Reproductive Health Priorities in an Emergency

WOMEN'S COMMISSION for refugee women & children

Assessment of the Minimum Initial Service Package in Tsunami-affected Areas in Indonesia - *February/March 2005*

Women's Commission for Refugee Women and Children

EXECUTIVE **SUMMARY**

MISP Assessment Findings

The Women's Commission for Refugee Women and Children (Women's Commission) conducted an assessment of the Minimum Initial Service Package (MISP) of reproductive health in February 2005 in Aceh province. Aceh is on the island of Sumatra, Indonesia, the area closest to the epicenter of the earthquake that triggered the devastating tsunami in the region in December 2004. The assessment team visited the districts of Aceh Besar in northern Aceh and Aceh Utara on the northeastern coast. Over all, despite some gaps, findings demonstrate that attention to and funding for reproductive health during the earliest days of an emergency can ensure that displaced populations have access to life-saving reproductive health services.

What is the MISP?

The MISP is a coordinated set of priority activities designed to prevent excess neonatal and maternal morbidity and mortality; reduce HIV transmission; prevent and manage the consequences of sexual violence; and plan for comprehensive reproductive health services.

Assessment Methodology

The Women's Commission team conducted structured interviews and meetings with 32 representatives of local and international nongovernmental organizations, United Nations agencies, donors and the Indonesian Ministry of Health (MOH). The assessment also included 10 focus groups with local people who were displaced by the tsunami. In addition, the team visited local health facilities and local health centers or "puskesmas" in the districts of Aceh Besar and Aceh Utara.

MISP Awareness/Understanding

Approximately half of the humanitarian staff interviewed had heard of the MISP, but only one person could accurately describe the MISP's objectives and priority activities.

Elements of the MISP

- Identify (an) organization(s) and individual(s) to facilitate the coordination and implementation of the MISP
- Prevent and manage the consequences of sexual violence
- Reduce HIV transmission
- Prevent excess neonatal and maternal morbidity and mortality
- Plan for the provision of comprehensive RH services integrated with primary health care as soon as the situation permits

Women's Commission Advocacy to Facilitate MISP Implementation

This is the second assessment the Women's Commission has conducted in a crisis setting to highlight the importance of the Minimum Initial Service Package (MISP) for reproductive health. The first was conducted in collaboration with the United Nations Population Fund (UNFPA) in Chad in April 2004 in response to the Darfur, Sudan crisis. The Women's Commission also conducted a year-long MISP assessment in Pakistan to advocate for improved reproductive health services for Afghan refugees who had fled their country from the bombings following the September 11 attacks on the United States. In addition, the Women's Commission promoted the MISP in Colombia as part of a comprehensive reproductive health assessment of the needs of displaced Colombians. Finally, the Women's Commission is currently working to develop a distance-learning module on the MISP to address the need to raise understanding and awareness among humanitarian workers.

RECO

for

Most of the recommendations are focused on the emergency in Indonesia; however, some are more general and can be applied in any emergency setting.

Overall

- All agencies working in the health sector should prioritize MISP activities before focusing on more comprehensive reproductive health services and training activities. In addition, although hygiene packages are important in assisting the population to maintain dignity, clean delivery kits should be distributed earlier or at the same time to ensure that the needs of pregnant women are prioritized.
- All international organizations should integrate the MISP into their emergency preparedness training and response plans.

MISP Understanding/Awareness

- All international organizations should provide staff, as part or their emergency deployment orientation, with a copy of the *SPHERE Humanitarian Charter and Minimum Standards in Disaster Response*, which includes the MISP.
- All organizations (including humanitarian, Indonesian government and all military actors) providing services in the health sector should address the reproductive health needs of the IDP population, prioritizing the MISP.

Identify (an) Organization(s) and Individual(s) to facilitate the Coordination and Implementation of the MISP

- All organizations should ensure that reproductive health coordination meetings, as part of overall coordination meetings, are established in all emergency sites from the beginning of the crisis.
- All organizations should ensure that local groups have the opportunity to participate in RH working group meetings in each site.

ALL AGENCIES WORKING IN THE HEALTH SECTOR SHOULD PRIORITIZE MISP ACTIVITIES BEFORE FOCUSING ON MORE COMPREHENSIVE REPRODUCTIVE HEALTH SERVICES AND TRAINING ACTIVITIES.

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WOMEN'S COMMISSION for refugee women & children

MMENDATIONS
EMERGENCY SETTINGS

Prevent and Manage the Consequences of Sexual Violence

- All organizations should facilitate the protection of women and girls by supporting the organization and participation of women and women's groups in the implementation of all aspects of emergency response, including identifying the specific security issues of concern in each internally displaced persons (IDP) setting.
- All organizations should promote separate male and female latrines, changing and shower facilities.
- All organizations should be informed of existing national guidelines, including *Information on Reproductive Health: Guidance in the Prevention and Management of Violence Against Women at the Basic Level* (2002) and *Guidance in the Operational Procedures of Integrated Services for Violence Against Women and Children at the Hospital* (2003) and international guidelines, for example, *Clinical Management of Rape Survivors, Revised Edition* (2004) to provide appropriate medical care to survivors of violence.
- Agencies working in the health and community services sector should undertake an information campaign to inform the community about the urgency of and the procedure for referring survivors of sexual violence.
- All international agencies should translate their code of conduct and orient their national staff on the code of conduct to ensure the safety and fair treatment of the IDP population. They should ensure national staff are aware of the standards to which they are implicitly or explicitly held.
- The UN Office for the Coordination of Humanitarian Affairs (OCHA) should identify a focal point and inform organizations of where to report incidents of sexual abuse and exploitation (SAE).

Reduce HIV Transmission

- All organizations working in the health sector should support training and the provision of adequate materials and supplies to ensure health workers practice universal precautions to prevent the spread of HIV/AIDS and other infections.
- All organizations working in the health sector should ensure an adequate blood supply and screening.
- Organizations should consult their national staff about how to introduce condoms into visible but discreet places, such as toilet areas.
- Community health workers (CHWs) and midwives have more knowledge than the communities about HIV and should be used as an entry point to educate the community in a culturally sensitive manner on this urgent issue.
- In the long term, TV could be used to provide information about HIV/AIDS prevention, care and support as many IDPs said the little knowledge they had about HIV/AIDS was obtained through TV.

Prevent Excess Neonatal and Maternal Morbidity and Mortality

- All agencies in the health sector should initiate their activities with a focus on identifying and supporting basic and comprehensive emergency obstetric care and the emergency referral system (rather than, for example, establishing antenatal care services).
- All agencies in the health sector should ensure supplies such as clean delivery kits have been distributed to visibly pregnant women and traditional birth attendants (TBAs) as well as midwives before undertaking training of TBAs or midwives.
- Agencies working in the health and community services sector should undertake an information campaign to inform the community about the urgency of and the procedure for referring women who suffer from complications of pregnancy or delivery.

The Women's Commission for Refugee Women and Children works to improve the lives and defend the rights of refugee and internally displaced women, children and adolescents.

RECOMMENDATIONS cont'd

Plan for the Provision of Comprehensive RH Services Integrated with Primary Health Care as Soon as the Situation Permits

- All agencies working in the health and community services sector should plan for comprehensive RH services with the involvement of refugee women, men and youth to include the management of sexually transmitted infections, family planning and gender-based violence programming.
- The RH focal point should continue to facilitate the collection of reproductive health data (e.g., maternal, infant and child mortality, cases of HIV/AIDS and contraceptive usage) in a standardized manner and share it at the RH coordination meetings to ensure coordinated planning and appropriate response.
- All agencies should ensure the participation of youth in the planning, implementation and evaluation of their program activities.

Other MISP-related Recommendations

Supplies:

- UNFPA should implement an internal emergency response system from which supplies could be deployed immediately in a crisis.
- UNFPA should streamline kit ordering to make it easier for agencies to understand the ordering process based on the three blocks of population (10,000, 50,000 or 100,000). A worksheet should be developed and a point person made available to work with staff on their population figures to accurately determine supply needs.
- International organizations should distribute clean delivery kits at the same time as hygiene packages and recognize that the materials can be procured locally, assembled and distributed with the participation of the affected communities. In addition, community-based midwife kits can be procured directly from the Directorate of Health.
- UNFPA should ensure that boxes containing RH kits should all be clearly marked in English, listing the contents of each box to ensure the exact contents of the box are known and easily identified.

Funding:

- Reproductive health should be integrated into funding proposals from the beginning of an emergency and not delayed until a more stable phase is reached.

GOOD PRACTICES

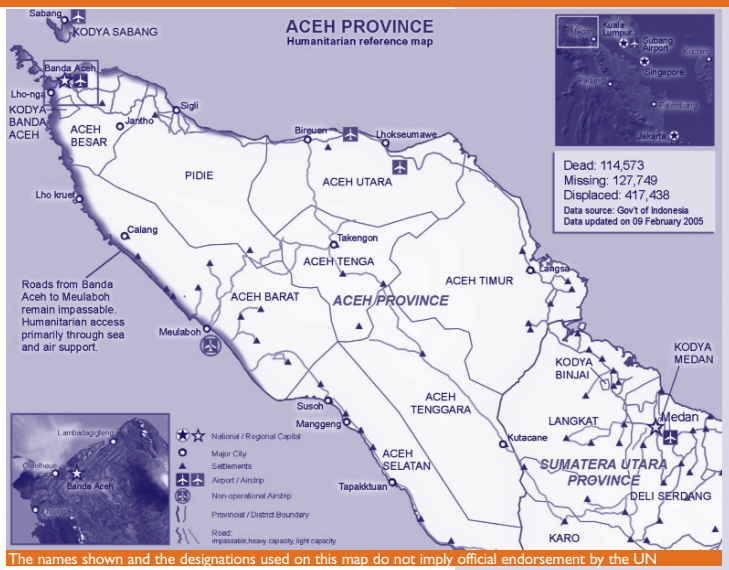
1. **When asked by national staff why there were condoms in the restroom, the organization representative explained: "X Agency is an international organization and wherever we work in the world we make condoms available to prevent HIV transmission in the region we are working." The staff person was satisfied with this answer and condoms had slowly begun to be taken from the condom basket located in the staff toilet.**

2. **One agency conducts an orientation on its code of conduct for its entire staff and then six weeks later provides a brief refresher session so that staff may share examples of issues discussed during the orientation. This is a promising way to ensure that staff do understand the code of conduct and can assist the agency in making any necessary modifications to the local cultural context.**

Aniran, a 22-year-old woman from Manseh Lambade now living in Pekan IDP camp, said she lost all of her family. She only survived because she was able to float on wood. Aniran said, "I don't want anything because nothing will make me feel better."

INTRODUCTION

BACKGROUND on Indonesia and the conflict-affected region of Aceh Province



The names shown and the designations used on this map do not imply official endorsement by the UN

The Republic of Indonesia is located between the Southeast Asian peninsula and Australia in the Indian and Pacific Oceans. It has a popluation of over 224 million, with nearly 60 percent of the population living in rural areas. Indonesia, the world's fourth-most populous nation, is the largest Muslim-majority nation in the world. Eighty-eight percent of the population identify as Muslim. The remainder of Indonesians are Christian, Hindu and Buddhist.[1] The country is divided into 33 provinces. Jakarta is the country's capital.[2]

Indonesia was ruled by the Dutch for over 250 years, until it gained independence in 1949. General Suharto seized power in a coup in 1965 and ruled the country for the next 33 years. He created "transmigration" programs, which moved large numbers of landless farmers from Java to other parts of the country. This program fueled conflict between various ethnic groups, and the Indonesian government has been fighting an on-again, off-again war with the armed separatist "Free Aceh Movement" (GAM) in Aceh, the northern-most province of the island of Sumatra, for more than 20 years. Approximately 10,000 people, primarily civilians, have been killed over this period.[3]

Indonesia has held free elections since 1999. The country has continued to face a great deal of unrest in the last decade. A ceasefire and peace negotiations were brokered between the government and the GAM in late 2002 for the province of Aceh, but in May 2003 the current president imposed martial law and a state of military emergency in Aceh.[4] The government withdrew from peace negotiations in May 2003 and soon thereafter began widespread military action in Aceh. Over 40,000 troops were sent to the province to fight an estimated 5,000 GAM rebels. This military operation became the largest in Indonesia since the invasion of East Timor in 1976. Three consecutive post-Suharto presidents have failed to address the economic, social, governmental and legal grievances which led to the initial fighting, and have allowed it to continue. The new conflict in Indonesia has led to massive human rights abuses against civilians and little prospect for a military solution.[5] The total number of people displaced by conflict in Indonesia is estimated to be 450,000.[6]

The December 2004 tsunami worsened the situation in Aceh. It killed nearly 230,000 Indonesians, the majority living in Aceh, and left 400,000 homeless in the province, where nearly half a million were already internally displaced due to the on-going conflict.[7]

THE TSUNAMI KILLED NEARLY 230,000 INDONESIANS... AND LEFT 400,000 HOMELESS IN [ACEH] PROVINCE...

[1] CIA. World Fact Book. Retrieved on 02/16/05. http://www.cia.gov/cia/publications/factbook/geos/id.html
[2] United Nations Population Division. World Urbanization Prospects: The 2001 Revision, 2001. http://www.un.org/esa/population/publications/wup2001/WUP2001_CH4.pdf
[3] Amnesty International, A brief human rights history of Aceh – http://www.amnesty.org.nz/web/pages/home.nsf/0/69f71454eba2a3b8cc256d3a000b8149?OpenDocument
[4] Human Rights Watch. Aceh at War: Torture, Ill-Treatment, and Unfair Trials, September 2004. http://hrw.org/reports/2004/indonesia0904/indonesia0904.pdf
[5] Human Rights Watch. Country Summary: Indonesia, January 2005. http://hrw.org/wr2k5/pdf/indone.pdf
[6] Global IDP Database. Internal Displacement in Asia & the Pacific, January 2004. http://64.233.161.104/search?q=cAceh:iW5BP96WGUwJ:www.idpproject.org/regions/Asia_idps.htm+number+of+IDPs+by+armed+conflict+in+Indonesia&hl=en
[7] Global IDP Database. Indonesia: Half a Million Wait to Return While Fighting Continues in Aceh, July 2004. http://www.db.idpproject.org/Sites/IdpProjectDb/idpSurvey.nsf/wSummaryPDFs/BF0277A9E883F267C1256E6A004CA996/$file/Indonesia_summary.pdf

Reproductive Health BACKGROUND

Health background

Prior to the tsunami, public health services included user fees except for the poorest of the poor under the social security network. However, since the tsunami, health care is free for one year in Aceh province and according to a WHO representative, this is seriously affecting the income of MOH providers in the province. Perhaps it is also affecting the motivation of these providers, as there were some reports of dissatisfaction with the care at the health centers or "puskesmas" and a preference for health care from the Indonesian military, particularly in Tanah Pasir. According to the WHO representative, the provincial health office (PHO) is planning to attempt to partially compensate the health providers in Aceh province. WHO is also providing support to the PHO and 12 district health offices (DHOs) in the affected areas after initially revitalizing offices and other infrastructure.

Although Indonesia has traditionally had a strong family planning program, resulting in widespread use of contraception among married couples, condoms have not been a high priority and are not widely used in Aceh province. According to a United States Agency for International Development (USAID) representative, family planning campaigns in the country have focused on married couples only, excluding single people. Condoms are part of national guidelines and trainings but have not been accepted like other forms of contraception. Due to the strong Islamic culture, sex outside of marriage is prohibited and condoms are believed by some to promote "free sex."

MISP RH background

There are an estimated 11,350 pregnant women in Aceh who require immediate care.[8] As in all populations, 15 percent of these women will suffer from unforeseen complications of pregnancy and childbirth, necessitating their access to life-saving emergency obstetric care. In addition, reports have noted the shortage of contraceptive supplies in the IDP camps which would lead to unwanted pregnancies in the coming months.

In 2003, the Indonesian MOH adopted and translated the *Inter-agency Field Manual, Reproductive Health in Refugee Situations (revised 1999)*. The MOH also initiated its work on gender-based violence in 2003, with a focus on violence against children. It also published two sets of guidelines on the prevention and management of violence against women. The first, *Information on Reproductive Health: Guidance in the Prevention and Management of Violence Against Women at the Basic Level,* was published in 2002. The second, *Guidance in the Operational Procedures of Integrated Services for Violence Against Women and Children at the Hospital,* was published in 2003 and is reportedly the more complete of the two. The documents include guidance on how to provide services to women at each level of the health system and standard operating procedures, including reporting forms. However, emergency contraception (EC) was not included in these guidelines because the MOH introduced EC after the publication of these documents. In fact, EC was introduced with the publication in 2004 of *Guidelines on Services for Emergency Contraception* in 13 provinces, not

Sabren an 18-year-old woman from Lamlede, told how she watched her parents get swept away while she held the hand of her 10-year-old sister, who also broke away from her. She has one surviving 24-year-old brother who, Sabren said, is also traumatized from the loss of their parents and sister. Approximately 50 percent of their village was totally destroyed and the other half was partially destroyed. Sabren explained that if homes were only partially destroyed the people stayed in the village instead of traveling to the IDP camps. Some of those living in the IDP camps have already moved to the barracks which, Sabren explains, are built in a field of rice far from the IDP camp and their villages. Sabren's brother wants to build a house in the area of their old village. If Sabren had the money she would like to go now to stay with an aunt and uncle in Meulobah.

[8] Estimation of target group in Nangroe Aceh Darussallam, UNFPA, March 8, 2005.

including Aceh province. Emergency contraceptive methods include the dedicated product *Postinor*, Yutzpe method with low dose contraceptives and intrauterine devices (IUDs). There has been some confusion with the use of *Postinor,* as the information, education and communication (IEC) materials surrounding the launch of the product were not updated with current research that states that EC pills can be used up to five days or 120 hours after rape or unprotected sex.

A representative of the MOH in Aceh reported that in April 2004, UNFPA had initiated training and support of the MOH to address sexual violence in two conflict-affected districts in Aceh province, Aceh Jaya and Aceh Selatan. The program included training physicians, nurses and midwives on violence against women. There was also an effort to include police officers; however, police did not participate in the trainings. UNFPA rape kits were provided. The Bureau for Women's Empowerment also provides support for survivors of rape. The Bureau of Women's Empowerment is headed at the national level and is active in 30 provinces and 440 districts. A gender unit was established in 2002 within the Bureau and is supported by UNFPA. According to a UNFPA representative that supports the Women's Empowerment Bureau, there was a GBV program already in place before the tsunami that supported five trauma centers in the province providing psychosocial support, income generation and other activities.

Indicators	Indonesia
Maternal Mortality Ratio per 100,000 live births	307
Infant Mortality Rate per 1,000 live births	35
Total Fertility Rate	2.3
Births per 1,000; women aged 15-19	55
Contraceptive Prevalence (all methods) %	57
Births attended by trained personnel (%)	55.8
HIV Adult Prevalence Rate (%)	0.1
People living with HIV/AIDS	110,000

Sources: State of the World Population 2004, UNFPA
2003 Indonesia Demographic and Health Survey
Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections 2004, UNAIDS

Assessment Methodology

The MISP assessment was undertaken by the director and the senior coordinator of the reproductive health program of the Women's Commission for Refugee Women and Children. The team traveled to Aceh province, Indonesia, from February 20-March 1, 2005 and visited the districts of Aceh Besar in northern Aceh and Aceh Utara on the northeastern coast.

The Women's Commission team conducted structured interviews and meetings with 32 representatives of local and international nongovernmental organizations (NGOs), including reproductive health coordinators, and United Nations agencies, donors and the MOH. The assessment also included 10 focus groups with 77 male and female youth, adults, TBAs and local midwives displaced by or surviving the tsunami. In addition, the team visited local health facilities including the provincial hospital in Banda Aceh (Zainal Abidin) and several local health centers or "puskesmas" in the districts of Aceh Besar and Aceh Utara in sub-districts Darussalam, Tanah Pasir and Seunudon. Site visits were made to IDP camps and new government barracks in these same sub-districts.

Tanah Pasir, which is approximately a half-hour drive from the city of Lhokseumawe, is an area with the majority of the almost 4,000 IDPs living in two camps. The Women's Commission team visited one camp set up on a soccer field and another located on the grounds of a mosque. Lapang is a small town located in Tanah Pasir in which the health center and ambulance were both destroyed. Health services are provided by a different health center and a military mobile clinic. Seunudon is about one hour from Lhoseumawe and the total IDP population of 5,674 lives in three camps.

Assessment Limitations

The assessment team was limited by time and inability to travel to the affected areas of Calang and Meulaboh on the west coast in the sub-district of Aceh Barat. Other constraints included the sheer number of actors responding to the crisis, with approximately 150 NGOs, some of them relatively new to humanitarian response. Provision of medical services was also dispersed among new actors such as military units, including the Indonesian, Australian and German armed forces.

Translation for most of the focus group discussions, with the exception of one male youth group, was primarily conducted by a female without reproductive health background. However, the focus group questionnaire was reviewed with the translator, who quickly understood the questions. One focus group with male youth was not in a private setting by choice of the youth themselves and this may have affected their responses. In addition, the other focus groups with men were likely constrained by a female translator.

The Women's Commission met Lia, a 30-year-old woman at Tanah Pasir camp in Aceh Utara subdistrict on the east coast of Sumatra. She has lived in the camp for more than three weeks and finds the tents hot and uncomfortable. Her house was destroyed by the tsunami. At the time the tsunami struck, she was working in the rice fields while her husband and three children were at home. After the tsunami, she and her family lived with others from her village of Matan Baru in a small field. They later moved to the IDP camp in Tanah Pasir. Although she would like to return to her village, there is no shelter, electricity or water, making this impossible. The government is building barracks where the IDPs in this camp will be moved.

FINDINGS

"Even the most experienced NGO partners and senior colleagues did not know the elements of the MISP necessary for this acute phase. The situation is distressing given the amount of funding that is being funneled to the region."

- Senior Public Health Officer, UNHCR, upon returning from a visit to Banda Aceh in January 2005

"We must wait until the emergency phase decreases and then build reproductive health activities from there."

- Humanitarian worker

"During the first two months of an emergency, reproductive health does not apply."

- Humanitarian worker

General Assessment Findings

The general concerns of the focus group participants included a lack of psychosocial assistance, livelihood support and cash for transport and to rebuild their lives. Others expressed concern at what will happen to their situation when international attention wanes. In other settings concerns were more focused on immediate problems, such as living situations, inadequate water and sanitation and desire for mosquito nets and better nutrition, such as milk for women breastfeeding their babies and for children. Satisfaction with health services varied by setting. Finally, children and youth lacked activities to occupy them.

MISP Awareness/Understanding

While slightly more than half (52%) of humanitarian workers interviewed had actually heard of the MISP, only one of 25 people could accurately describe its overall goal, objectives and priority activities. According to UNFPA, the booklets *Reproductive Health Kits for Crisis Situations*, detailing the MISP supplies available in 12 kits, were distributed to international NGOs early in the crisis. In addition, UNFPA made a presentation on the MISP to the RH working group in January.

Identify (an) Organization(s) and Individual(s) to Facilitate the Coordination and Implementation of the MISP

Coordination of the MISP was led by the United Nations Population Fund (UNFPA), which fielded a designated RH focal point in Banda Aceh within one week of the tsunami and initiated working group meetings among the numerous local and international organizations, as well as the Indonesian health authorities. While more than 100 participants attended a large meeting for humanitarian actors in the first week of the crisis, when the participants divided themselves into multi-sectoral working groups for health, water and sanitation, etc., only three representatives, including UNFPA, attended this first RH working group meeting. However, by the time of this assessment mission at least 35 participants from approximately 30 local, national and international organizations were attending weekly RH coordination meetings, demonstrating the effectiveness of having an RH focal point in place who can facilitate coordinated activities for RH in emergency settings. Successful efforts were also made to include local women's groups, such as Flower Aceh and Solidaritas Perempuan (Women's Solidarity), and national entities such as the National Family Planning Coordinating Board (BKKBN) and the Indonesian Midwives Association (IBI), in these working group meetings. However, there was some indication that ongoing attention was needed to ensure the continued participation of local women's organizations in the weekly RH working group meetings.

In addition, many agencies could identify an individual responsible for RH activities in their setting. WHO organized three RH working group meetings in Jakarta, the first one in mid-January 2005, approximately three weeks after the tsunami. No RH coordination meetings were reportedly taking place on the northeastern or western coast, although UNFPA was planning to initiate coordination activities in Meulaboh, on the western coast in the sub-district of Aceh Barat.

Prevent and Manage the Consequences of Sexual Violence

The team heard anecdotally of a few reports of sexual violence post tsunami from focus group participants and local and international agencies; however, the reports were isolated, unconfirmed and did not indicate a widespread problem. Women and girls in focus groups expressed concern with the lack of privacy and security in some settings and, in some camps, men and women shared latrines. Although rape does not seem to be an issue currently, it is still a concern given the proximity of the Indonesian military (TNI) and the rebel movement (GAM) in the province and reports of violence prior to the tsunami. Therefore, it is of concern that no MOH personnel and few organizations were able to state that they had a sexual violence protocol in place to respond to the clinical needs of rape survivors. One MOH staff said that a rape survivor should report the incident to police before receiving medical care but was then unable to describe any components of medical care, only stating that she would facilitate psychosocial assistance for the survivor. The Women's Commission identified a number of initiatives by local women's groups and international agencies to support trauma centers catering to the needs of the recovering population.

Most international agencies had a code of conduct (COC) in place to address the prevention of sexual abuse and exploitation (SAE) of the displaced population by humanitarian workers. However, many did not know where to report an incident of SAE. In addition, while several agencies were orienting local staff in the COC, most often the COC did not extend to the local or national partners of the international agencies. Given that local staff will continue to grow as international staff rotate out of posts and the Indonesian authorities mandate the exit of foreigners, it is essential to ensure that local and national staff are also oriented in the prevention and reporting of SAE.

- The assessment team heard of isolated incidents of trafficking of young girls by people in the camp, as well as foreigners coming in directly after the tsunami to abduct children. Young women are seen by some agencies as vulnerable as they are being approached by men offering protection and companionship. Some young women are without families, and there are also young widows with infants. Some young women walked around Aceh until they found families to offer them care and support; it is not clear whether the relationship in their living situation is supportive or not.

- Focus group participants did not report any incidents of sexual violence since the tsunami. However, this topic clearly made participants anxious and led to animated discussions. Participants in two focus group discussions agreed that when international NGOs leave the region, sexual violence could be a problem.

- One local NGO representative said that she was concerned that some women, particularly widowed women without any means to support themselves and their families, would turn to prostitution as a means to survive once external assistance ended.

"There are a lot of assumptions because of the Muslim culture but [gender] issues can be addressed if you go to the communities and talk to the people."

- Humanitarian worker

"We take the safety, security and participation of beneficiaries, including women, seriously in our programming."

- Humanitarian worker

- One agency described an internal debate within the organization as to whether local staff should sign a COC. The question has been whether it is realistic to ask people from other cultures to understand and sign a western model COC when, if they need a job, they will be forced to sign in any case. And whether they sign or not, this quote highlights the fact that staff, with or without the COC, are held to certain principles and therefore should receive a COC orientation: *"However, if we found someone breaking the code of conduct, I don't know how long he/she would be working for us."*

- The barracks being constructed by the Indonesian government raised several concerns among agencies and the IDPs themselves. It was noted that IDPs, particularly women, were not consulted in decision-making on shelter issues. Some IDPs were moved far from livelihood opportunities and children's schools. The rooms are built for five persons but it is not clear how people who are not in families of five will be housed. Another concern is that there is nothing for residents to do and no place for children to play. It was also reported that the government is offering IDPs 5,000rs/person/day plus some food and water supplies to those who go to the barracks. People would be allowed to return to their villages but would have to pay their own way and would not receive any of this assistance. IDPs would also be allowed to connect with any NGO cash assistance programs.

- Women were not receiving their own individual registration cards. In some sites visited, IDPs were registered by family and issued cards. In other areas registration lists were kept by the military personnel who were managing the camp.

- International agencies and focus group participants reported that women were not involved in the food or other commodity distribution in IDP camps.

- In many discussions, focus group participants said that if an unmarried couple was found to have had sex, they would be forced to marry. Participants also stated that a rape survivor would be forced to marry the perpetrator.

- No agencies or MOH staff could cite a specific clinical protocol to respond to rape survivors. The MOH in Aceh province was also not aware of the national protocol that was introduced in 2004.

- According to midwives participating in a focus group discussion, emergency contraception would not be provided to rape survivors due to the religious restrictions of Islam. Treatment of sexually transmitted infections would be provided.

Reduce HIV Transmission

Through focus group discussions with women, men and adolescents, the Women's Commission found that HIV knowledge among the population is quite low and stigma toward HIV-positive people is high.

MOH and WHO representatives reported that health workers fail to practice universal precautions, such as cleaning, disinfection and sterilization of medical supplies to prevent the spread of infections, including HIV/AIDS. This was reportedly a significant problem prior to the tsunami and international NGO representatives confirmed it was an ongoing problem. According to the MOH in Jakarta, safe blood transfusion is part of the national protocol and the Indonesian Red Cross (PMI) screens blood. However, one MOH representative in Banda Aceh said she did not think blood was routinely screened. In addition, some NGO representatives had not confirmed whether blood was screened in the hospital where they were working.

- Focus group participants described HIV as a virus that can kill you and a curse. Reactions varied among different groups with some groups saying – accompanied by nervous laughter – they were not worried about HIV – and others reporting they were very concerned. CHWs and midwives have more knowledge than the communities about HIV, prevention and transmission, but also said someone with HIV should be avoided.

- Focus group participants roundly stated that they had never seen anyone with HIV/AIDS and that HIV is not a problem in their area. Participants were reluctant to disclose any knowledge about HIV transmission routes or prevention mechanisms. It was noted that HIV was transmitted by having multiple sex partners or going to prostitutes and that there is no medicine for it. The little information participants did have about HIV, they said, came from television.

- It is taboo for unmarried couples to have sex; therefore, only married people have access to any contraception, including condoms, which are available for free at the health clinics serving displaced populations. Some women focus group participants reported never having seen a condom. For unmarried people to access condoms, they would have to purchase them and some focus group participants described how it would be important to do so away from the village to avoid attention.

- Focus group discussions demonstrated that condoms are very little used, difficult to obtain in some settings and often negatively associated with prostitution.

"HIV is an uphill battle."

- US government representative commenting on the lack of acceptance of condoms in Indonesia as a form of contraception and HIV prevention

"I think it [HIV] is not a big problem here in Aceh."

- Local organization representative commenting on the community perception of HIV

"Aceh people do not get HIV."

- Focus group participant in Aceh Besar district

"Universal precautions are pretty lax."

- Humanitarian worker

"This is a touchy subject here. It could cause us political problems and get us kicked out [of Aceh Province]. We think it is more important to continue our work here."

- Humanitarian worker commenting on whether condoms are visible and available for free in IDP settings.

"Our focus has been more on initial needs [not reproductive health]."

- Humanitarian worker discussing whether clinical protocols to respond to rape are in place – such as EC, post-exposure prophylactics, treatment for sexually transmitted infections (STIs).

Prevent Excess Neonatal and Maternal Morbidity and Mortality

The assessment team did not hear of any reported maternal deaths since the tsunami. Most supplies to support the MISP, such as clean delivery kits and midwife kits for health centers, were available to international agencies within or shortly after the first month of the emergency. However, some kits, such as the traditional birth attendant (TBA) kits, were not available and in some cases the supplies available had not been distributed from the agencies to visibly pregnant women or TBAs at the field level. In addition, three TBAs in one internally displaced setting reported a lack of supplies, stating they only had knives to cut the umbilical cord of newborns and were eager to receive a supply of gloves.

In terms of emergency obstetric care (EmOC), the team identified one successful referral of a woman with postpartum hemorrhage, but generally inadequate measures were undertaken to avoid unnecessary risks for women suffering from complications of pregnancy and delivery. For example, midwives in Aceh Utara provide only limited basic EmOC to stabilize patients, such as intravenous infusions and medication for hemorrhage, but they do not provide care for seizures before facilitating the transport of women. In one setting they also lacked newborn resuscitation equipment, but report providing cardio-pulmonary resuscitation as needed before transferring neonates to the closest hospital, which is approximately 1.5 hours from one district. On the west coast there are only two hospitals, one in Meulobah and one north of Calang, which has an impact on the emergency obstetric referral system according to a WHO representative and international NGO representatives. Sometimes the wait for a helicopter to arrive could be two to three hours, and then the trip is an additional one-half hour. Limited comprehensive emergency obstetric care is currently being provided by the MOH, international NGOs and the military in different sites. According to UNFPA, only one of Banda Aceh's three provincial hospitals still has the capacity to perform a cesarean section.[9] In addition, UNFPA reports that the referral system is not in place for IDPs or the general population in Aceh.

[9] UNFPA Frontlines: The Humanitarian Response Bulletin, Special Tsunami Issue, Forgotten Needs, Feb/March 2005.

Although Aceh province had not received as much attention as other parts of Indonesia in its reproductive health efforts, it has a strong midwives association and the national family planning association was also quite active. Reportedly, 10 percent of 5,500 midwives in Aceh died in the tsunami.[10] In addition, the director was lost in the tsunami and the office was damaged. With funding from USAID, an international health organization affiliated with The Johns Hopkins University in Baltimore, Maryland, was supporting the secondment of 120 midwives from Jakarta to health centers and IDP camps in Aceh for two to three week intervals through May 2005 as well as supporting the midwives' salaries, travel costs and accommodations. JHPIEGO will also refurbish the IBI office and support the infrastructure and administrative revitalization of IBI. In addition, JHPIEGO is planning to provide some counseling support to the surviving midwives. CARE International, Save the Children, Mercy Corps and the International Rescue Committee are also partnering with JHPIEGO to support rehabilitation of health centers and training of midwives. Finally, JHPIEGO has secured funds to revitalize two existing midwife schools in Banda Aceh. Their long-term plans include rehabilitating and refurbishing the schools as well as support to improve training methodologies.

UNFPA is working with the MOH in four districts (Banda Aceh, Aceh Besar, Chalang and Aceh Jaya) to improve basic EmOC. UNFPA and UNICEF have also provided community midwife kits that can be purchased from the Directorate of Health for approximately 700,000 rupiah ($70.00 USD).

- The local NGO Solidaritas Perempuan (SP) conducted an assessment in 14 subdistricts of Aceh and obtained a demographic breakdown of the population, including information on numbers of pregnant women. Its representative stated that pregnant women go to have their babies with other families or were not going to the clinic in some areas because they just want to have their babies in the camps and because there are no health centers around the camp. SP also learned that only a few IDP camps have programs for women and children, such as one in Aceh Jaya.

- Some women also reportedly deliver their babies in the local health clinic or at the home of the local midwife, accompanied by family members.

- Focus group participants had not heard of any maternal or neonatal deaths in any sites post-tsunami. Midwives in Darussalam subdistrict did reference the death of a three-month old baby due to the lack of care received after the death of his mother in the tsunami.

- Some midwives report that they are not provided with supplies and they purchase their own. Pregnant women did not receive clean delivery kits in the IDP camps visited by the assessment team.

Popie is a 73-year-old woman from Matan Baru village. The Women's Commission met Popie in the Aceh Utara subdistrict on the east coast of Sumatra. She was hit by the tsunami in front of her house. She showed how the water came up all the way to her chest and described how she was pinned against a fence by the water. Two of her daughters, her mother and sister were killed. Her house was flattened and she was left with nothing. Now she is living with her only remaining daughter. Directly after the tsunami, someone brought her to a field in Lhokseumawe where the government provided services to her and the other displaced people. She then moved to this camp in Tanah Pasir subdistrict. She and her daughter have enough food and water; her daughter goes to pick up the distribution. She said she feels disoriented, is never happy and wants to go home as soon as possible. The *chamat*, or subdistrict mayor, also helps with provision of food. She has not received any counseling but would like some help in this area. She said she does not know what will happen next.

[10] UNFPA Frontlines: The Humanitarian Response Bulletin, Special Tsunami Issue, Forgotten Needs, Feb/March 2005.

Emergency transport "is not there yet."

- Humanitarian worker on the west coast commenting on availability of emergency transport for pregnant women who experience complications during delivery

- According to focus group participants, a woman experiencing emergency obstetric complications would be referred to the main hospital by ambulance, public transportation, motorbike or the car of the midwife or a neighbor. Organizations in Banda Aceh are able to refer to the ICRC stadium field hospital or the provincial hospital to address emergency obstetric care, and ambulances are available for transport. According to local and international organizations, providing EmOC transport at night can be a problem due to security issues outside of Banda Aceh. However, focus group participants denied problems with transportation to referral facilities in most settings.

- Along the west coast of Sumatra, many roads are still damaged, making helicopter the only form of emergency evacuation, which is costly. Agencies are working to restore the previous referral system by ambulance to the referral hospital.

- Some agencies have prioritized training of TBAs and midwives over distribution of clean delivery materials, and some agencies did not have clean delivery kit supplies.

- Hygiene kits were made available before RH kit supplies in some settings.

Plan for the Provision of Comprehensive RH Services Integrated with Primary Health Care as soon as the Situation Permits

The need to plan for comprehensive RH services as part of the MISP, including ordering reproductive health supplies, was evident in the demand that women affected by the tsunami had for contraceptive supplies. The demand was quickly addressed through collaborative efforts of donors, the National Family Planning Coordinating Board (BKKBN) and UNFPA.

The RH working group was beginning to recognize the need to address the vulnerability of IDP youth, particularly young women, who have lost family members and are living now outside of their own villages among strangers. For example, one group of female youth said that they felt safer before the tsunami when their family would take care of them in their own homes. Now they are sharing shelter and living together with people they don't know.

- Contraceptives were made available by BKKBN and UNFPA in response to the high demand by the displaced population.

- UNFPA has put in place a system to collect information from all 21 districts of Aceh province on neonatal and maternal mortality, numbers of pregnant women and deliveries, spontaneous abortions, antenatal and postnatal services, and the numbers, type and agency where MISP kits are distributed.

Other MISP-related Findings

Supplies:

Some RH kits to support MISP implementation were already in the country when the tsunami struck. However, according to UNFPA's first-ever logistician, supplies were not sufficient and delays were encountered due to problems with UNFPA's supplier. By the time of the Women's Commission's visit, some RH kits were still not available, including kit 0 for administration (and for which materials are easily obtainable locally), kit 2B for the provision of clean delivery kits to TBAs, kit 5 for sexually transmitted infections, and kit 11 for the referral level. UNFPA's logistician recommends an internal emergency system for UNFPA as a way in which supplies can be deployed immediately when a crisis occurs. He also stated that the kits should be easier to understand as agencies currently are not familiar with the ordering process. He also recommended that the boxes containing the kits be clearly marked in English so that the contents of each box are obvious because people, "need to know what to grab when."

One humanitarian worker said her organization would order MISP supplies from UNFPA or WHO, and added, "We can prepare supplies by ourselves as well." Another humanitarian worker said, "We spend a lot of time getting the supplies out there [Banda Aceh], but we need to spend more time getting them to the field."

Funding:

- Only two agencies stated that they had applied for funding to implement RH activities specifically. However, other agencies are including it within primary health care activities.

"There are enough kits here for Acehnese kids to be born for the next 50 years."

- UNFPA logistician commenting on the inaccurate ordering of RH kits to implement the MISP in Aceh province, Indonesia

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Photographs by Sandra Krause and Julia Matthews.

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