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CHAPTER ONE

Fundamental Principles

Contents:

Reproductive health (RH) care should be available in all situations and be based on the needs and expressed demands of refugees, particularly women, with full respect for the various religious and ethical values and cultural backgrounds of the refugees while also conforming with universally recognised international human rights.

The above principle is the cornerstone of this Field Manual and should be the basis of all RH interventions.

Special Notes:

- ✔ This Field Manual is intended for use in refugee situations. It may also be of use in refugee-like situations, such as in situations with internally displaced persons or returnee-affected areas.
- ✔ The term “refugee” is used herein to describe the beneficiaries of RH care, regardless of their legal status.
- ✔ UNHCR defines an 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.”

Fundamental Principles

Definition of Reproductive Health

Reproductive health is a state of complete physical, mental and social well being and not merely the absence of disease and infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore 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. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

International Conference on Population and Development – Cairo 1994; Programme of Action, para 7.2

Timely Reproductive Health Interventions

Providing adequate food, clean water, shelter, sanitation and primary health care (PHC) are priority activities in any refugee emergency. These interventions help combat the major killers in refugee situations: malnutrition, diarrhoeal diseases, measles, acute respiratory infections (ARI) and malaria (where prevalent). However, RH care is also crucial for the physical, mental and social well being of any individual. As an integral part of PHC, RH care is important in overcoming such problems as:

- complications of pregnancy and delivery, which are leading causes of death and disease among refugee women of childbearing age;
- malnutrition and epidemics, which can further diminish the physiological reserves of pregnant or lactating women, thus endangering their health and that of their child; and
- an absence of law and order, commonly seen in refugee emergencies, which, together with men's loss of power and status, leads to an increased risk of sexual violence. Violence against refugee women, rape, sexual abuse, involuntary prostitution, even physical assault during pregnancy have been found to be far more widespread than was previously acknowledged.

Some General Facts About Reproductive Health

- ✔ 585,000 women die each year–one every minute–from pregnancy-related causes. Ninety-nine per cent of these deaths occur in developing countries.
- ✔ Girls aged 15-19 are twice as likely to die from childbirth as women in their twenties. Those under 15 are five times as likely to die from childbirth.
- ✔ More than 330 million new cases of sexually transmitted diseases (STDs) occur every year, affecting 1 of every 20 adolescents.
- ✔ By the year 2000, up to 40 million people could be HIV-infected.
- ✔ 120 million women say they do not want to become pregnant, but are not using any method of family planning.
- ✔ 20 million unsafe abortions occur every year–55,000 each day–resulting in some 80,000 deaths and hundreds of thousands of disabilities.

Source: WHO–World Health Day–Safe Motherhood–1998

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Unquestionably, women are most affected by reproductive health problems. For refugee women, this burden is further compounded by the precariousness of their situation.

The Complexity of Intervening

It is important that RH interventions are not only timely but also appropriate and consistent with national laws and development priorities. RH programmes affect highly personal aspects of life, so programmes must be particularly sensitive to religious and ethical values and cultural backgrounds of the refugee population.

It may not always be feasible for one organisation to implement the full range of RH services. Providing comprehensive RH services may require cooperation and coordination among agencies.

The complexities of reproductive health were discussed at the Fourth World Conference on Women (Beijing 1995). Participants listed the following as some of the reasons why many of the world's people do not benefit from reproductive health:

"*... inadequate levels of knowledge about human sexuality; inappropriate or poor-quality RH information and services; the prevalence of high-risk sexual behaviour; discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives.*"

Platform of Action, paragraph 7.3–Beijing 1995

"Adolescents are particularly vulnerable," they concluded.

Refugees face even greater difficulties in obtaining RH services. Among them:

- The breakdown of pre-existing family support networks means that young men and women lose their traditional sources of information, assistance and protection.
- Loss of income reduces the refugees' ability to make free choices.
- Women may become solely responsible for the welfare of their families. Fulfilling the role of breadwinner often represents a great emotional and physical burden that is not adequately compensated by appropriate services.
- Attention is often focused exclusively on immediate life-saving measures; RH care is not considered a priority. (Hence the development of this Field Manual and the recommendations for the Minimum Initial Service Package–MISP–described in Chapter Two.)

Guiding Principles for Intervention

A successful RH programme requires adequate and well-trained staff, sufficient funding, and effective

- community participation
- quality of care
- integration of services
- inclusion of information, education and communication (IEC) activities
- advocacy for reproductive health
- coordination among relief agencies.

These principles are applicable to every aspect of RH assistance and to all subsequent chapters of this Field Manual.

Community Participation

Community participation is essential at all stages to ensure the acceptability, appropriateness and sustainability of RH programmes. It is necessary for empowering refugees, particularly women, to have greater control over their lives and over the services that are provided to them.

In an emergency, refugees are extremely vulnerable. It may be easy to overlook their particular needs in the urgency of providing services. Their participation is vital in ensuring that this does not happen, and that the services are adapted to the users rather than vice versa. In each situation it is necessary to identify groups and channels through which participation can be fostered. However, it is also important to recognise that the leaders may not be best placed or able to provide the information and support needed to successfully adapt RH services to the population concerned. Participation may be best achieved through the family unit.

It is only by taking into account the cultural, economic, ethical, legal, linguistic and religious backgrounds of the refugees and host country population that appropriate services can be offered to and used by refugees. By actively participating, refugees develop the sense of "ownership" over programmes that is essential for sustainability.

It is through community participation that essential information will be gathered to direct the planning of services. Such information includes:

- identification of the training needs of care providers;
- selection of appropriate sites to avoid stigmatisation of users;
- analysis of the appropriate level of privacy and confidentiality required by local customs, cultures or beliefs;
- decisions on whether primarily female staff must be used; and
- recognition of birthing preferences.

A failure to obtain such information may have a negative impact on the use of services, for example, if family members are excluded from a birth when they have an important cultural role to play at such times.

It is important that both men and women be involved in many aspects of the RH programme to promote responsible and caring attitudes and behaviour for the benefit of all. Although men may be poorly informed about RH matters, they are often the decision-makers. Health providers need to be aware of the roles and decision-making process within the family so they can provide services effectively and in the best interests of the whole family.

Quality of Care

Quality RH services require that organisations, programmes and providers,

- use appropriate technologies and have trained staff,
- respect refugees' rights to informed consent by providing adequate information and counselling, and
- ensure accessible services, privacy, confidentiality, and continuity of care.

These aspects of quality of care are also guiding principles of medical ethics in the protection of human rights.

Appropriate Technologies and Skills

Appropriate technologies must be selected according to internationally accepted standards. Providers must be adequately trained, equipped and supervised. Appropriate supplies must be available, clean, and, when necessary, sterile. All invasive procedures must involve infection prevention, proper use of drugs, etc. All interventions must be safe– which requires a sufficiently staffed health facility, technically competent providers, properly functioning equipment, adequate supplies, and a responsive logistics system.

Access

Primary health care (PHC) services must be available within a reasonable distance from all patients. A referral network, including transportation, to higher-level facilities should be coupled to PHC services. Patients' access to services should not be contingent on social or cultural backgrounds nor on age, marital sta-

tus, parity, number of male children, sexual orientation, or partner or parental consent. Patients should not be required to accept one service in order to gain access to another type of service.

Informed Consent

A patient has the right to know, before any procedure is performed, what the procedure involves as well as its expected benefits, possible risks, duration of treatment, and cost to the patient or her/his family. This information must be presented to the patient in a language that s/he can understand.

Informed consent means that the patient not only has choices, but also can make an educated decision among various options. To make such a decision, the patient must know her/his condition and have ample opportunity to ask questions and receive answers from a knowledgeable provider.

Privacy

Visual and auditory privacy must be maintained during all phases of patient care–from presentation through diagnosis, testing, treatment, and counselling. Examination tables should face away from doors and windows so that a woman will not risk exposure during examination, particularly during pelvic examination. Windows should be covered, and partitions placed between examination areas. Others within the health facility should not be able to overhear the interaction between the patient and health provider.

Confidentiality

All information regarding the patient, her/his history, treatment, condition, circumstances, and prognosis is discussed only between the patient, the provider and supervisors. No staff member should share patient information with anyone who is not directly involved in the patient's care without the patient's permission. Medical records should be stored in a locked room or file cabinet to which only providers and supervisors have access. Medical records should never leave the clinic unless required for patient referral to another clinic.

Respect

All health staff should talk with patients politely and manage patient care in a compassionate and non-judgmental fashion. Patients have the right to ask questions and to expect those questions will be answered in a timely, complete and understandable manner. Patients need to know how to recognise and manage common complications of their condition, signs and symptoms indicating the need for additional medical attention, and when and how to obtain follow-up care.

Integrating Services

It is important to distinguish between different aspects of integration. Reproductive health services should be integrated into primary health care. Integration may occur in relation to the place at which services are provided or the personnel who provide those services.

The potential to integrate services provided at any particular site will depend on the skills and resources available. It is unreasonable to expect the community health worker to provide too wide a range of services. A health centre will have greater resources and more skilled personnel, and so greater integration at one site becomes possible. The referral-level facility must be able to provide services to meet all needs.

Successful integration is dependent on the quality of communication among the various personnel, at different levels, within the overall service. All personnel must be fully aware of how the system operates, what services are provided at each level, and how those who want to use the services can do so. The staff at one level must be able to provide information about all other levels. Communication must also ensure that when referrals are made between levels, adequate information is received about a patient at both ends of the service. Information must travel in both directions and must cover both the reasons for a referral and the eventual consequences of any action taken.

Good communication among levels is essential to deal satisfactorily with issues relating to support, supervision and training, all of which are essential in maintaining quality. Specific training of personnel may be necessary to ensure that the designated services can be provided at each level by appropriately skilled personnel.

RH services should be considered neither as optional nor as special projects. They should be integrated in a timely fashion within PHC and community service activities. Even when the delivery of RH services calls for special arrangements or resources, this cannot justify their postponement or neglect.

Information, Education and Communication (IEC)

Reproductive health requires knowledge and understanding about human sexuality and appropriate, adequate and accessible information.

It is important to raise the level of knowledge about reproduction and sexuality. Women, men and adolescents should understand how their bodies work and how they can maintain good reproductive health. Scientifically validated knowledge should be shared to promote free and informed choice and to counter misperceptions and harmful practices.

IEC activities are essential for sharing this knowledge. Such activities range from “one-to-one” conversations between service providers and refugees to highly developed formal campaigns.

There are also effective IEC strategies that promote community participation and individual commitment to changing behaviours.

IEC essentials can be found in Appendix One.

Advocacy for Reproductive Health

The active promotion of reproductive health should be part of all refugee assistance programmes from the outset. A lack of awareness of the issues involved in protecting and promoting reproductive health may be found in all groups involved in a refugee setting, from the providers of health care to the community they serve. This lack of awareness may become a real barrier to improved reproductive health and responsible sexual behaviour.

However, opportunities to promote RH issues may be limited. Any advocacy that is undertaken must demonstrate understanding of the culture, values and belief systems of the local population. Advocacy that is insensitive or disrespectful may be counterproductive and prompt rejection, or even reprisals, within the refugee community.

Coordinating Activities Among Relief Agencies

Coordination is needed among:

- sectors (health, community services, protection),
- implementing agencies (government, NGOs, UN agencies), and
- levels of service providers (doctors, midwives, Traditional Birth Attendants [TBAs], health assistants).

To foster this coordination, it is recommended that an individual be identified as RH Coordinator in each refugee situation. This person would assume the responsibility for overall organisation and supervision of RH activities, as well as the integration of these services within other health services.

The issue of sexual violence provides an excellent illustration of the need to coordinate among sectors. To deal with the causes and consequences of violence, health professionals must work closely with staff in the protection and community services sectors. By doing so, staff can develop detailed procedures on

appropriate care for survivors and strategies to prevent the occurrence of sexual violence.

Coordination among implementing agencies requires that, although each agency has its own expertise and range of qualified staff, there should be a standard approach used by all agencies involved. Even though an agency may not provide a full range of RH services, coordination with others would ensure that the end product is complementary and comprehensive RH care. Uncoordinated activities result in inappropriate allocations of scarce resources and reduced impact of the project.

Needs Assessment

RH services must be based on the expressed needs and demands of refugees. RH needs assessments should be carried out when the emergency situation has stabilised. This Field Manual does not give detailed guidance on conducting needs assessment, but refers the field staff to a set of tools created by the Reproductive Health for Refugees (RHR) Consortium for this purpose. (See Further Reading)

The following RH needs assessment tools have been developed by the RHR Consortium:

- Refugee Leader Questions
- Group Discussion Questions
- Survey (for analysis by computer)
- Survey (for analysis by hand)
- Health Facility Questionnaire and Checklist

These tools assist relief workers in gathering information to assess attitudes toward RH practices, local medical practices and policies, the scope of needed services and the degree to which current services provide what is needed.

The tools, which should be adapted to each situation, are designed to be used by people with field management experience and/or RH experience to design new RH programmes, assess existing capacity and monitor services. The refugee community should be involved in the needs assessment process from the beginning. Refugees should participate in:

- conceptualising the needs assessment framework,
- site selection for the assessment,
- translation/interpretation of tools,
- interviewing fellow refugees,
- data analysis and interpretation,
- feedback to the community,
- design or redesign of the RH programme based on the needs assessment findings.

The Structure of the Field Manual

The principles that have been developed within this introduction apply to all chapters throughout the Field Manual.

Not all components of RH service provision are appropriate within the initial phases of a refugee situation. This Field Manual is intended to assist field staff in implementing such services in phases, moving from minimal to comprehensive services as the situation gradually stabilises.

In recognition of the urgency in dealing with some RH issues, Chapter Two of this Field Manual describes in detail the components of a “Minimum Initial Service Package” (MISP). It is a range of core RH activities to be carried out from the beginning of the emergency. The activities outlined within MISP should be conducted alongside other initial-phase interventions that take place in any newly identified refugee or emergency situation.

A more comprehensive package of RH interventions must then be provided as the situation stabilises. These interventions should be integrated into Primary Health Care services.

The remaining chapters of the Field Manual and the main goal of each are:

CHAPTER 2: *MISP*
OVERALL GOAL: initiate selected RH activities as soon as feasible in an emergency

CHAPTER 3: *Safe Motherhood*
OVERALL GOAL: prevent excess maternal and peri/neonatal mortality and morbidity

CHAPTER 4: *Sexual and Gender-based Violence*
OVERALL GOAL: prevent and manage the consequences of sexual and gender-based violence

CHAPTER 5: *Sexually Transmitted Diseases (STDs) including HIV/AIDS*
OVERALL GOAL: prevent and treat STDs, reduce the transmission of HIV infection, and assist in caring for those affected

CHAPTER 6: *Family Planning*
OVERALL GOAL: enable refugees to decide freely the number and spacing of their children

CHAPTER 7: *Other RH Concerns*
OVERALL GOAL: prevent excess maternal morbidity and mortality due to the complications of spontaneous and unsafe abortions and promote the eradication of Female Genital Mutilation.

CHAPTER 8: *RH of Young People*
OVERALL GOAL: promote and support reproductive health of young people

CHAPTER 9: *Monitoring and Surveillance*
OVERALL GOAL: set objectives, measure progress and make programmatic decisions based on evidence

a1

APPENDIX One: *Information, Education, Communication*
OVERALL GOAL: promote reproductive health of refugee populations based on the refugee population's needs and desires

a2

APPENDIX Two: *Legal Considerations*
OVERALL GOAL: provide information on reproductive rights

a3

APPENDIX Three: *Glossary of Terms*
OVERALL GOAL: define important terms

a4

APPENDIX Four: *Reference Addresses*
OVERALL GOAL: assist the reader in obtaining additional reference documents

Each chapter of the Field Manual begins with an overall goal and provides detailed guidance on the elements of the RH component. These elements need to be adapted to each refugee situation in close collaboration with host-country authorities. A checklist for establishing the particular RH component is provided at the end of each chapter. This list can also be used for supervising and monitoring. Further references can also be found at the end of each chapter.

This Field Manual does not address a number of other issues related to reproductive health, either because they are relatively less significant in terms of public health, or because they may be approached as in normal situations and information on the issue is abundant elsewhere. This is the case for most needs of postmenopausal women, elective abortion, reproductive tract cancers and infertility.

Further Readings

"Declaration and Platform for Action", Fourth World Conference on Women, Beijing, 1995.

"Medical Ethics and Human Rights: Guiding Principles", Commonwealth Medical Association, London, 1997.

"Programme of Action", International Conference on Population and Development, Cairo, 1994.

"Refugee Reproductive Health Needs Assessment Field Tools", Reproductive Health for Refugees Consortium, New York, 1997.

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Reproductive Health One and Five Day Training Packages, RHR Consortium, New York, 1998.