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UNDERSTANDING OPERATIONAL BARRIERS TO FAMILY PLANNING SERVICES IN CONFLICT-AFFECTED COUNTRIES: EXPERIENCES FROM SIERRA LEONE

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DISCLAIMER

The authors' views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development (USAID) or the U.S. Government.

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ABBREVIATIONS

CDC	Centers for Disease Control and Prevention
DFID	Department for International Development
DHMT	District Health Management Team
FP	family planning
GBV	gender-based violence
HIV	human immunodeficiency virus
IAWG	Inter-agency Working Group on Reproductive Health in Refugee Situations
IDP	internally displaced person
IEC	information, education, and communication
IUD	intrauterine device
JSI	John Snow, Inc.
Le	Leones (currency)
MISP	Minimum Initial Services Package
NGO	nongovernmental organization
PES	Policy Environment Score
PPSL	Planned Parenthood–Sierra Leone
RH	reproductive health
RHRC	Reproductive Health Response in Conflict (Consortium)
STI	sexually transmitted infection
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
USAID	U.S. Agency for International Development
USD	U.S. dollars
WHO	World Health Organization

INTRODUCTION

The United Nations High Commissioner for Refugees (UNHCR) estimates that there were 20.8 million refugees and internally displaced persons (IDPs) at the start of 2006 (UNHCR, 2006). Forced migration due to war and persecution brings with it a host of risks and insecurities resulting from the loss of family and community ties, limited access to food and shelter, disruption of what may be already inadequate health and social services, and increased psychological trauma and physical abuse. Because of the severe social instability that they experience, refugee/IDP women are likely to have irregular access to family planning and little control over their sexual encounters. These factors place women in conflict situations at an increased risk for unintended pregnancies, poorly spaced or high-risk pregnancies, and sexually transmitted infections (STIs)/HIV. Furthermore, adolescents are at a heightened risk of being sexually abused and exploited—increasing their need for a range of complementary services, including appropriate contraception and counseling.

Through a Policy Lens

A number of organizations—including the Women’s Commission for Refugee Women and Children, Reproductive Health Response in Conflict (RHRC) Consortium, and the Inter-agency Working Group on Reproductive Health in Refugee Situations (IAWG)¹—have raised awareness of the reproductive health needs of refugees and IDPs. As a result, the international community has developed guidelines and protocols that can assist countries and organizations in meeting refugee/IDP health needs. However, despite the existence of guidelines and humanitarian laws and treaties, many countries delegate reproductive health service provision to organizations whose policies:

... do not always correspond to or fully promote international human rights standards ... When camps are assigned to different organizations without regard for whether they provide the full range of reproductive health services, refugees and those internally displaced suffer serious gaps in services (Girard and Waldman, 2000, p. 172).

There is a need for conflict-affected countries to address family planning/reproductive health (FP/RH) for refugees and IDPs at a broader level. The absence of national policies and guidelines means that decisions about who gets family planning and the conditions under which they receive services are determined by individual organizations and, to some extent, individual providers within those organizations. Policies that apply to all agencies functioning within a particular arena (e.g., camp clinics, community health centers)

BOX 1. UNHCR DEFINITIONS

- **Refugee:** Person outside his or her country and cannot return owing to a well-founded fear of persecution because of race, religion, nationality, political opinion or membership of a particular social group; or due to war and civil conflict.
- **Internally displaced person:** Person displaced from their home or place of habitual residence for the reasons noted above but who does not leave his or her country of origin.
- **Asylum-seeker:** Person who seeks recognition as a refugee and who is eligible for legal protection and material assistance.
- **Returnee:** Person who returns to their country or community when conditions permit; the UNCHR encourages voluntary repatriation as soon as conditions are safe and reintegration is viable.
- **Resettled person:** Person who cannot or is unwilling to return home and is resettled in the asylum of a third country.
- **Stateless individual:** Person who cannot claim a legal nationality.

Source: UNHCR 2006

¹ The IAWG is composed of a number of United Nations, NGO, and government agencies and representatives.

establish minimum standards of quality and access and help reduce the disparities in services offered by different providers.

Further, many barriers to health services can be alleviated, in part, by the adoption and implementation of appropriate “operational policies”—which are the “rules, regulations, codes, guidelines, plans, budgets, procedures, and administrative norms that governments use to translate national laws and policies into programs and services” (Cross et al., 2001, p. 1). Operational policies govern various aspects of service delivery, including medical norms, personnel and training, financing, and organizational structures, among others (see Table 1). Appropriate operational policies can facilitate the standardization of family planning services and help improve access and quality of existing services. Operational policy decisions can determine such things as the taxes levied on imported commodities (including contraceptives), the logistic arrangements to facilitate distribution of supplies, the personnel who are permitted to perform different procedures, the services that should be provided free-of-charge to clients, the regulations on spousal or parental consent, regulations on who is eligible for family planning, and more. Non-existent or inadequate operational policies can lead to inefficiency, waste, weak coordination systems, poor quality services, and lack of services, in general, as well as for specific populations. Often, the operational policy barriers that hinder FP/RH services in low-resource settings are exacerbated during times of conflict.

TABLE 1. CATEGORIES OF OPERATIONAL POLICIES

BARRIER	CATEGORY OF POLICY
<ul style="list-style-type: none"> • Frequent absence and turnover of personnel 	<ul style="list-style-type: none"> • Personnel, financing
<ul style="list-style-type: none"> • Disproportionate urban-rural or regional distribution of doctors and nurses 	<ul style="list-style-type: none"> • Organizational structures, personnel, financing, resource allocation
<ul style="list-style-type: none"> • Medical barriers, e.g., restrictions on the personnel permitted to distribute contraceptives or to administer drug treatment, and the requirement of spousal consent 	<ul style="list-style-type: none"> • Medical norms
<ul style="list-style-type: none"> • Limited choice of contraceptives 	<ul style="list-style-type: none"> • Medical norms, financing, taxes
<ul style="list-style-type: none"> • Stock-outs of contraceptives, drugs, and supplies 	<ul style="list-style-type: none"> • Supplies, financing, vehicle/transport
<ul style="list-style-type: none"> • Wastage of commodities 	<ul style="list-style-type: none"> • Supplies, information, financing
<ul style="list-style-type: none"> • Inadequate pre- and in-service training 	<ul style="list-style-type: none"> • Training, personnel, organizational structures
<ul style="list-style-type: none"> • Lack of transportation for emergency obstetric cases 	<ul style="list-style-type: none"> • Vehicle/transport, resource allocation
<ul style="list-style-type: none"> • Weak referral systems 	<ul style="list-style-type: none"> • Organizational structures, training
<ul style="list-style-type: none"> • Burdensome reports for management information systems (and lack of understanding of how the information from service statistics can be used) 	<ul style="list-style-type: none"> • Information
<ul style="list-style-type: none"> • Long delay in new directives from the central level reaching local levels 	<ul style="list-style-type: none"> • Organizational structures, communications

Source: Cross et al., 2001

Objectives of the Study

Recognizing the importance of a sound policy environment and the operational guidelines necessary for putting policies into practice, the USAID | Health Policy Initiative, Task Order 1, conducted a study in Sierra Leone in 2007 to:

- Explore refugee/IDP family planning needs before, during, and after conflict;
- Determine the root causes of the barriers to quality, accessible services;
- Build capacity of local groups to analyze operational barriers to services; and
- Devise policy actions and recommendations for overcoming barriers—that are applicable both in-country and in other conflict-affected countries.

This study highlights issues affecting provision of family planning in conflict-affected settings. It is important to note, however, that a range of complementary reproductive health services (e.g., safe motherhood, prevention of gender-based violence, HIV/STI prevention) are essential and have been identified as part of the Minimum Initial Services Package (MISP) for reproductive health in crisis situations.

In-country Partners

To ensure the study adequately considered the family planning needs of refugees and IDPs, the Health Policy Initiative worked closely with the U.S. Agency for Internal Development (USAID) and the RHRC Consortium in planning the study. USAID has a long history of promoting access to high-quality family planning services around the world and has identified meeting the reproductive health needs of refugees and IDPs as a key priority. The RHRC Consortium—which has seven member organizations²—is a recognized leader in supporting services and developing best practices for improved refugee/IDP reproductive health. The knowledge and expertise of the consortium’s members working in Sierra Leone helped ensure that the study reflected the in-country context. The local Reproductive Health Network and the Faith, Hope, and Charity Foundation provided valuable assistance in making local contacts, identifying study participants, and facilitating research activities on the ground.

Selecting the Study Sites

Sierra Leone was selected as the country in which to conduct the assessment for a variety of reasons. It offered the opportunity to research the needs and experiences of: 1) refugees (from Liberia); 2) IDPs who stayed in Sierra Leone during the conflict; 3) IDPs who fled to neighboring countries and then returned to Sierra Leone and remained displaced after decade-long civil war; and 4) internal populations who were not displaced. USAID, through the DELIVER and AWARE projects, is also assisting Sierra Leone in designing a contraceptive security strategy and use of the findings from this study can help ensure the strategy considers issues related to camps, re-integration and re-settlement of populations affected by conflict, and repatriation programs. Moreover, Sierra Leone was in the process of developing its National Reproductive Health Policy when our assessment began in February 2007. A draft had been submitted to the Cabinet for review earlier in the year and was adopted in June 2007. Therefore, the attention of national policymakers’ is focused on reproductive health issues.

The three primary study sites included the camp and surrounding community near Bo town; the Largo camp and community in Kenema District; and Lungi community in Port Loko District. Bo and Kenema districts are home to the highest number of refugees in Sierra Leone and also have large IDP populations. In Bo, one clinic provides services to both the refugee camp and surrounding community, while in

² Members of the RHRC Consortium include the American Refugee Committee, CARE, Columbia University, International Rescue Committee, John Snow, Inc. (JSI), Marie Stopes International, and the Women’s Commission for Refugee Women and Children.

Kenema/Largo, separate clinics have been established. Lungi was selected for comparison purposes because it does not have any refugee camps and has a smaller displaced population.

Methodology

The Health Policy Initiative collected data during site visits in February 2007 and May 2007. The assessment had four major components (see Table 2).

TABLE 2. DATA COLLECTION MATRIX

FOCUS GROUPS	JOURNEY OF A WOMAN	KEY INFORMANTS	POLICY ENVIRONMENT SCORE
<p>Bo</p> <p>Camp women and men</p> <p>Community women – IDPs who stayed</p> <p>Community women – IDPs who returned</p> <p>Community men</p> <p>Kenema</p> <p>Camp women and men</p> <p>Camp women</p> <p>Camp men</p> <p>Community women – IDPs who stayed</p> <p>Community women – IDPs who returned</p> <p>Community men</p> <p>Lungi</p> <p>Adolescent boys</p> <p>Community women – IDPs who stayed</p> <p>Community women – not displaced</p> <p>Men</p>	<p>Freetown</p> <p>Local NGO representatives (three groups of 5-6 participants, including women and men)</p> <p>Lungi</p> <p>Community women (one group of 12 women)</p>	<p>Providers</p> <p>Bo Camp Coordinator (1)</p> <p>Bo Clinic Coordinator (1)</p> <p>Largo Camp Clinic (1)</p> <p>Largo Community Health Clinic (1)</p> <p>Lungi Health Center (6)</p> <p>National and International</p> <p>CARE (1)</p> <p>International Rescue Committee (1)</p> <p>Marie Stopes International (1)</p> <p>Planned Parenthood–Sierra Leone (PPSL) (2)</p> <p>Reproductive Health Division (5)</p> <p>United Nations Population Fund (UNFPA) (1)</p>	<p>CARE</p> <p>International Rescue Committee</p> <p>Ministry of Development</p> <p>PPSL</p> <p>Reproductive Health Division</p> <p>UNFPA</p> <p>UNHCR</p>
Total: 14 groups	Total: 4 groups	Total: 21 key informants	Total: 7 respondents

- **Focus group discussions:** The research team designed a focus group discussion guide and the key informant and provider questionnaires based on the review of the literature, existing tools for studying operational policy barriers, and information on the policy environment provided by RHRC in-country counterparts and other refugee/IDP program implementers. The discussion guide addresses attitudes toward family planning, availability and costs for services, and changes in demand and access to family planning throughout the conflict period (see Appendix A). Focus groups discussions were organized with women and men in Bo camp and community, Kenema/Largo camp and community, and Lungi community. Participants were identified through purposeful sampling to ensure adequate representation of the groups noted in Table 2.
- **“Journey of a Woman” exercise:** This exercise uses drawing as an engaging method to explore and challenge various conditions and relationships (see Appendix B). It is adapted from a

qualitative approach to needs assessment for health education planning known as “Drawing as Dialogue” (Shaver et al. 1993) and a “Lifeline Exercise” that asks participants to depict important life events and influences using symbols or pictures (CARE Sierra Leone, 2005). Participants in the Journey of a Woman exercise included about 15 NGO representatives involved in the Health Policy Initiative’s advocacy training in Freetown (February 2007) and 12 women in Lungi (May 2007). Participants were asked to use drawings to tell the story of a woman and her family before, during, and after a conflict—highlighting changes in the woman’s desire to use family planning and her access to services along the journey.

- **Key informant and provider interviews:** The key informant questionnaire covers policies, medical norms and standards, access to family planning, and challenges (see Appendix C). The provider questionnaire asks for greater details on availability of family planning methods, logistics, provider attitudes and beliefs, family planning, demand, and conflict-related issues (see Appendix D). Interviewees included 21 policymakers and implementers representing the government, the United Nations Population Fund (UNFPA), Planned Parenthood–Sierra Leone (PPSL), Marie Stopes International, CARE, International Rescue Committee, and camp and clinic coordinators and service providers in Bo, Kenema/Largo, and Lungi.
- **Policy Environment Score:** The USAID-funded POLICY Project designed the Policy Environment Score (PES) to assess the degree to which the policy environment facilitates access to high-quality FP/RH services (Appendix E). The PES questionnaire explores seven aspects of the FP/RH policy environment: political commitment; national policy; organizational structure; legal and regulatory framework; program resources; program components; and evaluation and research. Respondents score each item, which are then averaged to obtain a country representation. The questionnaire is standardized so cross-national comparisons can be made when appropriate. For this study, the PES was adapted to collect information on the policy environment before, during, and after conflict. However, given difficulty in obtaining information for all three time periods, only the scores for after the conflict are presented.

In the subsequent sections, we present major findings on the needs of refugees/IDPs; assess the country’s reproductive health policy environment and identify key operational barriers to service provision; and propose recommendations for in-country and international stakeholders on improving access to family planning. Key recommendations include taking steps to improve contraceptive security, reduce the delays in access to family planning and programs for sexual violence survivors, and strengthen human resource capacity to provide services in conflict situations. It is our hope that this study will highlight the importance of FP/RH policies—and the means to implement them—as essential elements of comprehensive humanitarian relief programs for refugees and IDPs.

BOX 2. RECOMMENDED RESOURCES ON REFUGEE/IDP REPRODUCTIVE HEALTH

- *Inter-agency Global Evaluation of Reproductive Health Services for Refugees and Internally Displaced Persons* (IAWG, 2004)
- *Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations: A Distance Learning Module* (Women’s Commission for Refugee Women and Children, 2006)
- *Reproductive Health in Refugee Situations: An Inter-agency Field Manual* (IAWG, 1999)
- *Reproductive Health for Conflict-affected People: Policies, Research, and Programmes* (McGinn et al., 2004)
- *The Sphere Handbook: Humanitarian Charter and Minimum Standards in Disaster Response* (Sphere Project, 2004)

Issues Affecting the Reproductive Health of Refugees and IDPs: A Review of the Literature

In some cases, camp-based refugees and IDPs have been found to have better reproductive health outcomes than the populations in their host country or country of origin (Hynes et al., 2002). In particular, studies suggest that some risks, such as maternal and infant mortality, increase in early the stages of an emergency but can diminish as refugees benefit from health services in stabilized camp settings (Bartlett et al., 2002). However, a review of the literature finds that several challenges remain for improving the reproductive health of refugee/IDP populations:

- **Reproductive health programs are often not seen as emergency, life-saving interventions in crisis situations** (Beatty et al., 2001). Ideally, programs for refugees/IDPs should cover four main components: family planning, safe motherhood, STIs/HIV, and sexual and gender-based violence (IAWG, 1999). While support for these programs has increased considerably over the past 10–15 years, quality and availability of comprehensive services varies by country, setting, and service provider—with the greatest effort, especially during the emergency phase, afforded to STI/HIV prevention (Krause et al., 2000; IAWG, 2004).
- **Sexual exploitation, gender-based violence, and transactional sex increase during conflicts.** Warring factions often use rape to subdue and humiliate their opponents. In Sierra Leone, for example, more than a quarter million women were raped during the civil war, and rebels forced women and girls to become their wives or sex slaves (Human Rights Watch, 2003). Moreover, women may feel compelled to engage in transactional sex—to protect loved ones, to get food and shelter, or to gain passage through border crossings and get transportation to safer locations (Women's Commission for Refugee Women and Children, 2004).
- **Contraceptive options are often limited and stock-outs are common.** Various supplies are limited in camp settings, including delivery kits, contraceptives, clean water, gloves, soap, and other supplies (Women's Commission for Refugee Women and Children, 2003; Krause and Matthews, 2005). Stock-outs of contraceptives are common due to irregular supply and disrupted distribution systems, as well as difficulties in estimating needed quantities (Dixon, 1996; Beatty et al., 2001). In the context of limited supplies, high demand, and even corruption, clients may be charged informal fees or may be asked to provide their own supplies (Beatty, et al., 2001). In some cases, only one or two contraceptive options are available at a time and long-term methods, seen as less critical in crisis situations, are more limited (IAWG, 2004).
- **Lack of trained staff hampers service delivery.** Shortages of medical personnel are common in camp and non-camp settings (Pougin de la Maisonneuve et al., 2005). Critical issues include identifying and deploying staff with experience in emergency relief (Krause et al., 2000); ensuring staff are trained in family planning counseling skills and the latest contraceptive technologies (Women's Commission for Refugee Women and Children, 2004); retaining staff in difficult, low-paying jobs (IAWG, 2004); and maintaining appropriate gender balance of staff, particularly critical for women seeking care for rape or sexual abuse (Women's Commission for Refugee Women and Children, 2003; IAWG, 2004).
- **Providers lack adequate, consistent guidelines and protocols on service provision.** Despite the existence of guidelines and protocols,³ service providers may not be aware of the guidelines or may face obstacles in effectively implementing them, particularly in acute emergency situations (IAWG, 2004). In some cases, camps have not appointed reproductive health coordinators (Women's Commission for Refugee Women and Children, 2003), as recommended in the MISp. Others lack protocols for addressing rape that include provision of emergency

³ For examples, see Bosmans and Temmerman, 2003; Centers for Disease Control and Prevention, 2007; IAWG, 1999; and Women's Commission for Refugee Women and Children, 2004 and 2006.

contraception (Human Rights Watch, 2005). Policy frameworks for meeting the needs of urban refugees are also lacking (Michael et al., 2005). Inadequate guidelines on coordination and collaboration among service providers in camps can weaken quality and implementation (IAWG, 2004). In the absence of clear guidelines and supervision, service providers may rely on their own judgments to determine which clients are eligible to receive family planning services.

- ***Socio-cultural norms can influence uptake of family planning.*** Refugee/IDP women and men report various religious, cultural, gender, and social norms that prevent increased use of family planning (Morrison, 2000; IAWG, 2004; Women's Commission for Refugee Women and Children, 2003; and Human Rights Watch, 2005). For example, women may be unable to negotiate condom use or may face opposition from their husbands in using other contraceptive methods. Also, attitudes held by men and broader perceptions about male involvement in family planning may result in limited outreach to men. In terms of demand, the stress and uncertainties of conflict situations may result in increased demand for family planning. Conversely, in post-conflict situations, women may feel increased pressure to help re-populate the country, thus limiting demand (McGinn, 2000).

Other challenges include: lack of transportation and long travel distances; inconvenient hours of clinic operation; lack of youth-friendly reproductive health services; lack of appropriate information, education, and communication (IEC) materials for refugees/IDPs; and limited monitoring and evaluation of reproductive health services in camp settings.

FAMILY PLANNING NEEDS OF REFUGEES AND IDPs

Sierra Leone experienced a decade-long civil war that began in 1991 and came to an end with a cease fire in 2001 and the disarmament and reintegration of rebel forces beginning in 2002. The conflict left between 20,000 and 75,000 people dead or mutilated, internally displaced more than half of the population, and caused thousands to flee the country, mainly to neighboring Guinea. With the end of hostilities, from 2001–2005, an estimated 230,000 refugees returned to Sierra Leone (UNHCR, 2007)—many of whom became classified as “returned IDPs” because they remained displaced upon return. Meanwhile, a renewed conflict emerged in Liberia that raged from 1999–2003. The UNHCR estimates that Sierra Leone’s eight refugee camps were home to about 60,000 Liberian refugees in 2005. Over the past few years, with the end of the conflict in Liberia, a number of refugees have begun the repatriation process voluntarily, either on their own or with UNHCR assistance. UNHCR support ceased in June 2007 after having aided in the repatriation of more than 100,000 Liberian refugees from Sierra Leone, Guinea, Côte d’Ivoire, Ghana, and Nigeria. At the time of the study, about 13,000 Liberian refugees remained in Sierra Leone.

Given its history, Sierra Leone offered the opportunity to explore the family planning needs of a variety of conflict-affected⁴ populations, including:

- Refugees from Liberia (Bo and Kenema/Largo)
- IDPs who stayed in Sierra Leone during the civil war (Bo, Kenema/Largo, and Lungi)
- IDPs who left Sierra Leone and returned after the civil war (Bo and Kenema/Largo)
- And populations in Sierra Leone who had not been displaced during the civil war (Lungi).

Findings from focus group discussions with these populations are presented below.

Before the Conflict

All women—refugees, IDPs, and those not displaced during the conflict—reported that knowledge about, access to, and use of family planning were very limited before the conflicts in Sierra Leone and Liberia. Some women said they had not heard about family planning before the civil war and some used traditional methods. Others noted that contraceptives could be obtained from hospitals, clinics, and pharmacies, but could not provide further details on available methods or specific costs. Among men and adolescent boys, knowledge of family planning was even more limited. Family planning was considered “women’s affairs.” Men said that they did not know which services were available for women before the war. Condoms were promoted among men for HIV/STI prevention. Some men reported that they would have been interested in family planning if it had been available.

Knowledge, access, and use of family planning were very limited in Sierra Leone and Liberia before the recent conflicts.

⁴ “Conflict” refers to civil wars in Sierra Leone (1991–2002) and Liberia (1999–2003).

Barriers to family planning use included long travel distances to clinics; opposition from husbands; costs for services; and restrictions based on age, marital status, or parity.

“It was difficult because the clinic was seven miles away. You would have to walk. Then the clinic would not have commodities.” – Refugee woman

“Availability depends on where you were. In some cases, family planning was only given if you were married or if you had 5–6 children.” – Refugee woman

“People could not pay for services.” – IDP man

During the Conflict

The “during conflict” period has various phases. It includes periods of flight from dangerous zones; initial intake into camps where emergency needs are attended to; and the beginning of stabilization of life in camps or communities. Both refugees and IDPs may go through multiple moves within and across borders before finding a place with relative stability. During periods of flight, affected populations are likely to have the least access to family planning and women are most vulnerable to sexual abuse. Despite this, many women reported that their perceived demand during flight was low—primarily because they were on the move or in hiding and family planning was not a top priority in relation to their basic survival needs.

While still limited, refugees—through camps—experienced a greater increase in access to family planning than IDPs. Both populations were concerned mainly about basic survival, though some expressed growing interest in family planning.

“We were not thinking about family planning. Just hiding in the bushes and trying to save our children.” – Refugee woman

“I was off [of family planning] for five months during the war.” – Refugee woman

“There was shooting and raping.” – IDP woman

“I was captured by rebels and taken into the bush.” – IDP woman

Given the challenges associated with forced migration, some women expressed a growing interest in family planning during the conflict.

“Women were looking at suitcases and kids they had to move.” – IDP woman

For refugees, entering a camp offered the possibility of some support. Refugee women and men reported feeling safer after entering the Largo camp in Kenema District, but said that family planning was not available until after the conflict (2004 for condoms, and 2005 for pills and injectables). The priority when they entered the camp in 2002 was on the provision of food, water, and shelter. Refugees in Bo also reported limited access during the conflict, though some received family planning for free through the UNHCR. Men in Bo reported that their access to condoms increased during the war due to NGOs that held meetings and distributed condoms for HIV prevention. Given their own increased access to

commodities during conflict, some men perceived that women also had greater access to family planning, though most women did not share this view.

IDPs, generally not served by camps, had greater difficulty accessing services during the conflict. Men and adolescent boys in Lungi—a community that did not have refugee camps—had limited knowledge of family planning and said that family planning was not available. Women from Lungi discussed the various challenges they faced during displacement, particularly the lack of food and the deaths and torture of loved ones. For women in Lungi, access to family planning was limited.

“We did not have money to reach a doctor and you would have to pay.” – Woman in Lungi

“During the war, there was nothing available.” – Woman in Lungi

After the Conflict

After the conflict, family planning access increased, particularly for refugees and IDPs in communities with refugee camps. In camps, condoms were more readily available initially, followed by oral contraceptives and injectables over time. In Bo, one clinic serves both the camp and the community. The clinic is open five days a week, 8:00am–4:00pm, as well as on Saturdays for emergencies. Family planning is scheduled for Thursdays, but can be obtained any time. According to IDP women in Bo, the hospital offers oral contraceptive pills and injectables. In Kenema, the Largo camp clinic serves refugees and is open seven days a week; Saturday and Sunday are for emergencies only. IDPs are served by the community health center and district hospital. The health center is said to have pills and condoms only, while the hospital offers pills (one type), injectables, and condoms. Markets offer a greater variety of options. Intrauterine devices (IUDs) were not commonly available or used in either district. Some women reported that IUDs could be obtained in Freetown, Sierra Leone’s capital city, for 60,000 Le (~ 20 USD).

Stock-outs in Bo and Kenema were reported to last from one week to one month, with some focus group participants stating that stock-outs were common and others stating that they were not very common. During these periods, women reported that they try to abstain or use condoms, but that sometimes condoms are also not available. Men said that sensitization

activities and condoms were commonly available. While clinic services were said to be free, women disagreed as to whether hospitals and community health centers offer free services. Some IDP women reported that prices were lower in the markets, so they often bought injectables at a shop and took them to the hospital to have them administered.

While most women were not using family planning before the conflict, a majority reported demand after the conflict.

Among men and women in Lungi, focus group participants reported that family planning was not available during the first year after Sierra Leone’s civil war and that facilities such as hospitals were still in a state of disarray. IDP women in Lungi reported that they do not know what contraceptives are available in the market now, especially because they believe women who use contraception have to keep it hidden. Women said that family planning is available in hospitals in Freetown, but they do not travel there. Men and adolescent boys said condoms are available through NGOs, hospitals, and pharmacies, but there was disagreement as to whether they are provided for free or not. Women in both Bo and Lungi noted restrictions on family planning access for single women, adolescents, and women with low parity.

Women reported some demand for family planning during conflict; however, after the conflict, a majority of women and men said that they were interested in family planning. Some refugee women said that they

had been sensitized, by national and international NGOs, to the need for family planning and that they hope to help raise awareness among their sisters and other women when they return to Liberia. Before the war, they remembered being afraid of possible side effects of family planning use, but now had concerns about maternal mortality and large family sizes. Most participants also supported provision of family planning for adolescents, especially as a means for improving educational opportunities for girls.

“Everything depends on you. If you tell us [about family planning], we will come.” – IDP woman

“I hope I will be near a clinic [when I return to Liberia] so I can continue family planning use.” – Refugee woman

“If we have too many children, we can’t take care of all of their needs and some may become rebels.” – IDP man

“We want more training to teach our daughters to have fewer children and have more opportunities for education, maybe even higher education.” – IDP woman

Some women said that they were not interested in using family planning, primarily because they had lost children during the conflict.

Issues Affecting Service Quality and Access

In addition to issues such as costs and stock-outs, other barriers to improved family planning quality and access identified by focus group discussion participants include:

- Lack of community-based distribution.
- Shortage of trained reproductive health specialists who can provide adequate family planning counseling.
- Inability/unwillingness of providers to recommend different contraceptive options if the client experiences side effects.
- Long wait times and poor treatment at health facilities.
- Condom promotion that is limited to HIV prevention and does not take advantage of the opportunity to also raise men’s awareness of the benefits of fertility control.
- Greater attention needed for men’s reproductive health issues.

Journey of a Woman: The Vulnerability of Refugee and IDP Women

The “Journey of a Woman” exercise provided another way to explore the experiences of women affected by conflict situations. In the exercise, participants used drawings to depict the journey of a woman and her family before, during, and after conflict. Participants drew a line across a flipchart paper showing the different times in the woman’s life. Then they depicted important events and influences throughout the journey by drawing symbols and pictures with “happy” events above the line and “sad” events below the lines. Use of drawing as a qualitative research method can enhance investigative efforts by allowing for a deeper exploration of the participants’ world views, experiences, and emotional responses. Participants included women and men from NGOs in Freetown (three groups) and community women in Lungi (one group).

The experiences participants depicted in the drawings reinforced findings from the focus group discussions and key informant interviews (see Table 3). However, what came out more prominently was the experience of sexual violence and exploitation. In telling the story of the fictional woman, participants described having to exchange sex for food and the high incidence of rape during flight and even in camps. Men, too, experienced torture and violence. Families were often separated. Feelings of fear, insecurity, blame, and stigma—especially due to pregnancies resulting from rape—were common.

“We were all in the hands of God.”

“You have to play the game [to get more food rations].”

“Sometimes better to keep quiet and survive.”

While participants said the woman was interested in family planning, she had no access during the conflict and she was focused on survival. After the conflict, participants expressed the woman’s desire for family planning before being resettled, but again lamented the lack of services. The breakdowns in health facilities and in family support systems were significant concerns.

“Everything was destroyed.”

In observing the report back and sensing the emotions in the groups, it was clear that the participants were not only describing the journey of a woman, but also the real-life experiences that many of them had lived through and survived. Depicting the story of a fictional woman enabled participants to talk about sensitive issues and experiences that they may have felt reluctant to share about themselves in a focus group or interview setting. As such, it was a very powerful and emotional exercise.

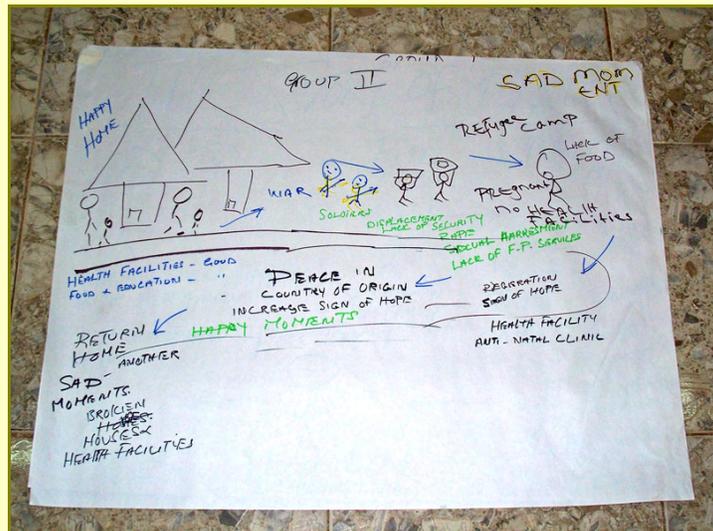


TABLE 3. SUMMARY OF PARTICIPANT DRAWINGS AND DISCUSSIONS

Before Conflict	During Conflict	After Conflict
<ul style="list-style-type: none"> Time of peace and happiness Presence of family composition Some desire but limited access to family planning 	<ul style="list-style-type: none"> General desire for family planning No access for family planning services No security Families were separated Rape was rampant during fleeing and in camps Focus on survival Fear Victimization and sexual exploitation (some by social workers) Exchanged sex for food Pregnancies resulting from rape, leading to stigma 	<ul style="list-style-type: none"> Still feeling of insecurity No healthcare or proper reproductive healthcare Facilities destroyed Desire for family planning, but no contraceptives available Want supply of contraceptives before being resettled Stigma and victim blaming, some pushed out of community Upon return to community, lack of extended family support due to deaths

FP/RH SERVICE PROVISION: KEY OPERATIONAL BARRIERS

The health system in Sierra Leone was weak prior to the outbreak of civil war and the long-term impact of years of conflict on health and social systems is evident (see Box 3). The country ranks 176th out of 177 countries in the Human Development Index, which considers life expectancy, education, and standard of living.⁵ Its maternal and infant mortality ratios are among the highest in the world. The total fertility rate is also high (6.5 births per woman), while the contraceptive prevalence rate is low (3.9% for modern methods). However, some progress has been made since 2002 in terms of post-conflict reconstruction.

To assess the reproductive health policy environment and family planning service provision, 21 key informants were interviewed in February and May 2007. Informants included representatives from the government, international donors, international and in-country NGOs, and camp/community-level service providers. This section reviews key findings regarding national policy; service provision guidelines; services offered; costs; eligibility; commodities; demand; and access for adolescents.

BOX 3. HEALTH INDICATORS

Human Development Index (out of 177)	176
Total Population	5.5 million
Life Expectancy at Birth	41.3 years
Maternal Mortality	2,000 deaths per 100,000 live births
Infant Mortality	162 per 1,000 live births
Total Fertility Rate	6.5 lifetime births per woman
Population Growth Rate	3.1%
Contraceptive Prevalence Rate, Modern Methods	3.9%
Contraceptive Prevalence Rate, Any Method	4.3%
Median Age of Total Population	18.4 years
Projected Increase/Decrease in Women of Reproductive Age, 2000–2015	+34.8%

Sources: UNDP, 2006; UNFPA and Population Reference Bureau, 2006

Organizations Lack Consistent Service Guidelines and Protocols

Prior to June 2007, Sierra Leone did not have a national policy on reproductive health. In the absence of national norms and protocols, key informants reported that their organizations adopt their own guidelines for service provision—generally by adapting guidance from agencies such as the World Health Organization (WHO), Médecins Sans Frontières, UNFPA, or International Planned Parenthood Federation. One provider in Kenema/Largo reported using protocols from the District Health Management Team (DHMT). While these protocols may include guidance on various types of contraception or about the side effects of different methods, various aspects of service delivery are undefined; therefore, many decisions are made at the organization/facility or even provider level. In particular, the lack of consistent protocols means that the services offered, costs for services, and eligibility for particular methods vary by organization.

⁵ Human Development Report 2006 Country Fact Sheet: Sierra Leone. Available at http://hdr.undp.org/hdr2006/statistics/countries/country_fact_sheets/cty_fs_SLE.html

Costs are Transferred to Clients

While a number of key informants said that family planning services are supposed to be “free,” with the lack of a policy, it is unclear if this includes all aspects (e.g., contraceptives, syringes, lab tests, etc.) or only certain aspects of service provision (e.g., contraceptives only). Some key informants—such as in Lungi community and Kenema/Largo camp—reported that they provide free family planning services. Other respondents provided the price lists for various commodities they provide (e.g., 500 Le [~ 0.17 USD] for one package of condoms). Another respondent reported that he provides commodities for free when the free stocks are available, but that clients pay for commodities and transportation if he has to go to the pharmacy to procure them (e.g., 1,500 Le [~ 0.51 USD] for one cycle of oral contraceptives). Further, one key informant noted that providers at the village and community level charge “informal” fees for reproductive health services that vary depending on the client (e.g., a friend of the provider pays less or not at all). A few respondents noted that fees go up when stocks are low and demand is high.

Lack of implementation guidelines and protocols results in disparities in the services offered by different organizations—particularly in terms of fees for services and restrictions based on age, parity, marital status, and spousal or parental consent.

Provider Bias Can Restrict Clients to Specific Methods

One international NGO representative reported that the organization provides the contraceptive method the client asks for, believing it should respect the client’s wishes and that this will increase use of the method. In other cases, there are varying types of information being given to clients that are not always accurate or based on current international recommendations and guidelines. As such, clients are restricted to certain family planning methods. Age, parity, marital status, and spousal or parental consent arose as the primary reasons that providers recommended particular methods or refused to provide family planning. For example, regarding injectables, key informants reported that:

- Injectables are only for women with multiple children
- Injectables are only for women who are 25 or older and who have had five or six pregnancies
- Women must be 30 or older to receive an injectable
- Women must be 35 or older to receive an injectable
- Injectables are not given to adolescents due to concerns about amenorrhea
- Women who want to hide their contraceptive use are given injectables, but are encouraged to talk with their husbands (“It will cause trouble in the marriage if you keep taking in private”)

Regarding oral contraceptives, key informants noted that:

- Women should have 1–2 children before taking oral contraceptives
- In some cases, when women request a pill that is not available, they are referred to a pharmacy to purchase the pills, as opposed to being counseled on alternatives
- If a woman has complications due to one type of pill, providers can only offer injectables because other pills are not available

Stock-outs of Commodities are Common

Sierra Leone's Reproductive Health Division receives contraceptives from UNFPA and USAID, and then provides them for free to DHMTs, who distribute supplies to community-level facilities and eligible NGOs. Affiliates of international NGOs also supply their own commodities. There is an informal system whereby the ministry and international and local NGOs share contraceptives with each other as needed and when supplies are available. Key informants reported that during the conflict "nothing was available," including basic medicines. Mobile clinics provided primary healthcare services, but not family planning. A key focus during the war was the provision of condoms to military forces to help prevent the spread of HIV. One international organization reported that there were restrictions on imports during the war and, as a result, the organization sent its own vehicles back and forth to Guinea to obtain commodities.

Key barriers are taxes, customs delays, and storage fees. When commodities are limited, costs are passed on to clients.

All key informants reported stock-outs and problems with importation and distribution of commodities as a primary barrier to family planning service provision, both during and after the civil war. Some of the barriers that contribute to stock-outs include:

- **Ordering process:** Supply ordering processes vary. One international NGO that receives commodities through its parent organization makes annual requests. Providers who get supplies from the government order supplies on a monthly basis, but reported that they do not always receive everything ordered. In some cases, order forms are used and, in others, requests are made "on any paper." One provider received supplies based on what was used in the previous month. A community health center provider stated that it is not possible to get commodities outside of the regular ordering process, while a camp clinic provider—which gets supplies from an international NGO—said that emergency orders are possible.
- **Taxes, customs, and storage fees:** While family planning commodities are supposed to be tax-exempt, most key informants reported issues with having to pay taxes on imported commodities. Other challenges include delays at the port and lengthy, slow customs procedures, which can result in damaged or expired supplies. While the supplies are held for customs, organizations are charged steep storage fees, which are often higher than the taxes. As a result, organizations often pay the taxes to avoid having to pay storage fees while the matter is sorted out.
- **Cost and quality control:** When supplies are not available, some providers turn to pharmacies or markets to procure them. The costs are then passed on to clients. Moreover, key informants warned that some oral contraceptives available locally are "fakes."

Community health center providers reported that they could provide more services if they had more commodities, a steady supply of commodities, and IEC materials. The Reproductive Health Division is working with the USAID-funded DELIVER and AWARE projects to draft and finalize a contraceptive security strategy.

Conflict Affects Demand for Family Planning

Prior to the war, providers report that knowledge, demand, and use of family planning were extremely low. Most respondents believe that demand for family planning has increased after the war due to a number of factors:

- Refugee women awaiting repatriation do not want to be pregnant or have to move more children, and they want extra commodities to take with them in case family planning services are limited in Liberia;
- Refugee women wishing to settle in Sierra Leone think that they cannot be pregnant if they want to stay;
- Families fear another conflict or are currently displaced in-country and, therefore, want to limit the number of children they will have to move;
- Awareness about family planning increased due to services provided through the camps;
- Food is more limited now and parents want to be able to feed and educate their children, causing people to limit their family size; and
- At the same time, improved economic conditions for some and a return to peace encourages interest in family planning.

In general, sensitization through refugee camps and the challenges in moving large families displaced by conflict have contributed to increased demand. However, some populations wish to re-build the families they lost during the conflict.

One community health center provider suggested that demand has increased among refugees, but has decreased among Sierra Leoneans because they want to re-build the families they lost during the war.

Youth-friendly Services are Limited

Respondents noted that, even without conflict, adolescents face socio-cultural pressures that affect their reproductive health—such as the expectation that girls should marry by the age of 16. In terms of family planning, youth may be reluctant to seek services due to lack of confidence in the facility, concerns about confidentiality, and fears regarding side effects from certain methods. Representatives from international NGOs operating in Sierra Leone observed that the concept of “youth-friendly” FP/RH services has yet to take hold in the country. These organizations do conduct programs for youth, including youth care centers and in- and out-of-school awareness-raising activities, but warned that family planning access varies according to the providers, who serve as “gatekeepers.”

All key informants stated that access to family planning for adolescents is severely limited in Sierra Leone. One respondent from an international organization reported being uncomfortable giving contraception to persons under 18 and that this is only done in emergency cases. In such cases, the clients are asked to return with their parents later. A community health center provider said that condoms are given to those under 18, but not pills. A camp clinic provider said that clients under age 16 are requested to bring their parents and that a home health worker will be sent to their house if they refuse to talk to their parents. A respondent from a local NGO stated that some adolescents, if they have parental consent, can access

Nearly all providers require parental consent. Provider biases and adolescents' own misconceptions about different methods also limit their access and choice.

family planning but that he believes it leads to “promiscuity.” In contrast, one provider at a community health center provides family planning to adolescents and they are not required to bring their parents. He also visits schools and encourages women, during regular antenatal checkups or under 5 exams, to bring their adolescent children to the clinic.

Providers reported that adolescents seeking family planning services prefer oral contraceptives and condoms. Some providers offer IUDs to adolescents. Many providers hesitate to offer injectables because, they explain, some girls believe they have become pregnant (due to amenorrhea) and seek clandestine abortions, putting their health at risk unnecessarily. However, one provider reported recommending injectables if girls are sexually active. In some cases, providers offer counseling on methods and side effects, but youth believe what they have heard from friends rather than the information imparted by medical professionals—thus affecting their choice of methods.

Services to Address Gender-based and Sexual Violence Require Greater Attention

Representatives from the Reproductive Health Division reported that UNFPA is working with the government to support programs to address gender-based violence (GBV). Bo camp and clinic coordinators also reported that a variety of services are provided to the camp by different NGOs, including GBV programs, HIV prevention, and reproductive health literacy training for women and girls. Given the high level of rape experienced by refugee and IDP women, access to emergency contraception is an essential component of comprehensive reproductive health programs in conflict situations. Most providers had limited knowledge of emergency contraception. In health facilities where emergency contraception was available, it was not well-publicized and was only available to women who go to the facility for care after an assault.

BOX 4. OTHER KEY CHALLENGES

Other barriers to improved family planning access and use identified by key respondents include:

- Inadequate infrastructure and minimal national budget allocation for health;
- Human resource shortages and lack of training (e.g., nurses are recruited to other countries);
- Limited knowledge and misconceptions about family planning among clients;
- Gender inequality, hindering women’s decisionmaking power regarding use of family planning
- Lack of community-driven services; and
- Camp clinic services depend on the funding source and implementing agency—if the donor or the organization operating the clinic changes, the services offered might also change.

National Policy Needs Implementation Guidelines

Sierra Leone followed a comprehensive, participatory process to draft its National Reproductive Health Policy and a number of the key informants in this study played a role in the process. They explained that, with support from UNFPA, the manager of the Reproductive Health Division convened a three-day workshop to initiate the formulation process. The event was attended by about 40 participants from

various ministries, UN agencies, WHO, and NGOs. A needs assessment was conducted and technical working groups were assigned different sections of the policy. The Reproductive Health Division manager visited other countries, including Ghana and Nigeria, to learn about their policies. The policy drafting team also organized community/rural consultations. The International Rescue Committee sponsored a policy writing workshop that resulted in the initial draft of the policy. About 200 copies of the draft policy were circulated to stakeholders for review and comment. A consultant supported by the United Kingdom's Department for International Development (DFID) incorporated feedback and prepared the final draft. The policy was submitted to the Cabinet in January 2007 and approved in June 2007.

As the final policy had not been adopted or publicly released when the interviews were conducted, key informants were limited in their ability to comment on potential gaps in the final policy. Based on an earlier draft, one respondent noted that the policy did not specifically mention post-conflict situations or camp services. (Note: A review of the final policy confirms that the unique needs of refugee/IDP populations are not mentioned in the policy.) As is the nature of national policy documents, Sierra Leone's final policy identifies priority objectives and broad strategies, but does not provide specific details or guidance on implementation—which is the domain of strategic plans and operational policies. Such plans and guidelines are needed to help put the policy into practice.

Following a participatory process, Sierra Leone adopted a National Reproductive Health Policy in 2007. Now, operational strategies and guidelines are needed to help put the policy into practice.

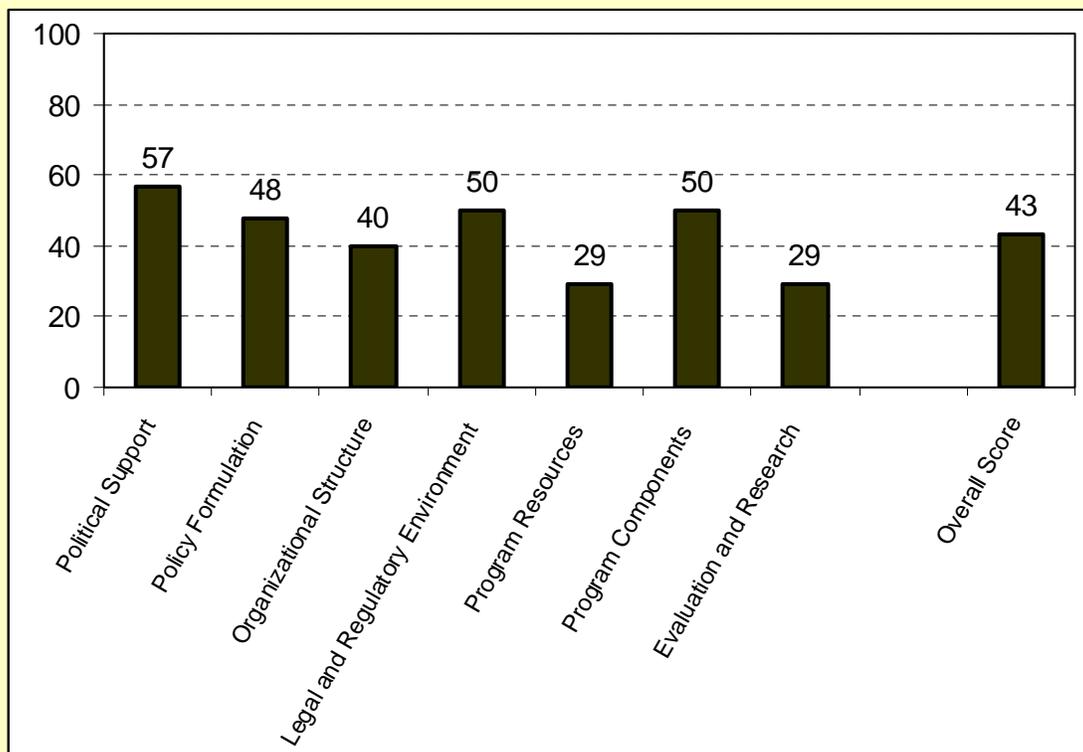
Sierra Leone's Policy Environment Score

In early 2007, seven key informants provided information on Sierra Leone's current family planning policy environment through the Policy Environment Score (PES) questionnaire (see Appendix E). The PES ranks seven aspects of the policy environment. An "enabling" policy environment is one that provides the necessary foundation to facilitate high-quality, cost-effective, and efficient services for all in need.

Sierra Leone received an overall PES of 43 (see Figure 1). The highest ranked items were political support (57), legal and regulatory environment (50), and program components (50), though all three show considerable room for improvement. The relatively high rankings for these three areas could reflect the fact that Sierra Leone was in the process of developing its National Reproductive Health Policy at the time of the study. Program resources (29) and evaluation and research (29) received the lowest scores. Aspects of the policy environment that received mid-range scores included policy formulation (48) and organizational structure (40).

Many of these components—from organizational structure and evaluation and research to better use of program resources—could be enhanced by the adoption and implementation of appropriate operational policies.

FIGURE 1. PES SCORES BY COMPONENT (AFTER CONFLICT)



Note: The PES questionnaire for this study was initially designed to capture information from three time periods: before, during, and after conflict. However, due to the difficulty in obtaining data regarding the before and during conflict periods, Figure 1 presents findings regarding the after conflict period only.

DISCUSSION AND RECOMMENDATIONS

A discussion of the key findings and recommendations based on the four components of the study follow below. The recommendations highlight how appropriate operational policies can help alleviate the barriers currently encountered in family planning service provision in conflict-affected areas.

Key Findings

- In general, awareness of and demand for family planning among refugee/IDP women and men increased over time due to sensitization through camps; increased availability of condoms through HIV prevention programs; and because of the challenges inherent in moving large families. Some individuals, however, wished to re-build the families they lost during conflict.
- Knowledge and access seemed to increase more for populations living in or near camps, as they had the greatest concentration of services provided by international organizations. Strategies are needed to help ensure that family planning needs of the host community, the IDPs, and refugees are met even after international assistance ends. In particular, repatriation plans—which often focus on issues such as shelter, nutrition, and economic stability—need to also consider health needs, including reproductive health.
- Despite greater awareness and demand, access to family planning for refugees and IDPs remains limited. In the initial stages of conflict, the primary focus was on condom distribution to prevent the spread of HIV. Women’s access to a variety of methods, particularly long-term methods, was delayed. Now, commodities are available only in certain facilities; costs may be high even though family planning is supposed to be provided for free; and the variety of options is limited. In some cases, women buy their supplies in the market and take them to the health facility for treatment.
- Access to family planning and the ability to choose from a variety of methods is even more limited for adolescents, unmarried women, and women of low parity, because providers may place restrictions based on marital status, age, spousal or parental consent, and parity. Provider bias or lack of knowledge on the latest contraceptive technologies, lack of consistent guidelines, and shortages in commodities are all reasons why providers may limit methods for certain groups. In these cases, condoms may be the only option available for young, unmarried, or low parity women—yet negotiating condom use may pose a challenge for many women.
- Services for survivors of sexual violence were delayed and both providers and women lacked knowledge of emergency contraception. Given the lack of information on emergency contraception, most women do not even know that it exists or is available. The only way women could receive emergency contraception is if they go to the health facility for care after an assault—which is not likely because of reticence to file police reports and fears about stigma from their community or poor treatment from providers.
- Greater involvement of men in reproductive health is also needed. Many programs focused on HIV prevention among men and did not raise awareness of family planning concerns or address men’s reproductive health issues—which may have resulted from torture and abuse during

conflict. Moreover, because of their improved access to condoms, men perceived that women's access to family planning also increased, which was not generally the case.

- Given the challenges in seeking services through facilities—including long travel distances (for women living outside of camps), frequent stockouts, long wait times or poor treatment at facilities, and high fees—both women and men expressed the need for community-based distribution of family planning commodities.
- Quality of care is hampered by a lack of trained reproductive healthcare providers and inadequate counseling skills, resulting in clients not receiving accurate information on family planning methods or referrals for different methods when they experience side effects. This issue highlights the need for improved human resource capacity across all organizations providing family planning services, both inside camps and out, and for both the technical and human aspects of family planning counseling. The fact that many women and men in conflict situations may have survived abuse or lost loved ones means that even greater compassion is needed among providers in conflict situations.
- Lack of operational guidelines and protocols, both inside camps and at the national level, results in disparities in the services offered by different organizations in Sierra Leone—particularly in terms of fees for services and restrictions based on age, parity, marital status, and spousal or parental consent. This means that the type, quality, and cost of family planning that women receive might not be based on their personal or medical needs, but on where they seek the service.
- Stockouts of commodities were common. Key barriers are taxes, customs delays, and high storage fees. Ordering processes also vary by organization. In some cases, orders are based on the previous month's consumption as opposed to projecting future needs or considering what could have been provided had more supplies been available. When providers must go to markets to buy commodities, costs are passed on to clients. The lapses in access to commodities may also reduce a woman's desire and willingness to continue to use contraception.
- Following a comprehensive, participatory process, Sierra Leone adopted a National Reproductive Health Policy in 2007. Now, operational strategies and guidelines are needed to help put the policy into practice, improve quality and access, and reduce disparities in services. This is particularly critical with the emptying of the Liberian refugee camps and the resettlement of some of the refugees into rural areas of Sierra Leone. Rural health facilities will be expected to absorb the new community members, some of whom are family planning users, which can increase pressure on an already overburdened system.

Recommendations for Stakeholders in Sierra Leone

- A clear and comprehensive strategy to implement the newly approved National Reproductive Health Policy should be created using a participatory process similar to the one that was used to create the policy. To reduce disparities in services, this strategy should include specific guidelines on what services are to be offered at specific locations, who is able to receive family planning (e.g., adolescents, single women, women with no children), and for what cost.
- Given the lower levels of family planning knowledge and access, areas of the country that did not have refugee camps should be geographical priority areas for rolling out the new reproductive health policy to equalize the environment as Sierra Leone moves out of the post-conflict period.

- The contraceptive security strategy developed in collaboration with the DELIVER and AWARE project should be used to reform and reinforce logistics to improve availability of contraceptives at all access points. Implementation should include emphasis on reducing stockouts and eliminating storage fees and unnecessary taxes.
- The Ministry of Health and NGOs working in Sierra Leone should collaborate to develop strategies for encouraging male involvement, addressing sexual violence, and increasing knowledge on the availability of emergency contraception.
- A plan to provide in-service training for all health facility personnel on reproductive health, including family planning and sexual violence, should be developed and implemented. Curricula should be standardized and based on best practices and the latest contraceptive technology updates. NGOs working in-country should participate in its development and implementation at health facilities they support to assist in the standardization of services for all, including refugees and IDPs. The in-service training should also focus on the importance of confidentiality, especially for adolescents.
- Marie Stopes International is implementing an effective model of community-based distribution. This approach should be replicated and scaled up to cover a larger geographical area. This will also assist in the readiness of communities to receive the resettled refugees and IDPs. In a camp environment, using community-based distributors may increase access and reduce scale-up time for services.
- Rebuilding of health facilities, with focus on upgrading and supplying equipment and improved sanitation, should be a priority.

Recommendations for the International Community

- The international community should advocate for the inclusion of family planning in repatriation plans with a focus on providing adequate supplies of commodities for women to be used during the transition back to their country of origin.
- Family planning should be included in the initial package of services provided to refugees during the camp registration process. At minimum, new arrivals should be asked if they are family planning users and if they want to continue using contraception. This information could be used for planning purposes to ensure that women are able to access family planning as soon as possible. Information regarding the contraceptive prevalence rate in the country of conflict should also be used for planning.
- A system for examining and strengthening the reproductive health knowledge of camp providers needs to be developed and implemented early in the intervention.
- Immediate access to comprehensive and compassionate care for sexual violence and torture survivors upon entering camps is essential. Services should include emergency contraception.
- A collaborative approach to importing commodities during the conflict could benefit all international organizations working in-country by allowing them to piggyback on effective logistics systems. A team effort should be used to reinforce successful logistics systems to allow continued importation of commodities during conflicts.

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APPENDIX A: FOCUS GROUP DISCUSSION GUIDE

1. **Can you tell us what was the availability of family planning services before the war?**
 - Did you have access?
 - Can you describe the services?
 - Did you and other women in the community want these services?
 - Did you use them?
 - What methods were you interested in?

2. **Can you tell us what was the availability of family planning services during the war?**
 - Did you have access?
 - Can you describe the services?
 - Did you and other women in the community want these services?
 - Did you use them?
 - What methods were you interested in?
 - Was this different for:
 - Refugees
 - IDPs
 - Single women
 - Adolescents

3. **Can you tell us what was the availability of family planning services during your displacement (DO NOT INCLUDE FOR WOMEN WHO STAYED DURING CONFLICT)?**
 - Did you have access?
 - Can you describe the services?
 - Did you and other women in the community want these services?
 - Did you use them?
 - What methods were you interested in?
 - Was this different for:
 - Refugees
 - IDPs
 - Single women
 - Adolescents

4. **Can you tell us what was the availability of family planning services for the first year after the war?**
 - Did you have access?
 - Can you describe the services?
 - Did you and other women in the community want these services?
 - Did you use them?
 - What methods were you interested in?
 - Was this different for:
 - Refugees
 - IDPs
 - Single women
 - Adolescents

5. **Can you tell us what is the current availability of family planning services now?**
 - Do you have access?
 - Can you describe the services?

Do you and other women in the community want these services?

Do you use them?

What methods are you interested in?

Is this different for:

Refugees

IDPs

Single women

Adolescents

6. What is the cost for family planning?

Public sector

Private sector

Pharmacy

Other

7. Would do you think would have improved access to family planning during each of the above time periods?

Before war

During war

First year after war

Now

APPENDIX B: JOURNEY OF A WOMAN ACTIVITY GUIDE AND TIPS

The Journey of a Woman exercise is based on a qualitative approach to needs assessment for health education planning titled “Drawing as Dialogue” (Shaver, et al., 1993) and a “Lifeline Exercise” that asks participants to depict important life events and influences using symbols or pictures (CARE Sierra Leone, 2005). These two approaches were melded to develop the “Journey of a Woman” tool used in our analysis.

Why use drawings in qualitative research? Drawings can enhance communication. Throughout history they have been used to describe the world and to express feelings. When we look at pictures we get an idea of the world being described as well as the artist’s emotional attitude toward that world. With drawing, unlike the spoken and written word, the drawer can record an immediate response. Anyone who has attempted to draw will recall the intense concentration involved in deciding how to put a mark on the paper. It is this concentrated thought and attention that can be focused on a particular topic and encourage people to describe their individual response. The method described proposes that drawings can be used in qualitative research to establish an understanding between the researcher and the people s/he seeks to understand and work with. It provides a wealth of information about world view, experience, and emotional responses.

Two groups participated in the Journey of a Woman exercise: about 15 NGO representatives involved in the Health Policy Initiative’s advocacy training in Freetown (February 2007) and 12 women in Lungi (May 2007). Participants were asked to use drawings to tell the story of a woman and her family before, during, and after a conflict—highlighting changes in the woman’s desire to use family planning and her access to services along the journey. This was a very powerful and emotional exercise. It reinforced the findings from the focus group discussions and in-depth interviews tools. What came out more was the level of violence and rape along the journey. In observing the report out and sensing the emotions in the larger group, it was clear that this was not just a journey of a woman, but real for a majority of the participants in the workshop who had gone through and survived the civil war.

It is important for the facilitator in this exercise to allow time, listen carefully, and have good communications skills to offer support for individuals who may be saddened during report out. The facilitator must convey in the group that each voice and drawing is valued. By gathering information in this way, an effort is made to bridge the gap in communication that often occurs in cross-cultural research. We would also recommend, based on our learning in conducting this exercise, that it is done in small groups and not reported out to a larger group.

Points to Remember

- Encourage, but do not influence participants as they begin to draw.
- Recorder and facilitator must use careful recording, listening, and communication skills when participants describe their drawings. Enquiry into color selection should follow after overall description of individual/group drawings.
- Methodical pairing of the drawings and descriptions is important.

- Whenever possible, keep the drawings and their accompanying description together so you can always return to the original data. Make copies which you can cut up and move around for the analysis.
- Do not lose the richness of people’s descriptions of their experiences by summarizing them in your own words—put your interpretation alongside their words.
- Ideally try to find time to go back to the people you have collected information from to explain how you have understood their ideas, and to see if they feel your interpretations are accurate.
- Where possible, involve the people who have given you information in any follow-up action that is being guided by the information you have collected.

Journey of an IDP Woman

Most people like to listen to stories. Stories are an entertaining and interesting way to explore and challenge various conditions and relationships.

Objective

This activity of drawing and telling the stories can also give some perspective on how culture and health services influence individual lives—and in this exercise—as culture relates to the reproductive health of women.

Step 1

Give participants a piece of paper and color markers.

Step 2

Ask participants to reflect on the journey of a woman and her family before and during conflict and then returning as an IDP. Then with the color markers draw a line across the flip-chart paper showing these different times in her life. Then draw along the journey what her desire is to use and her ability to access family planning methods. Participants should show important events and influences through this journey by drawing symbols and pictures with happy events/emotions above the line and sad ones below the line.

Step 3

When the participants are finished ask them to tell you the story of the imaginary local woman according to the drawing.

Step 4

Facilitate a discussion around the story. Ask the group:

- Do you agree with the story?
- Did anyone think her story is exceptional?
- Allow the group members to express their feelings about it.
- What do you think are the health needs and risks for the imaginary person at particular points in the story?
- What does society do to support the happy moments or the sad moments in her life?

APPENDIX C: KEY INFORMANT QUESTIONNAIRE

Policies

1. What was your role in developing the new RH/FP policy?
 - a. Who else was involved?
 - b. How were priorities decided upon?
 - c. Does it apply to the whole population including those in refugee camps?
 - d. Are there separate policies and procedures that are followed by NGOs?
 - e. Are there any other areas that should have been a priority or included in this policy?
2. We understand the policy is in draft form at this time, therefore, in the interim, can you describe how FP/RH services are provided?
3. What is the present situation for commodities acquisition and distribution?
4. Can you describe the challenges in regard to your health systems?

Access to Family Planning Services

1. What is your (Ministry of Health, UNHCR, NGO, etc.) role in providing family planning services?
2. What was your role during and post conflict?
3. Can you describe your role in providing family planning services in areas affected by IDPs and/or refugees and how does this differ from providing services in unaffected areas?
4. Do the following groups presently have access to family planning services?
 - a. IDPs
 - b. Refugees
 - c. Single women
 - d. Adolescents
5. Are there barriers for the following groups to access FP/RH services?
 - a. IDPs
 - b. Refugees
 - c. Single women
 - d. Adolescents

Medical Norms, Standards, and Protocols

1. These documents exist and are adequate?
2. Family planning providers are aware of these guidelines?
3. Materials and supplies necessary to provide these services are available?

Challenges

1. What do you see as the main challenges for providing family planning services?

2. Are there any remaining security issues affecting access to family planning?
3. Do you believe that women who want to have family planning services can access them freely?
4. Is there a difference for men to access family planning services compared with women?
5. What do you see as the challenges faced with the human resource issue in country?
6. Has the demand for family planning changed pre-, during, and post-conflict and why?
7. Is there any further information that you would like to add?

APPENDIX D: PROVIDER QUESTIONNAIRE

Health Provider Details

1. Are you a doctor, community health officer, nurse midwife, nurse, MCHA, other?
2. What is your position and the department in which you work?
3. How long have you worked in family planning?
4. How long have you been working at this facility?
5. Do you have any norms and procedures, flowcharts, or protocols assisting you to implement your family planning services?
 - a. If yes, can you show them to me?
 - i. Norms and procedures
 - ii. Flowcharts
 - iii. Protocols
 - iv. Other (specify)
 - v. Other (specify)
6. Are family planning services available every day, all day?

Policy Awareness

1. Were you involved in the development of the new draft reproductive health policy?
 - a. If yes, describe your role
2. Is there an official fee for family planning services?
 - a. If yes, what does it include:
 - i. Visit cost
 - ii. Commodity
 - iii. Supplies/materials
 - iv. Lab tests
 - v. Other
 - b. Is the fee different for first and follow-up visits?
 - c. Is the fee different for different types of women?
 - i. IDP
 - ii. Refugee
 - iii. Adolescent
3. Are there any other costs associated with receiving family planning services?
4. What policies are needed now, post conflict, to increase access to family planning services among all groups?
5. Anything specifically for refugee or IDP women?

Logistics

1. How do you order and receive contraceptive commodities?

2. How often do you order and receive commodities?
3. Do you receive exactly what your order?
4. How do you decide which commodities, and how many, to order?
5. Do you order all available contraceptives?
 - a. If no, why not?
6. Does your supply of contraceptives last until your next shipment:
 - a. Always
 - b. Mostly
 - c. Not usually
 - d. Never
7. Is it possible to get commodities outside of the normal procurement system when necessary?
8. How long does it take to receive ordered supplies?

Attitudes and Beliefs

1. What methods are available at your facility?
2. What methods have you discussed with women, couples, or men in the last three months?
3. Where do you refer patients who want a method that is not available here?
4. Are there any methods that you know about, but do not offer?
 - a. If yes, why?
5. Are there any methods that are available, but that you do not recommend to clients?
 - a. If yes, why?
6. Do you provide family planning to all women who request it?
 - a. Adolescents
 - b. Single women
7. When a woman comes in for family planning, does she request a specific method, or do you suggest one?
8. If you suggest a method, what criteria do you use to suggest which method:
 - a. Adolescents
 - b. IDPs
 - c. Refugees
 - d. Single women
 - e. Married women
9. How do you think family planning services can be improved to better serve all women?
 - a. Adolescents
 - b. IDPs
 - c. Refugees
 - d. Single women
 - e. Married women

Conflict-related Issues

In this section, the interviewer will ask about the family planning situation before, during, and after the conflict. The format will be less structured, but the topics to be covered include:

1. Are you aware of any changes in family planning policies from before the conflict?
2. Have norms and standards and/or protocols for care for family planning clients changed since the start of the conflict?
3. Were there special interim policies or norms and standards and/or protocols during the conflict?
Related to refugee or IDP women?
 - a. If yes, what?
 - b. If no, what policies would have been helpful?
4. Did you provide family planning services, in this facility or elsewhere, during the conflict?
 - a. If yes, what were the challenges you faced?
 - b. If yes, what methods did women request?
 - c. If yes, what methods were available?
 - d. If yes, how did they logistically get their commodities?
 - e. Were the costs the same?
 - f. Any other relevant information?
5. Do you have family planning clients that are refugees or IDPs?
 - a. If yes, what type of methods do they request?
 - i. Is this different than non-refugee or IDP women?
 - ii. If yes, why do you think there is a difference?
 - b. What type of methods do you recommend?
 - c. What types of methods are available for them?
6. How do you characterize the differences in providing family planning services before, during, and after the conflict?

Demand Side Questions

1. Is there demand for family planning services? Among:
 - a. Adolescents
 - b. IDPs
 - c. Refugees
 - d. Single women
 - e. Married women
2. What do you think influences this demand?
3. If you were here before the conflict, describe the demand for family planning then.
4. If you were here during the conflict, describe the demand for family planning then.
5. Since your posting at this center, describe the demand for family planning.

APPENDIX E: POLICY ENVIRONMENT SCORE QUESTIONNAIRE

MODULE: FAMILY PLANNING

I. POLITICAL SUPPORT

(Scoring: 0 = weak; 4 = strong)

1. High-level national government support exists for effective policies and programs.
2. Public opinion supports effective policies and programs.
3. Media campaigns are permitted.
4. Political parties support effective policies and programs.
5. The problem is recognized by top planning bureaus.
6. Major religious organizations support effective policies and programs.

	Status Pre- Conflict	Status During Conflict	Status Now

II. POLICY FORMULATION

1. A favorable national policy exists.
2. Formal program goals exist.
3. Specific and realistic strategies to meet goals exist.
4. A national coordinating body exists and functions effectively. (If none, enter zero.)
5. Ministries other than Health are involved in policy formulation.
6. Policy dialogue and formulation involves NGOs, community leaders, and representatives of the private sector and special interest groups.

III. ORGANIZATIONAL STRUCTURE

1. A national coordinating body exists that engages various ministries to assist the service delivery program. (If none, enter zero.)
2. The service delivery program has a high level placement in government.
3. The director for service delivery is full-time and reports to an influential superior officer.
4. Ministries other than Health are mandated to help with program implementation.
5. NGOs are formally included in policy deliberations.
6. The private sector is formally included in policy deliberations.

IV. LEGAL AND REGULATORY ENVIRONMENT

**Status
Pre-
Conflict** **Status
During
Conflict** **Status
Now**

1. Medical barriers do not exist for: (“4” means no barriers).

- a. Tubal ligation
- b. Vasectomy
- c. IUD
- d. Pill
- e. Injectable
- f. Condom
- g. Other? Specify _____

2. Eligibility barriers do not exist for: (“4” means no barriers).
(Examples: age, parity, husband’s consent, etc.)

- a. Tubal ligation
- b. Vasectomy
- c. IUD
- d. Pill
- e. Injectable
- f. Condom
- g. Other? Specify _____

3. The legal age at marriage is satisfactory for:

- a. Females
- b. Males

4. A firm policy exists to enforce these ages for:

- a. Females
- b. Males

V. PROGRAM RESOURCES

- 1. Funding from government sources is generally adequate.
- 2. Funding from donor sources is generally adequate.
- 3. Staffing for service provision is generally adequate.
- 4. Enough service points exist for reasonable access by most clients.
- 5. Resources are allocated by explicit priority guidelines.

VI. PROGRAM COMPONENTS

1. By formal policy, each of the following components is included in the program:

- a. Use of mass media to inform and motivate
- b. Postpartum provision of family planning
- c. Contraception social marketing
- d. Home visiting workers
- e. Community-based distribution

2. The private sector is deliberately encouraged through policies in which:

**Status
Pre-
Conflict** **Status
During
Conflict** **Status
Now**

- a. Contraceptive advertising is permitted.
- b. Import duties are minor or absent (attach amounts if available).
- c. Medical practitioners are free to provide contraception.
- d. Price controls on contraceptives are minor or absent.

VII. EVALUATION AND RESEARCH

- 1. A regular system of service statistics exists and functions adequately. (If none, enter zero.)
- 2. A system exists to monitor secondary data sources (surveys, censuses, local studies, etc.) for the benefit of policy guidance.
- 3. A system exists to bring evaluation and research results to management's attention.
- 4. Special studies are undertaken to address leading policy issues.

Comments:

APPENDIX F: USING THE TOOLS TO IDENTIFY OPERATIONAL BARRIERS

The tools required for the research in Sierra Leone were longer and far more detailed than what would be required in most other countries. The lack of available information on the policy environment in Sierra Leone required a more thorough investigation at the national level into the processes involved in policy development and implementation. This step can be skipped in most countries by collecting documents about the policy environment during an initial literature and document review.

Additionally, the purpose of this research project was to examine differences in demand and access to family planning services on the continuum of before, during, and after the conflict. In most cases, the time period after the conflict will be the most critical when examining operational barriers to family planning services and identifying policy recommendations.

This appendix intends to identify key questions from each of the tools that can be added into organizations' surveys and tools to collect critical information on operational barriers. This will enable organizations to identify select operational barriers to family planning services without duplicating the entire survey. The questions below were identified as providing the most critical information on operational barriers.

Focus Group Discussion Guide

Can you tell us what is the current availability of family planning services now?

Do you have access?

Can you describe the services?

Do you and other women in the community want these services?

Do you use them?

What methods are you interested in?

Is this different for:

- Refugees
- IDPs
- Single women
- Adolescents

What is the cost for family planning?

Public sector

Private sector

Pharmacy

Other

Key Informant Questionnaire

Access to Family Planning Services

Do the following groups presently have access to family planning services?

- IDPs
- Refugees
- Single women
- Adolescents

Are there barriers for the following groups to access FP/RH services?

- IDPs
- Refugees
- Single women
- Adolescents

Medical Norms, Standards, and Protocols

These documents exist and are adequate?

Family planning providers are aware of these guidelines?

Materials and supplies necessary to provide these services are available?

Challenges

What do you see as the main challenges for providing family planning services?

Do you believe that women who want to have family planning services can access them freely?

Is there a difference for men to access family planning services compared with women?

Provider Questionnaire

Health Provider Details

Do you have any norms and procedures, flowcharts, or protocols assisting you to implement your family planning services?

- If yes, can you show them to me?
 - Norms and procedures
 - Flowcharts
 - Protocols
 - Other (specify)
 - Other (specify)

Policy Awareness

Is there an official fee for family planning services?

- If yes, what does it include:
 - Visit cost
 - Commodity
 - Supplies/materials

- Lab tests
- Other

Is the fee different for different types of women?

Logistics

How do you order and receive contraceptive commodities?

How often do you order and receive commodities?

Do you receive exactly what your order?

How do you decide which commodities, and how many, to order?

Do you order all available contraceptives?

- If no, why not?

Does your supply of contraceptives last until your next shipment?

- Always
- Mostly
- Not usually
- Never

Is it possible to get commodities outside of the normal procurement system when necessary?

How long does it take to receive ordered supplies?

Attitudes and Beliefs

What methods are available at your facility?

What methods have you discussed with women, couples, or men in the last three months?

Where do you refer patients who want a method that is not available here?

Are there any methods that you know about, but do not offer?

- If yes, why?

Are there any methods that are available, but that you do not recommend to clients?

- If yes, why?

Do you provide family planning to all women who request it?

- Adolescents
- Single women

When a woman comes in for family planning, does she request a specific method, or do you suggest one?

If you suggest a method, what criteria do you use to suggest which method?

- Adolescents
- IDPs
- Refugees
- Single women
- Married women

How do you think family planning services can be improved to better serve all women?

- Adolescents
- IDPs
- Refugees
- Single women
- Married women

Demand Side Questions

Is there demand for family planning services? Among:

- Adolescents
- IDPs
- Refugees
- Single women
- Married women

What do you think influences this demand?

What policies are needed now, post conflict, to increase access to family planning services among all groups?

Anything specifically for refugee or IDP women?

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