxia.
- Trauma.
- Neonatal tetanus.
- Complications of preterm (hyaline membrane syndrome).
SLIDE 21: THE 3 DELAYS: A FRAMEWORK FOR REDUCING DEATHS

1. In deciding to seek care.
2. In reaching the health care facility.
3. In receiving appropriate treatment/quality care.

(Note: some specialists in maternal health use a “4 Delay” framework that includes “recognizing a complication” as the first delay.)

SLIDE 22: KEY STRATEGIES FOR PREVENTING MATERNAL AND PERINATAL DEATHS

- Prevent unwanted pregnancies through family planning.
- Early recognition of complications, with referral.
- Access to skilled attendants and emergency obstetric care.
- Management of abortion complications.
- Breastfeeding support.
- Essential newborn care.

Preventing unwanted and mistimed pregnancies through family planning is an effective strategy for preventing maternal and perinatal deaths.

SLIDE 23: ANTENATAL CARE

- Health assessment.
- Detection and management of complications.
- Maintenance of maternal nutrition.
- Health education.
- Health promotion interventions, such as tetanus toxoid (TT) vaccination, folic acid and ferrous sulfate supplements, malaria prophylaxis or presumptive treatment and testing for syphilis, depending on the context.

SLIDE 24: INTRAPARTUM/DELIVERY CARE

- 100 percent of women who develop a complication should be treated in an emergency obstetric care facility = skilled attendance is essential.
- Basic emergency obstetric care (equipped health center).
- Comprehensive emergency obstetric care (referral hospital).
- Transport for deliveries outside an equipped health facility.
- Support for breastfeeding.

SLIDE 25: POSTPARTUM CARE

- Monitor for danger signs and refer.
- Postpartum visit.
- Education.
- Newborn weighing and referral.
- Support for breastfeeding.
- Promoting health of newborn, including thermal protection, eye care, cord care, vaccinations and support for breastfeeding.
- Postpartum family planning.
SLIDE 26: POSTABORTION CARE

- Clinical assessment.
- Monitor for danger signs and refer.
- Manage complications.
- Family planning.

(Sources: Public Health in Complex Emergencies Training Course: Reproductive Health Module; PAI, A World of Difference: Sexual and Reproductive Health and Risks, The PAI Report Card 2001; Promoting Quality Maternal and Newborn Care: A Reference Manual for Program Managers; Corine Ronsman, London School of Hygiene and Tropical Medicine; Reproductive Health in Refugee Situations.)

STIs, INCLUDING HIV

SLIDE 27: SEXUALLY TRANSMITTED INFECTIONS (STIs) (TITLE SLIDE)

SLIDE 28: SEXUALLY TRANSMITTED INFECTIONS (STIs)

- Syphilis.
- Gonorrhea.
- Chlamydia.
- Trichomoniasis.
- Chancroid.
- Hepatitis B.
- Genital warts (HPV).
- Herpes.
- HIV.

Sexually transmitted infections (STIs) are infections that are passed from one person to another during sexual intercourse. Some STIs, such as syphilis, gonorrhea, and HIV, the virus that causes AIDS, can also be passed from mother to child. Public health specialists use the term STI (infection), rather than STD (disease), because people may be infected without any symptoms or obvious sign of disease.

All sexually active men and women as well as those who have been sexually abused (including children) are at risk of developing an STI.

There are 25 different microorganisms that make up the world of STIs. Common ones include gonorrhea, chlamydia, syphilis, trichomoniasis, and HIV.
SLIDE 29: EFFECTS OF STIs

- Health.
- Social.
- Economic.

Health effects of undetected and untreated STIs include pelvic inflammatory disease (PID), which can cause infertility. Infertility as a result of PID accounts for 50 to 80 percent of the infertility in Africa; in Latin America, about 35 percent. Urethral stricture in men is another health consequence of STIs. The microorganisms that cause syphilis, gonorrhea, and chlamydia cause illness in both the mother and the baby. Many cases of cervical cancer are attributed to human papilloma virus (HPV), another STI. Thus, STIs may lead to high rates of death and disease due to cervical cancer in low-resource settings.

Untreated STIs can also have painful social consequences, suffered primarily by women in the developing world. For too many, social stigma and personal damage due to infertility and pregnancy wastage may result in divorce or commercial sex work. In addition to the impact of infertility, STIs can give rise to conflicts between couples, their families who become aware, and friends who are part of their support system. The number of incidents of violence and abusive behavior or retribution as a result of discovering an STI remains undocumented, but experience shows that an STI can bring emotional consequences, including depression and its medical and social effects.

STIs also have economic consequences, although these have not been widely studied. The direct costs of diagnosing and treating STIs can exceed the per capita national health-care budgets in many developing countries. In fact, the cost of treating a woman for syphilis, chlamydial infection, chancroid, or gonorrhea may exceed the per capita national health-care budget. The indirect costs are also high. In terms of lost life and productivity, it has been estimated that five percent of the total disability adjusted healthy life years lost in sub-Saharan Africa is due to STIs, excluding HIV. HIV alone accounts for 10 percent of healthy life years lost. The costs of STIs in infant death and disease add to the economic burden placed on a society. For example, it is estimated that where 10 percent of pregnant women are infected with syphilis, five to eight percent of all pregnancies that extend beyond 12 weeks have an adverse outcome due to syphilis.
SLIDE 30: MANY STIs ARE CURABLE

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>North America</td>
<td>2-3%</td>
</tr>
<tr>
<td>Latin America and the Caribbean</td>
<td>7-14%</td>
</tr>
<tr>
<td>Western Europe</td>
<td>1-2%</td>
</tr>
<tr>
<td>Eastern Europe and Central Asia</td>
<td>3-8%</td>
</tr>
<tr>
<td>East Asia and the Pacific</td>
<td>1-2%</td>
</tr>
<tr>
<td>South and Southeast Asia</td>
<td>17% and 4%</td>
</tr>
<tr>
<td>North Africa and the Middle East</td>
<td>4-7%</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>11-35%</td>
</tr>
</tbody>
</table>


STIs are among the top five diseases for which health care services are sought. With the exception of viral STIs (HIV, herpes, and HPV), STIs can be cured, if they are detected early and treated. Globally, it is estimated that as many as 333 million new cases of curable STIs occur each year. 65 million of these new infections occur in sub-Saharan Africa. Rates of STIs vary considerably from region to region and among specific groups within a country.

SLIDE 31: GREATEST IMPACT OF STIs ON WOMEN AND CHILDREN

The majority of curable STIs in women cause subclinical or asymptomatic infection. For example, gonorrhea usually causes symptoms in men, allowing them to seek treatment, whereas women often have minor symptoms, if any. In women between 15 and 44 years of age, the morbidity and mortality due to STIs, not including HIV, are second only to maternal causes. The prevalence of curable STIs in women is highly variable by region and risk behavior.


Total = 40 million.

Twenty years after the first clinical evidence of AIDS was reported, it has become the most devastating disease humankind has ever faced. Since the epidemic began, more than 60 million people have been infected with the virus. HIV/AIDS is now the leading cause of death in sub-Saharan Africa. Worldwide, it is the fourth biggest killer.

At the end of 2001, an estimated 40 million people globally were living with HIV. About one-third of those currently living with HIV/AIDS are aged 15 – 24. Most of them do not know they carry the virus. Many millions more know nothing or too little about HIV to protect themselves against it.
Although gender differences in patterns of HIV infection vary substantially around the world, globally, HIV infection affects almost as many women as men. Among young people 15 – 24, often more young women are infected than young men. In some regions, adolescent women are as much as six times more likely than adolescent men to be infected.

**SLIDE 33: ESTIMATED NUMBER OF ADULTS AND CHILDREN NEWLY INFECTED WITH HIV DURING 2001**

Total = 5 million.

In many parts of the developing world, the majority of new infections occurred in young adults, with young women especially vulnerable.

**SLIDE 34: ESTIMATED ADULT AND CHILD DEATHS FROM HIV/AIDS DURING 2001**

Total = 3 million.

**SLIDE 35: THE STI/HIV RELATIONSHIP**

- STIs increase the transmission of HIV.
- Risk factors for all STIs are also risk factors for HIV:
  - Multiple sex partners;
  - Failure to use condoms;
  - Failure to seek health care; and
  - Gender inequities.

Studies show that STIs enhance HIV transmission. The presence of an STI increases the risk of HIV transmission during unprotected sex as much as ten times. A landmark study in rural Tanzania found that treating STI-symptomatic individuals using the syndromic approach reduced HIV incidence in the study population by 42 percent. (Source: Grosskurth H, Mosha F, Todd J, et al. Impact of improved treatment of sexually transmitted disease on HIV infection in rural Tanzania: randomized control trial. *Lancet* 1995; 346:530-536.)

Since HIV is a sexually transmitted infection, behaviors such as multiple sexual partners, failure to use condoms, failure to seek health care, and self-treatment increase risk for transmission. Sociocultural and environmental factors also increase the risk of STIs and HIV. These include poverty, gender inequities, commercial sex, community norms, stigma, and lack of appropriate or adequate health services.
SLIDE 36: POVERTY, POWERLESSNESS, AND SOCIAL INSTABILITY

- Sexual violence and exploitation.
- Prostitution.
- Displacement of rural populations to high-populated areas.
- Lack of information.
- Military presence.

HIV spreads fastest in conditions of poverty, powerlessness, and social instability. These conditions are often compounded in situations of forced migrations. During civil strife and flight, refugees, especially women and girls, are at increased risk of sexual violence, including rape. The disturbance of community and family life among refugees may disrupt social norms governing sexual behavior. Adolescents may take sexual risk and face exploitation in the absence of traditional sociocultural constraints. Women and children may be coerced into having sex to obtain their survival needs. Vulnerability to HIV increases when human rights are violated.

In situations of forced migration, populations from low prevalence areas may now be living close to a population with high prevalence. Peacekeeping forces, military and police tend to have higher prevalence of STIs, including HIV, and may also be susceptible to infection and a source of HIV exposure in situations of forced migration.

SLIDE 37: PROGRAM RESPONSE

- Universal precautions.
- Safe blood transfusion.
- Free condoms.
- STI care.
- Information, education, and communication (IEC).
- Care for people with AIDS.

These should be included as basic elements of response to every refugee situation.

SLIDE 38: FAMILY PLANNING: TITLE SLIDE

SLIDE 39: BENEFITS OF FAMILY PLANNING

- Saves women’s lives.
- Saves children’s lives.
- Offers women more choices.

Avoiding unwanted and mistimed pregnancies could prevent about one-fourth of all maternal deaths in developing countries. Especially, using contraception helps avoid unsafe abortions to end unwanted pregnancies. It also enables women to limit births to their healthiest childbearing years and to avoid giving birth more times than is good for their health. Spacing pregnancies at least two years apart helps women have healthier children and improves the odds of infants’ survival. Limiting births to a woman’s healthiest childbearing years also improves her children’s chances of surviving and remaining healthy. For many women, controlling their own childbearing, by using effective contraception, can open the door to education, employment, and community involvement. Also, couples having fewer children are more likely to send their daughters as well as sons to school. All sexually active people need to protect against STIs, including HIV/AIDS. Always using condoms correctly or avoiding sex except in a mutually monogamous relationship are the best ways to prevent contracting STIs. With enough support, FP programs – along with parents, schools, and peers – could help more young people make sexual decisions responsibly, avoiding STIs and unintended pregnancies.

SLIDE 40: FAMILY PLANNING SAVES WOMEN’S LIVES

- Avoids unsafe abortion.
- Limits exposure to the health risks of pregnancy and childbirth.
- Limits births to the healthiest ages.
- Limits the number of births.

Effective contraception prevents unwanted and mistimed pregnancies, which are often ended by unsafe abortions. Unsafe abortions cause nearly 80,000 maternal deaths each year.

Unwanted and mistimed pregnancies needlessly expose women to health risks, especially where good obstetric care is unavailable. Childbearing is safer for women between the ages of 20 and 40. Women who give birth four times or more face dramatically higher risks of maternal death.
SLIDE 41: FAMILY PLANNING SAVES CHILDREN’S LIVES

- Can assure at least two years between pregnancies.
- Healthier babies when births limited to healthiest reproductive years.
- Spacing births helps assure adequate breastfeeding.

Contraceptive use is often one of the most cost-effective measures available for improving infant and child health. Spacing pregnancies more than two years apart helps women have healthier children and increases their chances of survival (by 25 percent for children aged less than five years). Women under age 20 and over 40 are much more likely than other women to have babies who die in infancy. Breastfeeding saves the lives of about six million children each year.

SLIDE 42: FAMILY PLANNING HELPS WOMEN HAVE MORE CHOICES.

- Reproductive choices.
- Educational and employment choices.
- Education for daughters.

Women who have access to good-quality FP can make reproductive choices. For some women, control over their own fertility opens the door to other important choices and opportunities. FP helps young women delay motherhood in order to complete school. Unless sexually active young women use contraception, they face a risk that young men do not face: that they will become pregnant and may have to leave or forego school. Families with fewer children are more likely to educate their daughters as well as their sons. When families are smaller, their resources tend to be distributed more equally among sons and daughters.

SLIDE 43: FAMILY PLANNING ENCOURAGES SAFER SEX

- Communication, education, and counseling.
- Good public health investments.

Every day 16,000 people are infected with HIV and almost a million people become infected with other STIs. Reducing the spread of STIs would save many lives and relieve strain on health care systems. Communication, education, and counseling that encourage adoption of safer sexual behavior, including delayed sexual initiation, monogamy, condom use, and dual protection, are an important part of family planning. Programs that encourage safer sexual behavior can be good public health investments. Governments and health care providers could shift resources to meeting other needs for health care, education, and development.
SLIDE 44: UNMET NEED FOR FAMILY PLANNING

- 120 million women worldwide.
- Lack of knowledge.
- Lack of services.
- Ambivalence about childbearing.
- Opposition from partners and family.
- Health concerns.

An estimated 120 million women in the less developed world say they would prefer to delay or stop childbearing, but are not using any FP method. In some countries, more than one-quarter of all married women fall into this category. Several studies have asked women with an unmet need why they do not use contraception. The reasons are numerous, including a lack of knowledge about FP methods and services, unavailability of services, ambivalence about wanting a child, opposition from husbands and other family members, health concerns, and fear of contraceptive side effects. Although many people assume that there is interest in increasing the number of births in conflict-affected societies to replace those lost to war, when asked, men and women in conflict-affected situations respond with a range of views, including some who wish to become pregnant, some who wish to delay childbearing, some who wish to stop childbearing and some who are currently childbearing.

SLIDE 45: GENDER INEQUALITY

- Gender roles:
  - Limit women’s autonomy and decision-making authority; and
  - Limit benefits from using FP.

Many of these reasons overlap and relate to two underlying issues: the gender-related expectations that shape women’s lives and the quality of FP services available to women. Although women have long been the intended beneficiaries of FP and reproductive health programs, gender roles, particularly the unequal power wielded by men and women, influence the extent to which women can make decisions about their health and quality of life. In many societies, women’s autonomy is limited, so that major family decisions – including whether to use contraception and how many children to have – are the principal domain of husbands.

Gender expectations can also limit the benefits that women are able to gain when they do decide to use FP. Some women with fewer children may find that their opportunities in life differ little from their peers (or elders) who have had more children. Studies in parts of rural Egypt and Bangladesh showed that declines in fertility were not associated with measurable changes in gender roles or women’s opportunities.
Investments to improve the range of choices and opportunities available to women, including adolescents, include improving educational opportunities for girls and women, and more broadly, making girls’ and women’s empowerment a specific development objective; expanding women’s employment opportunities and child-care options for working mothers; revising laws, such as those on property and inheritance, that establish or reinforce women’s inferior position in society; supporting community-based initiatives that encourage men and women to discuss changing gender roles and norms; implementing programs for adolescents, in and out of school, to help them make better life choices and protect themselves from unintended pregnancies and sexually transmitted infections; and passing and enforcing international treaties such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).

SLIDE 46: QUALITY FAMILY PLANNING SERVICES

- Accessibility, availability, and acceptability of services.
- Organization of care.
- Technical competence.
- Facilities and supplies.
- Client rights.

FP and other reproductive health programs need to establish and evaluate quality approaches to providing services. Service quality depends on a combination of factors, such as a reliable supply of a range of contraceptive methods, technical competence and supervision of service providers, and offering convenience, respect, and privacy to those who use the services. Research shows:

- FP programs should improve people’s knowledge of the reproductive health system, contraception and reduce their fear of methods.
- Women and men need better information about how to use contraceptives and what side effects to expect once they do adopt a method.
- Programs should make greater efforts to reach men with services and information, and to encourage them to adopt or support their partner’s choice regarding FP.
- Health workers should treat people with dignity, explain possible problems and how to manage them, and provide clients with alternatives.
- Services should make greater efforts to reach out to adolescents, and at a minimum, not deny services to young or unmarried individuals.
- Community organizations and women’s groups should educate women to demand quality services.
SLIDE 47: CHOICE OF METHODS

- Range of contraceptive methods offered:
  - Right to choice; and
  - Encourage “dual protection.”

Good quality FP services offer a range of contraceptive methods and guarantee clients’ rights to choose the one that best fits their specific needs and circumstances. Information about protection from STIs, including HIV, is also an essential part of FP. Male and female condoms are currently the only methods that offer protection against both STIs and unwanted pregnancy – dual protection. Clients have the right to choose the method they want to protect against pregnancy, but they also need to understand whether their FP method protects them against STIs and that they can combine methods such as Depo Provera and condoms for dual protection.

SLIDE 48: FAMILY PLANNING IN SITUATIONS OF FORCED MIGRATION

- Situation in country of origin influences.
- Expectations.
- Perceived needs.
- Demand.

The situation in the refugees’ country of origin will be an important factor influencing the demand for FP. Laws, infrastructure, religious and ethical values and cultural backgrounds and the training of health-care providers from the host country have an important affect on the services that can be offered. Some refugee women may want to continue using a contraceptive method that they used before displacement. These women’s demands should be met as soon as possible.

SLIDE 49: CONTRACEPTIVE METHODS

- Barrier methods.
- Hormonal methods.
- Long-term methods.
- Permanent methods.
- Fertility-based methods.
- Traditional methods.

Barrier methods include condoms (both male and female), spermicides, diaphragm, cervical cap, and sponge. Hormonal methods include combined oral contraceptives, progestin-only contraceptives, injectables (including DMPA or Depo-Provera and others), Norplant implants, and emergency contraception based on oral contraceptives. Long-term methods include the IUD, some injectables, and Norplant. Permanent methods are male and
female sterilization. Fertility-based methods rely on recognition of the fertile days and abstaining from sex on those days. They include the lactation amenorrhea method, ovulation method, calendar (rhythm) method, and the basal body temperature method. Traditional methods include withdrawal and abstinence.

ACTIVITY
KEY ISSUE: COORDINATING THE RESPONSE TO
REPRODUCTIVE HEALTH PROBLEMS

Learning Objectives
1. Identify key stakeholders in RH in specific setting.
2. Outline mechanisms to facilitate coordination, collaboration, integration.

Methodology
Role play, analysis, and discussion.

Suggested Time
45 minutes.

Materials
• Flip chart, markers.

Preparation
• Adapt and modify the "Roles for the Coordination Role Play" (see page 62) to fit the situation and the number of people in the group. Make two sets of roles, with each role on a separate piece of paper.

Procedure
1. Facilitate a brief discussion on key stakeholders in RH and the importance of coordination, collaboration, and integration in responding to RH problems by asking the questions below. Note responses on a flip chart or ask a participant to do so.
   □ In light of the definition of RH, the many factors affecting RH, and the components of RH services, who are the stakeholders in RH (in this particular setting)? Why?
   □ What roles could the various stakeholders play in RH?
   □ What is needed to ensure that all stakeholders in RH can contribute effectively to resolving RH problems? (Coordination, collaboration, partnerships, and integration of services.)
   □ How and where should coordination take place?
   □ What are barriers or obstacles to coordination?
   □ What can be done to overcome these barriers?
2. Summarize the discussion or ask a participant to do so, being sure the Key Points on the following page are covered.
KEY POINTS

- Key stakeholders in RH may include women, their families, the larger community, health care providers at all levels, NGO and intergovernmental agencies, host governments, the international community. They represent many sectors, including community services, education, and protection.

- Coordination of activities among relief organizations is essential. Coordination is needed among sectors, implementing agencies, and levels of service providers.

- A RH Coordinator in each refugee situation can assist with overall organization and supervision of RH activities.

- Without coordination, activities result in inappropriate allocations of scarce resources and reduced impact.

- Barriers or obstacles to coordination, collaboration, and integration may include:
  - Insufficient funding;
  - Lack of recognition of the importance of RH;
  - Vertical programming;
  - Lack of appreciation of impact of gender roles and relations on RH;
  - Belief that “technical staff know best;”
  - Community opposition to RH services;
  - Rapid-response, crisis management style (beyond point in time when needed);
  - Competition or “turf wars” between NGOs and/or implementing agencies;
  - Corruption; and
  - Complacency, disinterest.

3. Divide participants into two groups for a role play. Give each group flip chart pages and markers. Give each person one of the roles from the “Roles for Coordination Role Play” (page 62).

4. Give the instructions for this activity:

   - Imagine that an urgent RH problem has arisen in your work setting. Each group chooses one of the following to address in its role play: 1) several women have recently come close to death during childbirth; 2) health services are reporting a large increase in the number of cases of gonorrhea among men; 3) several young women have been raped within the past week.
The health coordinator from an NGO wants to develop a response, but there are eight other health care stakeholder agencies also in the region. There are no regular meetings to discuss RH issues, and although there are several UN agencies present in the region, no one has called for a meeting to address this issue. The health coordinator doesn't know exactly what each agency is doing or planning to do regarding RH. What does the health coordinator do to coordinate a response to the problem?

Each person plays his or her role in the group, according to his or her understanding of the specific situation.

The goal is to develop a coordinated response to the problem.

5. Allow 20 minutes for this activity.

6. Facilitate a discussion by asking the questions below.
   - What kind of barriers, obstacles, and resistance did the health coordinator encounter? Give examples.
   - How were these barriers overcome? (For example, how did the coordinator advocate for RH? What aspects of RH were discussed?) What decisions were made?
   - How were the decisions made?
   - Who was involved in the decision-making process?

7. Summarize the discussion or ask a participant to do so, being sure the Key Points below are covered.

**KEY POINTS**

- Coordination calls for advocacy of RH for refugees among many stakeholders, often requiring good data to present a convincing case.
- All field level staff are in a position to identify RH problems and to call for a coordinated response.
- Coordination also calls for participatory processes, and short- and long-term planning.
ROLES FOR COORDINATION ROLE PLAY
(Note: add or change roles according to the specific situation and the number of people in the group)

- International NGO health coordinator.
- Representatives from other health care agencies in region (NGOs and Ministry of Health – at least four):
  - One who claims “we already do RH; if we add more players, we’ll just be stepping on everyone’s toes;”
  - Another who is sympathetic to RH issues; willing to be more involved; and
  - Ministry of Health – you and your staff are already pushed to the limits; you don’t see how you could add new activities, although you recognize the severity of the problem.
- UNHCR protection officer – you are aware of gender-based violence and would like to do something, but don’t see how it relates to health.
- Community leader – you believe that childbirth is a woman’s burden; if she dies it is fate (or that rape occurs when young women “provoke” their attackers – they should just stay at home and learn to be good wives and mothers; or that STIs are not serious diseases – all men get them at one time or another, and they can always cope with them through a traditional healer/self medication).
- UN agency representative(s) – 1) you believe that RH is not a priority in light of all the other issues facing refugees; 2) you are sympathetic to RH issues, but believe there is not enough funding to support new activities.
- Representatives from other sectors (education, community services, water and sanitation, housing, camp management, etc.) – some resist the idea of getting involved in RH – “it’s not our concern”, others see the relationship, but say they don’t have staff with expertise in RH – don’t know what they can do.
ACTIVITY
APPLYING A KEY PRINCIPLE:
ATTENTION TO GENDER AND ADOLESCENT ISSUES

Learning Objectives
1. Identify different problems men and women may face throughout their lives due to various vulnerabilities.
2. Describe RH program responses to problems.

Methodology
Small group activity, drawing, analysis, and discussion.

Suggested Time
30 minutes.

Materials
• Flip chart, markers, tape.
• Adolescent Reproductive Health in Refugee Settings.

Preparation
• Make a flip chart page with an example of a blank “Lifeline” (see page 65).
• Adapt and modify the lifeline stories as needed. Write each story on a separate piece of paper.

Procedure
1. Divide participants into six small groups. Give each group flip chart, markers, and tape, and one of the stories of an imaginary person living in a refugee situation. Show the “Example of the Lifeline” (page 65).
2. Give the instructions for the activity:
   □ Give the character a name, an age, and a place of origin.
   □ Draw the person’s life.
   □ Mark positive or happy events and/or influences above the line.
   □ Mark negative or sad events and/or influences below the line.
   □ Mark events or influences with both positive and negative influences on the line.
   □ Use words and symbols.
3. Allow 10 minutes. Ask each group to select a person to present its lifeline.
4. Allow each group two minutes to present its lifeline.
5. Facilitate a discussion about gender, age, risk, vulnerability, and program responses by asking the questions below. Note responses on a flip chart or ask a participant to do so.

- How do the lifelines vary for the different people?
- What situations and circumstances outside the individual placed the different people at risk for RH problems (made them more vulnerable to RH problems)?
- What situation and circumstances allowed the person to develop his or her capacity to avoid risk? To reduce his or her vulnerability?
- What characteristics and skills can empower people to avoid risk situations?
- What can RH services and programs do to help people avoid risk and to reduce the vulnerability of certain groups of people to RH problems?

6. Summarize the discussion or ask a participant to do so, being sure the Key Points below are covered. Refer participants to Adolescent Reproductive Health in Refugee Settings for more information on key principles in RH programming for adolescents.

**KEY POINTS**

- All people have experiences that can place them at risk of RH problems and that can empower them to avoid risk.
- People living in situations of poverty and instability and members of vulnerable groups (such as adolescents, single mothers, women subject to violence) often encounter many more risk factors and situations in their lives.
- Risk factors and situations occurring earlier in life may continue to have an impact much later in a person’s life.
- RH problems should be addressed from a “life span” approach, with interventions that can have an impact early in life (e.g., increasing young people’s capacities in assertiveness, negotiating skills, conflict resolution, and decision-making) and early in the course of arising problems (referral to medical and social help at the first signs of violence, offering emergency contraception to women who have had unprotected intercourse and do not wish to become pregnant, STI care, postabortion care, etc.)
- RH services should be integrated with other health services and involve sectors other than health.

Example of a Lifeline

Stories:

Adult woman who at some time in her life is raped, has an unwanted pregnancy, and abortion.

Young, newly-wed woman, victim of domestic violence.

An unmarried adolescent boy who has an STI.

A single mother with three children under the age of five.

An unmarried adolescent girl who has been raped while at the camp/settlement/refugee situation.

An adult man, who is now infertile as a result of an STI.
ACTIVITY
ACTION PLANNING

Learning Objectives
1. Prepare plan for actions to initiate, improve, expand RH programming in specific situation; OR
   Prepare plan to incorporate refugee RH issues into ongoing programming (when the Manual is used for training and awareness raising for organizations not currently involved in RH for refugees).
2. Identify agency and individual contributions, responsibilities, timing, and resources for action plan.

Methodology
Small group work, presentation and discussion.

Suggested Time
1½ hours (90 minutes).

Materials
• Flip chart, markers.
• Resource materials.
• Flip chart pages and notes from previous activities.

Preparation
• Make arrangements to have the final version of the action plan typed and distributed to participants.

Procedure
1. Divide the participants into groups by objective of RH services and interventions:
   □ Prevent and manage the consequences of sexual violence;
   □ Reduce transmission of STIs, including HIV;
   □ Reduce maternal and perinatal morbidity and mortality; and
   □ Prevent unwanted and mistimed pregnancies.
2. Give the instructions:
   □ Develop an “action plan” or list of “next steps to do”, based on their thinking about what they will be doing differently as a result of this workshop – and how they will do it;
   □ Use the resource materials and flip charts and notes from the previous activities;
Include program activities as well as individual and organization actions (such as “hold a seminar to share the information and resource materials from this workshop with my colleagues”, “request assistance from headquarters on community-based HIV/AIDS activities”);

Specify the individual and agency contributions and responsibilities, the timing of the action, and needed resources; and

Bear in mind the need to identify an organization(s) and individual(s) to facilitate the coordination of RH programming.

3. Select a person to present the results of the group’s work.

4. Allow 30 minutes.

5. Allow each group 10 minutes to summarize its action plan. Encourage participants to ask questions and make suggestions.

6. Encourage participants to agree on a final version of the action plan.

7. Discuss follow-up and next steps:
   - What do we need to do next as individuals and as organizations to follow-up with the work we have done today?
   - How will we use the action plans?
   - Who and/or what organizations have been proposed as RH coordinators? How will these individuals and organizations take on this role?
   - What kind of help (technical assistance, material and financial support) do we need to follow up? What are potential sources of this help?

8. Arrange to have final plans typed, copied, and distributed to participants before they return to their sites. (Or, add this step – typing, copying and distribution – to the work plan with its corresponding responsible agency, individual, and time.)
ACTIVITY
CONCLUSION AND EVALUATION

Learning Objectives
1. Describe if and how the training achieved its objectives.

Methodology
Presentation and discussion.

Suggested Time
10 – 20 minutes.

Materials
- Flip chart, markers.
- Flip chart page prepared for introduction session with workshop learning objectives and anticipated outcomes.

Preparation
- None.

Procedure
1. Close the workshop with a review of the learning objectives and anticipated outcomes, on the flip chart page prepared in the introduction session. Facilitate a discussion by asking:
   - Have we accomplished these objectives?
   - If not, what has not been accomplished?
   - How can we apply what we learned to our jobs?
   - What insights, new knowledge have you gained?
   - Which topics have not been relevant to your work?
   - Which topics were not covered that you need to do your work?

2. Lead a reflections session, by asking each participant to complete at least one of the following sentences:
   - Today I learned ________________________________.
   - Today I re-learned ______________________________.
   - Today I noted __________________________________.
   - Today I discovered ______________________________.
   - Today I realized ________________________________.
   - Today I was surprised __________________________.
   - Today I was glad ______________________________.
   - Today I was disappointed ________________________.

3. End the workshop with a ceremony, speeches, dinner, distribution of certificates, as local custom calls for.
Reproductive Health for Refugees Consortium (RHRC): Member Contact Information

The RHRC consists of seven members:

Four members – ARC, CARE, IRC, and MSI – focus specifically on the provision of reproductive health services for populations in need. JSI R&TI and Columbia University are primarily involved in project research, staff training and technical assistance. The Women’s Commission, an expert resource and advocacy organization, plays a coordinating role for the Consortium; it also provides technical assistance to local nongovernmental organizations (NGOs) that are providing refugee reproductive health services. As the sole European organization, MSI plays a vital role in the consortium’s advocacy work in Europe.

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TRAINER’S EVALUATION FORM

Please describe briefly the context in which you used the Training Manual. (Include the participants, language, trainers, country, context, and activities used.)

What was your training objective?

How useful did you find this Training Manual? (Please circle one.)

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<thead>
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What aspects of the Training Manual were most useful?

1._______________________________________________________________

2._______________________________________________________________

What aspects of the Training Manual were least useful?

1._______________________________________________________________

2._______________________________________________________________

Was there anything missing from the Manual that would have improved your training session? Please explain.

How would you rate the content and style of the Manual? (Please circle one.)

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The probability that I, or my organization, will use this Training Manual again, in part or in whole, is: (Please circle one.)

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What suggestions do you have for improving the content, style or format?

1. _____________________________________________________________________

2. _____________________________________________________________________

Do you have any additional comments/suggestions for improving the quality and usefulness of this Training Manual?

Please complete the following information: (Optional)
Your name, organization and address (including phone number, fax and/or e-mail address):
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Please let us know if you have translated any of the material into another language.

Thank you for taking time to complete this form. We greatly appreciate your feedback. Please return the completed form to:

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