

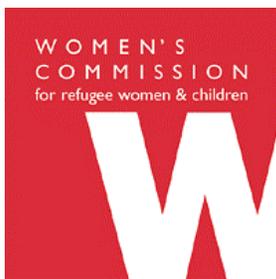
Assessment of Reproductive Health for Refugees in Zambia



Women's Commission for Refugee Women and Children

***On behalf of the
Reproductive Health for Refugees Consortium***

September 2001



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Printed in the United States of America

ISBN: 1-58030-016-2

Mission Statement

The Women's Commission for Refugee Women and Children seeks to improve the lives of refugee women and children through a vigorous program of public education and advocacy, and by acting as a technical resource. The Commission, founded in 1989, under the auspices of the International Rescue Committee, is the only organization in the United States dedicated solely to speaking out on behalf of women and children uprooted by armed conflict or persecution.

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Acknowledgements

The Women's Commission would like to thank Margaret O'Callaghan and her staff at the United Nations Population Fund (UNFPA) Zambia for their support, without which this assessment would not have been possible. In addition, we would like to express our gratitude to Ahmed A. Gubartalla and his staff at United Nations High Commissioner for Refugees (UNHCR) Zambia for providing the necessary logistical assistance to conduct our visit. We would also like to acknowledge the work of our colleague, Margaret Mutambo, whose knowledge of the local environs enhanced our study immeasurably. Finally, we would like to thank the refugees at all of the camps with whom we met for their time, opinions and candid manner.

This assessment was made possible by the generous support of the Bureau of Population, Refugees and Migration.

*Cover photo: Maternal and child health clinic in Nangweshi refugee camp © Julia Matthews
All other photos © Julia Matthews, Sandra Krause, Janet Meyers*

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1. Acronym List

| | |
|--------|--|
| AHA | African Humanitarian Action |
| AIDS | Acquired Immune Deficiency Syndrome |
| ANC | Antenatal Care |
| CBD | Community-based Distribution |
| CDC | Centers for Disease Control |
| CDW | Community Development Worker |
| CHW | Community Health Worker |
| COCs | Combined Oral Contraceptives |
| CORD | Christian Outreach Relief and Development |
| DFID | Department for International Development in the United Kingdom |
| DRC | Democratic Republic of the Congo |
| EC | Emergency Contraception |
| EmOC | Emergency Obstetric Care |
| FP | Family Planning |
| GBV | Gender-based Violence |
| GRZ | Greater Republic of Zambia |
| HDI | Human Development Index |
| HDR | Human Development Report |
| IOM | International Office for Migration |
| IUD | Intrauterine Device |
| HIV | Human Immunodeficiency Virus |
| JSI | John Snow, Inc. |
| LWF | Lutheran World Federation |
| MCH | Maternal and Child Health |
| MISP | Minimum Initial Service Package |
| MOH | Ministry of Health |
| MMD | Movement for Multi-party Democracy |
| MSF | Médecins Sans Frontières (Doctors Without Borders) |
| NGO | Nongovernmental Organization |
| OCHA | United Nations Office for the Coordination of Humanitarian Affairs |
| OCP | Oral Contraceptive Pills |
| ONAPO | Rwanda National Population Bureau |
| PLWA | People Living With AIDS |
| POPs | Progesterone Only Pills |
| PPAZ | Planned Parenthood Association of Zambia |
| PTSD | Post-Traumatic Stress Disorder |
| RH | Reproductive Health |
| RHR | Reproductive Health for Refugees |
| RHRC | Reproductive Health for Refugees Consortium |
| SM | Safe Motherhood |
| STI | Sexually Transmitted Infection |
| TBA | Traditional Birth Attendant |
| UN | United Nations |
| UNAIDS | Joint United Nations Program on HIV/AIDS |
| UNDP | United Nations Development Program |
| UNFPA | United Nations Population Fund |
| UNHCR | United Nations High Commissioner for Refugees |
| UNIP | United National Independence Party |

| | |
|-------|---|
| UNITA | National Union for the Total Independence of Angola |
| USAID | United States Agency for International Development |
| VCT | Voluntary Counseling and Testing |
| VSU | Victim Support Unit |
| WF | Vesico-Vaginal Fistula |
| WHO | World Health Organization |
| WRA | Women of Reproductive Age |
| WVI | World Vision International |
| YMCA | Young Men's Christian Association |
| ZIHP | Zambian Integrated Health Project |
| ZRCS | Zambia Red Cross Society |

2. Map of Zambia



3. Executive Summary

Currently, Zambia hosts more than 260,000 refugees; almost three-quarters come from Angola and the remainder are primarily from the Democratic Republic of Congo and other African countries including Rwanda, Burundi, and Somalia. Zambia continues to accept more refugees as conflicts continue in bordering nations.

The reproductive health of refugees is being addressed in Zambia as evidenced by the wide-ranging efforts of United Nations organizations and numerous local and international nongovernmental organizations in the country.

In general, most refugees - with the exception of the urban/peri-urban refugee population, which suffers from transportation and communication barriers - have good access to safe motherhood services. The extent of unsafe abortion demands additional study. The availability of the Minimum Initial Services Package in transit centers and other areas where arriving refugees cross into the country was not investigated. Both of these areas require further exploration to determine the level of need. Supplies for syphilis testing of pregnant women are not consistently available.



Community Development Workers in Nangweshi Camp shown with the charts they use to track camp residents.

Community health workers play an active role in most camps to educate refugees about their family planning options, but there is a lack of community-based distribution of supplies which hinders refugees' access. Also, refugees are reluctant to use family planning methods due to the losses these communities have suffered from the ongoing conflicts in their countries.

Generally, there appears to be a good level of awareness concerning the prevention of sexually

transmitted infections, including HIV/AIDS; however, perception of risk differs within the refugee population. Although there are numerous suspected HIV/AIDS cases, there are few diagnosed patients and still a persistent skepticism about the existence of the disease. Other concerns include untreated sexually transmitted infections causing sterility, male circumcision practices and lack of compliance with infection treatment protocols. In regard to services and supplies, condom availability is inconsistent, community distribution systems are not in place and voluntary counseling and testing services are not widely available or accessed.

Gender-based violence is a topic most people are reluctant to discuss. Domestic violence, exacerbated by alcohol and drug use/abuse, is reported to be the most common form of violence. Most health facilities lacked protocols to manage the consequences of rape. Victim

Support Units are in place at some camp police stations but it is not clear that the units' staff are adequately trained to care for victims of violence. CARE is initiating gender-based violence prevention projects in two camps and other organizations have expressed interest in pursuing programming.

Reproductive health services for adolescents are limited and ad hoc at best. There are nascent efforts by nongovernmental organizations to establish youth-friendly centers, youth anti-AIDS clubs and use of peer educators to target the adolescent population. However, adolescents are clearly a sexually active population and are particularly vulnerable, given the lack of comprehensive services targeting their needs.

The chief recommendations of the assessment team are as follows:

- Establish a reproductive health working group in Lusaka for implementing health agencies, including refugee representatives, United Nations agencies and local and international nongovernmental organizations to facilitate information sharing on reproductive health for refugees and coordinate potential collaborations among partners.
- Ensure presence of a reproductive health coordinating agency/coordinator to lead a working group in each camp.
- Increase Information, Education and Communication materials in all camps.
- Safe Motherhood: Ensure emergency transport in all camps; availability of the Minimum Initial Services Package in all transit centers; and syphilis testing of all pregnant women.
- Family Planning: Improve demand and supply for family planning services and supplies; increase access to services and supplies for youth; involve men in programming; ensure consistent supply and community-based distribution of male condoms and explore possibility of supplying female condoms; and collaborate with capable partners on technical assistance.
- Sexually transmitted infections, including HIV/AIDS: Ensure access to condoms through community distribution channels; improve access to diagnosis and treatment for sexually transmitted infections; monitor progress of voluntary counseling and testing in Zambia; and target the needs of the commercial sex worker population.
- Gender-based Violence: All camps should be aware of and consider training on clinical management of violence; make emergency contraception available in all camps; identify and support needs of Victim Support Unit staff; and address domestic violence and alcohol abuse to reduce incidence of violence in camps.
- Adolescent Reproductive Health: Work with adolescents in separate gender groups; develop/obtain good assessment tools for adolescent reproductive needs; include adolescents in program development activities; and ensure access for youth to comprehensive reproductive health services.

4. Methodology

The Women's Commission for Refugee Women and Children in collaboration with the Reproductive Health for Refugees Consortium (RHRC)¹ conducted an assessment of

¹ Reproductive Health for Refugees Consortium members: American Refugee Committee, CARE International, Columbia University's Heilbrunn Center for Population and Family Health at the Mailman School of Public Health, International Rescue Committee, John Snow, Inc. Research and Training Institute, Marie Stopes International, and Women's Commission for Refugee Women and Children. Website: www.rhrc.org.

reproductive health among refugees in Zambia from September 13-24, 2001 on behalf of the RHRC.

Zambia was selected as a site to conduct a reproductive health (RH) needs assessment based on the Reproductive Health for Refugees Consortium (RHRC) criteria for assessment missions. The criteria include identifying sites where there is a significant number of refugees² and where RHR Consortium members do not have a significant presence. [Although RHRC member CARE International is working with refugees on HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) prevention in Zambia's capital, Lusaka, currently it is not supporting comprehensive RH services.] Zambia was also selected because of new refugee arrivals from the Democratic Republic of Congo (DRC) and Angola over the past year. In addition, this assessment will complement an assessment that was carried out in Angola by the RHRC in February 2001.

The purpose of the assessment was to advocate to and educate United Nations (UN) agencies, nongovernmental organizations (NGOs), donors and others to increase refugees' access to a broad range of quality, voluntary comprehensive reproductive health services in Zambia, including four areas: safe motherhood, including emergency obstetrics; family planning; the prevention and management of sexually transmitted infections and HIV/AIDS; and the prevention and management of gender-based violence.³ In addition, the team paid particular attention to adolescents as a population.

Initially, the assessment team met with agencies based in Lusaka to better understand, from the organizations' perspective, the challenges and accomplishments of the programs in the field and finalize the assessment agenda. Next, the team split up with two people assigned to Kala and Mwange camps in the Northern province and two people evaluating the situation in Nangweshi camp in the western region. The team utilized the group discussion questions from the Refugee Reproductive Health Needs Assessment Field Tools (www.rhrc.org/fieldtools/index.htm) to conduct focus groups with women, men, girls and boys. In addition, the teams conducted health facility assessments and met with health providers. Each discussion with representatives of implementing agencies and providers addressed the four RH technical areas noted above. After time in the field, the team arranged meetings with local health authorities and other NGOs and presented a final briefing on the preliminary findings of their assessment to the United Nations High Commissioner for Refugees (UNHCR) and United Nations Population Fund (UNFPA) representatives, as well as to NGO staff. Due to the great distances between camps and limited time of the visit, only three camps were directly assessed. However, Meheba refugee settlement and the numerous refugees located in the urban and peri-urban region were also included in this assessment report by making use of available reports at the UNFPA, UNHCR and the Young Men's Christian Association (YMCA), conducting interviews with key staff in the capital, and conducting focus groups with RH peer educators.

² Refugees have crossed an international border; the internally displaced are still in their own country. In this document the term refugee refers to both categories.

³ The term gender-based violence signifies any harm perpetrated on a person against her/his will, the origins of which are based on power relationships determined by socially ascribed roles of males and females. Violence may be physical, sexual, psychological, economic or socio-cultural, and is almost always and across all cultures disparately impacting women and children.

5. Zambia Background

a. Geography and Recent History

Zambia, formerly known as Northern Rhodesia under the British until its independence in 1964, is a landlocked country located in southwestern Africa. It is bordered by Angola, Democratic Republic of Congo (DRC), Malawi, Zimbabwe, Botswana, Namibia and Tanzania. The country is divided into nine provinces and 73 districts.

Although its lack of seaports limits Zambia's access to international markets, its central location affords the country numerous trading partners and opportunities to pursue poverty reduction. Zambia is a member of Common Market for East and Southern Africa and the Southern African Development Community and is an integral part of the United Nations Development Program (UNDP)-supported Zambia-Malawi-Mozambique Growth Triangle.

Although Zambia typically receives sufficient rainfall, droughts and floods are recurrent and irrigation methods are underutilized.⁴ Tall grasses and woodlands make this a lush country; ebony and teak are plentiful, and common mineral resources include copper, cobalt, gemstones and coal.

b. Political and Economic Context

Despite the ongoing turmoil experienced by its neighbors to the north and west, Zambia enjoys relative peace within its borders. Two major political parties have governed Zambia since independence, the United National Independence Party (UNIP) from 1964 to 1991, followed by the Movement for Multi-party Democracy (MMD) up to present day. The country has moved from a paternalistic governing style with free social services and price controls under UNIP to a more liberal approach of market-based economics and increased social and legal reforms instituted by the MMD.

In the last decade, the Zambian economy has suffered from inconsistent growth, double-digit cost of living increases, major depreciation of the kwacha (the local currency), external debt payments higher than its annual loan amounts, low levels of gross national savings and investment, and extremely high interest rates. Zambia has endured a number of economic and structural reforms in recent years, which are intended to culminate in the assurance of debt relief, the combination of which is hoped to remedy these financial maladies and reverse the long-term economic decline.

"Poverty in Zambia is clearly widespread, deep and gender biased."⁵ Based on the UNDP's 1999 Human Development Report (HDR), 84.6 percent of Zambians subsist on US\$1 per day and the 1998 Living Conditions in Zambia Survey⁶ indicates that almost three-quarters are below the national poverty line. According to the World Bank, GNP per capita is USD \$370. Both poverty indicators show a consistent worsening of Zambians' quality of life during the 1990s. In terms of urban and rural poverty, poverty is more common in rural areas (56 percent and 81 percent respectively); however, as poverty levels declined in the rural regions in the last decade, it surprisingly increased in the urban centers. Female-headed households endure poverty disproportionately as compared to their male counterparts, with 80 percent of females classified as extremely poor in 1993, compared to 72 percent of their male counterparts. In

⁴ United Nations High Commissioner for Refugees (2000). UNHCR Common Country Assessment: Zambia 2000.

⁵ Ibid.

⁶ Central Statistics Office (1998). Living Conditions in Zambia 1998: Preliminary Report.

addition, fewer girls attend school than boys and females are employed less than males. This indicates that women not only are impacted more severely by poverty but also women's alternatives to escaping poverty are limited.

In regard to human rights, customary law, which is recognized by the Constitution of Zambia, treats women as inferior to men with respect to property, inheritance and marriage. Despite attempts to redress these inequities, common practices still persist that place women in subordinate positions and even put them at risk of contracting HIV through cultural practices such as sexual cleansing⁷ of widows or widowers.

c. Demographics

The Zambian population has grown rapidly in the last forty years from 3.5 million in 1963 to almost 11 million today.⁸ The current annual population growth rate is 2.4 percent.⁹ The population is heavily weighted toward the young, with nearly half of Zambians under the age of 15. Women of reproductive age (WRAs) comprise 25 percent of the population. However, the impact of AIDS is predicted to stem future population growth significantly and reduce the rate to 2 percent growth per year in the next decade. UNHCR estimates that 42 percent of the population lives in towns. Life expectancy at birth is estimated between 40¹⁰ and 46.1 years.¹¹

Zambia is home to 73 culturally distinct ethnic groups that have peacefully co-existed for decades. Although most ethnic groups are matrilineal, patriarchy - reinforced through government policies that recognize men as heads of households - dominates and male heirs are preferred. Traditional leaders, who are usually males, allocate land and solve disputes; they typically discriminate against women. Tribal socialization processes that tend to have negative impacts on women's sexuality and right to personal property perpetuate gender inequities.

English is the official language but seven indigenous languages are taught in schools and heard on radio and television. Zambia has declared itself a Christian state, although there are many religious groups, including Muslims and Hindus. A number of cults exist which pose dangers to their followers' health owing to the stated prohibitions on school attendance and taking medication to cure illness.

d. Refugee Population

For the last thirty years, Zambia has provided a safe haven for Africans fleeing colonialism, racist oppression and occupation. During this time, there has been little conflict between the host and refugee populations. However, the continuing economic decline and resulting poverty of many Zambians has caused tensions to surface among the host population where it did not previously exist. Added to this unease is the Angolan government's suspicion that Zambia is supporting the UNITA rebel forces.

Refugees have come from Angola, Mozambique, Namibia, South Africa and Zimbabwe. Currently, Zambia is host to approximately 261,000 refugees, consisting of more than 200,000

⁷ Sexual cleansing is a ritual that symbolizes that a widow has been freed from her marriage and can remarry. It involves sexual intercourse with a male relative of the deceased, thereby increasing her risk to sexually transmissible diseases including AIDS.

⁸ United Nations High Commissioner for Refugees (2000). Id.

⁹ World Health Organization and Joint United Nations Program on HIV/AIDS (2000). Epidemiological Fact Sheet: Zambia.

¹⁰ United Nations Population Fund.

¹¹ Government of the Republic of Zambia/United Nations Population Fund (2001). End of Country Program Evaluation: Draft for Discussion.

Angolans, over 50,000 from the DRC and some 5,000 from other African countries such as Rwanda, Burundi and Somalia. New camps have opened to accommodate the rapid influx in the past few years. Changing circumstances have allowed some refugees to repatriate. However, ongoing conflict and instability continue to produce new refugees, raising the overall number of refugees in Zambia over the past decade.¹²

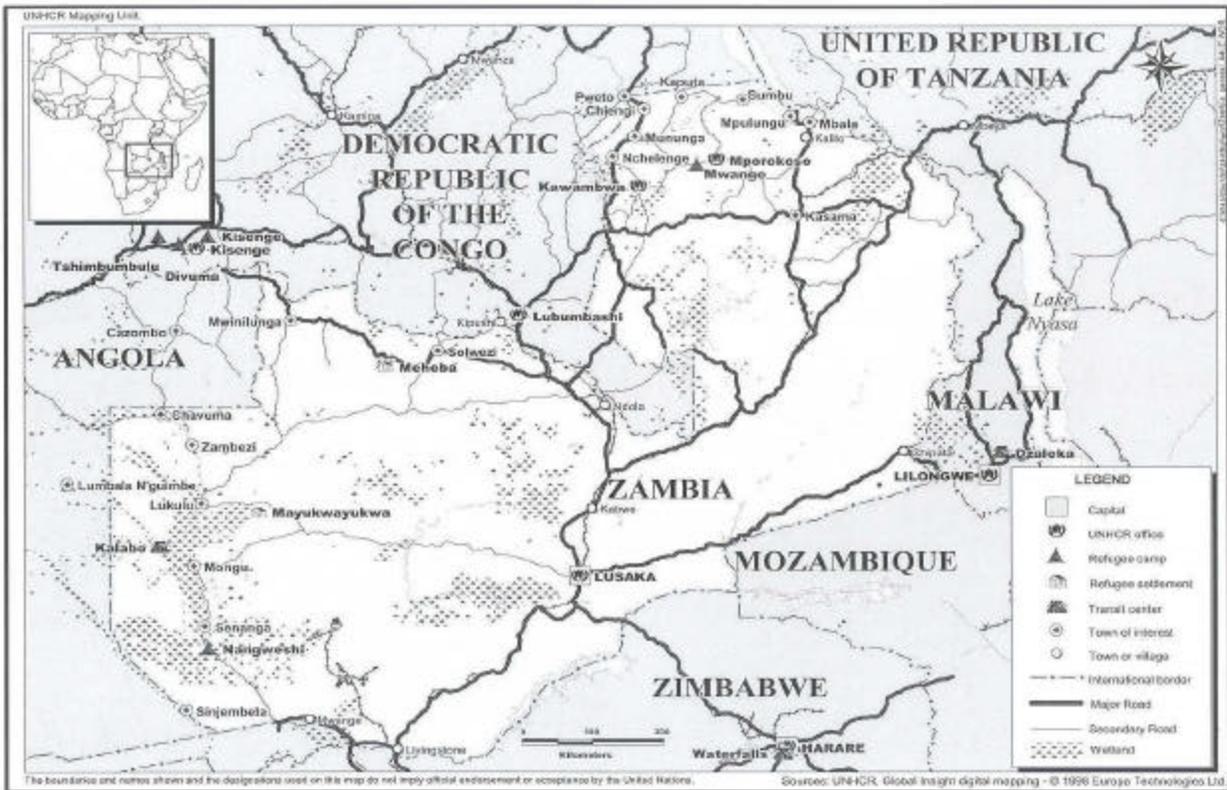
Under Zambian law, refugees have equal rights as citizens. In the past Zambian citizens had free access to health care, but now fees are charged. UNHCR is responsible for the health fees incurred by refugees. The Zambian government supports referral services for refugees to the local district hospitals with support from UNHCR and provides some health supplies (e.g., contraceptives) to the refugee population through the Ministry of Health (MOH).

UNHCR is the main coordinating body for the refugees in Zambia. UNFPA's work in Zambia supports national development objectives in RH. The agency's work with refugees primarily focuses on Meheba camp. UNHCR and UNFPA appear to have a strong collaborative relationship, visible in the joint hosting of the assessment team's visit to Zambia.

The table below illustrates where refugees are located, the population of each camp/region and the major implementing partners providing services to the refugees. The map (on the next page) shows the locations of the primary refugee camps in the country.

| Camp | Province/District | Population | Implementing Partners |
|---------------------|---------------------------------------|-------------------|------------------------------|
| Kala | Luapula (North)/ Kawambwa District | 18,209 | WVI, MSF Holland |
| Mwange | Northern/ Mporokoso District | 23,009 | CARE, ZRCS |
| Meheba | Northwestern | 53,597 | UNFPA/YMCA, LWF |
| Mayukwayukwa | Western/Kaoma District | 19,215 | LWF, AHA, CORD, HODI |
| Nangweshi | Western/Senanga District | 14,217 | CARE, AHA, CORD |
| Ukwimi | Eastern/Petauke District | 981 | LWF |
| Urban/Peri-urban | Lusaka | 3,692 | YMCA, Africare |
| Spontaneous Settled | all over | 130,000 | |
| Total | | 262,920 | |

¹² U.S. Committee for Refugees (2001). World Refugee Survey 2001.



Half of the refugees in the country are housed in six different camps and are also found in and around the capital city of Lusaka. The remaining refugees are “spontaneously settled” in different regions of Zambia. The following is a brief description of the camps and the conditions for urban/peri-urban refugees.

Most of the refugee camps in Zambia host between 15,000 and 25,000 refugees, with the exception of Meheba - a sizably larger settlement - and Ukwimi – the most recently activated camp hosting the fewest refugees. Kala camp was established in August 2000 in the Northern region of Zambia in the Luapula Province. It is approximately 125 miles south of the Congolese border. Mwange camp, opened in 1999, is located in the Mporokoso District in the Northern Province near the border of northern Zambia. It houses primarily Congolese refugees. Meheba is the largest camp in the country, with a permanent population of over 50,000 refugees settled there since 1971. The land area is 872 km² located near to the borders of the DRC and Angola. Due to its long-term nature, Meheba is better described as a rural settlement with farming plots and small villages rather than a typical refugee camp. The only tents belong to newcomers who are not yet established. Mayukwayukwa is located in the Western Province in the Kaoma District and covers an area of 2,500 hectares. Mayukwayukwa is the oldest camp in Africa, established in 1966. For many years, it hosted a stable population of approximately 4,000 refugees, but this number tripled to 18,000 in 2001, when another influx from Angola occurred.¹³ Nangweshi camp was established in January 2000 in Zambia’s Southwestern Province about 150 kilometers from the Angolan border. Access to the camp is difficult, particularly during the

¹³ UNHCR Branch Office for Zambia (2001). UNHCR Activities in Zambia.

rainy season, due to marginal roads and the necessity of crossing the Zambezi River. Recently, Nangweshi has become overloaded due to more Angolans fleeing renewed fighting in their country between the government and the UNITA rebel forces. It is likely that the new arrivals will be moved to Ukwimi camp in the Eastern Province. In the past Ukwimi hosted Mozambican refugees and recently was reactivated to house ex-UNITA rebel combatants and their families. Urban and peri-urban refugees are mostly settled in and around Lusaka. Official estimates are regarded as low and it is suspected that the total population of urban/peri-urban refugees is close to 14,000.

6. Refugee and Host Country Health Context

The table below provides important health indicators for Zambia and the major countries from which refugees have emigrated. The data clearly illustrate the RH challenges facing the host country and refugee populations. The maternal mortality ratios and infant mortality rates are some of the highest in the world. Adolescents are a highly susceptible population, particularly given the low use of contraception, lack of access to condoms and high birth rates of this group. Coupled with the low number of women using family planning methods, the high fertility rates are easily understood. Also alarming is the extremely high HIV prevalence rate in the host population.

| Indicators | Zambia | Angola | DRC | Burundi | Rwanda |
|---|--------|--------|------|---------|--------|
| Maternal Mortality Ratio per 100,000 live births | 940 | 1500 | 870 | 1300 | 1300 |
| Infant Mortality Rate per 1,000 live births | 112 | 170 | 128 | 106 | 105 |
| Total Fertility Rate | 6.1 | 7.2 | 6.6 | 6.6 | 6 |
| HIV Prevalence Rate (%) | 20.0 | 2.78 | 5.07 | 11.32* | 11.21* |
| Annual Growth Rate (%) | 2.4 | 3.2 | 3.2 | 2.5 | 2.1 |
| Women Aged 15-19 giving live births each year (%) | 16 | 24 | 17 | 6 | 6 |
| Women Aged 15-19 using contraception (all methods) % | 26 | -- | 8 | 9 | 21 |
| Women Aged 15-19 using contraception (modern methods) % | 14 | -- | 3 | 1 | 13 |
| Births attended by trained personnel % | 47 | 17 | -- | -- | -- |

Sources: State of the World Mothers 2001, Save the Children; IPPF website: Socio-demographic profiles; UNAIDS & WHO, Epidemiological Fact Sheet, as of end of 1999.

*1999 estimate, CIA world fact book.

The Human Development Index (HDI) tells the story of Zambia's progress through the 1980s to its downfall in the 1990s meriting the dubious distinction of the only country of 100 others ranked that dropped below its 1975 HDI level. This precipitous downturn was caused by declining per capita income and a reduced life expectancy. This decline also resulted in the snubbing of two essential human rights: education and health facilities, leading to a further erosion of human capital in the country. Adding to this dire situation are the significant losses resulting from AIDS which has caused a reduction in the workforce, decreased productivity and increased labor costs due to higher health care costs, burial fees and absenteeism.

a. National General Health Services/Conditions

In 1997, Zambia spent USD \$27 per capita or 5.9 percent of its GDP on health care,¹⁴ which represents a decline in overall health care spending from the 1980s. The government provides 65 percent of the health services in the country, whereas churches serve almost a third of the population and another 5 percent of Zambians access services through private entities. Health services emphasize curative and outpatient care to the detriment of preventive services such as maternal and child health (MCH) services and health education. A large portion of the population frequents traditional healers in addition to accessing conventional care. Because of the distance and poor terrain between facilities and communities and the insufficient number of new facilities to keep pace with population growth, access to services has declined from 1985 to 1995. Recent changes instituted by the Community Board of Health require Zambians to contribute to the cost of drugs and services. Even though most basic health services for children under five years of age, pregnant women and the elderly are free, the majority of poor families – approximately 60 percent of the population - do not access health services because the services they obtain are of poor quality and medications are not affordable.

Zambia's health system infrastructure has suffered greatly over the past decade due to the major economic decline which has resulted in poorly maintained health facilities and equipment ill-suited to meet the needs of an increasingly impoverished and needy population. In addition, government as well as church health centers encounter difficulties in referring patients due to barriers to transport. These circumstances have only been exacerbated by the increasing toll that HIV/AIDS – and its accompanying opportunistic infections such as tuberculosis - is taking on the country. Life expectancy has decreased by 14 percent, from 50 years in 1980 to 43 years in 1997.¹⁵ This rapid decline is attributed to the AIDS pandemic. Zambia's economic and social challenges, which were once due to its high population growth rate, are now found in dealing with AIDS which has a prevalence rate of almost 20 percent in the country.

The Zambian government is supporting a number of initiatives that indirectly benefits humanitarian assistance to refugees. The country has signed on to various programs and strategies in order to address its development challenges. The Health Sector Reform Program and a draft National Health Strategic Plan are geared to increase the equity and quality of health care in the country, particularly primary health care (PHC); the National Strategic Framework on HIV/AIDS 2001-2003 seeks to prevent and manage the disease; the National Gender Policy aims to make women full and equal partners at all levels of national development; and the National Population Policy is under revision to incorporate the International Conference on Population Development (ICPD) and the impact of HIV/AIDS.

¹⁴ The International Bank for Reconstruction and Development/The World Bank (2001). World Development Report 2000/2001: Attacking Poverty.

¹⁵ Government of the Republic of Zambia/United Nations Population Fund (2001).Id.

Malaria is the leading cause of death in Zambia and chronic malnutrition, diarrheal diseases and sexually transmitted infections (STIs) are widespread.

b. Reproductive Health - Zambia

Safe Motherhood (SM): The maternal mortality ratio in Zambia is 940/100,000 live births,¹⁶ representing one of the highest rates in Sub-Saharan Africa. The main causes of maternal morbidity and mortality are unsafe abortion, puerperal sepsis,¹⁷ hemorrhage, eclampsia,¹⁸ malaria and HIV/AIDS.¹⁹ The problems for women are many, including lack of education, early age at first pregnancy, poor birth spacing, lack of pre- and post-natal care and use of untrained traditional birth attendants (TBAs). In addition, obstetric emergencies turn fatal due to the delay in women reaching a health facility or lack of transportation to a health facility. Anemia and the related factor of malaria are also reasons for women's high risk of death or disability during pregnancy and delivery.

Family Planning (FP): Despite an increase in the contraceptive prevalence rate in the country from 15 percent in 1992 to 26 percent in 1996 (14 percent modern and 12 percent traditional methods), the total fertility rate has shown only a modest decline and is still high, at almost six children per family. The excessive fertility rate is attributed to the high value placed on motherhood and a cultural preference for many children, especially among the poor, who perceive children as economic security in old age. As in other countries, the better educated in Zambia tend to have fewer children. Regardless of the great awareness of modern contraceptive methods, use of contraception is hindered by limited access to supplies and preference for traditional methods. In addition, women often are not allowed to control their fertility due to inequities that exist between the sexes.

STI/HIV/AIDS:

It is difficult to quantify the prevalence of STIs in Zambia because so many infected people self-treat. Therefore, even though 10 percent of outpatient attendance in public health facilities is for STI treatment, this number cannot be used reliably to estimate the scope of the problem. According to the World Health Organization (WHO), there are an estimated 870,000 Zambians living with HIV/AIDS as of the end of 1999, 5 percent of whom are children under 14 years of age. This represents an almost 20 percent HIV prevalence rate²⁰ among adults and means that nearly one in five people from 15-49 years of age will probably die from AIDS in the next decade.²¹ In 1999, approximately 99,000 adults died of AIDS in Zambia.²² The resulting havoc wrought upon children by AIDS is quantified by the WHO/UNAIDS as follows: almost 450,000 children under the age of 15 at the end of 1999 lost one or both parents to AIDS. A 2000 study on female sex workers found that there is a high proportion of teenage sex workers, a very high prevalence of curable STIs, a moderate level of condom use despite good availability of condoms, high levels of HIV-related knowledge and poor family planning practices.²³ Since the early 1990s, when the MOH recognized AIDS was not limited to the health arena, it has worked

¹⁶ World Health Organization and Joint United Nations Program on HIV/AIDS (2000). Id.

¹⁷ A bacterial infection and blood poisoning that sometimes follows childbirth.

¹⁸ The gravest form of poisoning of pregnancy, marked by grand mal convulsion, coma, high blood pressure, water retention and protein in the urine (Mosby Medical Encyclopedia).

¹⁹ Government of the Republic of Zambia/United Nations Population Fund (2001). Id.

²⁰ World Health Organization and Joint United Nations Program on HIV/AIDS (2000). Id.

²¹ Government of the Republic of Zambia/United Nations Population Fund (2001). Id.

²² World Health Organization and Joint United Nations Program on HIV/AIDS (2000). Id.

²³ Tropical Diseases Research Centre and National AIDS Council Ministry of Health Zambia (2000). Round 1 Behavioral and Biologic Surveillance Survey Zambia: Female Sex Workers.

through the National AIDS Program to implement a multi-sectoral approach to address the epidemic. This includes working with NGOs, religious communities and the private sector to ensure the integration of HIV/AIDS programming into organizational activities.

Gender-based Violence (GBV): “Violence against women is widespread and culturally tolerated throughout the country.”²⁴ Violence – which is often alcohol-related – takes many forms, including femicide (the act of killing a woman), spouse battering, property grabbing by relatives after the death of a husband, rape (in and outside of marriage), incest and defilement. The spread of HIV in combination with women’s lack of sexual negotiating power has led to more severe and fatal consequences. Some of the barriers to addressing violence are: lack of knowledge by the community of the criminal nature of domestic abuse, community tolerance of violence and inaction by police in reported cases of violence. Violation of women can also take on an economic form; women receive only 10 percent of income and they are deterred from improving their financial status due to low education levels, domestic responsibilities, men’s prejudice against women’s participation in the workplace and lack of access to credit. However, education and sensitization of the community on violence issues, as well as the establishment of victim support units (VSUs) at police stations, demonstrate that some progress has been made. However, much remains to be done to involve men in combating GBV, provide sufficient funding for education efforts and change social norms to value women and girls in Zambian society.

Adolescent Reproductive Health: Zambian youth commonly engage early in sexual activity, one study indicating that girls have their first sexual encounter at age 12 and boys at 14 years of age.²⁵ It is also common practice for Zambian women to marry by age 19. Early sexual activity places girls at high risk of pregnancy and abortion and all adolescents at risk of contracting STIs, including HIV/AIDS, given the low rate of modern contraceptive use among this age group. Adolescents are especially susceptible to these health dangers due to their lack of education, information, negotiating skills, poverty and their unfulfilled need for youth-friendly health services. Also working against the youth are the cultural traditions surrounding sexuality in Zambian society. Access to sex education is limited due to the belief that knowledge promotes promiscuity, which has led to such detrimental actions such as policy-makers banning condom advertisements in the media.

c. Reproductive Health – Angola

Angola falls into the category of a chronic emergency, yet even the most basic minimum standards for RH services are not being met. This is primarily due to a lack of resources and partly to the pervasive attitude of international health agencies that RH services fall outside of emergency life saving interventions. Although comprehensive reproductive health services are virtually non-existent or difficult to reach for most Angolans, there are efforts to increase services in some locations such as through the UNFPA, which provides some support for the national RH program and NGOs that augment government services in certain provinces.

Angola has one of the highest maternal mortality ratios in the world, estimated at 1,500 per 100,000.²⁶ This rate is attributed to many home deliveries without access to emergency obstetric care and unsafe abortion. Numerous barriers to family planning exist, including: lack

²⁴ United Nations High Commissioner for Refugees (2000). Id.

²⁵ Government of the Republic of Zambia/United Nations Population Fund (2001). Id.

²⁶ World Health Organization and United Nations Children’s Fund (1996). *Revised 1990 Estimates of Maternal Mortality: A New Approach by WHO and UNICEF*.

of awareness; inadequate services outside of the provincial capital; insufficient funding; lack of consistent and reliable supplies due to theft and difficulty in transporting supplies; and the high cost of contraceptives due to the necessity of importing all supplies. Scarce supplies and the cost of medicines hinder the prevention and treatment of STIs, including HIV/AIDS, even though STIs are believed to be extremely common in Angola. Syndromic management²⁷ is relied upon for diagnosis. Many Angolans also rely on traditional methods of treatment, which can be dangerous and result in miscarriage and/or infertility. The percentage of Angolans with HIV/AIDS between the ages of 15-45 is estimated to be 2.1 percent.²⁸ However, due to the lack of testing and difficulty in collecting statistics, the reality is assumed to be higher and rising swiftly. Angola does not have any specific laws protecting women from physical or sexual violence, but currently greater attention is being focused on this issue with the establishment of the Ministry of Family and the Promotion of Women. Studies from this agency indicate that violence is a significant problem throughout the country. RH programs specifically targeting adolescents are limited and are considered to be an unaffordable luxury due to the lack of funding for RH services in general in the country. This makes it difficult for youth to access services due to the possibility of being seen by family members or neighbors when going to a clinic for services. (More information on Angola can be obtained from the report "Assessment of Reproductive Health for IDPs, Angola, 2001" accessible at www.rhrc.org/assessments/index.htm.)

d. Reproductive Health – Democratic Republic of Congo (DRC)

In spite of attempts to bring peace and political stability to the DRC following the signing of the Lusaka Peace Agreement in September 1999, there have been frequent violations of the peace plan and refugees have continued to cross into Zambia. DRC is bordered by the Central African Republic, Sudan, Uganda, Rwanda, Burundi and Lake Tanganyika, Zambia, Angola and Congo Brazzaville. It is rich in natural resources but development has been stalled due to more than 20 years of economic crisis, inflation and political instability. These factors have negatively impacted reproductive health services as well. More than 80 percent of the population is nominally Christian, primarily Roman Catholic, while the remainder primarily follow traditional beliefs. There have been and continue to be progressive programs promoting child spacing and safe motherhood practices. These programs recently have been revitalized, however, there is little access for much of the population to contraceptives. According to a WHO DRC health update in July 2001, the high maternal mortality rate is linked to anemia, malaria, sexually transmitted infections, poor spacing of pregnancies and a high rate of adolescent pregnancy. Health care in DRC has been facility-based; however, up to 70 percent of the population is excluded from accessing these basic health services which points to the need for an increased public health focus.

DRC was one of the first countries to design and implement an HIV/AIDS program supported by the World Bank and UN agencies. However, in recent years funding has declined. Security for blood transfusions has decreased due to deteriorating infrastructure. The prevalence of HIV/AIDS countrywide remains unknown, but due to the instability, there are fears that the prevalence might be much higher than the often-quoted 5 percent. Multiple troop movements and displacement in recent years to and from neighboring countries where prevalence ranges from 12 percent (Central African Republic) to 20 percent (Zambia) has made DRC extremely

²⁷ In syndromic management, the clinician bases diagnosis and treatment not on specific diseases identified through testing but rather on syndromes, which are groups of clinical findings and patient symptoms. Treatment is then offered for all diseases that could cause that syndrome. (Family Health International, 1999.)

²⁸ Population Reference Bureau (2000). 2000 World Population Data Sheet.

vulnerable. Currently, five sentinel sites are producing HIV/AIDS information, in Kinshasa, Karawa (Equateur), Mikalay (Kasai Occidental), Kabondo (Orientale) and Sendwe (Katanga). These are the remnants of a 14-site project set up by UNAIDS in 1992. Anecdotally, there is a high incidence of sterility, due to untreated STIs.

Gender-based violence is frequently reported; domestic violence and sexual violence by militias is common. A few NGOs are working with adolescents in RH but the efforts are few, uncoordinated and scattered.

An 18-month project, funded by UNFPA and implemented by WHO, which was designed to introduce integrated reproductive health care programming throughout DRC drew to a close in June as funds depleted. The project focused on discussion of care for at-risk mothers, strategies for intervention and the resources necessary for action. It also started the process of defining a minimum package of reproductive and family planning services based on the national policy for all levels of the health system.

e. Reproductive Health – Burundi

Burundi shares a border with DRC, Tanzania and Rwanda. It is one of the poorest and most highly populated countries in Africa and has been torn for many years by economic hardship and ethnic struggles between the Hutu and Tutsi. The health system was in satisfactory condition in 1993 but suffered severe damaged during the conflict that followed. There is a general lack of sufficient RH services throughout the country. Nonetheless, the government has started to build a foundation for FP, including a national maternal and child health/family planning project and the inclusion of population education in school syllabi. Abortion is illegal except for medical reasons; however, a study into clandestine abortions indicates that many clients are young (less than 20 years), some being students in secondary or even primary school. The average age of first marriage is 19.5 years. There is a preference for boy children. Anecdotally, it has been reported that a high percentage of the women report domestic violence.

f. Reproductive Health – Rwanda

Rwanda is a small landlocked country in Equatorial Central Africa and is the most densely populated African country. The majority of the population is Roman Catholic, with fewer Rwandans belonging to Muslim or traditional faiths. Before the 1994 genocide, Rwanda had implemented a very progressive family planning program through the National Population Bureau (ONAPO). Post-conflict, the MOH has continued to make RH a priority; however, RH indicators remain poor in comparison with overall sub-Saharan figures. Many health facilities were destroyed during the war and those remaining are without adequate staffing or equipment. Since 1994 there have been positive efforts made toward the rehabilitation and construction of health facilities as well as in training health care workers. In addition to the assistance provided by NGOs and international organizations, UNICEF, WHO, UNFPA, and ONAPO are all working in the areas of family planning, maternal and child health services and STI/HIV/AIDS prevention.

Thirteen percent of all households are headed by children, leading to the sexual abuse of many young girls and involvement of boys in criminal behavior. GBV during the war led to 17 percent of rape survivors being infected with HIV. Many local NGOs, such as Tweshamwe, and international organizations are working with rape survivors, but the needs continue to be greater than the services available. Family planning has not been a priority for much of the population; however, attitudes and behaviors are changing. Abortion is illegal under current legislation but political pressure has been applied to revise the law. Rates of STI/HIV/AIDS infection are high although there are a number of programs promoting behavior change, condom use (through social marketing campaigns) and voluntary counseling and testing. IEC is another strategy used

to combat the epidemic, employing a variety of media with a special emphasis on adolescents. The Department for International Development in the United Kingdom (DFID) and UNFPA are both financing large-scale national AIDS programs, with the DFID effort focusing primarily on strengthening the National AIDS Commission.

7. General Refugee Findings

These findings provide an overview of refugees' access to reproductive health services in Zambia, the challenges they face in obtaining these services and the common needs of the overall refugee population. The assessment team looked at four areas of RH: safe motherhood, including emergency obstetric care; family planning; STI/HIV/AIDS; and gender-based violence, as well as the adolescent population specifically.

The reproductive health of refugees is being taken seriously in Zambia. UNHCR hosted an RH workshop focusing on HIV/AIDS in June 2001 attended by field staff working with the refugee populations all over the country. This is a good effort toward addressing RH within all camps and ensuring that RH is a priority of all implementing partners. In addition, two camps (Nangweshi and Mayukwayukwa) have recently hired RH coordinators who will be very helpful in facilitating the work of the various implementing partners in the camp and reducing any inefficiencies in agency efforts. Kala camp plans to fill the RH coordination role shortly and Mwange camp is exploring this option as well. A newly formed National AIDS Council is working to address HIV/AIDS in the country, including the refugee community. Gender-based violence is becoming a higher priority issue and CARE is initiating pilot-projects to start the process of dealing with this difficult issue in the refugee population. UNFPA, Lutheran World Federation (LWF) and other organizations have also expressed interest in gender-based violence programming.

In regard to **Safe Motherhood (SM)**, including emergency obstetric care (EmOC), most refugee women deliver at health facilities with the assistance of clinic staff, traditional birth attendants (TBAs) and/or female family members. Untrained TBAs were found in Kala camp as in the urban/peri-urban area. SM services are usually better for the refugees than the local population and refugees typically receive satisfactory antenatal care (ANC). According to the physicians at the Senanga District Hospital, the referral site for refugees in Nangweshi camp, they are seeing the appropriate number of EmOC cases based on the number of pregnant women of reproductive age (WRA) expected to have complications in the camp. Unfortunately, this is not the case for the local population from which the doctors have not seen any emergency obstetric cases in the past year and had expected to see at least 15. It is clear refugee women have better access to emergency services which could be due to the transportation offered, level of awareness of the refugees and/or the good referral services provided in the camp. The only exception to this is the urban/peri-urban refugees who, like the local population, have difficulty with transport. Communication is another barrier to accessing health services cited by urban/peri-urban women. In the camps, communication between patients and clinical staff is generally good due to refugees working in the camp health facilities; however, desire for confidentiality sometimes inhibits refugees from engaging in candid conversation.

The assessment team was unable to ascertain the prevalence of unsafe abortion in Nangweshi, Kala and Mwange camps, although a variety of sources – district hospital, refugees, NGO staff – noted that traditional methods such as herbs are used to abort. As one Senanga physician said, “Yes, it’s very effective, the women miscarries or she dies.” The physician believes what they see is only the “tip of the iceberg.” The YMCA indicates that many cases of incomplete

abortions have been reported from the urban/peri-urban population. In most camps, maternal deaths were rare (refugees could cite only one in the last year) whereas neonatal deaths were more common (2-3 in prior months). In the urban/peri-urban area, refugees noted that a contributing factor to maternal and infant mortality was early discharge from health facilities leading to women suffering complications at home where they lack any medical assistance.

“Yes, it’s (traditional abortion method) very effective, the women miscarries or she dies.”
Senanga District Hospital Physician discussing unsafe abortion practices

In Mwange camp, syphilis rates are 14 percent compared to 21 percent positive syphilis rates in Kala camp. Providers in Nangweshi and Mwange camp do not routinely test pregnant women for syphilis due to a lack of testing supplies.

In regard to the availability of the Minimum Initial Services Package (MISP),²⁹ the assessment team was not permitted to visit transit centers to investigate whether the MISP was available to incoming refugees due to security issues.

Refugees are reluctant to use **Family Planning (FP)** methods. Angolans, for example, have endured 30 years of war and some feel the need to produce the next generation after the many losses they have suffered. Other barriers include: husbands not wanting their wives to use FP, religious and community beliefs that women should have as many children as God gives them, the notion that FP methods are only suitable for women who already have children, lack of community-based distribution programs and women’s difficulty in persuading their partners to use condoms. There were 13 FP users in Nangweshi camp (population 14,217) and 136 in Meheba camp (population 53,597). Traditional methods such as abstinence and rhythm are also used. In Mwange camp (population 23,009), user rates were significantly higher with almost 3,000 acceptors of modern FP methods. The most commonly used methods were condoms, pills and injectables. Traditional methods and abstinence are also used. Planned Parenthood Association of Zambia (PPAZ) and the MOH provide some supplies to camp health facilities but supply problems still exist. Community health workers play an active role in most camps to educate refugees about their FP options, but there is a lack of community-based distribution of FP supplies. In Nangweshi camp, adolescents expressed a clear desire for fewer children (4-6) than their parents (10-12). In nearly all camps, emergency contraception (EC) is an unknown concept to refugees and health staff, and even though some clinics carried the proper oral contraceptives to prescribe EC, none were doing so.

Generally, there is good level of awareness concerning the prevention of **STIs, including HIV/AIDS**, with focus group participants in the western and northern camps being able to cite the main methods of prevention and where they may be tested and treated for STIs. In Nangweshi camp, there is a great deal of fear surrounding HIV/AIDS - and for good reason. Premarital sex and polygamy are common practices. This is true for Mwange and Kala camps as well where premarital sex, polygamy and sex for survival are also common and alcoholism is prevalent.

²⁹ The MISP is a set of supplies and activities that reduces maternal and neonatal mortality, reduces the transmission of HIV, and prevents and manages the consequences of gender-based violence.

However, perception of risk differs among the refugee population. Although there are numerous suspected HIV/AIDS cases, there are few diagnosed patients and still a persistent skepticism of the existence of the disease. For example, all focus group participants in Nangweshi camp reported that they had never seen a person with HIV/AIDS. In April 2000, a physician at Senanga District Hospital took part in an HIV-related study in the Senanga secondary school which teaches 15- to 19-year-old Zambian students. Researchers expected to find an 8.4 percent rate of HIV prevalence and instead were shocked to find a 30 percent HIV prevalence.

Researchers expected to find an 8.4 percent rate of HIV prevalence and instead were shocked to find a 30 percent HIV prevalence.

Results from an HIV-related study in a Zambian secondary school

There are a number of other concerns related to STI/HIV/AIDS as well. Refugees in Mwanze camp seek treatment for sterility, a condition most likely due to untreated STIs. In Nangweshi camp, Angolan refugees reported that male circumcision is typically performed in the community by indigenous providers when boys are two to ten years old. UNFPA staff suspect that circumcision practices may be unsafe, e.g., use of unhygienic equipment by community providers. Many patients do not comply with the recommendation of partner notification and go to a pharmacy instead to self-treat, posing further danger to the individual's and partner's health.

In regard to services and supplies, male condom availability is inconsistent in many of the sites visited. For instance, in Mwanze camp, female condoms are available sporadically and male condoms were sometimes out of supply. In Nangweshi camp, users must go to the MCH clinic to obtain condoms, which poses a formidable barrier for those who would prefer anonymity, particularly adolescents. Voluntary Counseling and Testing (VCT) is available in only two camps – Kala and Mwanze – as well as at some district hospitals and two centers in Lusaka. However, the degree of counseling provided with testing is unclear. Nevertheless, the VCT services are not well used. One reason is that the community doesn't see the purpose of testing without having treatment available for HIV-positive diagnoses. Recently, a pilot VCT project was in place in a number of sites throughout the country but funding was withdrawn due to the Dutch donor's dissatisfaction with the counseling component.

Gender-based violence (GBV) is a topic most people are reluctant to discuss. In spite of this reticence and discomfort with GBV, most NGOs, UNHCR representatives and refugees acknowledge that GBV is happening in the camps. Adolescent boys were the most candid group in discussing the topic and they were the only focus group to confirm the presence of sex workers in Nangweshi camp. The most common form of violence is domestic violence, i.e., husbands beating their wives. It is widely acknowledged that domestic violence is exacerbated by alcohol use/abuse and also drug (marijuana) use/abuse. Another less common form of GBV is teachers violating young schoolgirls due to the teachers' position of authority and the respect afforded to their position. This is particularly poignant given that girls must overcome a number of barriers to get to school to begin with and then may face danger upon arrival. In Kala camp, Médecins Sans Frontières (MSF) is attempting to respond to the complaints of female refugees by increasing the number of female maternity staff – currently only four of the fourteen health providers are females. Women do not feel comfortable seeing male providers and the lack of female midwives limits the services provided in the maternity clinic.

Most health facilities lacked any type of protocol to manage the consequences of rape. Women and girls having sex for survival and material goods was acknowledged in most camps. Rape

incidents are sometimes resolved by the victims' families forcing the perpetrator to marry the victim. Victim Support Units (VSU) are in place at camp police stations and some focus group participants acknowledged awareness of these services. However, it is not clear that the VSU staff are appropriately trained to serve victims of violence. CARE has recently been funded to implement GBV projects in Mwange and Nangweshi camps and part of their work will be to collaborate with the police department, provide necessary training, and strengthen the links between the refugees and VSUs so appropriate referrals can be made.



Peer education youth group in Nangweshi camp.

The assessment team did not encounter any comprehensive **Adolescent Reproductive Health Services**, with most services being ad hoc. For example, Jesuit Relief Services (JRS) established a youth club in Nangweshi camp for young people to attend after school. However, due to their responsibilities at home, not many girls visited the youth center and this was a benefit mostly enjoyed by adolescent boys. In addition, a Nangweshi CARE staff person - acting of his own volition outside of CARE's

camp mandate - established a peer education youth group to allow adolescents to learn and share information about reproductive health. Also in Nangweshi, adolescents would need to visit the maternal and child health clinic to obtain condoms, an unlikely proposition for young people who do not want their elders to be aware of their sexual activities. In Kala camp, World Vision International (WVI) recently initiated anti-AIDS clubs among youth. In Meheba camp, the YMCA uses peer educators to target the adolescent population to address issues such as early child-bearing, unsafe sex, unsafe abortion, unwanted pregnancy and STI/HIV/AIDS. In Nangweshi camp, many children lost parents during the war. Early marriage is common for girls who may marry as early as 13, while most men marry at 20-25. Adolescents are clearly a sexually active population and are particularly vulnerable given the lack of readily available condoms and comprehensive services targeting their needs.

8. Refugee Findings and Recommendations by Camp/Region

a. Kala

Kala camp was established in August 2000. As of early 2001 it was host to 11,300 Congolese refugees. The camp is located 125 miles south of the Congolese border.

Safe Motherhood
Comprehensive ANC services (including syphilis testing) are provided and are well attended. In August 2001, 21 percent of syphilis tests were positive. Approximately 85 percent of deliveries are performed at the camp



Kala Refugee Camp

hospital. TBAs have not received any training as of yet. Médecins Sans Frontières/Holland (MSF) has been considering the possibility of training them. In addition to TBAs, female family members or friends often assist with deliveries. An emergency referral system is in place for obstetric emergencies; however, the ambulance is not available at the hospital in the evenings or weekends. In August 2001, one obstetric case was referred for a cesarean section at the Kawambwa Hospital. Not all basic emergency obstetric care services are available due to lack of skilled staff. Anemia is not a major problem but blood transfusions can be given when necessary. Blood is screened for HIV. There is an active home visitors program run by MSF.

Recommendations:

- Increase involvement of the TBAs and other home birth attendants and decide how the implementing partners will work with them.
- An ambulance is needed at the camp hospital seven days a week and 24 hours per day to manage emergency obstetric cases as well as other emergencies.

Family Planning

FP services are available at the camp hospital (condoms, pills and injectables, which they receive from the MOH) and there have been no stock outs. At the time of the team's visit there seemed to be a sufficient supply of family planning commodities. Women joked about how they could increase their ration if they had more babies but they also seemed to be somewhat serious in making this statement. Natural FP methods were discussed (e.g., abstinence) and traditional methods with beads were also mentioned. Many women feel pressured to have babies for their "clan" and/or to keep their husband.

Recommendations:

- A well-planned IEC campaign at the community and clinic level is needed to promote benefits of child spacing and increase the demand for FP.
- Partners should explore community-based distribution method to ensure supplies reach the community in a timely and efficient manner.
- The Planned Parenthood Association of Zambia (PPAZ) and Society for Family Health are excellent local NGOs which can provide the training for peer educators.

STI/HIV/AIDS

VCT is available but not really used. Blood transfusions are tested for syphilis, Hepatitis B and HIV. Last month, two of the five donors tested positive for Hepatitis B and none were HIV-positive. While people in the focus groups knew about HIV/AIDS and modes of transmission, there seems to be a very low perception of risk. Sex workers do have access to condoms through home visitors, however other women asked for access to female condoms. As noted from the hospital statistics, syphilis cases among pregnant women are extremely high. Anecdotal evidence from the camp hospital staff showed a high rate of sterility, most likely related to untreated STIs. The community members are unhappy with how STI cases are treated (asked to bring in partner to clinic to be treated) and would much rather spend limited resources on drugs in the market and self-treat infections.

Recommendations:

- A good IEC strategy on STI/HIV/AIDS is needed at both the community and clinic level to clear up the many misconceptions surrounding HIV/AIDS. The strategy can be built upon the network of committees and social workers that WVI has trained and the community outreach workers of MSF as well.
- Focus on creating a strategy for caring for people living with AIDS (PLWAs), as this has not yet been developed. The next step would be to encourage people to take advantage of VCT, since testing is already available in the camp.
- Explore possibility of providing female condoms to women in the community.
- A strategy to assure detection and treatment of STIs is needed (may need to include private pharmacists, traditional healers, etc.).

Gender-based Violence

The camp hospital doctor is concerned about post-traumatic stress disorder (PTSD) among the refugees which manifests itself in many ways among the women coming to the clinic. Men do not come to the clinic but most likely are suffering from PTSD as well. There is only one woman working as a midwife in the maternity clinic although a new graduate female nurse was recently hired. Among the 17 clinical health staff working at the hospital only four are women. Women complained about this situation in the focus groups. MSF is well aware of the problem but has been unable to recruit and hire qualified refugee staff. Women and men had not heard of emergency contraception and the camp hospital does not provide it. There have been no rape cases reported to the clinic and community members denied any incidents of rape since coming to the camp; however, domestic violence is a big problem. Community-based counseling services are available supported by WVI community services. There is a VSU in the police office at the camp but personnel have not been trained. There are also many cases of coerced sex and sex for survival. Polygamy has increased since the population has become refugees.

Recommendations:

- The magnitude of the problem still needs to be assessed and there is a variety of strategies to do this.

- A well thought-out multi-sectoral strategy is needed to deal with GBV to include confidentiality, counseling, medical treatment (including emergency contraception) and protection. It is essential that this plan is carried out on a slow step-by-step basis with the support of the camp leadership.
- Begin to address domestic violence because it is recognized by everyone as a problem.
- Follow guidelines for the clinical management of violence according to the Interagency Working Group's Draft Guidelines on the Clinical Management of Rape Survivors.

Adolescent Reproductive Health

Communities spoke of early marriages, wife stealing and young girls having sex for material items. They also expressed the desire to have male circumcision done at the camp hospital. Youth are engaging in sex earlier than they did before the population became refugees. WVI has begun working with anti-AIDS clubs among many other youth programs.

Recommendations:

- A plan for specifically targeting youth in all aspects of RH is needed – one that builds upon what is already being done by WVI and that includes respected community leaders such as the religious leaders, etc.
- Youth-friendly services in all areas of RH are needed. Explore options of different strategies that have been tried in other camps and development programs in Zambia.
- Develop materials for a comprehensive IEC strategy using existing resources from UNFPA (Meheba), YWCA, YMCA, CARE and ZIHP youth programs.
- Assure that STI treatment, FP services and SM services are available, accessible and utilized by the youth (youth friendly corners, peer educators, etc.).

b. Mwange

Mwange camp is located in the Mporokoso District in the Northern Province near the border of northern Zambia. It is home to approximately 23,000 Congolese refugees since 1999.



Maternal and child health clinic in Mwange Camp

Safe Motherhood
Community Response: ANC services are good. TBAs make some home visits and conduct deliveries and women visit TBAs if sick during pregnancy. In August 2001, 38 deliveries were conducted in the community and 30 at the clinic. All focus group participants mentioned one maternal death in the last year - which appeared to be the same one. Typically, there are one to two neonatal deaths per month. Abortions are performed by traditional

methods such as a douche of traditional herbs. One girl died this year after having an abortion. According to young men, a frequent cause of abortion is when the father refuses to accept responsibility for pregnancy.

Refugee Health Facility: A referral system is in place for emergency obstetric transports and comprehensive ANC services including routine syphilis testing. There was one maternal death in August 2001 due to postpartum hemorrhage after a home delivery but the baby survived. There are six (mostly Congolese) midwives working at the maternity health clinic.

Zambian Health Facility: There is a specialist coming to Mansa (a referral point 200 kilometers from Mwanze) in October 2001 to do vesico-vaginal fistula (VVF) repairs. All post-partum women are given information about FP. The hospital is very short staffed. There is one nurse for each ward including pediatrics, maternity, female and male wards. The hospital receives an average of 9-13 maternity referrals per month, half of which are true emergency obstetric cases. There are also many ectopic pregnancies (from the camp and local population). Not all women are tested for syphilis. Testing is limited to suspected cases due to the lack of sufficient testing supplies. At times, communication is a problem with refugees on the wards although there is one Congolese refugee nurse who can provide translation. One half of the clients are camp refugees.

Recommendations:

- Assure that the TBAs are well supported, supervised and continuously supplied with needed stores.
- Conduct an in-depth health facility assessment of the camp hospital to assure that systems and supplies are in place to provide RH services.
- Consider reviewing criteria for emergency obstetric referrals based upon the high number of these referrals being normal deliveries.
- Contact Felicitas Willem, one of the doctors at Mporokoso hospital, for patients who need VVF repair.

Family Planning

Community Response: The feeling on the part of men and women is that God provides babies. In spite of this belief, some women did express interest in FP. Women use some natural FP methods but they are not very effective; abstinence is also used. People were aware of FP services at the clinic but many people complained of the lack of availability of condoms since May. Condoms are not available in camp pharmacies and are only available in Mporokoso town. There was no awareness of emergency contraception. CARE did recently receive a supply of female and male condoms, which will be distributed through the HIV/AIDS program.

Camp Hospital/Clinic Response: Since the start of the camp, there were 1,427 newly registered clients for FP and as of mid-2001, new acceptors have reached 2,798. Methods available are combined oral contraceptives (COCs), progesterone only pills (POPs), noristerat and lefemale (vaginal suppositories). Female condoms have been sporadically available and male condoms were available until 3-4 months ago. Condoms were supplied through the MOH.

Mporokoso Hospital: Many people, including refugees, are seen for fertility problems, most likely related to sterility secondary to untreated STIs. Condoms are available but the method and quality of distribution are unclear. FP services are available at the outpatient clinic including oral contraceptive pills (OCP), noristerat, foam tabs, male and female condoms, and intrauterine devices (IUDs). Very few bilateral tubal ligations are performed.

Recommendations:

- Assure that each of the implementing partners has a consistent supply of condoms.
- Support CARE's plan to distribute female condoms, which will provide an excellent opportunity to test the acceptability of female condoms in this setting.
- Use "child spacing" terminology which may be more acceptable than family planning for this community.
- Ensure that all staff providing family planning services are adequately trained in counseling techniques.
- Consider using community-based distribution (CBD) approach with pills, foaming tablets and condoms to increase coverage.

STI/HIV/AIDS

There has been a high rate of positive syphilis tests among those routinely tested at the camp antenatal clinic. In August 2001, 14 percent tested positive. All the positive cases were treated with their partners. The Zambia Red Cross Society (ZRCS) keeps a separate logbook with syphilis test results to facilitate better case follow up. ZRCS shared some of their testing supplies with the Mporokoso Hospital and is concerned they may run out of the tests. Based upon group discussions, community members do not go to the clinic for treatment of STIs if they can avoid it; they would rather buy drugs at the local pharmacies and self-treat rather than go through the embarrassment of being treated with their partners in the clinic. As mentioned earlier, a physician at the Mporokoso Hospital had noted that there seem to be many couples, including refugees, requesting treatment for sterility which is most likely related to untreated STIs. ZRCS stated that they have the drugs for treating STIs using the Greater Republic of Zambia (GRZ) Syndromic treatment guidelines for STIs.

There have been eight documented cases of HIV/AIDS in the camp so far; five of the infected people have died. The test can only be done at the district hospital and so far very few people want to be tested. People are concerned about AIDS, have heard of it and know how to prevent transmission. The young men in one focus group complained about not having condoms in the camp since April.

CARE has done a series of trainings for peer educators in HIV/AIDS and recently received a stock of male and female condoms for their community-based program there.

Recommendations:

- Other IEC approaches may be needed in order to convince the population of their personal risk in regards to HIV infection.
- Continue to explore the use of community mobilization strategies, including drama, etc., to educate the community on STI/HIV/AIDS.
- In addition to IEC resources that have already been developed by the implementing partners in the field, consider collecting materials from other programs such as those from the ZIHP and UNFPA projects. All IEC materials need to be pictorial or written in a local language that is understood by the camp population.
- Obtain pictorials on how to use male and female condoms.
- An assessment as to specific barriers to clients seeking treatment for STIs at the clinic needs to be completed to identify ways to overcome these barriers. Some of the barriers are: lack of confidentiality, issue of partner treatment, lack of the appropriate drug.

Gender-based Violence

The clinic did have emergency contraceptives available but have run out. There are no treatment protocols for rape cases in place at the camp hospital. Staff from ZRCS said they had

not received any post-rape survivors in their clinic but that the CARE community services staff were more likely to hear about these incidents. Most groups denied there having been any rape cases although the young girls did state their knowledge of two rape cases. One mentally ill woman was raped last year, became pregnant and is now living with that child. The procedure in place is to report rape cases to the section leader who then reports to the CARE and police offices. Women spoke of sex for survival as being common in their situation and the need for support. Domestic violence is reported to be a problem by those interviewed in the clinic and community.

Recommendations:

- An intersectoral approach working from the community and health facility level is needed to address GBV in order to ensure protection and to bring to justice the perpetrators of GBV.
- The camp clinic may consider using the recently developed UNHCR treatment of rape survivors guideline in their clinic. All staff at the clinic will need training in the counseling and management of rape victims to include strict confidentiality and psychosocial support (presumptive treatment of STIs should be offered to rape survivors).
- Ensure that emergency contraceptives are available for rape survivors.
- Consider partnering and collaborating with BWAFFWANO, a good local NGO in Mporokoso that has done a lot of work in women's rights, HIV/AIDS and some GBV.
- Support the work of all implementing partners who are concerned about alcoholism and trying different approaches to reduce the incidence.
- Work with victims as well as perpetrators to identify the best strategies for approaching GBV.
- Consider working with GBV consultant, Beth Vann, who will be working with CARE in the fall of 2001. This is a good opportunity for all of the implementing partners to come together and plan their integrated strategy to address sexual and domestic violence.

Adolescent Reproductive Health

Adolescent programs focus on education concerning the consequences of rape, which in many cases leads to early marriage. Young girls are forced to have sex and then the families of the man/boy and woman/girl usually resolve the case by having the perpetrator and victim marry. This is not recognized as a form of sexual violence or rape. The adolescents spoke of early onset of sexual activity (girls 13 and older and boys 14 or 15 and older), yet few to none of them registered at the clinic for family planning services.

Recommendations:

- Build upon and strengthen the anti-AIDS clubs with which CARE has worked.
- Build upon and strengthen the peer educators network supported by ZRCS.
- Include the youth in identifying strategies and interventions for addressing their RH needs (consider programs such as youth friendly programs, etc.).
- Work with local NGOs that are experienced in training adolescent peer educators such as the Society of Family Health (used by CARE and ZRCS), YMCA, YWCA and Youth Activist Organization (YAO) recommended by ZIHP.
- Assure that peer educators have IEC materials and a consistent supply of condoms for distribution.

c. Meheba

These findings are based on the information collected from the UNFPA/YMCA Refugee Reproductive Health Project Progress Reports for the months of May and June 2001 and the experience of an assessment team member.

Meheba is the largest camp in the country, with a permanent population of 50,000 refugees and land area of 872 km². It is located in the Solwezi District in the Northwestern Province, close to the borders of the DRC and Angola. Last year, its area was increased by 100 km² to accommodate the growing numbers of asylum-seekers. Meheba is home to refugees who have been there since 1971, and therefore is better described as a rural settlement with farming plots and small villages rather than a typical refugee camp. The only tents belong to newcomers who are not yet established. Refugees are provided with a plot of land, a tent, kitchen utensils, farming tools and seeds, and food rations until the first harvest. The following organizations provide services: UNHCR, LWF, MSF, JRS, Zambia Red Cross Society and YMCA/UNFPA.

Safe Motherhood

Meheba has eight clinics situated in eight separate zones. For the months of May and June 2001, clinics reported 229 antenatal care visits, 20 post-natal care visits, 20 deliveries, 2 maternal and antenatal complications and 162 tetanus toxoid vaccinations. However, during May 2001, tetanus toxoid vaccination was only available in the MSF supported clinics due to lack of supply in the other facilities.

A very effective referral system is in place and complicated cases are referred to Solwezi General Hospital, which is approximately 45 minutes from the settlement. Clinics are also being assisted to strengthen the referral system. In addition, RH has been integrated into a malaria prevention and management program.

The collaborating agencies have also formed an Emergency Preparedness Committee to address a number of issues, including supplies, drugs, IV fluids, reagents, specimen containers, transport, etc.

There are 15 UNFPA-trained peer educators who play a major role in carrying out awareness and educational activities in the settlement. Part of the peer educators' work is to address the community beliefs about RH issues.

Recommendations:

- Host regular refresher training for peer educators to learn more strategies on addressing misconceptions.
- Consider the RH needs of the Zambian community around the settlement for inclusion into the referral program to the general hospital.

Family Planning

There are a number of community beliefs that challenge the provision of FP. For example, women should produce as many children as God gives them, FP methods are only suitable for women who already have children, condoms are not good and they reduce sensitivity, and FP is "women's business." However, peer educators managed to reach 237 male and 356 female refugees with their sensitization and educational program, including a video presentation called "Dangerous Numbers on Family Planning." Some clients were still not familiar with the lo-feminal contraceptive pill, because it was a new brand in the area. Some women willing to use modern FP methods were prohibited from doing so by their husbands.

During July and August 2001, 136 clients were using some method of contraception. Condoms were the most popular method with 76 users, followed by 23 clients using microgynon, 21 using noristerat and 16 using microlut. No clients were using lo-feminal or foaming tablets. PPAZ supplied the settlement with 7,200 condoms and 400 ampoules of noristerat.

FP training was also extended to Community Health Workers (CHWs) on commonly used contraceptives in Meheba, which included combined oral contraceptives, mini pill, condoms and injectables.

Recommendations:

- Involve men in FP activities.
- Increase the number of peer educators to meet the needs of the refugee population.
- Continue to include members of the Zambian community in trainings as this approach contributes to good relationships between the host population and the refugees.
- Obtain more videos on various relevant RH topics.
- Preceded introduction of new FP contraceptives by an intensive IEC campaign.

STI/HIV/AIDS

Group discussions with peer educators indicated that refugees want to know more about STI/HIV/AIDS. Discussions also highlighted some misconceptions on HIV/AIDS, such as AIDS carriers are only men and some African roots cure AIDS. The peer educators addressed these misconceptions through discussions and video presentations. Condom use was still very low during the two months. The peer educators also held post-counseling sessions with some of the clients who required further information on specific issues, such as condom efficacy.

Recommendations:

- Undertake an awareness campaign to promote condom use.
- Institute a community-based distribution system to supplement peer educators' efforts in condom distribution.

Gender-based Violence

GBV was not addressed in the two monthly reports reviewed. However, the UNFPA Evaluation Report indicates that during focus group discussions conducted by peer educators, a number of issues concerning sexuality, sex education for adolescents, FP, GBV awareness, communication and counseling skills and case studies were reviewed.

Recommendations:

- GBV issues should be reflected in monthly reports, including causes and action taken against perpetrators, if any.
- Consideration could also be given to formation of a specific counseling group trained to address GBV, with an emphasis on domestic violence.

Adolescent Reproductive Health

Peer educators also work to meet the needs of adolescents through awareness messages including film and video presentations. One well-known film called "Yellow Card" addresses RH issues such as early child bearing, unsafe sex, unsafe abortion, unwanted pregnancy, sexually transmitted infections and HIV transmission.

Recommendations:

- Initiate more IEC programs designed specifically for adolescents as a target group.
- Introduce youth-friendly RH services in all eight clinics.

- Involve youths in identifying strategies and interventions to address their RH needs.

d. Mayukwayukwa

Mayukwayukwa is located in the Western Province. It has a population of 14,000, primarily Angolans with some Congolese, and covers an area of 2,500 hectares. The settlement is expected to receive a further 600 hectares. The assessment team did not visit Mayukwayukwa camp and the findings below are based on reports gathered from organizations working in the camp. The organizations that are providing RH services in Nangweshi camp are providing the same services here. LWF serves as camp manager, African Humanitarian Action (AHA) provides clinical care and Christian Outreach Relief and Development (CORD) is responsible for community services. CORD noted that there is a mix of new and old refugee caseloads and conditions are not good for new arrivals, with many in forested areas with only plastic sheeting.

During conversations with AHA and CORD, the assessment team verified the similarity in programming between Mayukwayukwa and Nangweshi camps. Therefore, many of the same recommendations made for Nangweshi can be applied to Mayukwayukwa.

Safe Motherhood

AHA provides clinical services whereas community-based activities are organized by CORD and HODI. See Nangweshi camp notes for description of services.

Family Planning

AHA provides clinical services whereas community-based activities are organized by CORD. See Nangweshi camp notes for description of services.

STI/HIV/AIDS

CORD has recently initiated a program to address HIV/AIDS programming in Mayukwayukwa camp. An RH coordinator was hired and a training workshop on RH and HIV/AIDS was conducted to educate community development workers. CORD also plans to recruit refugee motivators. As in Nangweshi camp, CORD plans to coordinate RH activities through the development of a working group with LWF, which is responsible for camp management, and AHA.

Gender-based Violence

According to CORD, many young women and children are coming into the camp on their own because the males are away fighting or have been killed in the war. This makes for a vulnerable population.

Adolescent Reproductive Health

Some children who come to the camp alone are taken to orphanages whereas others are integrated into camp life. There is a danger of schoolgirls being violated by their teachers who are given a great deal of respect in their position. The assessment team did not explore the possibility of abuse by the people who take orphaned adolescents into their homes but suggests follow-up in this area.

e. Nangweshi

Nangweshi camp was established in January 2000 in Zambia's Western Province about 150 kilometers from the Angolan border. Access to the camp is difficult, particularly during the rainy season, due to marginal roads and the need to cross the Zambezi River. During the assessment team visit, UNHCR was awaiting the arrival of a boat it had purchased to make crossing the Zambezi River during the rainy season possible.

Most of the refugees have fled from the fighting in Angola. The refugees include professionals but also a large number of subsistence farmers and businessmen. There have been allegations that senior National Union for the Total Independence of Angola (UNITA) military figures operate from within the camp and some estimate as many as 8,000 former combatants are housed at Nangweshi. UNHCR noted that former combatants were being moved to Ukwimi camp located near Zambia's eastern border in order to distance them from UNITA rebel forces in Angola. However, during the writing of this report, NGO contacts in Zambia report that conditions at Nangweshi have recently become more difficult due to renewed fighting on the Angolan border. The International Office for Migration (IOM) reported that the IOM and UNHCR were relocating some 1,300 Angolan refugees from Nangweshi camp to Ukwimi camp.³⁰ Nangweshi camp has moved beyond its carrying capacity of 15,000 to almost 16,000 refugees.

Safe Motherhood

Focus group participants and African Humanitarian Action (AHA) clinical staff reported that most deliveries take place at the AHA clinic, with few home deliveries. A good referral system is in place for refugees to reach emergency obstetrical care at Senanga District Hospital when complications arise during labor and delivery. According to the doctors at the District Hospital, they are seeing the appropriate number of referral cases based on the number of women of reproductive age expected to have obstetric complications in the camp.

Unfortunately, this is not the case for the local population from which the doctors have not seen any emergency obstetric cases in the past year; they had expected to see at least 15. The assessment team was unable to ascertain with focus groups and AHA any issues with post-abortion care. Focus group participants denied any involvement of the community use of traditional medicine, including for addressing unwanted pregnancy. Representatives from the district hospital expressed that the use of traditional medicine may result in unsafe abortions. District health representatives rarely see complications from unsafe abortions among refugee populations.

When they do encounter a case, dilation and curettage is used due to a lack of manual vacuum aspiration supplies. The district hospital suffers from inadequate supplies, which could impact the quality of care of refugees referred for care. Transportation is a concern because the pontoon used to cross the Zambezi River is not available at night and transport during the rainy season is difficult. Pregnant women are not routinely tested for syphilis due to a lack of necessary materials. At present, only high-risk pregnant women are tested.



Maternal and child health clinic in Nangweshi Camp

³⁰ International Office for Migration (2001). IOM Press Briefing: October 23, 2001.

Recommendations:

- Ensure that an emergency transportation plan is in place for emergency obstetric cases occurring at night.
- UNHCR is expecting to receive a new boat this fall, which should make crossing the Zambezi easier during the rainy season. Make certain that this arrangement satisfies this need.
- Follow up on supply problem of Senanga District Hospital to ensure that refugees referred for care can be properly treated.

Family Planning

FP services could be improved. Currently, there are only 13 acceptors of modern FP methods in the camp. The preferred methods are the pill and injectables. Low-dose progesterin-only pills are the type of oral contraceptive available in the MCH clinic. Male condoms are available only at the MCH clinic and female condoms are not offered. Adolescents in the focus groups expressed a desire for fewer children (4-6) than their parents who they reported having 8-12 children.

Recommendations:

- Intensify efforts by AHA community health workers and CORD community development workers (CDWs) to educate refugees about importance of family planning with a focus on child spacing to protect the health of mother and child and reduce family size.
- Conduct clinic health provider training on emergency contraception and ensure that supplies are available.
- Document condom use in camp population to track progress.
- Implement community-based distribution of condoms and other contraceptives when appropriate and feasible.

STI/HIV/AIDS

Information collected from focus groups with men, women, boys, girls and CORD CDWs indicates that the participants were very aware of how to prevent contracting STIs, including HIV/AIDS. Focus group participants also indicated that commercial sex was occurring and premarital sex and polygamy is common. Further, despite awareness of HIV prevention, there were expressed doubts about the reality of HIV/AIDS. Participants and AHA denied seeing HIV patients and the district hospital representatives reported seeing very few cases. VCT is not available in the camp or Senanga District Hospital. As noted earlier, syphilis testing is only done for high-risk pregnant women due to a lack of necessary supplies.

Recommendations:

- Make condoms visibly and readily available in multiple locations in the camp and make sure that CHWs and CDWs have them available as they visit their sections.
- Make syphilis testing for pregnant women routine in the AHA clinic.
- Monitor progress and identify protocols for VCT in Zambia so that this service can be initiated once it becomes available for the host country population. In the meantime, provide training for counselors who could be available once VCT is possible.
- Continue to improve IEC campaigns on HIV/AIDS and establish a protocol for people living with HIV/AIDS.
- Do outreach to commercial sex workers in the camp and make female condoms available, particularly to this population.

Gender-based Violence

Many of the people the assessment team interviewed, including implementing partners, UNHCR representatives and local medical personnel, believe GBV does occur in the camp, although most were reluctant to discuss the topic. Among focus group participants, only the adolescent boys acknowledged the presence of GBV in the camp. However, almost all contacts acknowledged the prevalence of domestic violence, which is exacerbated by alcohol abuse. The adolescent boys also noted the incidence of marijuana use/abuse. UNFPA is starting a GBV program in January 2002 which will address adolescent sexuality and link to a VSU and the district hospital. This will also incorporate community-based education to respond to men's needs and frustrations so that they may better deal with the difficulty of being a refugee and impoverished.

Recommendations:

- Train AHA staff on the clinical management of sexual violence using the Interagency Working Group's Draft Guidelines.
- Solicit technical assistance TA to conduct GBV sensitization activities with the camp population so that this issue can begin to be discussed in the refugee community. Community sensitization can be followed by an assessment in order to determine which future interventions would be most appropriate for the population.
- Consider addressing the stated domestic violence problem to initiate a GBV program.

Adolescent Reproductive Health

There have been many successful efforts in the camp to target youth, such as CARE's volunteer work to raise awareness of HIV/AIDS among adolescents through peer education and JRS youth centers. From focus group discussions, adolescent males were clearly the most forthcoming with regard to sensitive reproductive health and related information while adolescent girls were the most reluctant to speak. Of the four different focus groups, adolescent males were the only participants to state that sexual violence occurred in the camp citing specific incidents. In addition, adolescent males were the only group indicating that traditional practices were sometimes used in the camp. Unlike adult participants in focus groups, both adolescent boys and girls responded that there was a drug problem in the camp. The girls did not know the drug whereas the boys indicated it was marijuana. Many adolescents indicated they had lost a parent in the war. As with other focus group participants, adolescents could describe the three major ways to prevent HIV/AIDS, including to abstain, be faithful to one partner and use condoms. Adolescent girls often referenced the issue of money. For example, girls mentioned that commercial sex work occurred because of a lack of employment opportunities and that women had sex with men who had money, to obtain their survival needs.

Recommendations:

- Work with adolescents in separate gender groups to ensure full participation of girls.
- Consider ways to include girls in youth activities so that their home responsibilities do not preclude them from becoming informed about important RH topics.
- Renew efforts to develop and distribute an adolescent camp newsletter.
- Consider separate focus on adolescents from 12-14 years of age.
- Provide youth-friendly services to ensure access for youth to comprehensive RH services.

f. Ukwimi

Located in the Eastern Province of Zambia in the Petauke District, this camp housed refugees from Mozambique during their civil war which ended in 1992. After the resettlement of Mozambican refugees, it was used to resettle poor and landless Zambians and now the GRZ has made it a camp for demobilized Angolan ex-combatants and most likely demobilized

Congolese ex-combatants will be sent there as well. As of the end of October there were 2,280 refugees - many of them single men, whose wives did not accompany them from the border with Angola and it is expected that there will be 3,000 refugees by the end of the year. There is clearly a need to address GBV in this camp and people familiar with this camp expressed this need and concern. Currently LWF is the implementing partner for UNHCR. LWF is providing services for the refugees and has a fairly extensive agricultural development and environmental rehabilitation and community development program.

Comprehensive reproductive health services are not currently available and therefore only limited findings and recommendations are offered. Some safe motherhood services are provided but do not seem to be well accepted by the refugee community. The supply of tetanus toxoid is inadequate and TBAs operate independently with limited support from the health system. FP services are not well accepted by the population despite GRZ sensitization campaigns. STI/HIV/AIDS prevention education is done and treatment for opportunistic infections is provided. Safe blood transfusions are provided at the hospital 86 kilometers from Ukwimi. There is no consistent or regular supply of condoms. GBV prevention and care for survivors is needed and although adolescent specific RH services are recognized as a need, no services are offered as of yet.

g. Urban/Peri-urban

Information concerning the urban and peri-urban refugees living in and around the capital was collected with the assistance of the YMCA and UNFPA through focus group discussions with 14 RH peer educators and separate meetings with the Lusaka urban male and female refugees. The peer educators came from Angola, Rwanda, Congo and Uganda and had originally been supported by UNFPA. Separate meetings were held with 12 male and 10 female refugees in Kanyama Township. A briefing meeting was also held with the YMCA education counselor.

The YMCA, with support from UNHCR, is the principal organization serving the urban and peri-urban refugees. Prior to the YMCA program, UNFPA had provided support towards RH activities and trained peer educators. Some of the educators have continued to carry out the RH and other awareness programs among urban refugees.

The YMCA maintains one clinic specifically for refugees in the Kamwala area. At least three quarters of the refugees in Lusaka pass through this focal point clinic. When necessary, patients are referred to the University Teaching Hospital. The clinic has two health workers, a nurse and a clinical officer, and operates from 8 a.m. to 5 p.m. When this clinic is closed, refugees may go to any government clinic where they pay for service and get reimbursed by the YMCA.

Safe Motherhood

Most deliveries take place at the clinics. However, many women are also forced to deliver at home with the help of friends or untrained TBAs. Typically these women cannot pay for the health services at government clinics or cannot afford to meet the pre-admission requirements such as baby napkins (diapers) and other necessary baby wear. Other women are reluctant to deliver at a clinic because they are unmarried or have difficulty communicating. Another barrier for women to deliver at a clinic is transportation from home to the facility, which can pose a particular problem at night.

Pregnant women are routinely tested and treated for syphilis. ANC services are comprehensive at government clinics; however there is no emergency transportation plan. It was not possible to visit specific government clinics serving pregnant refugee women because the refugee population in Lusaka is dispersed throughout the city.

There have been many known cases of maternal deaths as well as infant deaths among the refugee population. The refugees noted that a contributing factor to maternal and infant mortality is early discharge from clinics and hospital. Mothers are discharged a day after delivery and sometimes complications start while at home.

There are some untrained TBAs among the refugee community. Abortion services are not easily available and they can only be performed according to the Zambian Law, which requires approval of three medical doctors.

Recommendations:

- The refugee TBAs should be trained so that they can assist the women who are unable to reach the clinic for deliveries.
- Provide seed funds to start an income generation project for women. Many women are keen to raise money to pay for antenatal and delivery services at government clinics and hospitals.
- UNHCR and the YMCA should consider the possibility of providing an ambulance to the refugee clinic in Kamwala area. Very good referral arrangements have been made with government clinics and the University teaching hospital; however, this should be backed with the provision of transport, especially for emergencies.

Family Planning

Family planning is not prevalent among the refugees interviewed in the discussion groups. Many refugees stated that children are a gift from God, others expressed their desire to replace children and members of the family who died during the war, and some women explained that they get pregnant deliberately because they receive a very expensive wax Chitenge material from their husbands. However, other refugees stated their preference for fewer children. This was particularly true among those refugees from Rwanda and Burundi.

One hindrance to family planning/child spacing is a lack of adequate FP supplies at the YMCA clinic, which does not stock injectables or IUDs. Refugees also cited the lack of recreational activities and difficulties in convincing men to use condoms as barriers to FP. In their country of origin, refugees used traditional FP methods and had a great respect for cultural values. Some men cited polygamy as a FP method. Government clinics offer contraceptives pills, IUDs and injectables. Adolescents do not have anywhere to go for FP services and as a result purchase contraceptives from the market, where products may be expired and dangerous to their health.

Recommendations:

- Provide further training for peer educators, especially in skills that can change attitudes towards the importance of FP.
- Involve males in FP awareness programs.
- Increase FP services at the YMCA Clinic, train service providers and make injectables accessible at the clinic.
- Initiate youth-friendly services needed for the adolescents.

STI/HIV/AIDS

There are many known and suspected cases of AIDS among the refugee community. Most of the refugees interviewed said they did not know anything about AIDS until they arrived in Zambia. Despite the awareness of HIV/AIDS among peer educators, some still doubt the existence of AIDS and associate it with witchcraft. Commercial sex workers avoid AIDS awareness meetings and they charge a higher fee for men who do not use condoms. The

YMCA clinic's records document a high incidence of STIs. Some refugees receive treatment from government and private clinics, while others shy away especially when requested to bring partners for treatment. Others seek treatment from traditional healers or purchase medicines from pharmacies. Condom use did not seem to be popular especially among men.

Recommendations:

- Extend training seminars for peer educators on STI/HIV/AIDS to church groups.
- Different strategies are needed in handling STI cases. Those who visit the clinic should be treated but other approaches should be advanced to ensure partners also obtain treatment.
- Promote income generation activities among widows and commercial sex workers to provide alternative ways of earning a living.
- Involve and train commercial sex workers as peer educators.
- Increase availability of condoms at the YMCA clinic and use of peer educators for community-based distribution of condoms.
- Provide library materials to peer educators in the following languages: English, French and Portuguese.

Gender-based Violence

The YMCA clinic did have emergency contraceptives (EC) available but rarely gave them out because EC is seen as comparable to abortion. Sometimes rape cases are resolved through the marriage of victim and perpetrator. Domestic violence is reported to be primarily due to alcohol abuse and frustration at the situation of being a refugee. Women may increase their risk of abuse when they disobey the wishes of their husbands.

Child abuse is reported to be common. Some girls leave school to go into commercial sex work. Some women who have sex for survival may end up with five to seven children from different men. Polygamy is still common, especially among the Congolese. Drug abuse (mainly marijuana) is common among adolescents.

Recommendations:

- Consider training of health providers on ECs and making EC supplies available.
- Train peer educators to handle GBV cases by involving other organizations such as the YWCA.
- Develop well thought-out strategies aimed at keeping men and adolescents constructively occupied.
- Offer income generation activities for commercial sex workers to provide an alternative way of earning a living.

Adolescent Reproductive Health

Currently, there are no specific activities or services targeting adolescents. Pre-marital sex is common among boys and girls. Some girls marry as young as 13 years, while boys wait until they are 20 to 30 years old, although there were a few cases among those interviewed of boys marrying at the age of 18 years. Some tribes are very adamant that women retain virginity in order to command a higher dowry at marriage.

It is reported that many unaccompanied minors, particularly girls, leave school to enter the child labor market, which may include commercial sex work. Anecdotally, girls have suffered serious side effects from ineffective contraceptives purchased from markets. There have been two reported cases of teen pregnancy and many cases of incomplete abortions recorded at the YMCA clinic. In the past, girls were not eligible for scholarships and only boys benefited from

these awards. However, now there is a deliberate effort to ensure that more girls obtain scholarships.

Male circumcision is practiced. Some focus group participants said that female circumcision is also practiced.

Recommendations:

- Continue to provide more scholarships for girls.
- Arrange for youth-friendly services to ensure adolescents benefit from safe and recognized RH services.
- Encourage youths to form and participate in anti-AIDS clubs and train them as peer educators and also as community-based distributors for condoms.
- Involve youths in identifying strategies for addressing their RH and survival.
- Involve other NGOs, especially Zambia Youth organizations, to exchange RH experience with the refugee youths.
- Carry out a specific needs assessment among the urban/peri-urban refugee adolescents.
- Initiate GBV discussion with youth groups.

9. Conclusions and Recommendations



Angolan refugee participating in a women's craft club in Nangweshi camp.

Communication is one area in which reproductive health for refugees (RHR) programming could be strengthened. The team recognizes that this weakness could be a result of the renewed energy for RHR and that people and NGOs may not have caught up yet with the increase in information flow. The team would also like to emphasize that RH is an extremely broad area, with many new and challenging technical areas. Therefore, collaboration among partners is crucial to utilizing scarce resources efficiently and achieving improvements in the availability of reproductive health for refugees. The team would also like to note that there are differences between the camps in Zambia, which reflects good potential for sharing of expertise among camps. Although certain camps may have already addressed some of these suggestions, the team hopes that the recommendations from this assessment will highlight the most urgent needs to be addressed and offer an opportunity for increased technical support and guidance for all involved.

General RH

- Consider establishing an RH working group in Lusaka for implementing health agencies including refugee representatives, UNHCR, UNFPA, CARE, AHA, CORD and other NGOs which could include RH trainings to keep

- updated on new protocols, guidelines and resources.
- Ensure presence of an RH coordinating agency/coordinator to lead RH working group in each camp.
- Information, Education and Communication (IEC) materials should be available in all RH technical areas in each camp. Recommend use of IEC materials already in existence and translate into local languages with an emphasis on pictorial materials.
- The Centers for Disease Control (CDC) should consider a study of RH indicators.

Safe Motherhood (SM)

- Explore improving inclusion of and collaboration with TBAs and peer educators for community-based SM activities.
- Ensure 24-hour emergency transport availability 7 days per week in all camps.
- Ensure that the Minimum Initial Service Package (MISP) is available in all transit centers.
- Ensure syphilis testing of all pregnant women.
- Consider inclusion of the local population in referral systems for emergency obstetric cases.
- Attempt to address supply problems at referral district facilities.

Family Planning (FP)

- Improve demand and supply for FP services and supplies including emergency contraception (e.g., IEC campaign, community-based distribution of condoms and other contraceptives).
- Increase acceptance of FP services and supplies through involvement of men, active participation and ongoing training of peer educators and community workers, and use of most appropriate terminology for each community (e.g., child spacing).
- Improve access for FP services and supplies for youth.
- Ensure consistent supply of male condoms and explore possibility of supplying female condoms.
- Collaborate with capable partners (e.g., PPAZ, Society for Family Health and others) to obtain technical assistance.
- Maintain good relationship with Zambian community by involving local population in trainings.

STI/HIV/AIDS

- Ensure access to condoms for the entire community through community distribution channels.
- Improve access to STI diagnosis and treatment including individual compliance and partner treatment. Consider creative strategies to overcome the barriers (e.g., lack of confidentiality/privacy) to adequate services.
- Monitor progress of VCT in Zambia so that this service can be initiated once it becomes available for the host-country population. In the meantime, provide training to increase the number of counselors who will be available once VCT is possible. Make population aware that good care, support and antibiotics for HIV-positive persons may prolong life.
- Continue to improve IEC campaigns on STI/HIV/AIDS prevention and establish a protocol for People Living With AIDS (PLWAs).
- Do outreach to and provide income generation activities for commercial sex worker population.
- Assess community traditions regarding male circumcision and implement training of traditional practitioners as needed.

Gender-based Violence (GBV)

- All camps should be aware of and consider training on clinical management of violence according to the Interagency Working Group's Draft Guidelines on the Clinical Management of Rape Survivors.³¹
- Consider using the RHR Consortium GBV Technical Advisor (Beth Vann) as a resource for an interagency meeting/training on GBV issues.
- Make emergency contraception available in all camps.
- Identify and support needs of VSU staff and ensure continuing education for VSU staff in each camp police station.
- Consider addressing domestic violence and the contributing factor of alcohol abuse to reduce incidence of violence in camps.
- Following the establishment of GBV clinical protocols, initiate community sensitization campaigns on GBV.

Adolescent Reproductive Health

- Make every effort to work with adolescents in separate gender groups to ensure full participation of girls.
- Develop/obtain good assessment tools specifically catering to adolescent RH needs. Review existing materials and models for training and peer education from organizations such as UNFPA, Zambian Integrated Health Program (ZIHP) and local network of RH NGOs.
- Include adolescents in program development activities, paying particular attention to the barriers that girls face in participation (e.g., household chores).
- Build on current and prior efforts for development of adolescent-focused IEC materials (e.g., newsletters).
- Consider separate focus on adolescents from 12-14 years of age.
- Consider addressing youth-friendly services and explore other possibilities to ensure access for youth to comprehensive RH services (i.e., STI, FP, HIV/AIDS, antenatal care, etc.).
- Replicate UNHCR's initiative in Nangweshi camp to provide adolescent girls and women cloth (to make sanitary napkins) for menstruation.

There is a great deal of work to be done to ensure safe deliveries for pregnant women, provide couples with the necessary tools to plan their families, prevent STI/HIV/AIDS, address gender-based violence and ensure quality RH services for adolescent refugees. However, the assessment team found many knowledgeable, skilled and enthusiastic people who are passionate about their work to improve the lives of refugees in Zambia. These workers on the "frontlines" must be given the support necessary to carry out their programs and the political will to move forward the agenda of reproductive health for refugees must be encouraged.

The Women's Commission for Refugee Women and Children will be making a follow-up visit in 2002 to provide technical support to organizations and that the Women's Commission has provided new small grant funding for RH services.

³¹ Inter-agency Working Group (2001). Clinical Management of Rape Survivors: Guide to assist in the development of situation-specific protocols. Draft for field testing. Available: www.rhrc.org/fieldtools/index.htm

10. Appendices

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- Get the Facts Right: Condom
- It's Never Too Late: Make a right decision to protect yourself from STDs, HIV/AIDS
- Abstinence: The only surest way of protecting yourself from pregnancy, STDs, and HIV
- AIDS and You!
- Understanding HIV and AIDS: Common questions and simple answers
- Avoid Teenage Pregnancy
- Dr. Kalulu Says: Be wise! Learn about AIDS and keep yourself safe!
- Violence – is a crime.
- Me! Get AIDS? No Way!
- Are you worried about sexual abuse?
- Alcohol and Drug Abuse: Don't be a victim
- Reproductive Tract Infections and Sexually Transmitted Infections
- Rape is a Crime – Avoid It
- Facts about Boys' Reproductive System
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d. Agency Descriptions

African Humanitarian Action (AHA)

AHA was founded in 1994 to provide emergency and sustained development assistance to communities in Africa affected by instability and disasters, and to strengthen the capacity of civil society in general and local organizations in particular. AHA is an independent, nonprofit, Ethiopian-based agency providing emergency and development health services, disaster management policy, relief, rehabilitation and reintegration, and post-conflict recovery. In Zambia, as an implementing partner of UNHCR, AHA provides curative health services in Mayukwayukwa (since January 2000) and Nangweshi (since June 2001) camps.

Africare Zambia

Africare has a number of programs in Zambia. First, Africare manages a Regional HIV/AIDS initiative funded by The Bill and Melinda Gates Foundation. In addition, Africare is an implementing partner for Zambian Integrated Health Project (ZIHP) which receives funding from USAID. UNDP supports Africare's Youth for Community Action project. Finally, Africare works in Makeni with primarily Congolese refugees to provide vocational training for these urban refugees through UNHCR funding.

CARE Zambia

CARE has been working in Zambia since 1992 and is implementing a number of programs in the areas of agriculture and natural resources, health, education, micro-finance, infrastructure, and water and sanitation. Some of the specific projects are: 1) Livingstone Food Security Program, 2) partner in ZIHP, and 3) camp managers for Mwange and Nangweshi refugee camps. In Mwange Camp, CARE is implementing the REP (Refugee Empowerment Project) and in Nangweshi Camp CARE is implementing the WEAR Project (Western Province Assistance to Angolan Refugees). CARE recently carried out RH assessments in the Mwange and Nangweshi Camps in which they identified gaps in RH services particularly in GBV. They were recently funded to implement two new programs: HIV/AIDS in Mwange Camp and GBV (Gender-based Violence) in Mwange and Nangweshi Camps.

CARE's Work in reproductive health (RH) has been extensive. CARE has been instrumental in developing programs to address adolescents' RH needs, has provided training for a number of health practitioners in general RH, and has expanded the range of contraceptives available in a number of clinics. CARE has also successfully introduced integrated RH services into a number of clinics, making it possible for a woman to access all services related to RH in a single consultation. Through work with both men and women, RH is addressed at the community level and links are reinforced with the health facilities.

Central Board of Health (CBOH)

The CBOH launched the Prevention of Maternal Mortality Network (PMMN) in the Southern Province of the country in the Kalomo District. This project includes 14 health centers; the farthest one is a distance of 80km. There is an STI officer with the HIV Secretariat in the New Council. A GBV officer conducts sensitization workshops countrywide. When the IMF reduced civil service, the MOH offered a voluntary separation package to health staff including nurses and clinical officers. Many people newly recruited and trained took the package, leaving a reduced workforce.

Christian Outreach and Development (CORD)

CORD is a Christian relief and development agency based in the U.K, which has worked for over 30 years with children, refugees and other vulnerable people. CORD is active in a variety

of sectors: health care, water and sanitation, training for local workers, road construction, development of small businesses and rehabilitation for children with disabilities. In Zambia, CORD initiated community services in Mayukwayukwa camp in July 2002 and started providing community services and education programs in Nangweshi camp in June 2001. RH programs in both camps were started in August 2001.

Family Health Trust (FHT)

Family Health Trust (FHT) is an anti-AIDS project that operates in partnership with UNHCR. FHT conducted a “Reproductive Health and Psychosocial Life Skills Workshop” for participants (coordinators, community services officers, nurses and RH workers and implementing partner representatives) from the six refugee camps in Zambia. The objectives of the workshop were: 1) To impart knowledge and skills on HIV/AIDS to the participants; 2) To empower RH workers with knowledge in sexual reproductive health, HIV/AIDS, STDs and psychosocial life skills; 3) To enable RH workers to acquire training skills for peer education, reporting, monitoring and evaluation of peer-to-peer activities; 4) To equip participants with the means of identifying children and young people in distress and help them cope with situations; 5) To train RH workers in developing appropriate links with other institutions or person in refugee camps and settlements that may provide counseling services to refugees with HIV/AIDS; 6) To enable RH workers to acquire skills to facilitate and effectively manage programs; and 7) To provide knowledge and skills that will enable RH workers to appreciate and effectively conduct peer education activities and to monitor and assess the impact of HIV/AIDS interventions. The focus of this workshop was on life skills, some basic Safe Motherhood, HIV/AIDS and adolescents. It did not include family planning, obstetric emergencies, GBV or STIs.

Girl Guide Association of Zambia

The Girl Guide Association of Zambia, established in 1924, is a nongovernmental organization for girls and young women that is active in the nine provinces of the country. The goal of the Association is to lay the foundation for the complete development of girls’ and young women’s full potential in life skills and self-sufficiency to enable them to meet societal challenges. The Association is committed to achieving this goal through providing skills training activities and leadership development in order to increase self-esteem and allow girls and women to take equal responsibility as boys and men in society.

In Zambia, the Girl Guides are implementing a reproductive health for refugees project that aims to improve the health of adolescent girls and young women refugees through health education programs. The project builds on the Health for Adolescent Refugees Project (HARP) which was an innovative peer education and clinical services program for adolescents on Meheba camp. The project focus is on health education activities including safe motherhood practices, STI/HIV/AIDS prevention and contraception. Among the major project objectives are strengthening current health services, promoting parental RH, involving boys and non-school attending adolescents, extending the program to Mayukwayukwa camp, including STI/HIV/AIDS prevention and management for health providers.

Hodi (“Knock Knock”)

Hodi is an indigenous NGO created to enhance the capacity of community-based and intermediary organizations working in rural Zambia. Hodi was registered in 1996 and took over management of several rural development projects originally started by Harvest Help UK (HHUK). Hodi promotes the self-reliance of community groups and the sustainability of their activities. Funds are channeled to Hodi which then channels through a local community institution usually formed as a prerequisite to the start of development co-operation who then work with their own communities. As such Hodi aims to give marginalized communities control

and choice over the process of change which is confronting them. In 2000 Hodi partnered with CORD to work together in Mayukwayukwa Refugee Settlement making it the first indigenous organization to get involved in refugee work. Hodi uses its experience from other parts of the country to implement the activities in the settlement.

John Snow, Inc. (JSI)

JSI is actively involved through its support of the Girl Guides Association in Zambia and the Zambia Integrated Health Project.

Lutheran World Federation (LWF)

LWF operates in the Western, Northwestern and Eastern Provinces of Zambia. The refugee program constitutes more than half of the agency's total funding (2000). LWF is active in Meheba and Mayukwayukwa camps and is involved in health and community services. LWF augments the government program, which provides direct curative care in clinics, through providing medical supplies, monitoring nutritional status, training, educating mothers and ensuring availability of food stuffs. LWF has also recently entered Ukwimi camp where the agency's role will involve community services.

Ministry of Home Affairs

The Ministry of Home Affairs is a central point to gather information on the refugee population including health and protection issues, registration process, land distribution system and current issues or concerns of the refugee population in the camps as well as in the urban area.

Planned Parenthood Association of Zambia (PPAZ)

PPAZ is an excellent source of technical expertise for other organizations working directly with refugees as demonstrated by their range of activities. PPAZ distributes contraceptives to service delivery points such as clinics, district hospitals, grocery stores and cooperative society offices, and trains service providers. Using community-based distribution, PPAZ aims to provide reproductive health services to vulnerable groups. Activities include training a team of national trainers, conducting regional training workshops and expanding current community-based distribution services. PPAZ's family planning centers provide comprehensive health services in Lusaka through the clinic-based and outreach service approach. Activities include the strengthening of follow-up services, counseling, detection and treatment of sexually transmitted diseases, redesigning service hours to meet client preferences, training staff and volunteers in special skills, soliciting voluntary support from professional counselors and sensitizing police and health personnel in casualty departments on emergency contraception and counseling. PPAZ also uses a varied IEC component, including material on unsafe abortion and condom use.

United Nations Population Fund – Zambia (UNFPA)

Initiated in 1967, UNFPA's program in Zambia is aimed at supporting the government in implementing its National Population Policy and is guided by and promotes the principle of the Program of Action of the 1994 International Conference on Population and Development – of which the Government of Zambia is fully supportive. UNFPA's activities in Zambia include three main areas: reproductive health, population and development strategies and advocacy. In regard to reproductive health, UNFPA provides technical assistance to strengthen the quality of reproductive health service delivery at the district level; focuses on the adolescent population to prevent unwanted pregnancies and STIs, including HIV/AIDS; works with the Ministry of Education to include population issues in school curricula; and researches specific RH topics in order to improve policies, education and service delivery.

UNFPA has been working with refugees since 1999. Specific to refugee reproductive health, UNFPA provides culturally sensitive RH education and services in close cooperation with the Zambian government, other UN agencies and nongovernmental organizations. UNFPA has an active program in Meheba camp and works closely with the YMCA to assist urban refugees in three sites. The YMCA/UNFPA refugee project started in 1998 in Meheba camp. The project trains health providers on reproductive health issues, offers technical assistance to health centers, and provides contraceptives to health centers and hospitals. The project also implements information, education and communication campaigns with condom distribution through peer educators and promotes male involvement in family planning. With help from the Japanese International Cooperating Agency (JICA) the project is able to procure and distribute STD drugs. In addition, the project has introduced reproductive health clubs into the schools.

United Nations High Commissioner for Refugees – Zambia (UNHCR)

As of 2001, 51 staff maintain offices in five locations in addition to the capital: Kaoma, Kawambwa, Meheba, Mongu, Moporokoso (UNHCR 2001 Global Appeal). The regional office in Lusaka is also responsible for operations in Zimbabwe and Malawi (UNHCR 2001 Global Appeal).

United States Agency for International Development (USAID)

USAID is present in 30 of Zambia's 72 districts and provides \$30 million of assistance to the country annually with the main goal of helping Zambia to realize its development potential. Fifty percent of USAID activities in the health sector focuses on HIV/AIDS. USAID supports the consolidation of the government's reforms, focusing on four key sectors: increasing rural incomes, improving basic education, health services and democratic governance. To improve the health status of the population, USAID assists the government's health care decentralization program. Working within the system, USAID focuses on improving infant and child health (including orphans), reducing death rates, helping with family planning and controlling the spread of HIV/AIDS. Community-based education programs are stressed and a wide variety of family planning methods are promoted.

World Vision International (WVI)

World Vision has been working in Kala Camp since February 2001 and is working in the areas of community services and education. WVI is working through a number of committees, such as entertainment (sports and cultural groups), social (assisting the vulnerables), pastoral, women's affairs, agricultural, women's home economic group and tailoring groups. They are also coordinating construction of schools, etc. Within these groups they work with community health workers, peer educators and social workers. Through the tailoring group, sanitary pads are being made. HIV/AIDS is being addressed through the pastoral committee, teachers, and they are targeting youth through the schools and in forming Anti-AIDS clubs. Through the committees, people have sought assistance in domestic violence situations. Workshops on HIV/AIDS, protection issues and leadership have been conducted with various members of the camp. The social committee has paid members providing assistance to the vulnerables.

Young Men's Christian Association (YMCA) Refugee Project

The YMCA is active in every province and works to provide durable solutions to urban refugees and provide accommodation and transportation for new refugees to settlements. There are four programs funded by UNHCR. The first is focused on educational scholarships. With support from a German agency scholarships are provided to 25 persons to go to the University of Zambia. In September 2001, there were 300 students in primary, 150 in secondary and 120 in tertiary schools. Vocational skills training (e.g., auto, carpentry and computer skills) is also provided. Secondly, social services are offered to assess needs of refugees and determine the

level of vulnerability, provide opportunities, psychological counseling for trauma. Health services are another component. The YMCA runs a clinic, which is free for refugees. It provides access to basic drugs and is funded by the National YMCA and UNHCR. The local integration program has two components. An internship program allows refugee to work without pay for an employer for 6 months during which time the YMCA supports the refugee. This makes it easier for refugee to obtain job after he has proven that he can do the job. The second component involves small business grants for activities such as carpentry and dentistry, which allows refugees to integrate with other professionals. The YMCA also works with UNFPA on an RH program. For more information, see UNFPA agency description.

Zambia Integrated Health Programme (ZIHP)

A USAID-funded program that has four main implementing partners: 1) ZIHPCOMM – Communication and Community Partnership implemented by JHU/CCP with CARE, Africare and Manoff; 2) ZIHPSERV – Service Delivery and NGO Strengthening implemented by JSI with CARE, Initiatives, Manoff and the International HIV/AIDS Alliance; 3) ZIHPSYS – Policy, Planning and Systems Support implemented by Abt Associates with Pathfinder, Initiatives, AMEG and UNZA; and 4) ZIHPSOM – Social Marketing implemented by the Society for Family Health and Population Services International. The focus of this program is to develop systems at the national level while concentrating on 12 Districts with technical assistance in the following areas: communication/behavior change; community partnerships; improved health worker performance; NGO strengthening; private sector partnerships; systems support. The technical interventions are: HIV/AIDS, malaria, integrated reproductive health and child health and nutrition. One of the 12 focus Districts is Kasama, near Mwange refugee camp. ZIHPCOMM has developed a number of IEC tools, brochures and strategies that might be useful for RH work in the camps.

Zambia Red Cross Society (ZRCS)

The assessment team met with the field staff in Mporokoso to learn more about ZRCS activities. ZRCS has been providing reproductive health services in Mwange camp since its establishment in 1999. The agency provides family planning services, antenatal and postnatal care, delivery services in the community and the health facility; promotes the prevention of HIV/AIDS through their HIT (health information teams) and peer educators in the community; and carries out health education and condom distribution.

e. Focus Group Summaries

Focus group summaries and other notes are available upon request. Please contact:

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