Reproductive Health KAP Survey among Communities Affected by Conflict in Darfur

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Executive Summary

Background

The armed conflict in Darfur, which escalated in early 2003, has exploited and brutalized over two million civilian, and further immobilized an already decaying infrastructure. It has caused systematic forced migration of populations across the region estimated at 2.5 million IDPs. Large numbers of displaced women are pregnant, facing delivery under dangerous conditions; others victims of violence including rape. Furthermore, the first half of this year, was marked by continued conflict, resulted in further new displacement of about 137,000 IDPs across Darfur; the expulsion of 13 international NGOs and dissolution of 3 national NGOs. These recent developments have made the situation much more complex and have also had a major impact on humanitarian access to conflict-affected populations. Those displaced through conflict hold no lesser claim to the fundamental right to health and health information than those living in stable situations. Yet there has been strong move towards the introduction of reproductive health IEC and advocacy package in the context of conflicts. However, what methods do these target groups prefer is still based on the planners' assumptions. Therefore it worthy enough to produce an innovate communication approach that takes into account the prevailing cultural, educational and social contexts be used to inform, educate and communicate with these communities.

Aim

To help the IEC (Information Education Communication) team to define their strategy:

- On which topics to focus their activities,
- With which groups in society,
- Which attitudes could be a barrier to behaviour change, therefore needing methodologies that address attitudes,
- Through which channel each group could be addressed.
- To have a baseline to measure any increase in knowledge

Methods

This study is a descriptive exploratory study using both quantitative and qualitative methods with greater weight given to the quantitative. The qualitative method was done through rapid appraisal approach. This comprised interviews with key informants, in-depth interviews, and group discussions. Freelisting, ranking, and scenarios were used to obtain information.

Participants were purposively selected. Then quantitative method was thought to be appropriate to collect baseline data on multiple health indicators including both RH and GBV issues. These data was collected through a two-stage cluster sample approach and random selection was applied. Participants for the quantitative were solely women of reproductive age with a child five years or younger.

Key findings:

Reproductive health and GBV were important issues for IDP communities the key themes were: (a) there were clear needs in reproductive health; (b) there was a mismatch between the views of service providers and the community; (c) there was variation in the perception of need according to age and sex,; and (d) there were numerous barriers to accessing services.

The survey sample included 881 mothers. The mean age of the respondent was 28.7 years. 96.8 % of the women were ever married, the mean age of marriage was 16.2 years old and the majority (469, 53.2%) of the respondents married before the age of 18 years. The majority (59.1%) of respondents had not completed any formal education and nearly two third of the respondents, 519 (58.9%) reported that they were not engaged in any type of livelihood activity or income generating activity.

Maternal health indicators:

- The majority (62.0%) of mothers reported attending at least three antenatal care (ANC) visits during their last pregnancy and just more than half (53.2%) of women reported having received at least two doses of tetanus toxoid vaccine.
- The majority (50.3%) of women reported that they were assisted by untrained traditional birth attendants (TBAs). Moreover, significant majority (72.9%) of women reported their last delivery took place at their home.
- In addition, a greater percentage of women in the program area appeared to have sought postnatal care (PNC) with a skilled attendant in comparison to 2006 (59.5% versus 52.1%)
- Almost twenty percent (19.4%) of women were unable to name any danger signs of pregnancy related complications and nearly half (45.9%) of women could name only between one to two danger signs

Family Planning indicators:

- The majority of respondents (65.6%) could name at least one method of FP.
- 14.3% of women interviewed have ever used birth spacing.
- CPR was (77, 11.5%) and the pills was the most frequently used method (60, 77.9%); injections were the next most common method (15, 19.5%).

STIs - HIV/AIDS indicators

- Significant majority (81.6 %) of respondents had ever heard of AIDS. However, this percentage is lower among women with no formal education (67.6%).
- Nearly one third (272, 30.9%) of the respondents surveyed knew no means of HIV/AIDS transmission and just above a quarter (26.2%) could name three or more means of HIV/AIDS transmission.
- More than one third of the women (322, 36.8) knew no mean of prevention.
- Only 35.6% of the responded ever heard of STIs and only 13.7% were able to name signs or symptoms of STIs that would cause someone to seek treatment.

Gender based Violence (GBV) Indicators:

- GBV indicator seemed to be better than the RH indicators. Significant majority (84.1%) of respondents could name at least one type of GBV. The most common types named were rape, domestic violence and early marriage.
- Overwhelming majority of respondents (83.5%) could name at least one service that could be provided to rape survivors.
- The most frequent reasons cited for FGM were maintain culture and tradition (321, 36.4%), and social pressure (293, 33.3%).
- The most frequent reported types of violence as the most harm to the community were rape (381, 43.2%) and domestic violence (378, 42.9%).

Finally the main source of information reported were: from person they know (332, 36.5%), health worker at the clinic (183, 20.8%), and radio (181, 20.5%).

Implication for Policy and Practice

Based on the results of this survey, UNFPA should concentrate on the following:

- Knowledge of danger signs of pregnancy and childbirth
- Safe delivery attended by skilled personnel and delivery preparedness

- TT coverage remains a significant low
- Large gap between contraceptive knowledge and use
- Early marriage is a phenomenon that is quite embedded in the society.
- Knowledge of STIs symptoms, prevention, partner(s) notification very low

To address these issues UNFPA should support either the MOH or NNGOs to implement a family centred project utilising CHVs from the IDP communities to provide community health education at the doorstep. These workers should be supported by target print-based IEC materials to low-literate or non-literate audiences preferably pictorial and health videos to be played at the public centres such as community and women centres. Furthermore, reproductive health should be seen in a broader perspective than only from a health care provider point of view. Therefore, UNFPA should strongly advocate for the education of girls / women and support literacy classes.

Acknowledgement

I am very grateful to the UNFPA - Sudan for giving me this opportunity to conduct this survey. I wish to acknowledge people, that the work could have been difficult without their contribution:

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List of abbreviations

BCC = Behaviour Chang Communication	MOH = Ministry of Health
CBO = Community Based Organization	MVA = Manual Vacuum Aspirator
CHW = Community Health Worker	MW = Midwife
CMR = Clinical Management of Rape	NFIs = Non – Food Items
CO = Country office	NGO = Non Governmental Organization
CPR = Contraceptive Prevalence Rate	NMW = Nurse Midwife
DHP = Darfur Humanitarian Profile	NR = No Response
DK = Don't Know	PAC = Post Abortion Care
EMOC = Emergency Management of Obstetric Care	PAC = Primary Health Care/ Centre
EWARS = Early Warning Alert and Response System	PHC = Primary Health Care/ Centre
FCP = Family Centred Model	PIHD = Pregnancy Induced Hypertensive Disorders
FGD = Focus Group Discussion	PMTCT = Prevention of Mother To Child Transmission
FGM = Female Genital Mutilation	PNC : Post Natal care
FP = Family Planning	RHRC = R H Response in Conflict RI = Relief International
FSU = Field Support Unit	SGBV= Sexually Gender base Violence
GOS = Government of Sudan	SHHS = Sudan Household Health Survey
HIV/AIDs = Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrom.	SMOH = State Ministry of Health
HV = Health Visitor	STIs = Sexually Transmitted Infections
ICPD = International Conference for Population and Development	TBA= Traditional Birth Attendant
IDP = Internal Displaced People	TT = Tetanus Toxoid
IEC = Information Education & Communication	VCT = Voluntary Counselling & Testing
INAP = Inquiry Not Applicable to Participant	UNFPA = United Nations Population Fund
IP = Implementing Partner	UNOCHA= UN Office for the Coordination of Humanitarian Affairs
KAP = Knowledge Attitude and Practice	VMW= Village Midwife
MA = Medical Assistant	WFP = World Food Program

Background

Introduction

The armed conflict in Darfur, which escalated in early 2003, has exploited and brutalized over two million civilian, and further immobilized an already decaying infrastructure. It has destroyed the livelihood base and caused systematic forced migration of populations across the region estimated at 2.5 million IDPs (Darfur Humanitarian Profile #32, 1 July 2008, UN OCHA, Sudan). These large concentrations of people in IDPs camp setting have been suddenly deprived of all services; access to health care is cut off, yet needs persist, even escalated. Large numbers of displaced women are pregnant, facing delivery under dangerous conditions; others victims of violence including rape.

Current Context in Darfur

The first half of 2009 in Darfur was marked by continued conflict and population movements and the departure of thousands of aid workers following the expulsion of 13 international NGOs and dissolution of 3 national NGOs.

By mid-May, more than 137,000 people had been newly displaced across Darfur, mainly as a result of clashes among rebel groups and Government efforts to suppress them. Fighting between SLA-MM and JEM in Muhajiriya, South Darfur, led to Government efforts to regain the town, which caused thousands of civilians to flee. In El Fasher, North Darfur, Zam Zam camp population reached approximately 105,000, far exceeding its capacity. Authorities consider the newly arrived population as migrants originally from North Darfur, and have therefore denied requests for a new site. The influx has put enormous pressure on water services in the camp.

The expulsion of the NGOs initially affected approximately 1.1 million beneficiaries receiving food assistance, 1.5 million beneficiaries accessing health services, 1.16 million receiving water and sanitation support, and 670,000 beneficiaries receiving non-food items. Short-term actions were implemented to address the immediate gaps. Thanks to efforts of the Government, the UN and remaining NGOs, the gaps created in four life-saving sectors have been narrowed, but concerns remain about standards.

The expulsions have also had a major impact on humanitarian access to conflict-affected populations in remote areas. The number of national and international aid workers in the region dropped from 17,700 to 12,658; the number of expatriates now working in Darfur is the lowest since September 2004. Deep field presence has been reduced dramatically as a result, severely limiting early warning reporting, protection by presence and programme delivery.

Joint UN and GoS Assessment

Findings of a joint assessment by UN and Sudanese government officials conducted from 11 to 19 March 2009 in all three Darfur States indicated major live-saving gaps in four key sectors: Health and Nutrition, Non-Food Items (NFIs) and Emergency Shelter, Water and Sanitation, and Food Security and Livelihoods (food aid component).

Health and Nutrition Sector

The HN sector lost 16% of health delivery capacity and 30% of all therapeutic feeding capacity following the expulsion of the 16 NGOs. The joint GoS-UN assessment indicated that over 840,000 people remain without full access to health and/or nutrition services. Early Warning Alert and Response System (EWARS) and Nutrition Surveillance System (NSS) reporting systems have been disrupted due to the loss of coordination channels. In order to minimize the maternal morbidity and mortality the situation demands urgent action to fill the gaps of delivery of emergency, life-saving reproductive health services. Alternative health service provision mechanisms need to be identified for areas inaccessible to the government. These areas include Jabal Merra, Kabkabya, Kalma Camp and Muhajiriya.

Impact is high where only one agency remained, managing and delivering community-based basic health services. The overall programme management including logistics is weak. Critical monitoring and surveillance of disease undertaken by several of the suspended NGOs will not be as comprehensive which will reduce the “early warning” capacity. As a result, morbidity and mortality may increase. Cases of meningitis have already been reported in West and South Darfur.

In the immediate term, the sector is focusing on:

- Detecting and treating severe acute malnourished children;
- Re-establishing health and nutrition surveillance and early warning system and capacity to respond to epidemics and outbreaks;
- Treating selected communicable diseases, e.g. meningitis, malaria and TB;
- Ensuring access to emergency life-saving basic services; and
- Reactivating reproductive health services with priority to BEmOC and CEmOC, and MISP.

Justification

Those displaced through conflict hold no lesser claim to the fundamental right to health than those living in stable situations. The 1994 International Conference on Population and Development (ICPD) Programme of Action specifically included displaced populations in its affirmation of the link existing human rights treaty provisions and reproductive rights. Yet, the capacity of displaced people to exercise their rights is severely compromised. It is essential; therefore, that national and international policy supports equitable systems which maximize accessibility to critical reproductive health services and information to communities in crisis.

Yet there has been strong move towards the introduction of reproductive health IEC and advocacy package in the context of conflicts. However, what methods do these target groups prefer is still based on the planners' assumptions. Therefore it worthy enough to produce an innovate communication approach that takes into account the prevailing cultural, educational and social contexts be used to inform, educate and communicate with these communities to enable them acknowledge their reproductive needs and rights and to utilize the available services and make inform choices about their sexual and reproductive health.
Furthermore, there had been almost no systematic gathering of information on how beneficiaries prioritised reproductive health or on the services they wanted. Therefore, it was very important and valuable to conduct this survey to produce baseline for indicators that can be used to plan and develop beneficiaries' centred strategy and need based interventions. It would be even further justified if it is used in designing and developing of IEC and BBC interventions and materials.

Objectives:

General Objective

To develop beneficiaries' oriented strategy and needs – based interventions for UNFPA – Darfur on Advocacy/IEC/BCC Strategy, focusing on individual needs, institutional, cultures, social norms, policies and legislation

Specific objectives

1. To identify the need for reproductive health care among communities affected conflict in Darfur, and to ascertain the priority given by the community to reproductive health issues.

2. To determine the level of knowledge, practice, attitude, source of the information and factors influencing the existing behaviour of RH/GBV issues among the study population.

3. To explore the policies, legislation, current interventions and the different stakeholders views to address the issues.

4. To analyse the potential changes in UNFPA strategy and interventions including the messages, materials, potential partners and the channels for messages to address the different target groups.

Study Methodology

Study design

This baseline survey is a descriptive exploratory – cross sectional study, utilizing both quantitative and qualitative methods by using the rapid appraisal approach.

Setting

Communities affected by conflict in the three states of Darfur, and who settled in Internally Displaced People (IDP) camps.

Sampling

In this study there were two different types of sampling for each method: qualitative and quantitative sampling.

Qualitative Sampling (non – probability sampling):

Sampling in qualitative research is unlike in the quantitative research (probability sampling), where samples are chosen randomly. Samples in the qualitative research are purposely chosen, base on the research topic; so called non- probability sampling: "units are deliberately selected to reflect particular features of groups within the sampled population" (Ritchie and Lewis, 2003: 78). The type of sampling used in the qualitative portion of this study was the criterion- based or purposive sampling. Based on the complexity of the research topic we deliberately selected respondent on the basis of features and characters that enable a detailed understanding of the topic. Wide range of study population with different level of knowledge about RH, different sexes, ages, social status and tribes was selected to satisfy the topic.

Quantitative Sampling **(probability Sampling):**

Sample Size

The objectives of this section of the study were to collect baseline data on multiple health indicators including both RH and GBV issues. These data was collected through a two-stage cluster sample approach. Since statistical precision increases as prevalence estimates

approach 50%, rather than using prevalence rates for proxy indicators within each health topic, prevalence rates utilized for this survey were assumed to be approximately 50%. In addition, sample size calculations used the following assumptions: 1) the limit of statistical significance (*alpha*) is 0.05, and 2) the power (*beta*) equals 0.80. Because the survey utilized a two-stage cluster sample design methodology, the sample size was multiplied by a factor of 2 to allow for design effect[1]. This sampling estimate was increased by 15% to allow for non-response bias, and to account for possible missing or "dirty" data. Based on these calculations, the number of clusters targeted was 30 with 30 households in each cluster.

Selection of Primary Sampling Unit (clusters)

Primary sampling units (clusters) were drawn from all IDP camps in all the three Darfur states. The list of conflict affected persons together with the sites was generated using the 2008 World Food Program (WFP) population registration as calculated for the general food distribution program.

Insecurity and logistical access to locations throughout Darfur is fluid and unpredictable. Since it is important to gather information on all of the communities, no areas was excluded from the original sampling frame. However, during data collection, two four clusters became inaccessible and additional clusters were chosen randomly to replace them (Table 1).

The allocation of clusters per site was based on population-proportionate to size sampling methodology. Once the number of clusters was allocated to each area, the actual location of the clusters in each area was based on random sampling. While many camps have been in existence since 2004 and have divided either naturally or by camp management into sub-sections, existing maps with population data per section are either unavailable or unreliable. As a result, the location of the clusters per camp could not be based on population-proportionate to size methodology and was instead based on assigning numbers to each sub-section and choosing sections

[1] The minimum sample size of households to be surveyed was determined using the following formula: $N = PQ/(E/1.96)^2$ where: N = Minimum sample size, P = Maximum expected prevalence (.5), Q = 1 – P, E = Error tolerated (20 %), 1.96 = Constant for 5 % probability level.

Table 1: Areas and Allocation of Cluster

Location	Total population	Initial no. of Clusters	Final no. of Clusters
Aboshok	**54,141**	**2**	**3**
Al Riad	**20,709**	**1**	**1**
Al Salam – El Fashir	**48,788**	**2**	**2**
Al Salam - Nyala	**60,607**	**2**	**2**
Ardamata	**27,340**	**2**	**2**
Beleil	**25,987**	**1**	**1**
Dreij	**25,699**	**1**	**1**
Hamedia	**42,471**	**2**	**1**
Hesahesa	**39,795**	**1**	**2**
Kalma	**88,036**	**3**	**3**
Krinding	**23,091**	**2**	**2**
Mornei	**73,350**	**2**	**2**
Mosey	**03,273**	**1**	**1**
Otach	**70,272**	**2**	**2**
Sakali	**08,190**	**1**	**1**
Shanglitobaya	**39,150**	**1**	**1**
Tawila	**53,244**	**2**	**1**
Zamzam	**59,060**	**2**	**2**
TOTAL	**736230**	**30**	**30**

Selection of Basic Sampling Unit (Household)

A household was those sleeping within the same compound as delineated by wooden fencing or brick walls. The target population to be interviewed was mothers of reproductive age with at least one child between 0 and 60 months of age.

Once the cluster location was identified, the data collection team met with community leaders (sheikhs) to estimate the number of households in that cluster. The cluster was then divided into portions (with a minimum of 100 and a maximum of 300 households) and one was selected randomly to be surveyed. The number of households in the division was divided by 30 to provide a sampling interval. With the help of the sheikh, the team identified the central point of the division and spun a pen to determine the direction of the starting point. The first

house was randomly selected by the team with the second selected after counting the sampling interval number.

After selecting a household, the interviewer ascertained whether a women of reproductive age with a child five years or younger lived in the house and was available to be interviewed. If no one found, the interviewer continued to the next house on the right until an eligible mother is identified; due to time and logistical constraints the team did not attempt to locate the mother or revisit the originally selected household, rather the interviewer moved on immediately. After obtaining initial verbal consent, the team will mark the household with a white strip of cloth.

Training and data collection tools:

A standardized administered questionnaire:

Structured questionnaire was developed for data collection from the women. The questionnaire was preceded by the consent and covered the following:

- **Part 1: Demographics**: 1.Following consent, interviewers asked a series of demographic questions including education status, livelihood activities and household configuration.
- **Part 2: RH knowledge**, **Attitudes and Practice**: The second section pertained to reproductive health questions, specifically maternal health, family planning, and STI - HIV/AIDS with separate section for each.

RH knowledge attitude will be assessed based on the woman's last live-birth

- **Part 3: GBV:** This section was solely GBV questions

Picture 1 interviewer conducting interview using structured questionnaire

Interviews

Key informant interviews and in-depth interviews were carried for all the research groups. It is face to face interview using topic guidelines for asking open ended questions, prompting and probing so as to get full understanding about the research topic and to obtain in-depth and contextual information about the respondents' experiences, beliefs, and perceptions. (See annexes 4 and 6).

Picture 2: Key informant interview with health manager

Picture 3: Key informant interview with health provider

Focus Group Discussion:

To achieve further depth about the community perception Focus Group Discussions were conducted with all demographic groups of the study IDP community. FGD is not group interview, whereby participants individually respond to series of questions, rather it is interactive and dynamic group discussion to achieve further depth in the social views and attitudes. The topic guidelines were iterative open to accommodate new emerging themes (see appendix 5 for FGD topic guideline).

Picture 4: FGD with men

Picture 5: FGD with women

Selection of the techniques: Ranking, freelisting, and scenarios

Several techniques were used in the discussions and interviews. The first of these was free listing, whereby respondents were asked to develop lists of illnesses, healthcare resources, or community priorities. Their main advantage was that they gave an idea of the degree of general awareness of a problem. Freelisting was used in all interviews and group discussions. The second technique was matrix ranking, whereby problems or illnesses were ranked according to several different criteria. This provided information about the priority the community gives to one problem over another. Common diseases identified by the community were ranked alongside problems in reproductive health inserted into the list by the consultant. Each problem was ranked according to (*a*) prevalence, (*b*) impact on the duration of sickness, (*c*) impact on mortality, and (*d*) the availability of treatment. To include illiterate people each disease was represented by a drawing on a card, with the name written below in Arabic. The third technique was the use of scenarios, whereby hypothetical stories of an event were presented to the group or individual who are then asked to state what the outcome would be if that problem occurred in their own community. This method was particularly useful in discussing sensitive issues, as the discussion was not based on the experience of any person present. It was used in the group discussions and in-depth interview

Selection and training of the interviewers:

22 interviewers with health background and adequate experience in interviewing and data collection techniques were recruited. All interviewers were women recruited from the survey location (IDP camps surveyed). All interviewers were fluent in at least one of tribal languages spoken by the predominant tribal groups (Masalit Zagawa and Fur). The interviewers were thoroughly trained for two days by the consultant; proper training and the experience of the survey assistants was considered as very essential to the success of the study. The training was focused on:

- The study objectives.
- Confidentiality protocols
- Interviewing techniques and methodology.
- Communication skills.
- The survey instruments to ensure the interviewers are comfortable with them
- Field work activities.
- Data cleaning and editing.
- Informed consent.

The training also contained role plays. Furthermore, on the second day of training interviewers were brought to areas of the camps not selected for data collection to complete at least one questionnaire. The completed questionnaires were then checked by the consultant to address any needs for continued education. Interviewers received compensation for their participation in the survey.

Picture 6: Training of the interviewers

Pre-testing of the data collection instruments:

The instruments were reviewed by the Emergency Coordinator and the technical taskforce in UNFPA Humanitarian Response Unit in order to ensure the content validity. They updated terms, clarified confusing items, and commented on the apparent validity of each item. They were reviewed again by the consultant. Furthermore, the instruments were pre-tested in the field before being used for data collection. The respondent for the testing were from locations other than those included in the sample, but similar context. After pre-testing, necessary modifications and corrections were made.

Selection of Methods:

In emergencies needs are most often assessed using rapid assessment procedures. These do not routinely include contributions from the community. This contrasts with the techniques of rapid appraisal, which have been used in many different contexts to assess health needs in primary care. The original objectives of this survey were to provide good quality and timely information, and to include local people, producing results that would lead directly to interventions. For this study several methods were selected in order to deliver results in a short time frame, to address sensitive topics, and to be flexible enough to be used in a conflict zone. Detailed methodology per objective is discussed below:

1. ***Objective 1: To identify the need for reproductive health care among a community affected by conflict, and to ascertain the priority given by the community to reproductive health issues***.

Qualitative method through the *rapid appraisal* approach as the first step to involving communities in assessing needs and planning service provision; was thought to be appropriate for this objective. This comprised:

a. Interviews with key informants: three types of key informants were selected:

Administrators, health workers, community leaders and other authorities were interviewed using non-structured questionnaire (Annex 6). The sampling strategy for theses interviews was criterion- based purposive sampling and the sample size till the saturation point is reached

b. Focus Group Discussions.

Group discussions were conducted with all the population groups, using topic guide (see annex 5). It was chosen to generate ideas and provide information about social views, attitudes and knowledge of RH and GBV. Camps leaders were informed of the study the day before, and volunteers were then assembled on the day the discussions took place.

c. Secondary data

Secondary data from analysis of routinely collected RH information was collated which acted as mechanism to enhance the validity through triangulation with data from FGDs and the interviews.

2. ***Objective 2: To determine the level of knowledge, practice, attitude, source of the information and factors influencing the existing behaviour of RH/GBV issues among the study population***

Quantitative method by using structured questionnaire was thought to be appropriate for this objective. Sampling techniques and sample size for this objective is discussed above. Participants for this objective were solely women of reproductive age with a child five years or younger as they were most likely to face problems in reproductive health and the primary target for the awareness program.

3. ***Objective 3: To explore the policies, legislation, current interventions and the different stakeholders views to address the issues.***

Key informant interview for health manager and program designers from MOH, UNFPA, and its partners coupled with desk review of the materials and project documents was thought to be appropriate for this objective

4. ***Objective 4: To analyse the potential changes in UNFPA strategy and interventions including the messages, materials, potential partners and the channels for messages to address the different target groups.***

The findings of objective 1 (the RH/GBV need and priority ascertained by the community); and objective 2 & 3 (the level of knowledge, attitude and practise; current intervention, policy and legislation) was analysed. The results of this analysis will determine the modification or the potential change in the strategy and the program design, further it draws the future direction and the recommendation.

Community Approval and Consent

The final questionnaire was presented to the State Ministry of Health and the Humanitarian Aid Commission in the three Darfur states for approval by the Government of Sudan. The questionnaire and survey plan were also presented to sheikhs in each survey location for community approval. The survey team assured the community leaders that neither refusal to participate nor respondents' answers would adversely affect UNFPA's services in the location. Once sheikhs agreed to participate, the consultant asked these leaders to inform their communities of the upcoming survey.

Prior to being selected, the interviewer provided household members with a verbal explanation of the survey, its goals and the nature of the questions. Households were chosen only if its members consented to the survey. Verbal consent from the interviewee was obtained and recorded by the interviewer. Households were informed that their responses were confidential and that their answers would not affect services offered to them.

Analysis

Qualitative data analysis:

The qualitative data was collected in a form of recording, transcripts and field notes. Hence data was analysed using the framework approach manually. Analysis of the survey qualitative data started from the day of the data collection and it was an ongoing process. Then the ranking and listing was summarised, tabulated and analysed manually.

Quantitative data entry and analysis:

Data entry was conducted in Khartoum, Sudan from May/June 2009. Data entry was completed using ***EPI INFO, Version 3.3.2, Statcalc package***. All data cleaning and analysis was conducted using the same computerized statistical package ***EPI INFO, Version 3.3.2, Statcalc package*** software.

Quality Assurance

The quality of the data was assured by the following measures:

- Triangulation: information was deliberately sought from different sources and methods to enable comparison of information.

- The consultant has extensive experience in qualitative and quantitative research methods as well as RH, HIV/AIDS and GBV. The consultant also does speak the local language. The consultant was flexible in conducting the interview so as to probe and prompt further as themes and issues raised. Building trust and rapport at the beginning of the interview and ensuring confidentiality was always preserved.

- The protocol was presented to the Emergency Coordinator and some experts in the CO. This gave them the opportunity to make contributions from their experiences to refine the topic guidelines, check lists and the questionnaire to ensure data quality. In addition, there was regular review of the guidelines based on the emerging themes as the study proceeded.

- Data was collected and maintained in meticulous records. With the permission of each respondent, interviews and FGDs were taped and logbook with information about

impressions and decisions was always kept with the consultants. Moreover, all the process of the analysis was documented in detail.

- Validation strategies were used as participants were checked during the interview to confirm that what the data captured was a correct presentation of what they had said or reasonable accounts of their experiences as expressed during the interviews.
- Preliminary findings were presented in a seminar to the CO. The presentation was followed by questions and answers, comments and further recommendation which helped much in further validation and confirmation of the findings and the analysis.

Ethical Consideration

Protection of the Respondents

Reproductive Health issues are very sensitive, so the interviews with the women might have touch such sensitive issues; this could have been distressful and might caused discomfort. Also women who have lost babies in childbirth they might find too distressing to discuss. These concerns were fully recognized by the consultant and all effort was done to minimise these effects

The training have put much emphasis on issues of being sensitive in the questioning process and should be frame and asked within acceptable cultural values and norms and free from judgemental phrasing.

The participants were advised that they can withdraw from the interview process at any time without any negative consequences.

The survey made sure that the respondent had fully understood the background and the objective of the research before starting the discussion.

Confidentiality and privacy

The training put much emphasis on issues of the confidentiality for participant and within the survey team. Confidentiality and privacy was assured in all the interviews. Efforts were exerted to identify places for the interviews which ensured privacy, participant choice and no interruption.

Anonymity was maintained throughout this survey from the data collection up to the write-up of the dissertation

All data collected: tapes, transcript, field notes was kept in a secure place and under lock and key in the care of the consultant. All data including the electronic copies of the data was stored in secured (locked) location during the field work. The tapes were destroyed after the survey. All other unwanted data was destroyed

Interviews were conducted in a private and suited the participant convenience and ensure confidentiality.

Public and local services

The study did not pose any adverse effects on the public and did not place any demand on the local health services

Consent

Interview or the FGD did start only after obtaining consent from the participants. Individual consent was culturally acceptable and appropriate within the local context of this study area and verbal consent was also appropriate for those who cannot read

Dissemination of the reports and the findings

At the end of the study the consultant did present the preliminary findings to the Emergency Coordinator who had planned formally with the advocacy officer the dissemination process and the audience. They did consider which groups and individuals can act on the findings of the report; he may produce summaries for health care planners, policy-makers and health care workers.

Results

The findings are organised in three sections, reflecting the study objectives. The first section is about the need for RH/GBV care among communities affected by conflict in Darfur and ascertains the priority given by these communities to RH/GBV issues. Section two is focusing on RH/GBV indicators to determine the level of knowledge, practice, attitude, source of the information and factors influencing the existing behaviour. The last section is exploring the policies, legislation, current interventions and the different stakeholders' views to address the issues.

Section 1: RH/GBV Care and the Priority Issues

Within seven weeks 21 interviews with key informants, and 17 group discussions were undertaken (table 1). The group discussions had an average of 15 people, with a minimum of eleven and a maximum of 22. Groups were made up of people of the same sex and a similar age (with the exception of one mixed sex group). All tribes in the area were represented, and two group discussions were held with community leader. The key informants included 9 health providers, 9 local leaders, three representatives from non-governmental organisations.

Table 2: Demographic data of both groups and individual interviewed

	Key informant interviews (n=21)	Focus Group discussion (n= 17)
Type of community	Displaced communities (15) Host communities (6)	Displaced communities (14) Host communities (3)
sex	Male respondents (13); female respondents (8)	Male groups (6); female groups (10); mixed groups (1)
Age	Predominantly middle aged (about 35-45 years)	Groups of young people (4) (about 13-20 years); groups of middle aged people (9) (about 21-39 years); groups of older people (4) (40 years and older)

The FGDs and the interviews emerged four main themes: (a) there were clear needs in reproductive health and gender based violence; (b) there was a mismatch between the views of service providers and the community; (c) there was variation in the perception of need according to age and sex,; and (d) the lack of supplies coupled with numerous barriers to accessing services.

Clear needs in Reproductive Health:

Childbirth and problem during labour was the most commonly mentioned problem in reproductive health. Perceived prevalence of this problem was very high. Of 21 key informants who ranked diseases in their community in order of prevalence, thirteen placed childbirth and labour problems in the top five. Miscarriages were the most commonly mentioned problems in reproductive health after childbirth problems. In FGDs men and women of all ages were concerned about miscarriage, child birth and problems during labour and their consequences. Another problem that perceived prevalence was also high, particularly among health providers is of sexual transmitted infections.

"Sexual transmitted infections are very common here" (Interview: key informant; health provider).

Furthermore, data from the health service confirmed the perceived high prevalence of sexually transmitted diseases. The matrix ranking exercise undertaken by some of the groups also showed much concern about these problems (table 2).

Table 3: Ranking of condition according to studied communities' prioritisation

List of health problems	Frequency or Prevalence	Severity[2]	People's concern[3]	Lack of treatment
HIV/AIDS	10th	3rd	1st	1st
Childbirth	4th	5th	9th	3rd
Cough	3rd	9th	8th	10th
Diarrhoea	2nd	4th	7th	9th
Hernia	9th	7th	5th	4th
Infertility	8th	10th	3rd	2nd
Malaria	1st	1st	10th	8th
Miscarriage	5th	2nd	6th	6th
Skin diseases	7th	8th	4th	5th
STIs	6th	6th	2nd	7th

A rank of 1st suggests that the disease is a high burden, occurs often, results in many days of sickness or death, or has little treatment available within the community concerned.

[2] Severity in terms of case fatality rate (how many people die from the disease? Or in term of percentage of people disable as the result of the disease and duration of sickness.

[3] People's concern: in term of social stigma attached to the disease and in terms of fear.

Clear needs in Health and Gender Based Violence:

The most consistent Gender Based Violence identified, often spontaneously, was that of the sexual violence (rape). Perceived prevalence of this problem was very high. Some key informants thought that the incidence was falling, but the majority of respondents in interviews and FGDs disagreed. Almost all men and women were prepared to discuss this issue; during the discussion those at risk [of rape] were identified:

Inconsistency between the views of service providers and those of the community

Some providers of health services stated that abortions were not taking place, but discussions with local people revealed that abortion was an issue. The following methods of abortion were described in response to a scenario and key informant interview:

"Sometimes girls put some plants inside them 90% of the girls who do this will die. They also put it in water and drink." (Group discussion; young girls.)

"Some people don't want to be pregnant, they take herbs and chloroquine injections by breaking the glass and drinking it. They also take Zahar [a washing blue dye]…people die because of this." (Key informant; community leader.)

Similarly, some service providers thought that domestic violence was not occurring.
"Violence against women is not occurring in Darfur as women are treasured." (Key informant; health service provider.)
Group discussions with men and women, as well as interviews, showed that this was not true; summaries of their responses are given below:

"*No stranger has been violent to me, but at home this violence is normal*." (FGD; displaced woman.)
Responses to scenarios provided information on the context of the violence:
"The reasons for beating are mismanagement of funds, misconduct, improper way of receiving visitors, infidelity, abuse of her husband or his relatives (FGD; displaced women)
"…. Some husbands are always drunk and don't provide for their wife or children . . . when the wife asks him he just starts beating the wife." (FGD; displaced women)

" the main reason for domestic violence is that most men here (at the camp) do not have money and needs are there, then women continue to ask them; that is how it start….. "
Perceptions of the prevalence of problems occurring in labour also varied. Some service providers thought that "not many women die in childbirth," or said

"I don't think the problems are too bad."
However, there was a recognition, that it was difficult for them to obtain accurate information.
"I don't think too many women are dying, but if a women dies in the village she will be buried, and there is no way of knowing." (Key informant interview; health service provider.)

In group discussions maternal mortality and morbidity were perceived to be high.
"*Yes, yes, yes, we know of many women who die in childbirth. We know of about eight in the last year."* (Group discussion; displaced women.)

Differences in perceived need according to age and sex

Different age and sex groups within the communities held different views. Older men were least likely to think miscarriage and STI were common problems, ranking them last. Young women, however, ranked them third and sixth. Men thought that the extent of maternal mortality and morbidity was not great among their community.

"Some women die but it is not that common." (Group discussion; displaced men.)

Women, however, thought that many women were dying and others suffering complications after birth.

"*Many women die in childbirth. Seven to eight last year. Also there are cases of the child dying inside the mother. This problem was there before but has now increased*." (Group discussion; displaced women.).

Numerous barriers to accessing services

Communities complained about a lack of medical supplies, which largely attributed to the recent expulsion of 13 NGOs. When asked about general threats, people were most likely to mention health, complaining about "continuous death" and "lack of medicines."

"Sometimes people go to the hospital for treatment but the medicine will not be there until you die."(Group discussion; displaced men, and a health provider agreed.)

Reported barriers to accessing services together with summaries of responses were:

difficulties in obtaining transport;

"*We used to have ambulances from the organisations here now no transport to carry sick women*" (key informant interview, community leader)

a reluctance to admit to sexually transmitted infections; traditional

"In most cases women are shy [to go for treatment for sexually transmitted diseases] and don't go to the hospital unless the man also gets the disease. She will just stay with it." (Group discussion; displaced men.)

beliefs; and conflicting demands on women. The following information was given in response to a scenario.

"We as displaced people we do not have money, before we did not pay at the hospital, but now days you must pay for everything; therefore we don't go" (Key informant, community leader)

" It is much better for us to stay at home than going to angry nurse and give you the wrong drug" (FGD, displaced women)

Section 2: RH/GBV indicators of knowledge, practice and attitude

Description of the Survey Sample

Households:

The survey sample included 881 mothers. Mothers reported having between one and fourteen children with the mean being 4.54. The population sampled is the displaced communities in Darfur as demonstrated in table 4. The recent displacement is represented only 7.4% of mothers in our survey who reported having lived in the camp or area for one year less. In particular, areas with the highest percentage of new arrivals are those living closest to the hot areas, where fighting is still going on. The formal IDP camps surveyed such as Aboshok, Kalma and Krinding, have the highest percentage of people reporting residence between one and five years. At the same time, the areas representing informal camps or villages to which IDPs fled have the highest number of host residents, described by a time in the area of more than 6 years (pre-conflict).

Individuals

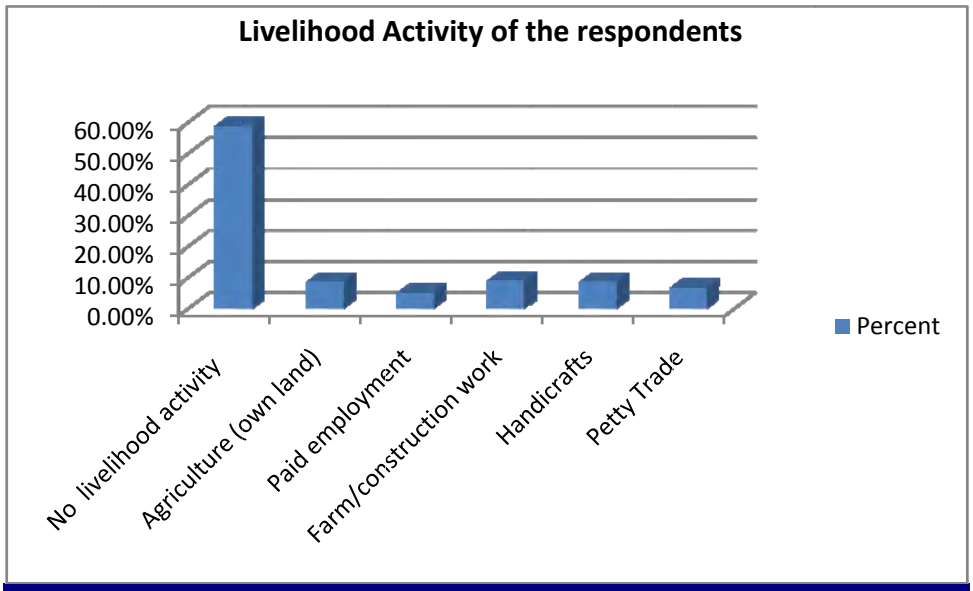
The mean age of the respondent was 28.7 years, and half of the respondents were between 25 and 34 years old (50.2%). 74.0% % of the women were married, 12.8% were either separated or divorced and 10% widowed; among them, the mean age of marriage was 16.2 years old and the majority (469, 53.2%) of the respondents married before the age of 18 years. Then 3.2% of respondent are single or never married. Finally the majority (59.1%) of respondents had not completed any formal education (table 3 summarises the demographic information by individual).

Table 4: Demographic Information by Individual (n=881)

Age	Frequency	Percent
14 to 24	261	29.6%
25 to 34	442	50.2%
35 to 45	178	20.2%
Marital status	**Frequency**	**Percent**
Married	651	74.0%
Divorced or Separated	113	12.8%
Widowed	88	10.0%
Single/ never married	29	3.2%
Schooling	**Frequency**	**Percent**
No formal education	4520	59.1%
Up to 2 years of schooling	81	9.2%
2 - 4 years of schooling	113	12.8%
4 - 6 y of schooling	2	0.2%
6 - 8 y of schooling	84	9.5%
Age at marriage	**Frequency**	**Percent**
Less than 18	469	53.2%
18 to 25	315	35.8%
26 to 35	32	3.6%
DK	36	4.1%
INAP	29	3.3 %

The majority of the respondents, 519 (58.9%) reported that they were not engaged in any type of livelihood activity or income generating activity, while about two fifth were involved engaged in at least one livelihood activity. Figures 2 detail these activities.

Figure 1: Livelihood Activity of the respondents

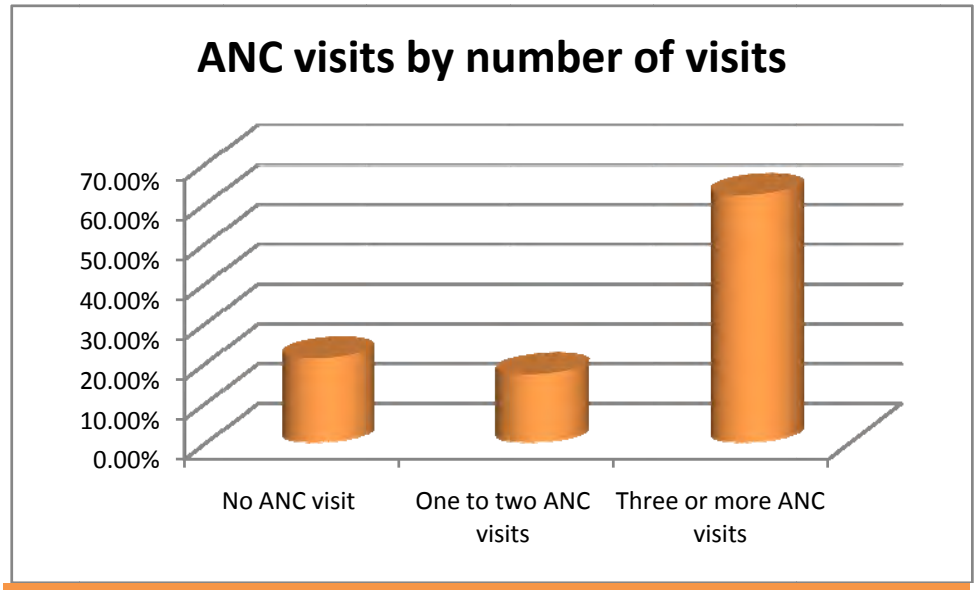


Livelihood Activity	Frequency	Percent	
No livelihood activity	519	58.9%	
Agriculture (own land)	77	8.7%	
Paid employment	45	5.1%	
Farm/construction work	79	9.0%	
Handicrafts	76	8.6%	
Petty Trade	60	6.8%	
Other	25	2.8%	
Total	881	100.0%	

Maternal Health Indicators

Access and utilization of antenatal care services (ANC) were explored using respondents' last live birth as the reference. . The majority (62.0%) of women attended at least three ANC visits during their last pregnancy. However, more than twenty percent (21.0%) of women sought no antenatal care; results are depicted in figure 2. It is also important to note that the women's educational level seems to influence the proportion of pregnant women receiving ANC, as adj OR [95% CI] for schooling mother is 4.83 [2.21 Ð 10.33]. These results reflect 2006 SHS statistics very closely. The 2006 SHS report noted that the percentage of women who received no ANC was only 13% in the case of women with secondary or higher education compared to 33.7 %for women with no education (SHHS, 2006).

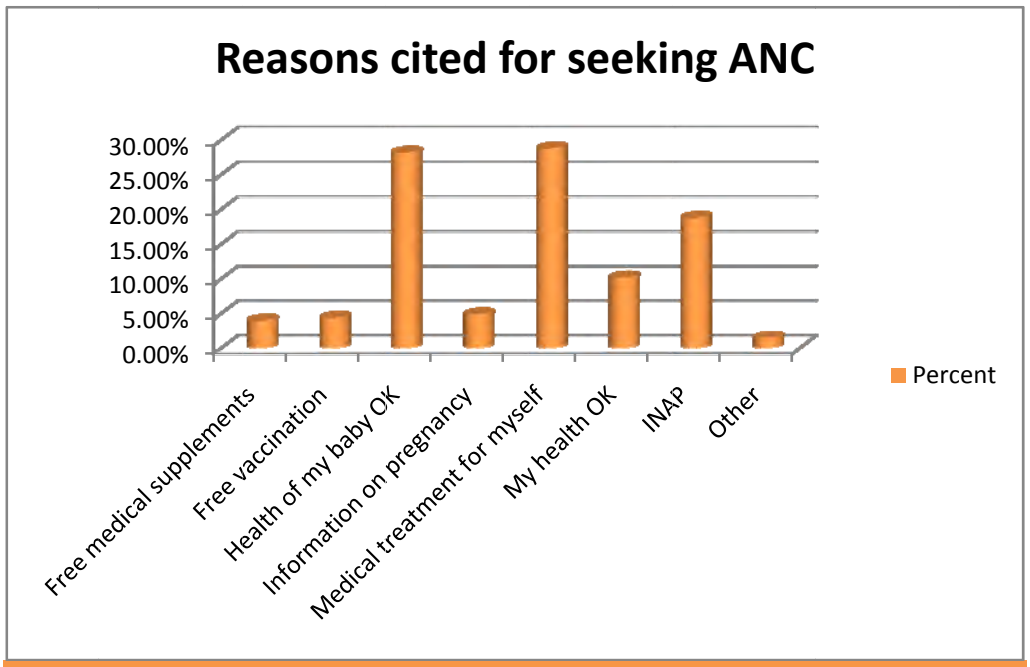
Figure 2: ANC visits coverage by number of visits



Number of ANC visits	Frequency	Percentage
No ANC visit	**177**	**21.0%**
One to two ANC visits	**143**	**17.0%**
Three or more ANC visits	**561**	**62.0%**

Reasons cited for going to ANC detail in figure3. However, it is important to note that only 4.8% of respondents thought ANC to earn knowledge on pregnancy.

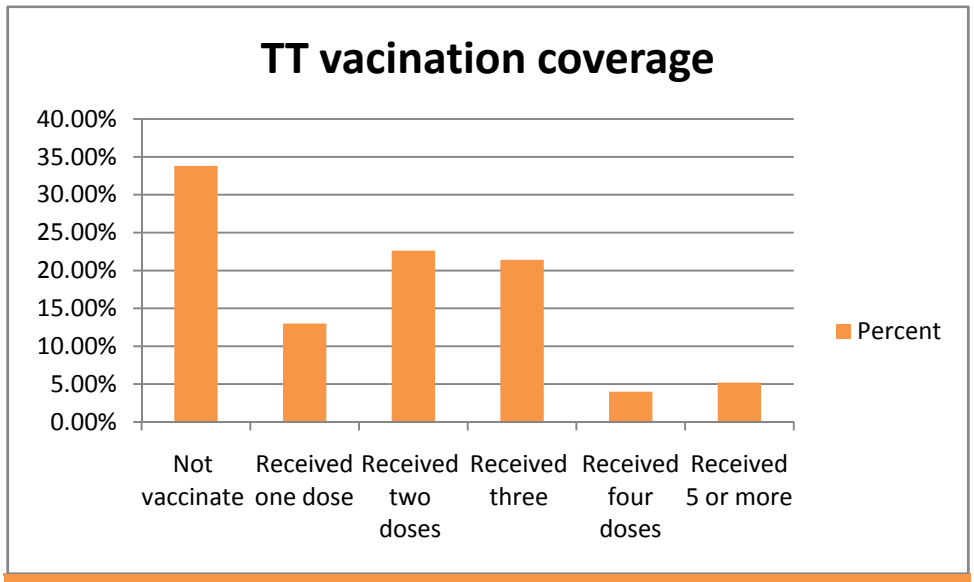
Figure 3: reasons cited for seeking ANC



Reason for going to ANC	Frequency	Percent
Free medical supplements	34	3.9%
Free vaccination	38	4.3%
Health of my baby OK	248	28.1%
Information on pregnancy	42	4.8%
Medical treatment for myself	253	28.7%
My health OK	89	10.1%
INAP	165	18.7%
Other	12	1.4%

A woman is considered fully vaccinated against tetanus toxoid (TT) once she receives at least two doses of the vaccine. The results indicate that just more than half (53.2%) of women received at least two doses of TT vaccine during their most recent pregnancy. It is also important to note that about one third of the respondents received no TT vaccine.

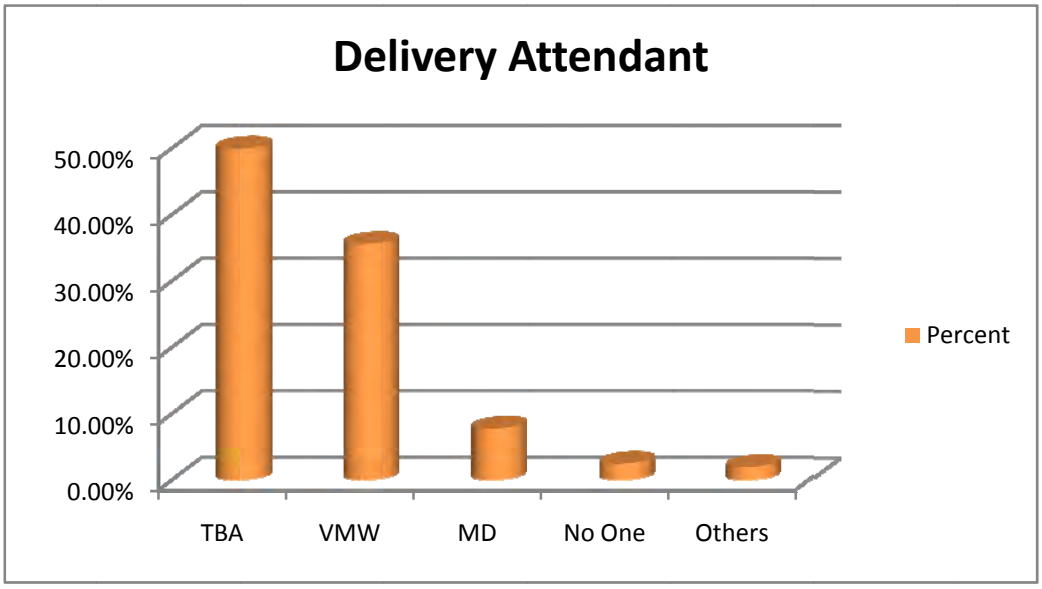
Figure 4: Tetanus Toxoid Vaccination Coverage



Number TT received	Frequency	Percent	Cum Percent
Not vaccinate	297	33.8%	33.8%
Received one dose	114	13.0%	46.8%
Received two doses	199	22.6%	69.4%
Received three	188	21.4%	90.8%
Received four doses	35	4.0%	94.8%
Received 5 or more	46	5.2%	99.2%
Total	879	100.0%	100.0%

Capturing statistics on maternal death was outside the scope of this survey. However, figure 5 reflects delivery practices and indicators for the population which are used as proxies to estimate the risk for maternal death in the population. Thus, it is very important to note that, when women asked who assisted them in their last delivery; the majority (50.3%) of women reported they were assisted by untrained traditional birth attendants (TBAs). And about one third (35.2) of women reported that a village midwife was present. Village midwives are an essential part of obstetric services. These women receive approximately nine months of education and are considered part of the trained health cadre.

Figure 5: Delivery Attendant/s



Delivery attendant	Frequency	Percent	Cum Percent
TBA	439	49.9%	64.5%
VMW	312	35.5%	100.0%
MD	68	7.7%	10.3%
No One	21	2.4%	12.7%
Others	17	1.9%	14.7%
Total	880	100.0%	100.0%

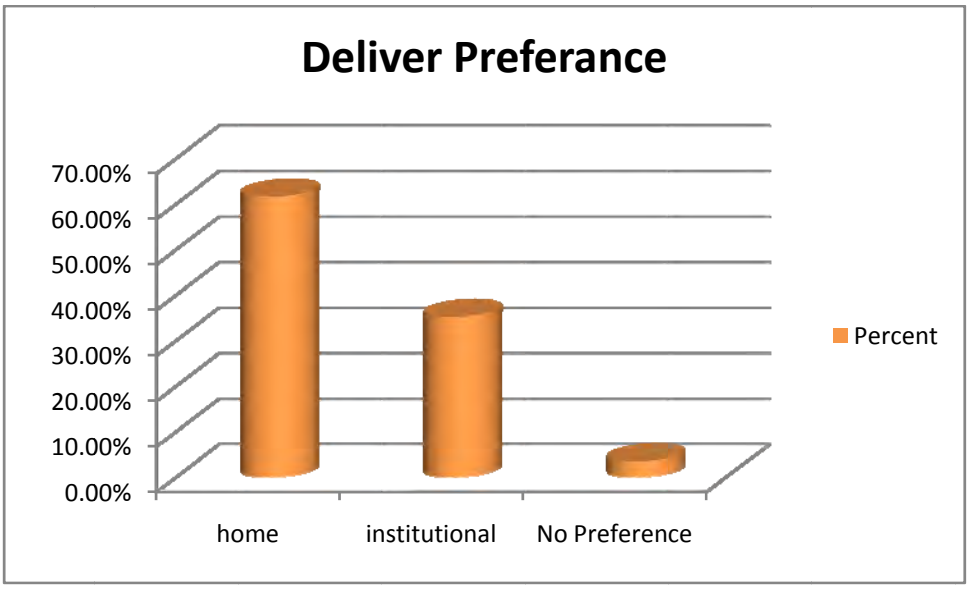
As shown in figure 6 overwhelming majority (72.9%) of women reported their last delivery took place at their home. When further broken down, one finds that about two thirds (67.4%), of these deliveries were attended by TBAs.

Figure 6: Place of deliver

home	**642**	**72.9%**	
institutional	222	26%	
Others	8	1.1%	

When asked where they prefer to deliver, the majority of women reported that they prefer delivery at home; while just one third reported institutional delivery (figure 7)

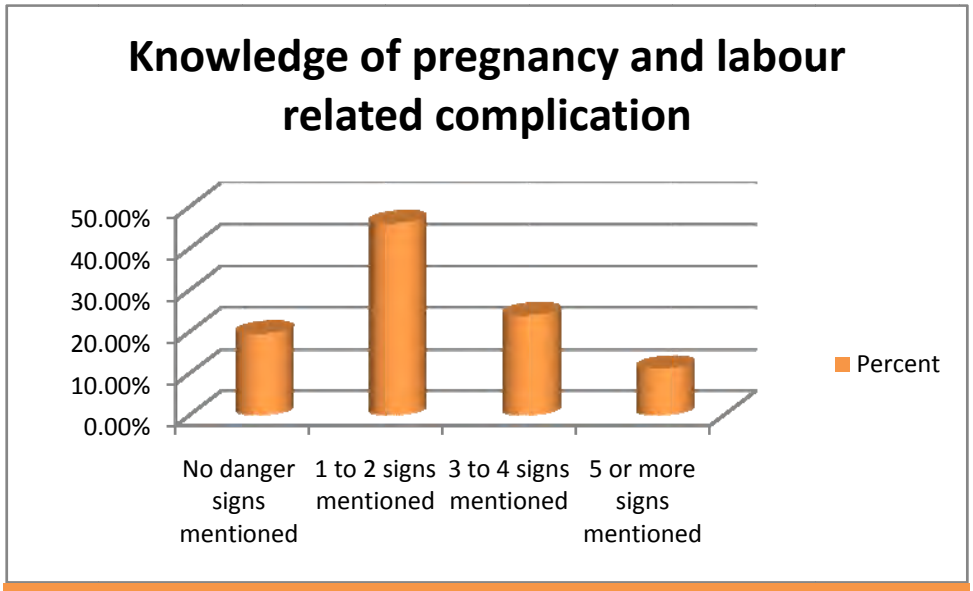
Figure 7: Delivery Preference



Delivery preference	Frequency	Percent
home	541	61.5%
institutional	309	35.1%
No Preference	31	3.4%
Total	880	100.0%

Given that the majority of deliveries happen at home and the high percentage of these attended by unskilled personnel, it is important that women know the signs of complications associated with pregnancy and delivery to increase the likelihood of seeking a trained assistance should complications arise. To assess this knowledge, women were asked to list (without prompting) any pregnancy-related complications of which they were aware. Results are depicted in Table 8

Figure 8: knowledge of pregnancy and child birth-related complications



Danger signs mentioned	Frequency	Percent
No danger signs mentioned	171	19.4%
1 to 2 signs mentioned	404	45.9%
3 to 4 signs mentioned	209	23.8%
5 or more signs mentioned	97	11.0%
Total	880	100.0%

Almost twenty percent (19.4%) of women were unable to name any danger signs of pregnancy related complications and nearly half (45.9%) of women could name only between one to two danger signs. The most frequently mentioned complications were vaginal bleeding (338, 38.4%), excessive vomiting (287, 32.6%), fever (284, 32.2%), Dizziness (239, 27.1%), weakness (208, 23.6%), abdominal pain (191, 21.7%), and loss of foetal motility (176, 20%) (Table 5).

Table 5: Knowledge of danger signs by type

Danger sign	Frequency	Percentage
Vaginal Bleeding	338	**38.4%**
Excessive vomiting	287	**32.6%**
Fever	284	**32.2%**
Dizziness	239	**27.1%**
Weakness	208	**23.6%**
Abdominal pain	191	**21.7%**
Loss of Foetal Mobility	176	**20.0%**
Long or delayed delivery	102	**11.6**
Vaginal Discharge	99	**11.2%**
Convulsion	95	**10.8%**
S.O. B	**84**	**9.5%**

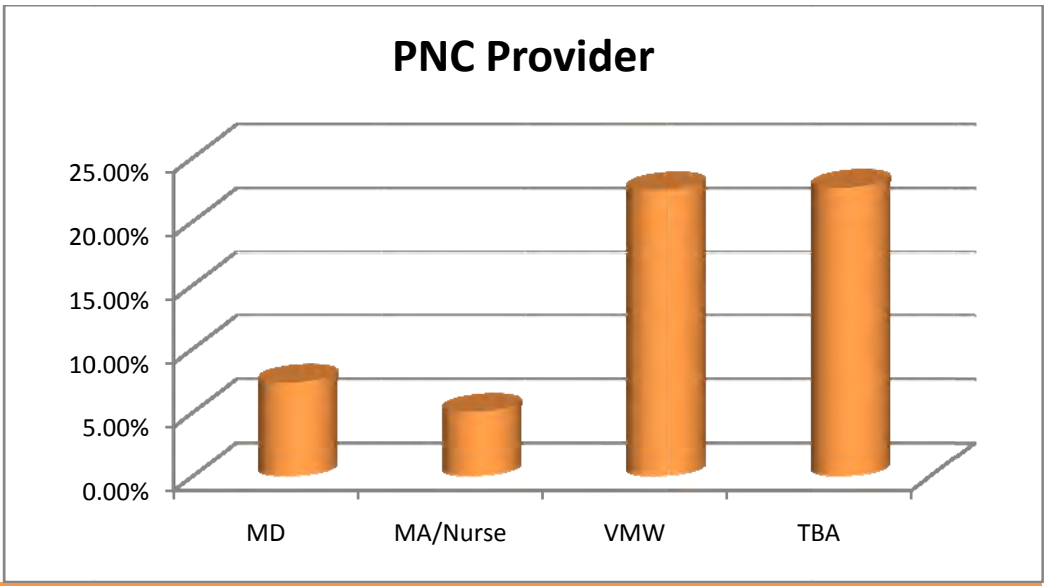
Of particular note are the statistics calculated above for knowledge of pregnancy and labour-related complications. Two thirds (65.3%) of the women could not mention more than two danger signs associated with pregnancy and delivery. Given that 72.9% of women deliver at home and the majority of deliveries (54.3%) are not attended by a trained birth attendant, it is strongly recommended that health education programming should focus on this issue; so as to increase the probability that women will know early of potential complications and seek assistance.

In terms of post-natal care (PNC) the majority (504, 57.3%) of the women attended at least one visit within the first six weeks of delivery (table 6). However, only 42.7% of them received PNC by a trained provider (Figure 9).

Table 6: PNC Coverage

PNC	Frequency	Percent	Cum Percent	
No	377	42.7%	41.3%	
Yes	504	57.3%	100.0%	
Total	880	100.0%	100.0%	

Figure 9: Provider of PNC



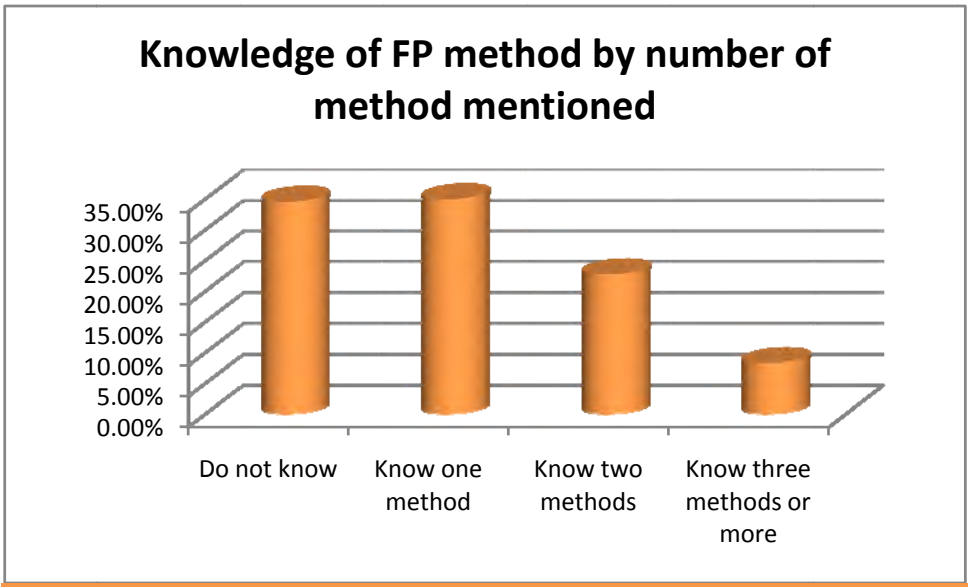
PNC by	Frequency	Percent	Cum Percent	
MD	64	7.3%	7.3%	
MA/Nurse	44	5.0%	12.3%	
VMW	197	22.4%	37.7%	
TBA	199	22.6%	57.3%	

Family Planning – Knowledge and Behaviour

One of UNFPA's reproductive health goals is to increase knowledge among women of reproductive age of modern contraceptive methods. To measure progress toward this goal, women were asked to name any methods of modern family planning of which they were aware and where they could access these methods.

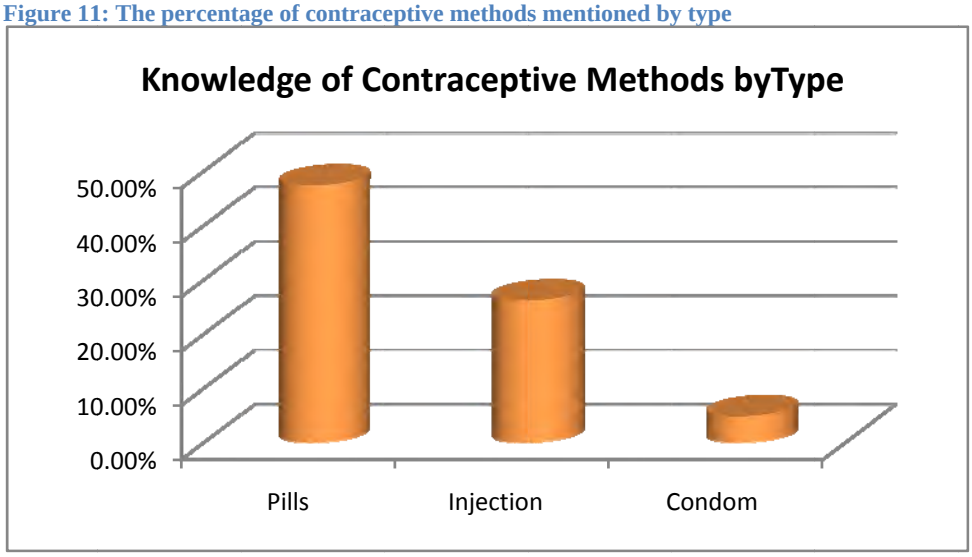
A majority of respondents (578, 65.6%) could name at least one modern method of family planning. More than fifth (199, 22.6%) knew of two methods and nearly 10% (72, 8.2%) named a total of three (figure 10). The most common methods mentioned were oral contraceptive pills (47.3%) and injections (26.1%). Condoms were mentioned far less frequently (4.8 %) (figure 11).

Figure 10: knowledge of FP methods by number of methods mentioned



Knowledge of FP	Frequency	Percent	Cum Percent
Do not know	303	34.4%	34.4%
Knew one method	307	34.8%	69.2%
knew two methods	199	22.6%	91.8%
knew or more 3 methods	72	8.2%	100.0%
Total	881	100.0%	100.0%

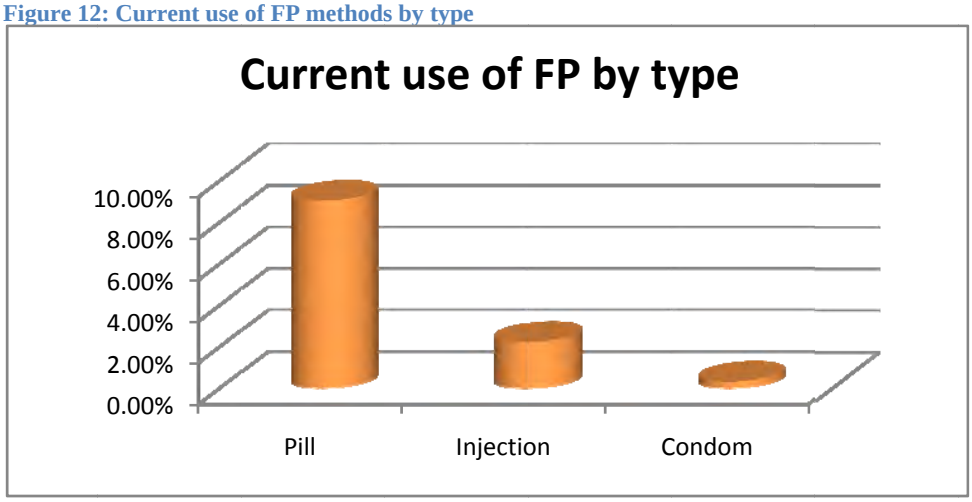
Figure 11: The percentage of contraceptive methods mentioned by type



Contraceptive Prevalence Rate (CPR)[4]

Of the 881 women interviewed for the survey, (212, 25.1 %) were pregnant at the time and therefore were excluded from questions regarding current contraceptive use. Of the remaining 669 women, 77 (11.5%) reported current use of a modern method of family planning. Of the women who reported using contraceptives, the pill was the most frequently used method (60, 77.9%); injections were the next most common method (15, 19.5%). Condoms were the least frequently used method (2, 2.6%). Results are depicted in figure 12. It is also important to note that only 14.2% of women interviewed have ever used birth spacing.

Figure 12: Current use of FP methods by type

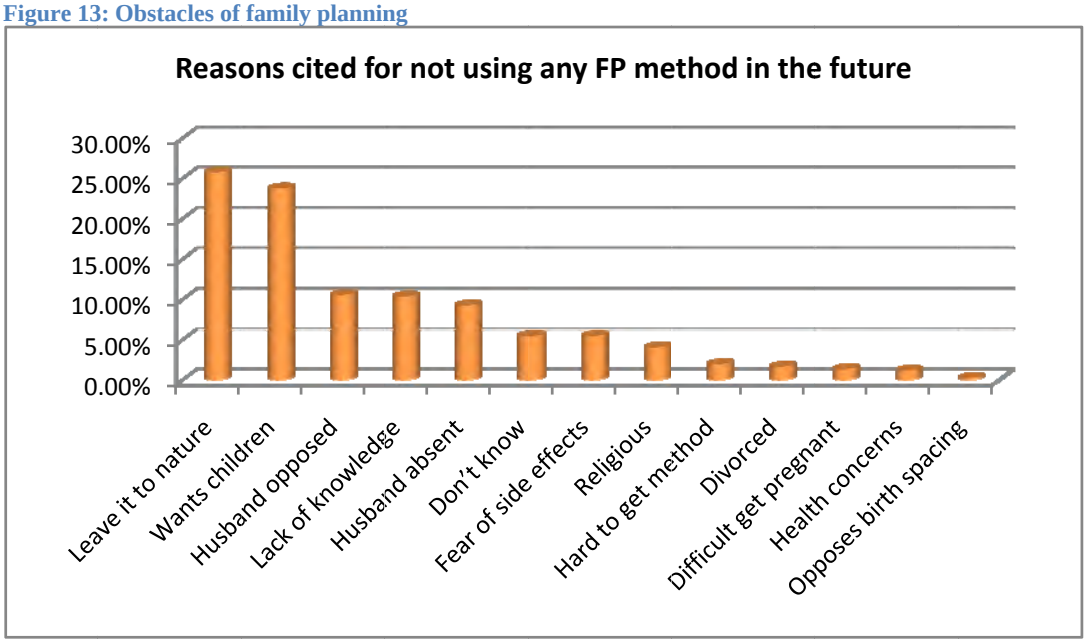


FP type	Frequency	Percent	Cum Percent
Pill	60	77.9 %	77.9%
Injection	15	19.5%	97.4%
Condom	2	2.6%	100.0%
Total	77	11.5%	100.0%

[4] percentage of women aged 15-49 years currently married or in union who were using or whose partner is using a contraceptive method

Of a particular note that most of the respondents (50.9%, 448), reported that they were not willing to use any contraceptive or birth spacing method in the future. The most important obstacles for FP use cited were: to leave it to nature (25.7, 115); wanted another child/ children (106, 23.7%), husband opposition (47, 10.5%); and lack of knowledge (46, 10.3%). Results are depicted in figure 12

Figure 13: Obstacles of family planning



Main not using FP	Frequency	Percent
Leave it to nature	115	25.7%
Wants children	106	23.7%
Husband opposed	47	10.5%
Lack of knowledge	46	10.3%
Husband absent	41	9.2%
Don't know	24	5.4%
Fear of side effects	24	5.4%
Religious	18	4.0%
Hard to get method	8	1.9%
Divorced	7	1.6%
Difficult get pregnant	6	1.3%
Health concerns	5	1.1%
Opposes birth spacing	1	0.2%

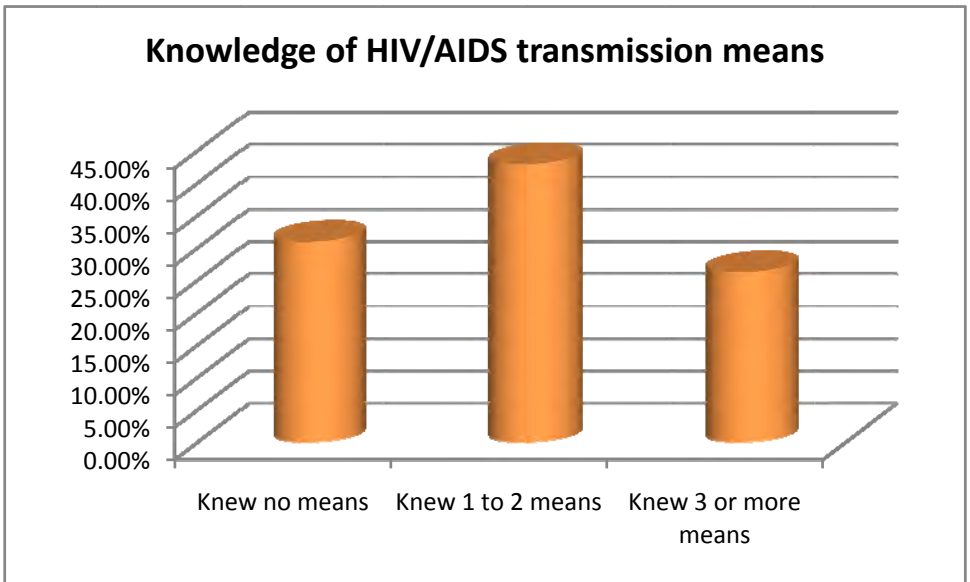
HIV/AIDS Knowledge

Although HIV/AIDS prevalence in adults (15 years old and older) in Northern Sudan is estimated to be low (1.6%) significant efforts are being made to increase HIV/AIDS knowledge among the conflict affected population. The main indicators to measure the knowledge of HIV transmission and prevention include the following:

- Awareness about AIDS among women: Proportion of the respondents who have heard of AIDS;
- Knowledge of about HIV prevention: Proportion of respondents who correctly identify two main ways of avoiding HIV infection/transmission (i.e., having only one uninfected partner and using condoms);
- Knowledge of means of transmission of HIV: Proportion of respondents who correctly identify three means of transmission.

Overall, more than four fifths (81.6 per cent) of respondents had heard of AIDS. However, the awareness of AIDS is low among women with no formal education. Only 67.6 per cent of them have heard of AIDS. On the other hand, as much as 95.5 per cent of women with 6 to 8 years of education and 98.2 per cent of women with more than 8 years of education have heard of AIDS.

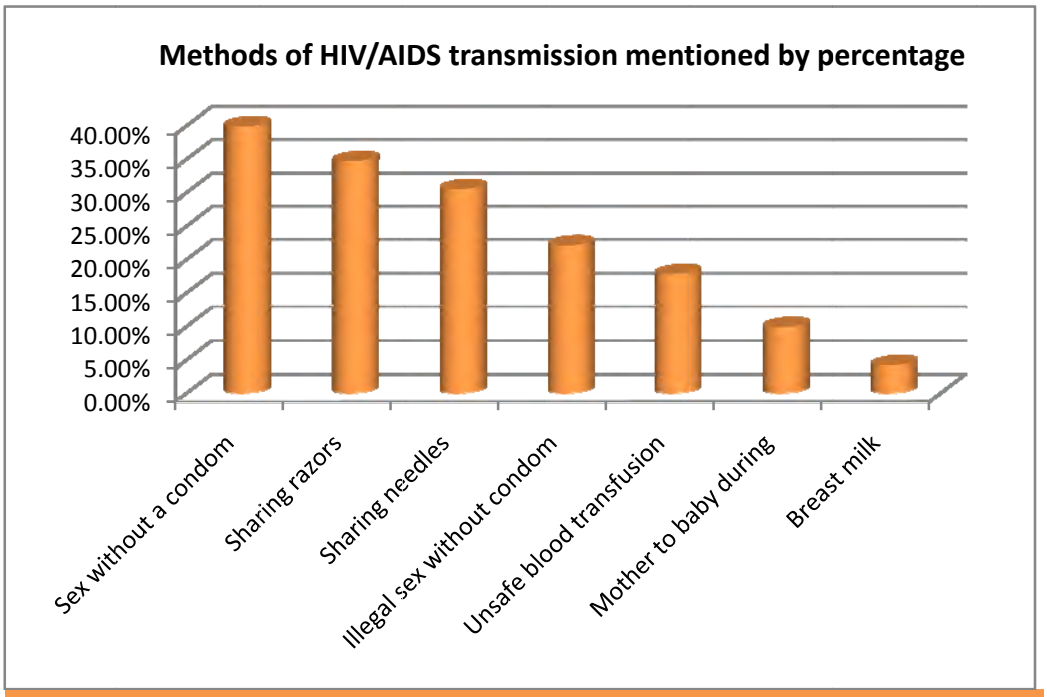
Figure 14: Knowledge of HIV/AIDS mode of transmission



M of HIV trans.	Frequency	Percent
Knew no means	272	30.9%
Knew 1 to 2 means	230	42.9%
Knew 3 or more means	230	26.2%
Total	879	100.0%

As shown in figure 14, nearly on third (272, 30.9%) of the respondents surveyed knew no means of HIV/AIDS transmission. More than two fifths of the respondents (42.9%) mentioned one to two means and just above a quarter (26.2%) mentioned three or more means of HIV/AIDS transmission. The most common methods of transmission mentioned were sex without a condom (351, 39.8%), sharing razors (305, 34.6%), sharing needles (268, 30.4%), and "illegal sex" or sex outside the marriage without a condom (194, 22.0%); see figure 14.

Figure 15: Methods of HIV/AIDS transmission mentioned

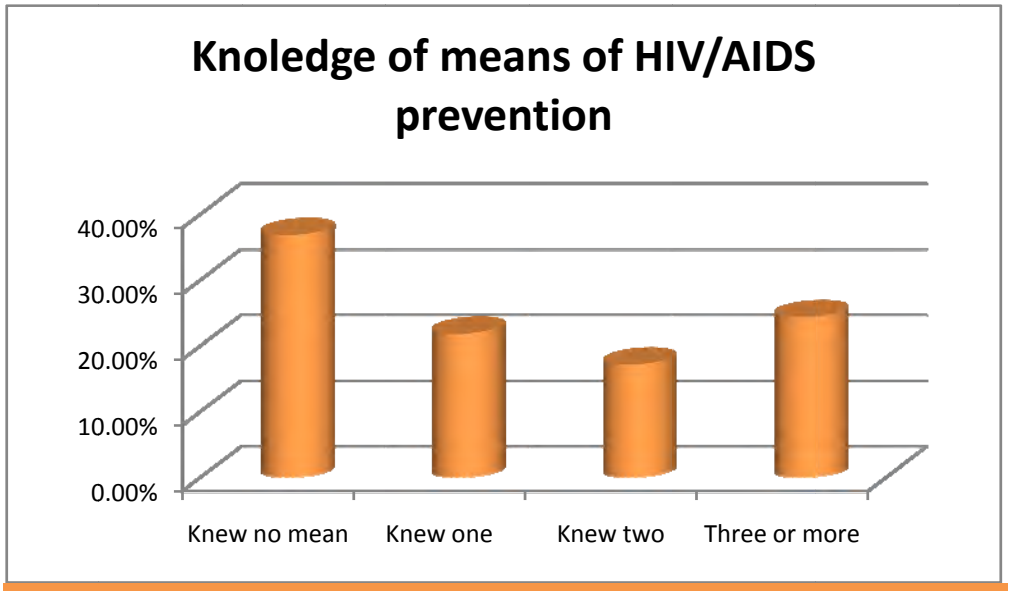


Mode of transmission	Frequency	Percentage
Sex without a condom	351	39.8%
Sharing razors	305	34.6%
Sharing needles	268	30.4%
Illegal sex without condom	194	22.0%
Unsafe blood transfusion	156	17.7%
Mother to baby during	86	9.8%
Breast milk	36	4.1%

More than one third of the respondents (322, 36.8) knew no mean of prevention. On the other hand, approximately a quarter of respondents (24.3%) could name three or more means of preventing the transmission of HIV/AIDS (figure 15). The most common means of

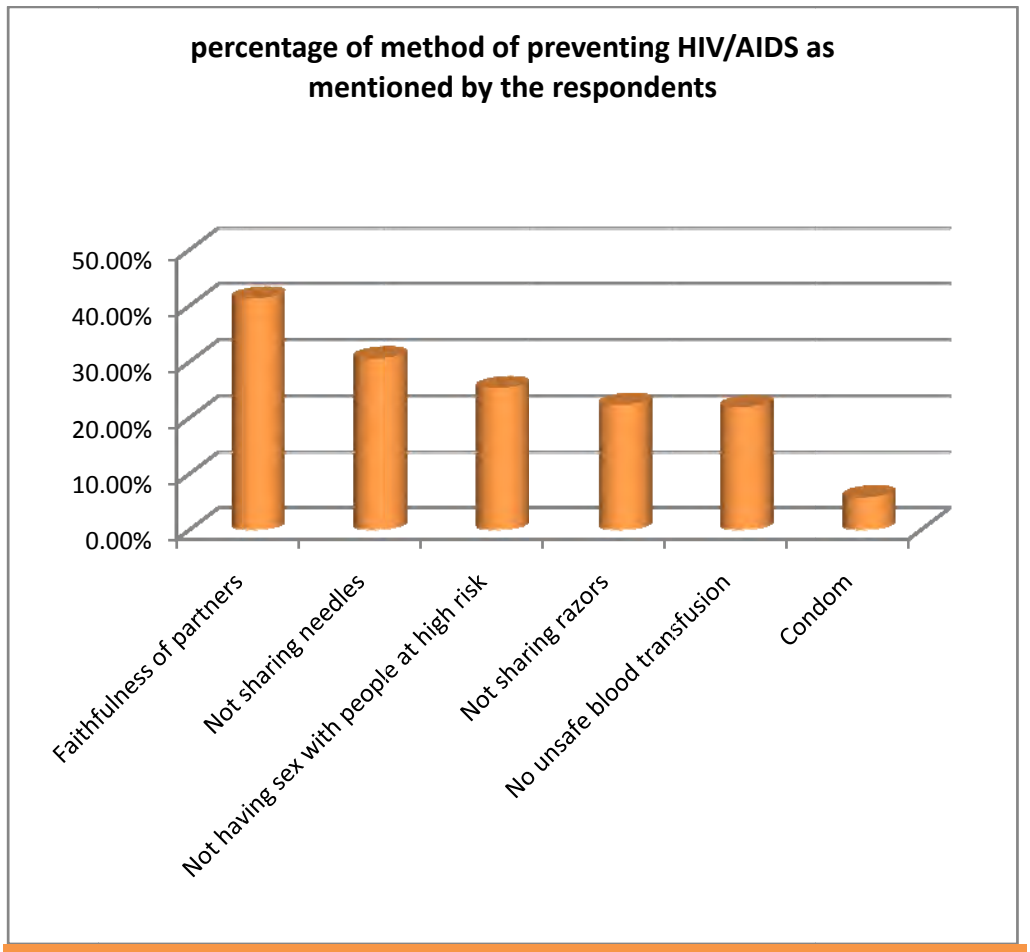
prevention mentioned were faithfulness of partners (363, 41.1%), not sharing needles (269, 30.5%), not having sex with people at high risk (222, 25.2%), not sharing razors (196, 22.2%) and no unsafe blood transfusion (192, 21.8). It is important to note that condoms as mean of prevention were mentioned far less frequently (5.7%), see figure 16.

Figure 16: Knowledge of HIV/AIDS prevention methods



K of HIV prev.	Frequency	Percent	Cum Percent
Knew no mean	322	36.8%	36.8%
Knew one	191	21.8%	58.6%
Knew two	150	17.1%	75.7%
Three or more	213	24.3%	100.0%
Total	876	100.0%	100.0%

Figure 17: knowledge of HIV/AIDS prevention method by types



Method of prevention	Frequency	Percentage
Faithfulness of partners	363	41.2%
Not sharing needles	269	30.5%
Not having sex with people at high risk	222	25.2%
Not sharing razors	196	22.2%
No unsafe blood transfusion	192	21.8%
Condom	50	5.7%

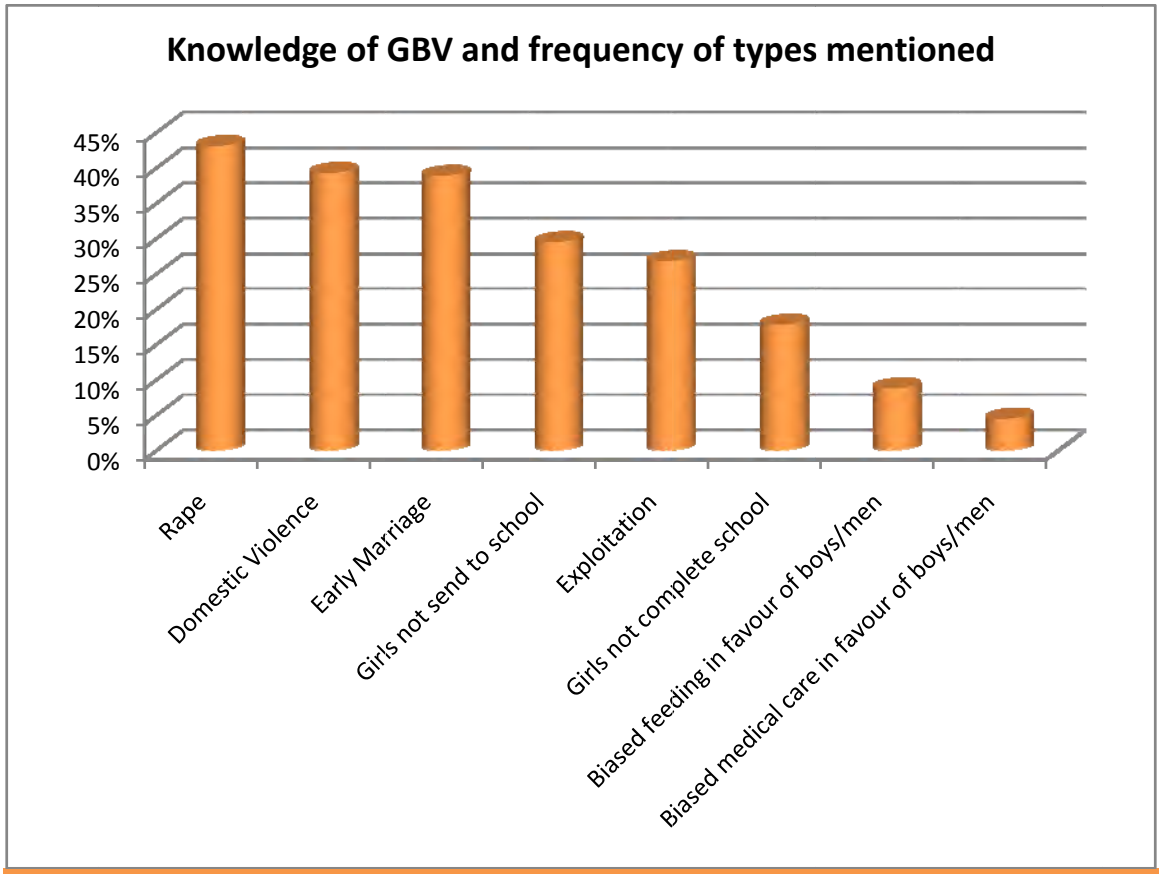
Knowledge of STIs

All respondents were asked whether they have ever heard of sexually transmitted infections (STIs) rather than HIV/AIDS; only 35.6% responded affirmatively. These women were then asked about their knowledge related to STI transmission, symptoms, and prevention. The STIs most commonly know by women who have ever heard of STIs were gonorrhea (81.7%) and syphilis (48.2%). Very few women (13.7%) were able to name signs or symptoms of STIs that would cause someone to seek treatment.

Gender Based Violence

One of UNFPA' goals is to increase knowledge of Gender Based Violence. To measure progress toward this goal, a series of GBV questions were added to the data collection tools. Women were asked to name things that happen in the community that harm to women/girls of which they were aware. The most common types of violence/harm mentioned were sexual violence (380, 43%), domestic violence (345, 39.3%), early marriage (342, 38.8%), girls not send to school (259, 29.4%) and exploitation (235, 26.7%). Results are depicted in figure 17.

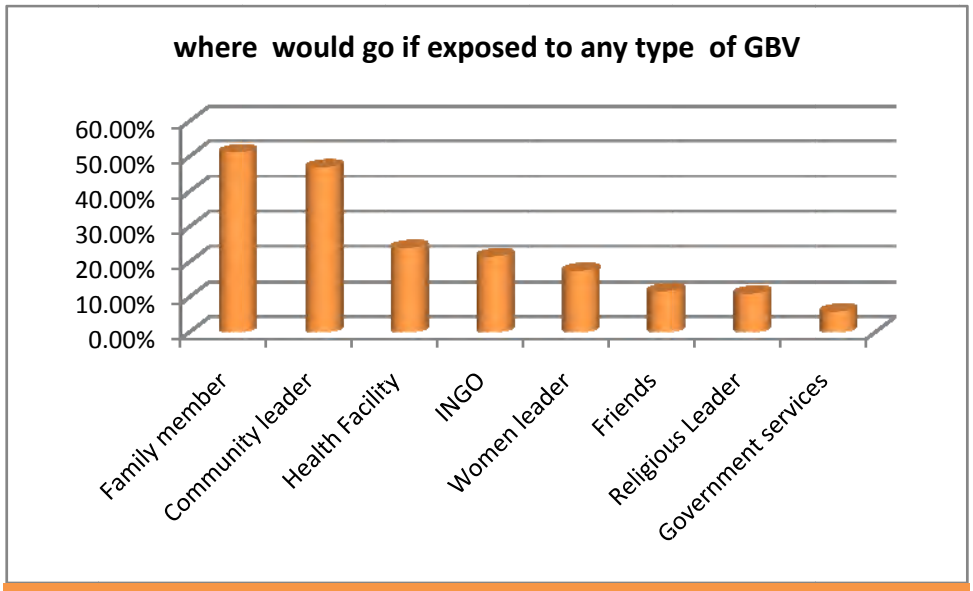
Figure 18: Knowledge of GBV and frequency of types mentioned



Type of violence mentioned	Frequency	Percentage
Rape	380	43%
Domestic Violence	345	39.2%
Early Marriage	342	38.8%
Girls not send to school	259	29.4%
Exploitation	235	26.7%
Girls not complete school	156	17.7%
Biased feeding in favour of boys/men	77	8.7%
Biased medical care in favour of boys/men	39	4.4%

They were also asked about if women/girls face any of the problems mentioned, where they look for help. Slight majority of the respondents (51.0%) reported that they would seek help from family member. The next common for help was the community leader (46%). Seeking help at the government facility was the least frequent to be reported (5.7%). Results are shown in figure 18 below:

Figure 19: Carer preference if exposed to any GBV (more than one option possible)

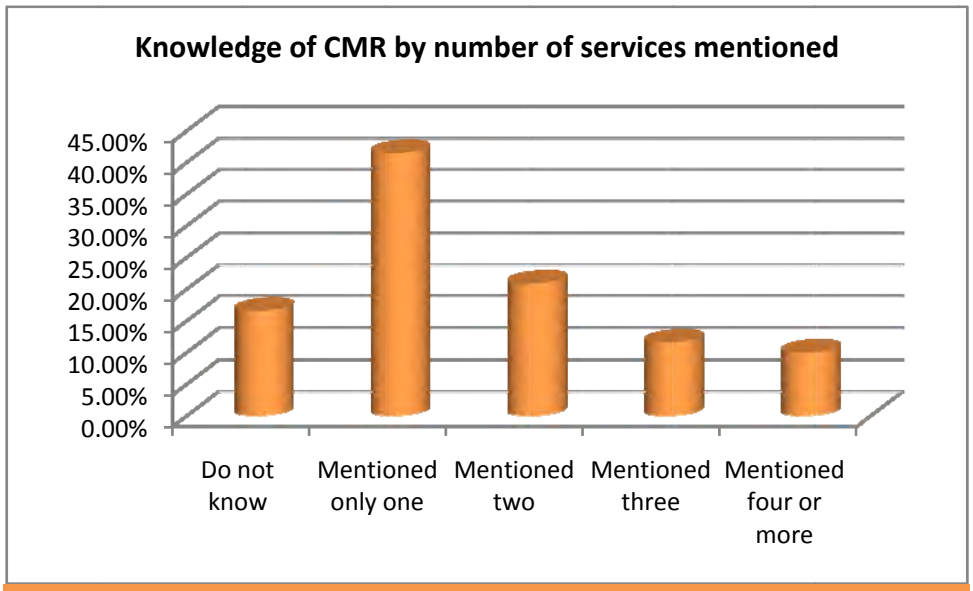


Where would go if exposed to any type of GBV	Percentage
Family member	51.0%
Community leader	46.7%
Health Facility	23.8
INGO	21.4%
Women leader	17.3
Friends	11.5%
Religious Leader	10.8%
Government services	5.7%

One of the main GBV unit objectives is to increase knowledge among women of services or treatment provided to woman experiences forced sex[5]. To measure progress toward this objective, women were asked to name any type of services or treatment offered to the SGBV survivors of which they were aware and where they could access these services.

[5] The package of service provided to the rape survivors include: 1.emergency contraception, 2.HIVPEP, 3.TT, 4.Hepatitis B, 5.STI prevention, 6. injury treatment and 7. psychosocial support

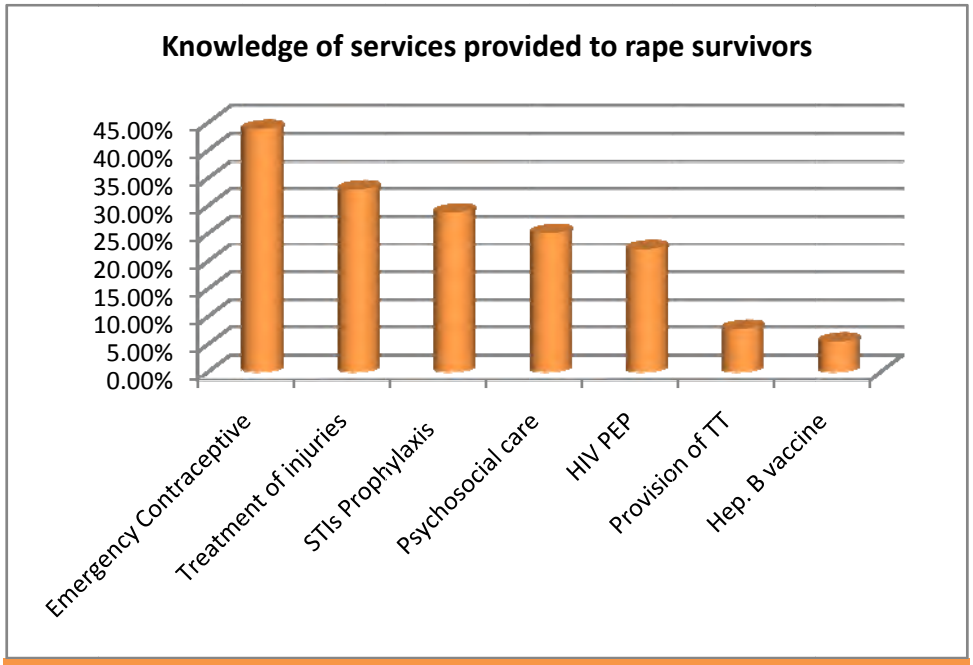
Figure 20: Knowledge of services provided for rape survivors



SGBV services mentioned	Frequency	Percent
Do not know	145	16.5%
Mentioned only one	364	41.4%
Mentioned two	183	20.8%
Mentioned three	101	11.5%
Four or more	87	9.9%
Total	880	100.0%

Overwhelming majority of respondents (83.5%) could name at least one service. More than fifth (21.5%) knew of at least three services and nearly 10% (9.9%) named a total of four or more services (see figure 19). The most common services mentioned were provision of emergency contraceptive pills (43.8%), treatment of injuries (32.9%) and STIs prophylaxis (28.7%). Results are depicted in figure 21.

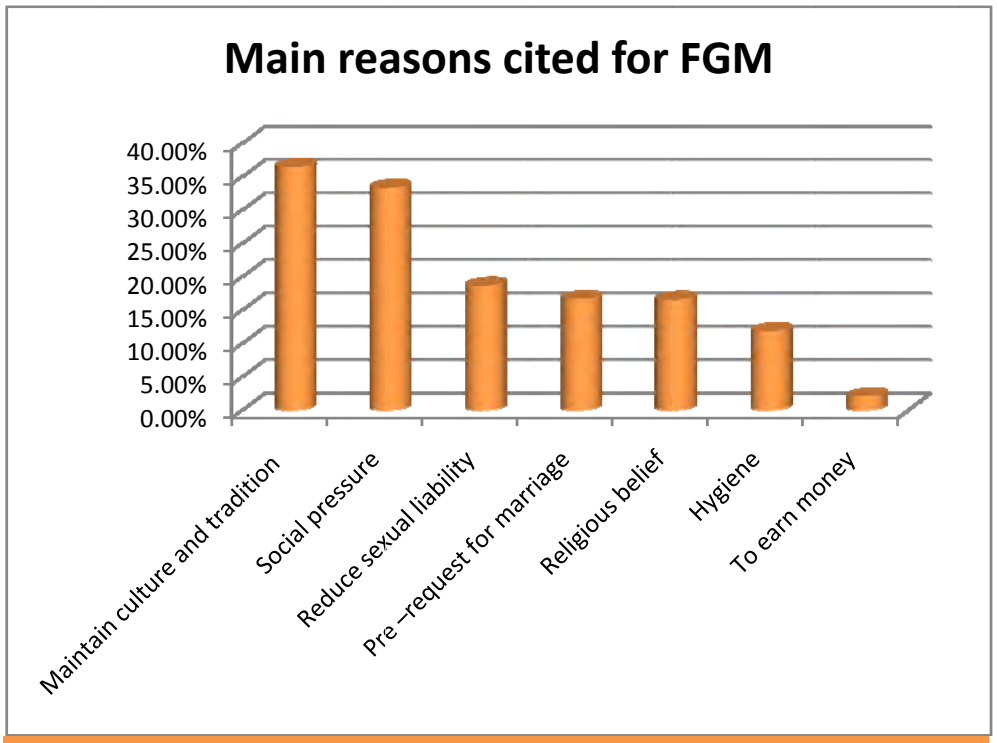
Figure 21: knowledge of services provided for rape survivors by percentage



Type of services provided	Frequency	Percentage
Emergency Contraceptive	386	43.8%
Treatment of injuries	290	32.9%
STIs Prophylaxis	253	28.7%
Psychosocial care	220	25.0%
HIV PEP	195	22.1
Provision of TT	68	7.7%
Hep. B vaccine	48	5.4%

FGM was one of the GBV issues included in the survey. It is partial or total removal of the female external genitalia and/or injury to the female genital organs for cultural or any other non-therapeutic reasons. FGM is considered to be one of the most important harmful traditions widely practiced in Sudan; thus fighting against FGM is one of UNFPAs' goals. However, it is vital to understand the reasons for the practice before embarking on information campaigns. To identify the main reasons for FGM, and its roots respondents were asked why this practice happens. The most frequent reasons cited were maintain culture and tradition (321, 36.4%), and social pressure (293, 33.3%). Results are depicted in figure 22.

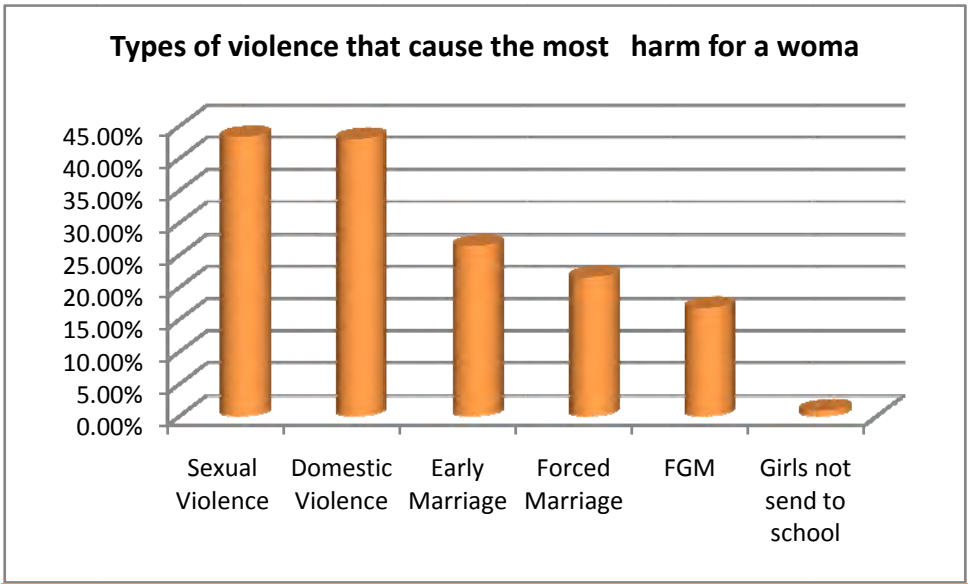
Figure 22: Reasons cited for FGM by percentage



Reason for FGM	Frequency	Percentage
Maintain culture and tradition	321	36.4%
Social pressure	293	33.3%
Reduce sexual liability	164	18.6%
Pre –request for marriage	146	16.6%
Religious belief	145	16.5%
Hygiene	104	11.8%
To earn money	53	2.0%

Finally to identify the harmful GBV type in term of occurrence, consequences and negative impact on the displaced community; respondents were asked to name the types of violence that cause the most harm for a woman in the camps. The most frequent reported types of violence were sexual violence (381, 43.2%) and domestic violence (378, 42.9%). Early marriage was reported by more than a quarter (232, 26.3%) of the respondents and forced marriage by more than one fifth (189, 21.5%). It is also important to note that FGM was reported by nearly fifth (147, 16.7%) of the respondents as being harmful (see figure 23).

Figure 23: Types of violence that cause the most harm for a woman

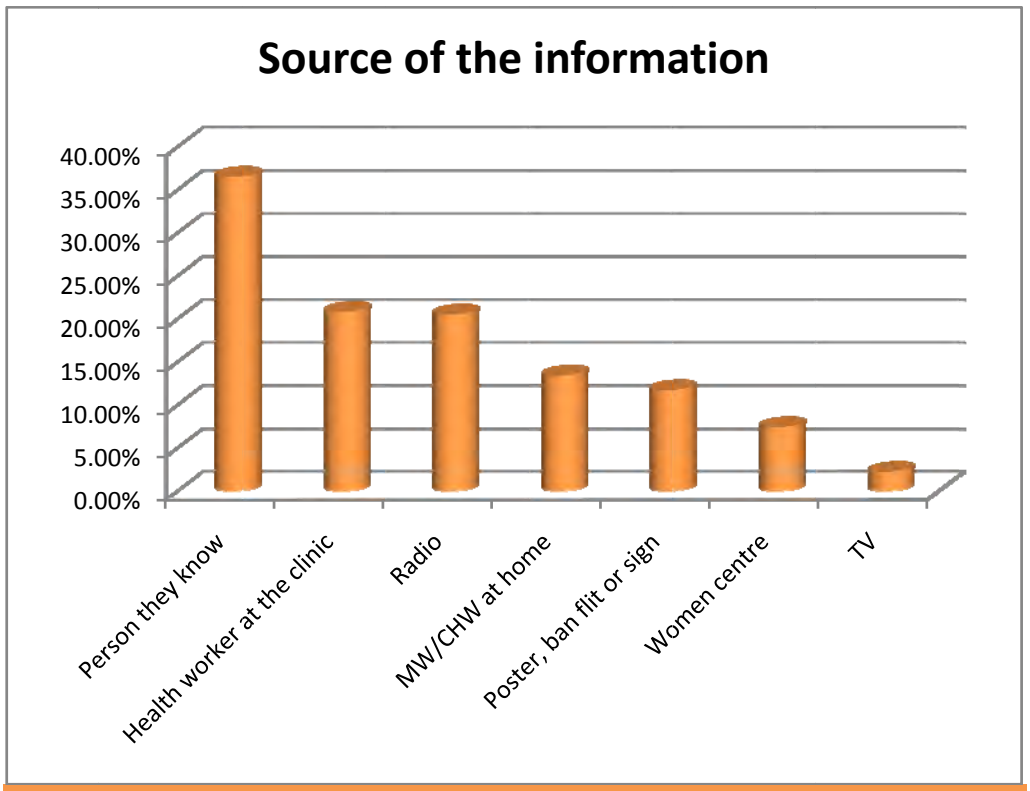


Type	Frequency	Percent
Sexual Violence	381	43.2%
Domestic Violence	378	42.9%
Early Marriage	232	26.3%
Forced Marriage	189	21.5%
FGM	147	16.7%
Girls not send to school	7	0.8%

Source of Information:

The need for accurate information is the foundation of achieving the needed behaviours in all issues related to RH. However, what methods or means of communication do our target groups prefer is vital to design our communication strategy. Therefore, respondents were asked from where they get RH/GBV information. The most frequent source of information mentioned were: from person they know (332, 36.5%), from health worker at the clinic (183, 20.8%), from the radio (181, 20.5%) and from MW/CHW at home. Results are shown in figure 24

Figure 24: Source of the information



Source of the information	Frequency	Percentage
Person they know	332	36.5%
Health worker at the clinic	183	20.8%
Radio	181	20.5%
MW/CHW at home	118	13.4%
Poster, ban flit or sign post	103	11.7%
Women centre	65	7.4%
TV	19	2.2%

Section 3: Policies, legislation and current interventions

As it has been established from various government official pronouncements the BCC strategy was built on involvement of seven strategic elements including:

1. Universal right to know
2. Cultural sensitivity
3. Gender sensitivity
4. Community participation
5. Multi-level partnership
6. Appropriate media mix interventions
7. Research, monitoring and evaluation

It has also been established that the communication strategy is guided by the following Principles:

1. The communication approach is **people-centered** and **client-friendly**.
2. Communication efforts and initiatives are **process**- rather than product oriented.
3. Detailed planning, choice of communication channels and monitoring are **decentralized**
4. Communication strategies **address social and cultural issues** related to RH.

For Nongovernmental organisation partners at the field level; although there was no detailed beneficiaries' oriented BCC interventions for RH, it was established from the interviews with the health managers that interventions include:

1. Public sessions
2. IEC materials focusing on the pictorial items
3. Peer education
4. VCT
5. Mass media
6. At work place and school health education
7. And other inter-personal communication approach such trilogies approach

In addition to the above mentioned currently interventions, there was UNFPA's community based health education project supported implemented by RI in Zamzam camp – North Darfur. The project's goal was" To i**mprove women's status in the Zamzam camp by the**

establishment of volunteers' patronage system" and through this to address critical gaps assessed in sexual and reproductive healthcare access, particularly for women of childbearing age and youth.

RI has worked with Ministry of Health (MoH) to redevelop the Zamzam camp health network and increase services to pregnant and lactating women via training for Community Health Workers (CHWs) and TBAs, and improved patronage system for early diagnosis of pregnancy complications and referrals. Despite this work there are certain gap areas continue to need attention in the sustained complex emergency in Zamzam camp and they require an emphasis on training, outreach activities, and local supply resources. The focus of the project was to balance increased community capacity for beneficiaries and health providers, as well as to improve the accessibility and quality of RH services and HIV/AIDS/SGBV prevention and response through strengthening the existing community volunteers network in Zamzam, training of women-volunteers and of establishment volunteers' patronage system, by involvement them in patronage activities to SGBV and RH needs of IDP population

Moreover, there is a similar community based health education project has been in operation for the past four years (since 2005) in Aboshok camp with the support of IRC. The objectives of the project were to: create skilled health human resources at the community level to offer health information at the doorstep. The front line workers are called Community Health Promoters "CHPs" and supervised by "CHPs supervisors.

Recommendations:

Based on the results of this survey, the key issues to be addressed include the following:

1. Knowledge of danger signs of pregnancy and childbirth: Approximately 20% of respondents could not identify danger signs of pregnancy complications. Given that the vast majority of deliveries happen at home and the high percentage of these attended by unskilled personnel, it is important that women know the signs of complications associated with pregnancy and delivery to increase the likelihood of seeking a trained assistance should complications arise. Therefore, educate women on signs of danger during pregnancy and delivery.

2. Safe delivery, delivery plan and preparedness: With approximately 72.9 percent of women delivering at home without the assistance of a skilled birth attendant and not seeking skilled postnatal care, health education and programming should continue to both educate mothers (on safe delivery and birth preparedness) and develop creative solutions to mitigate the negative impacts of unskilled TBAs.

3. TT vaccine: coverage for TT remains a significant low. About one third of the respondents (33, 8%) thought no TT vaccination. Further research needs to be conducted regarding TT vaccination coverage barriers.

4. Family Planning: Large gap between contraceptive knowledge and use: The reproductive role is the most important role for women in Darfur. Therefore, program should not try to advocate for decreasing fertility rates through family planning. However explanation on the risks of multiple pregnancies in a short period of time and the use of family planning methods to space pregnancies and proper counselling is really important. Furthermore, knowledge of the most fertile period during a woman's menstrual cycle is very low, so women should be educated on this issue.

5. Sexually Transmitted Infections: Knowledge of signs and prevention of STIs remains very low; therefore, they should be education about STIs' symptoms, prevention, partner(s) notification and treatment.

6. Knowledge of transmission and prevention of AIDS is low, therefore when talking about HIV it should be made clear routes of transmission and non-transmission and means of prevention

7. Early marriage is a phenomenon that is quite embedded in the society. Community education on the risks of early pregnancy could be attempted.

8. As only 9.9 % of the respondents could name up to four services that provided to rape survivors, community education on SGBV response and awareness should continue as SGBV including rape and exploitation are is still prevalent. Furthermore, ways to mitigate domestic violence should be attempted

To address these issues, UNFPA should implement the following strategies:

1. Family Centred Model:

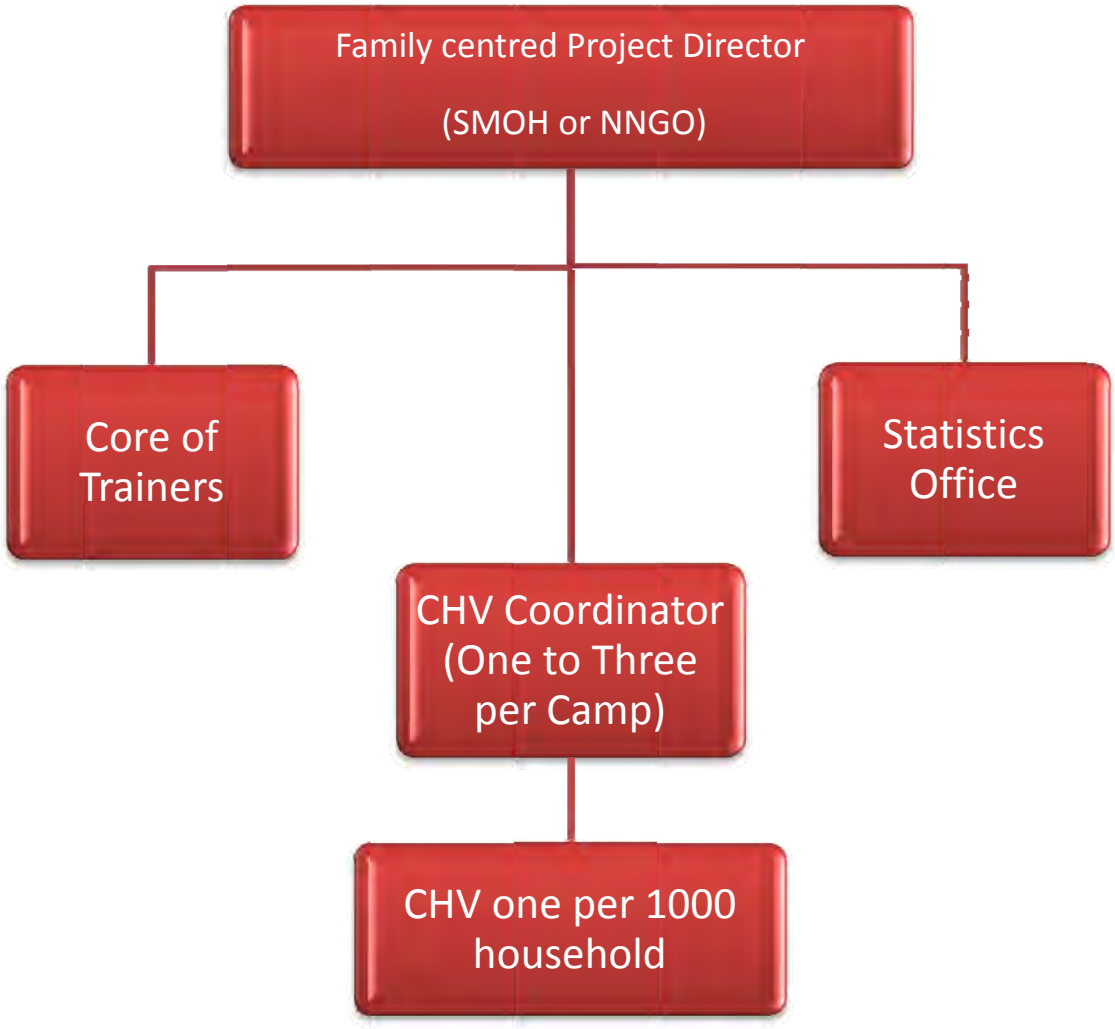
Family Centred Model is an effort not only to expand health education into the community and increase knowledge, but also to influence health seeking behaviours and t promote safe motherhood GBV awareness and response. It is built upon community-based family centred approach to reach all the displaced population of Darfur. The objectives of the project is to create skilled health human resources at the community level to offer RH/GBV information at the doorstep for a community that has been historically deprived of adequate health information and hindered by so many cultural barriers. It is also to ensure satisfactory ANC, birth preparedness, complication readiness and enhance and strengthen referral linkage with the health facilities. This should be done through developing a network of community health workers in close collaboration with MOH.

The structure of the program's network should be consists of a community health volunteers as a front line worker of the project; However, intervention measures working with CHV should not be implemented without due consideration of issues including: Mobilization and engagement; skills and competency of the CHV; and their effectiveness and efficiency towards the attainment of the project goals. Therefore CHV selection criteria, tasks, motivation, training, monitoring and supervision are very important aspect of the CHVs that need to be assessed in order to examine the effectiveness of the CHV. Furthermore, the scheme should be implemented by the MOH or NNGO and occasionally by INGO.

CHW should be selected by the community to enhance the community participation towards a community based interventions, and should be literate female to be able to collect maternal data. They should have basic foundation training for 1 to 3 weeks, and refresher training (one to five days) in regular intervals. The basic training should focus on maternal health, GBV prevention and response, preventive health, and health education. It should also focus on interpersonal communication, how to provide counselling, how to conduct meetings, or how to teach and present information. The primary responsibility of the CHW is to conduct home visit to all pregnant women in her catchment area and perform health promotion, education and delivery plan and preparedness and the session should include all the family members particularly the husband and the elders.

The second line health workers are the supervisors, preferably NMW or of equal capacity and who should supervise not more than15 CHWs. The training officer and statistics officer should be directly link to the director (see figure 1).

Figure 25: Family Centred Model Organogram



It is of particular important to mention that, this model is very similar to the community based project implemented in Zamazm camp by RI and which has been mentioned earlier. The project has been successful, however it has been constrained by secured issues and as the result of the expulsion of INGOs from North Darfur RI stopped most of project's activities in camp; the situation became complicated and RI could not continue the project's activities. Therefore it is strongly recommended that this model should utilised local NGOs, CBOs and full collaboration with MOH; ensure it sustainability and success.

2. In addition to the proposed model approach UNFPA should support the introduction of the following interventions:

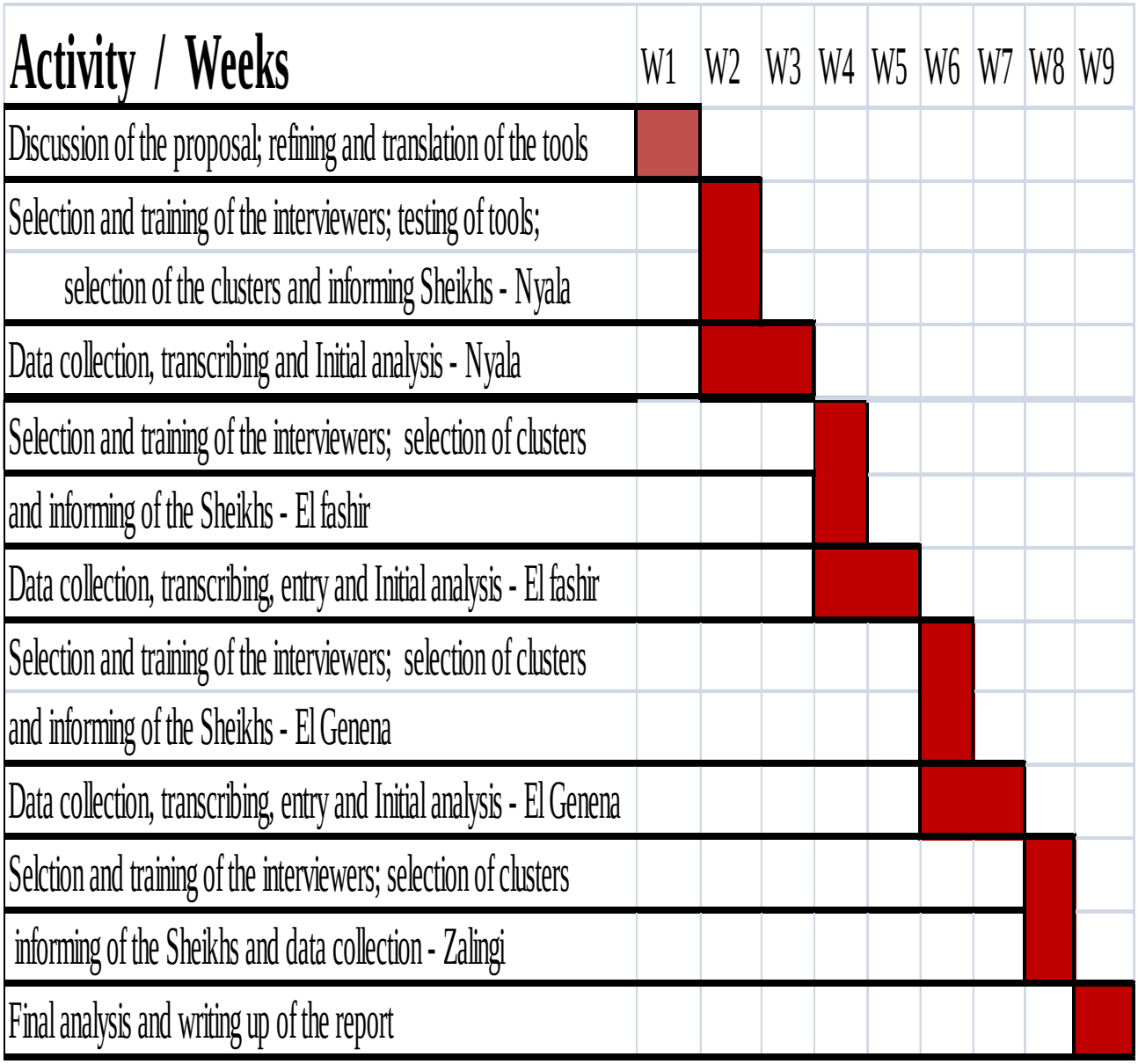
- Reproduce and distribute reproductive health videos to be played at the public centres such as community and women centres.
- Support RH programs in the local community radios and CHW should inform the people of the dates and times of all existing radio programs about reproductive health issues so they can listen.
- Production of target print-based IEC materials to low-literate or non-literate audiences preferably pictorial.

3. Not only women but the whole society – especially community leaders, religious leaders and other leaders - should be involved in health education programs. Therefore supervisors of the above model should conduct advocacy sessions for these leaders as well as public sessions. Health education should also target adolescent women. These are not well represented among the population attending PHC facilities. Therefore we recommend health education programs actively targeting female adolescents where they are (e.g. at house, in schools, or youth centres); this activity could be carried by both CHW and supervisors
4. Reproductive health should be seen in a broader perspective rather than only from a health care provider point of view. The results of this KAP survey consistently show that Reproductive Health indicators are worse for illiterate women than for literate ones. UNFPA should take the lead in advocacy and promotion of the education of girls / women and that access to primary schooling for every girl is and should be a priority in the general reconstruction efforts of Darfur crisis. Furthermore, the importance of literacy is recognized by the women since schooling of women is

something almost all interviewed and FGD’s women desired. Therefore literacy classes in women and community centres should be supported. Moreover, women should be acquitted with some handcraft skills as the best way to achieve empowerment is probably through promotion of education for women, linked with increased income.

5. The KAP survey should be repeated after one year after the implementation of the recommendation to evaluate effect of change in strategy.

Annex 1: Plan of Action



Annex 2: Structured Questionnaire

State:
Locality: **Area:**
Cluster #: **Questionnaire #:**
Interviewer Name: **Date:**

(All words in italics are notes to the interviewer)

Ask all questions to women (ages 15-49) who have at least one child under the age of 5.
Before the interview:

INFORMED CONSENT

Hello. My name is (your name). I am an Interviewer working for UNFPA is interested in learning more about a variety of Reproductive health concerns in this community.

I am grateful for your participation in this survey. The interview will take about 30/35 minutes to complete. Whatever information you provide will be kept strictly confidential and will not be disclosed to other persons.

Participation in this survey is voluntary and you can choose not to answer any individual question. However, we hope that you will participate in this survey since your views are important.

At this time, do you want to ask me anything about the survey?
May I begin the interview now?

RESPONDENT AGREES TO BE INTERVIEWED.....1

RESPONDENT DOES NOT AGREE TO BE INTERVIEWED.....2 ──> END

PART 1: DEMOGRAPHICS

We will begin with some questions about your background.

1) What is your age (in years) currently?

DK .....

NR .....

2) What is your marital status? Would you identify yourself as?
Married, (ASK A) .....
Separated, (ASK A) .....
Widowed, (ASK A).....
Divorced, (ASK A) or.....
Single/Never married? .....
DK .....
NR .....

A) How old were you when you first married?

DK .....
NR .....

3) How many years of schooling have you completed?
No formal education.....
0+ to 2 years of schooling .....
2+ to 4 years of schooling .....
4+ to 6 years of schooling .....
6+ to 8 years of schooling .....
8+ years of schooling .....
DK .....
NR .....
.....

4) How long have you lived in (name of camp or area)?
Less than 1 month .....
1+ to 3 months.....
3+ to 6 months.....
6+ to 9 months.....
9+ to 1 year.....
1+ to 3 years.....
3+ to 5 years.....
5+ years .....
DK .....
NR .....

5) Are you engaged in a livelihood activity? In other words, are you engaging in an activity for which you either receive money, or goods or services in exchange?
Yes (ASK A).....

No .....
DK .....
NR .....

A) What is your primary livelihood activity?

i) Agriculture/Farming (owns own plot)..... ....
ii) Livestock ....
iii) Employment/Salary ....
iv) Farm Work (paid by landowner) ....
v) Wood/Charcoal Seller..... ....
vi) Petty Trade/Small Business..... ....
vii) Handicrafts/Skilled Workers ....
viii) Other (Specify :_____) ....

6) Do you usually listen to radio at least once a week?

Yes .....
No

7) Do you usually watch television at least once a week?
Yes .....
No

PART 2: REPRODUCTIVE HEALTH
SECTION 1: BASIC OBSTETRIC CARE

Thank you, the rest of my questions are specifically about the health of you and your family. First, I'd like to ask you about your health as a woman and a mother, in other words, these next questions are about reproductive health.

8) How old were you when you first gave birth?

DK .....

NR .....

9) How many children total have you given birth to?

DK .....
NR .....

10) How many of the children you gave birth to are currently living?

DK .....
NR .....

11) Where were you living during your last pregnancy?

In an IDP camp, (Specify: _____).....
In a village (Specify: _____), or.....
In a different location? (Specify: _____) .....
DK .....
NR .....

12) During your last pregnancy, how many times did you go for Antenatal Care (ANC) check-up?

DK .....
NR .....

13) Why do you go for ANC?

A) Health of my baby OK..... ....
B) Medical treatment for myself..... ....
C) Free vaccination ....
D) My health OK ....
E) Information on pregnancy
F) Free medical supplements ....
G) Other (Specify: _____)

14) During your last pregnancy, did you have a shot in your arm against tetanus (TT)?

Yes (ASK A).....
No
DK.....
NR

A) How many injections against tetanus (TT) did you receive?

INAP .....
DK.....
NR.....

B) How many shots should you have in total?

INAP .....
DK .....
NR .....

15) During your last delivery, where did you deliver?
Home .....
Clinic .....
Other location (Specify: _____) .....
DK .....
NR .....

16) Where do you prefer to deliver?
Home .....
Clinic .....
No Preference .....
DK .....
NR .....

17) Who assisted you with your last delivery? (PROBE: Anybody else?)

A) No One .....
B) Untrained Traditional Midwife .....
C) Medical Doctor .....
D) Medical assistant or Nurse .....
E) Village Midwife (trained health cadre) .....
F) Other (Specify: _____) .....

18) After your last delivery, did you receive any medical care within the first six weeks after delivery?
Yes (ASK A) .....
No .....
DK .....
NR .....

A) From whom did you seek care? (PROBE: Anybody else?)

i) No one .....
ii) Untrained traditional midwife .....
iii) Village Midwife (trained health cadre) .....
IV) Medical Doctor .....
v) Medical Assistant or Nurse .....
vi) Other .....
(Specify) _____

19) Sometimes labor and delivery can become quite dangerous for both mother and child. In these situations it is important to seek medical care at a clinic or hospital. From what

you've seen and heard, what are some danger signs women may experience before, during and after labor? (DO NOT READ LIST – MORE THAN ONE ANSWER POSSIBLE)

A) Vaginal bleeding ....
B) Vaginal discharge (not blood)..... ....
C) Loss of fetal motility ....
D) Delayed/long delivery..... ....
E) Fever..... ....
F) Convulsions/shaking..... ....
G) Abdominal pain..... ....
H) Excessive vomiting ....
I) Shortness of breath ....
J) Weakness..... ....
K) Dizziness ....
L) Swelling of hands and feet ....
M) Other (Specify: _____)..... ....
N) Other (Specify: _____) ....

Thank you for that response. Doctors recommend that women seek immediate medical care if they experience the following danger signs before, during or after pregnancy: vaginal bleeding or discharge, fever, pain in the abdomen, decreased or loss of the baby's movement, delayed or long labor, shortness of breath, weakness, swelling of hands and feet. These are some of the main signs of complications during pregnancy.

20) During your last delivery, did you have any of the above mentioned signs of complications with your pregnancy?
Yes.....
No.....
DK.....
NR .....

21) From whom do you seek care when you have a problem? (PROBE: Anybody else?)

i) No one ....
ii) Untrained traditional midwife ....
iii) Village Midwife (trained health cadre) ....
iv) Medical Doctor..... ....
v) Medical Assistant or Nurse ....
vi) Other ....
(Specify) _____

22) During your last delivery, did you delivery by Cesarean Section? By Cesarean Section I mean when a woman needs surgery to remove the baby from her abdomen.
Yes.....
No.....
DK.....
NR .....

PART 2, SECTION 2: FAMILY PLANNING

In the next few questions, I'll be asking about family planning. When I say family planning I'm referring to techniques families can use to space pregnancies for the better health and development of their families or the ways or methods that a couple can use to delay or avoid a pregnancy

23) From what you've seen or heard, what are some methods of family planning you are aware of? (PROBE: Can you think of any other methods?) (DO NOT READ LIST – MORE THAN ONE ANSWER POSSIBLE.)

A) Condoms (ASK i) ....
B) Pill (ASK i) ....
C) Injections (ASK i) ....
D) Breastfeeding ....
E) Abstinence ....
F) Rhythm Method ("sex during safe period") ....
G) Other (Specify: _____) ....
H) Other (Specify: _____) ....

i) Where can you purchase/receive these methods? (DO NOT READ LIST – MORE THAN ONE ANSWER POSSIBLE.)
a) Clinic..... ....
b) Pharmacy ....
c) Other (Specify :_____) ....

24) How old is your youngest baby (boy or girl)?

DK .....

NR .....

25) Are you currently pregnant?
Yes (A) .....
No (ASK B).....
DK (ASK B).....
NR .....

A) Was this your pregnancy intended or did you want to get pregnant?

Yes.....
Did not want to get pregnant at all.....
It has happened before the planned date .....
NR .....

B) Are you currently using any family planning method to space pregnancy?
Yes (ASK i).....
No.....
DK.....

i) Which family planning method or methods do you currently use? You can say more than one. (DO NOT READ LIST – MORE THAN ONE ANSWER POSSIBLE.)

a) Condoms ....
b) Pill..... ....
c) Injections..... ....
d) Breastfeeding ....
e) Abstinence ....
f) Rhythm Method ("sex during safe period"). ....
g) Other ....
(Specify) _____

26) Have you ever used any family planning methods to prevent or to space pregnancy?

Yes (ASK i).....
No.....
DK.....
NR .....

i) Which family planning method or methods did you use? You can say more than one. (DO NOT READ LIST – MORE THAN ONE ANSWER POSSIBLE.)

a) Condoms ....
b) Pill..... ....
c) Injections..... ....
d) Breastfeeding ....
e) Abstinence ....
f) Rhythm Method ("sex during safe period"). ....
g) Other ....
(Specify) _____

27) Do you want to use a birth spacing method in the future?

Yes.....
No (ASK i) .....
DK.....
NR .....

i) What is the main reason you do not want to use a method?

a) Wants children
b) Lack of knowledge
c) Husband opposed
d) Too expensive
e) Fear side effects
f) Health concerns
g) Hard to get method
h) Opposes birth spacing
i) Leave it to nature

j) Religious
k) Husband absent
l) Difficult get pregnant
m) DK
n) Other – Specify ----------

28) Have you ever got pregnant while you are using a modern method?
Yes.....
No.....
DK……
NR .....

29) Is it more likely for a woman to become pregnant?

a) During her period,
b) Right after her period,
c) In the middle of her cycle,
d) Before her period?
e) DON'T KNOW

PART 2, SECTION 3: HIV/AIDS/STI

I'll be asking you know specifically about HIV/AIDS

30) Have you heard of a disease called HIV/AIDS?
Yes (ASK A and B).....
No.....
DK.....
NR .....

A) From what you've seen and heard, how is HIV/AIDS passed from one person to another~~,~~? (PROBE: Any other ways?) (DO NOT READ LIST – MORE THAN ONE ANSWER POSSIBLE.)

i) Sex without a condom ....
ii) Illegal sex without a condom..... ....
("Illegal sex" refers to sex outside of marriage)
iii) Sharing needles ....
iv) Injections ....
v) Mother to baby during pregnancy/childbirth..... ....
.....
vi) Breast milk..... ....
vii) Sharing razors..... ....
viii) Unsafe Blood Transfusions..... ....
ix) Kissing..... ....
x) Holding Hands..... ....
xi) Mosquitoes ....
xii) Other ....

(Specify) _____

B) From what you've seen and heard, what are some ways you can protect yourself from getting HIV/AIDS? (PROBE: Any other ways?) (DO NOT READ LIST – MORE THAN ONE ANSWER POSSIBLE.)

i) Abstinence
ii) Using a condom
iii) Faithfulness of both partners
iv) Not having sex with people at high risk (ie - sex workers, drug addicts, etc)
v) Avoiding sharing needles
vi) Avoiding sharing razors
vii) Avoiding unsafe blood transfusions
viii) Avoiding mosquitoes bites
ix) Seeking protection by traditional healers
x) Other
(Specify) _____

31) Apart from HIV/AIDS, have you heard of any other sexually transmitted infections or diseases that one can get through sex? I mean the ones, such as gonorrhea and syphilis.
Yes (ASK A)
No
DK
NR

A) From what you've seen and heard, what are some of the symptoms of these sexually transmitted infections? (PROBE: Any other ways?) (DO NOT READ LIST – MORE THAN ONE ANSWER POSSIBLE.)

i) Abdominal Pain
ii) Discharge from penis/vagina
iii) Itching in genital area
iv) Burning or pain upon urination
v) Pain/Pelvic pain during sex
vi) Genital ulcers or open sores
vii) Swelling in the genital area
viii) Blood in urine
ix) Failure to pass urine
x) Loss of weight
xi) Incontinence
xii) Other
(Specify) _____

32) Some women experience an unusual discharge from the vagina, or pain in the bottom of their stomachs not associated with their periods. During the last 12 months, have you noticed any such discharge or pain?
Yes (ASK A & B)
No
DK
NR

A) Did you seek any medical care when you had these symptoms?

Yes .....
No.....
INAP .....
DK.....
NR.....

B) Did you urge your husband to seek any medical care when you had these symptoms?

Yes .....
No.....
INAP .....
DK.....
NR

33) Some women experience sores or ulcers in the genital area. During the last 12 months, have you noticed any such sores or ulcers?

Yes (ASK A).....
No.....
DK.....
NR .....

A) Did you seek any medical care when you had these symptoms?

Yes .....
No.....
INAP .....
DK.....
NR.....

34) Are there things that happen in the community that harm to women/girls? Please give examples (examples (DON'T READ LIST- can be more than one answer)

Early marriage
Forced marriage
Female genital cutting
Domestic violence (physical, sexual,emotional, economic abuse by a husband)
Forced sex/rape
Sexual abuse
Sexual harassment
Sexual exploitation
Girls not sent to school at all
Girls stopped attending schools before completing schooling years
Biased feeding in favour of boys/men
Biased medical care in favor of boys/men
Others:
specify……

35) If women/girls face any of the problems you have just mentioned, where do they look for help?

Family member

Friend
Community leader
Women leader
Religious leaders
INGO
National NGO
Health clinic
Government service
Other: _____

36) If a woman experiences forced sex, what services or treatments can she receive?
Emergency contraception
HIV PEP
Tetanus Toxoid
Hepatitis B
STI prevention
Injury treatment
Psychosocial support
Other: _____

37) For female genital cutting, why does this practice happen? (DON'T READ LIST)
For religious belief
To maintain cultural traditions
Due to societal pressure
Pre requisite for marriage
To reduce sexual lability
for hygiene/cleansing
to earn income for the family

38) Considering violence against women, what are the types of violence that cause the most harm for a woman? (DON'T READ LIST):
Domestic Violence
Sexual violence/ exploitation/abuse/harassment
Female genital cutting
Forced marriage
Early marriage
Others, specify……..

39) Excellent, you know so many things; from where do you get all this information? You could PROBE like where else; IEC
Health work at the clinic
Midwife at home
Sign post, poster or band flit
Radio
TV
Friends
Other (specify) ----------

Thank you so much for your time!

Annex: Focus Group Discussion & In-depth interview Guideline

INTRODUCTION: I am interested in learning about some of the health needs of people in this camp. I would like your permission to ask you questions about health care, health needs and other issues that may be related to health care. I hope the answers to these questions will help to improve health interventions; I expect our discussion to last about one hour and individual confidentiality will be respected.

First, I'd like to ask you some general questions about health, health needs and services.

What kind of health services do you use in this camp? What kinds of workers provide these services? Can you go there any time during the day or night?

Are they free? Do they help you and your children?

What kinds of sicknesses do people get here? Can you develop lists of illnesses, healthcare resources, or community priorities in this camp? What are they and which are the most important?

Priority setting

List of health problems	Frequency or Prevalence	Severity[6]	People's concern[7]	Availability of treatment	Total
HIV/AIDS					
Childbirth/delivery					
Cough					
Diarrhoea					
Hernia					
Infertility					
Malaria					
Anaemia					
Miscarriage					
Skin diseases					
STIs					

Now, I'd like to ask questions about women having babies in this camp.

[6] Severity in terms of case fatality rate (how many people die from the disease? Or in term of percentage of people disable as the result of the disease and duration of sickness.

[7] People's concern: in term of social stigma attached to the disease and in terms of fear.

How do women in this camp take care of themselves when they are pregnant? What do the health workers do for them? Do health workers ever visit pregnant women in their homes? What kind of health workers do they see? (doctor, nurse, midwife, traditional healer)

What do people do here in the first six week after delivery for both the mother and the baby? What type of health problems do they normally have? And from whom do people seek help if a problem arises?

Where do women generally have their babies in this camp? Who stays with them while they are in labour? Do you know women who have died while having a baby? or their babies died? Do you know why they died?

Are women treated differently -- better or worse -- by their partners or others -- during pregnancy? If yes, how?

Do most women here breastfeed their babies? Do they start right after the baby is born? How many months/years do they usually breastfeed? How many month do they exclusively breast fed? When does the child receive something in addition to breast milk?

If a woman has a problem when she is pregnant or when she is delivering the baby, who decides how to take care of her? Who is called? Where is she taken? What do they do for her?

Next I'd like to ask some questions about food habits during pregnancy and lactation. What is the food culture, food practices, feeding habits in pregnancy and during lactation period?
What is the local food stuff and cooking methods?

Next, I'd like to ask some questions about family planning/child spacing.
How many children do most couples want? Has this number changed since you arrived here? And how many years should couples have between each birth and why?

What do women and men do to prevent or postpone having babies? Who decide within the couple on family planning? What are the traditional ways? What are the modern ways? In this setting, where do they go to get help for this? What did they do before?

What, if anything, do women do immediately after having unprotected sex to prevent a pregnancy? Where do they get help for this?

Sometimes women are pregnant but they don't want to be because they do not have enough food to feed their children, or they are not married, or they got pregnant when they were raped. What do women do when they think or know they are pregnant but do not want to be?

OK; if a young girl finds that she is pregnant. She is not married. What is she most likely to do? What else could she do? What will happen to her? What else could happen? What would be a good outcome for the girl? What would be a bad outcome for the girl?

Would you mind if we talked about AIDS and Sexually Transmitted Diseases (STDs) for a few minutes?
Have you heard of AIDS?
What are the modes of transmission and modes of non transmission of HIV/AIDS/ STIs?
Are people in this camp worried about getting AIDS? What do they do to prevent it?
What about other diseases you can get from having sex (STIs)?
What do people do when they think they have STIs or AIDS? Can they get tests or get treated here at the camp?
do you know what is the condom and for what use? Is there a place to get condoms in this camp? Who uses them? Married couples? Single adults? Adolescents? People who are sick? Commercial sex workers? Men having sex with men?
One last question...
IEC materials
Can you demonstrate these and what does it mean? (IEC materials)
Are there other healths services that you would like to have in this camp?

Before the end of the discussion, I would like to ask few questions on the safety and security of women and girls and whether they are experiencing domestic violence or other forms of violence; please remember that names or reference to anyone must not be mentioned:

At what age do women usually marry in this community? Are there cases of forced marriage in the community? How often does this happen? What factors make parents/families marry their child early?

What are the traditional practices that could harm women/girls and are commonly practiced in this community? Is female genital cutting practiced? How often does it happen? What motivates people to practice this?

There are men who treat their wives well and men who don't. What are some things that husbands do if they are treating their wives well? What are some things that might be examples of husbands treating their wives badly?

Does a husband have the right to physically punish his wife? Are you aware of violence practiced by women against men?

Do you believe that a wife should never question her husband? Does a husband have the right to physically punish his wife for any reason?

Are you aware of problems with the safety and security of women and girls in this community? (As for examples.) What are the circumstances that cause problems of safety and security of women and girls in this community? (Ask for examples.)

Which groups of women/girls feel the least safe, or most at risk for violence? Why? What actions should be taken to ensure the safety and security of women and girls in the community?

If a woman or girl experiences forced sex, where can she get help? What kind of health treatment can she get?

Is there ever a situation where a woman might be partially responsible or to blame (or at fault) for violence that happens to her? Is it possible that some women ask for sexual assault through their behaviors or attitudes?

Do you have suggestion on how violence can be worked against? What should be done to prevent violence in the family /community? By awareness raising? What is done or need to be done to help violence survivors?

Are there any women's groups/centres in this community? If yes, do women/girls attend organized activities in these centres? What kind of activities/support these centres provide? are they useful for women and girls?

Do women's support networks exist to help survivors? What social and legal services exist to help address problems associated with violence (i.e. health, police, legal counseling, social counseling)? Who provides these services? How could these efforts be improved?

Thank you for your time. I have learned quite a bit about your health concerns. This information will be helpful when my organization reviews health program needs and priorities. Your contribution is appreciated.