

Getting it right?

Women's sexual-and reproductive health and health services in Darfur, Sudan

A qualitative study

Sara Rivenes

**Supervisor:
Professor Johanne Sundby**

**University of Oslo
Faculty of Medicine
Institute of General Practice and Community Medicine
Section for International Health
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To the people of Sudan
In hope of a better future.

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List of Abbreviations

ACT- Action by Churches Together
AIDS- Acquired Immunodeficiency Syndrome
AU- African Union
CEDAW - the Convention on the Elimination of all forms of Discrimination against Women
DERO- Darfur Emergency Response Operation
FC- Female circumcision
FGC- Female Genital Cutting
FGM- Female Genital Mutilation
HIV- Human Immunodeficiency Virus
ICPD- International Conference on Population and Development
IDP's- Internally Displaced Persons
IAWG - Inter-agency Working Group on Reproductive Health in Refugee Situations
JEM- Justice and Equality Movement
MA- Medical Assistant
MD- Medical Doctor
MISP- Minimum Initial Service Package
MSF- Médecins Sans Frontières
NCA- Norwegian Church Aid
NGO- Non-Governmental Organization
OCHA- Office for the Coordination of Humanitarian Affairs
PTSD- Post Traumatic Stress Disorder
SGBV- Sexual and Gender Based Violence
SPLM/A- Sudanese People's Liberation Movement/ Army
STI- Sexually Transmitted Infection
TBA- Traditional Birth Attendant
UN- United Nations
UNAIDS- United Nations Joint Programme on AIDS
UNFPA- United Nations Population Fund
UNHCR- United Nations High Commissioner for Refugees
UNICEF- United Nations Children's Emergency Fund
US- United States of America
WHO- World Health Organization

Abstract

Title: Getting it right? Women's sexual-and reproductive health and health services in Darfur, Sudan. A qualitative study

Researcher: Sara Rivenes

Supervisor: Prof. Johanne Sundby

Background: There are 25 million internally displaced in the world due to armed conflict. 70- 80% of these are women and children. The conflict in Darfur have received massive international attention due to the forced displacement of over 2 million people, mass killings and widespread use of sexual- and gender based violence. A number of NGO's are providing humanitarian assistance to the people of Darfur, including women, who have specific needs and concerns related to their reproductive- and sexual health. When these are not addressed adequately this part of women's health is a major cause of morbidity and mortality. Few studies conducted during conflict have focused on the health services directed at women's sexual- and reproductive health.

Objectives: The overall objective of the study was to acquire new knowledge about how women's sexual- and reproductive health concerns are catered for by the health services available during conflict. The specific objectives where the following; to explore women's experiences of safety and/ or danger in their lives, to explore quality issues in the availability of family planning methods, to explore quality issues in the antenatal and postnatal care, to explore women's perception of the health care available and to identify recommendations for improvements and/ or changes of these services.

Method: Qualitative research methods were used, including interviews with 14 women, 9 IDP's and 5 women of the host community, interviews with 6 health care workers and 60 hours of non- participant observation of the health services.

Results: All the informants said they felt safe in the current lives. The IDP's had before the displacement experienced threats of violence and witnessed severe forms of violence, including killings. The women in the study had limited access to family planning methods. A limited selection of oral and injectible contraceptives were available at cost, which meant that this was unattainable for most, especially the women living in the IDP camp who had limited resources and income. The antenatal services were less than optimal. Antenatal examinations were unfocused and random and essential components such as identifying risk cases or interventions to ensure adequate nutrition during pregnancy where not adequately addressed. The women interviewed were in general pleased with the health services, but expressed a need for more equipment in the primary health clinics and more attention on nutrition during the antenatal and postpartum period. Recommendations are to include pregnant and lactating women into the nutrition programme, strengthen income generating activities for women, improve reproductive-and sexual health education and information, reinforce procedures and guidelines of health care workers, especially with regards to antenatal-and postpartum examination and emergency obstetric care, provide oral and injectible contraceptives free of charge to all women and improve procedures related to monitoring and evaluation of the health services.

Conclusion: the health services directed at women's sexual- and reproductive health should be strengthened and improved to more adequately address the concerns and needs of the women included in the study.

1.0 Introduction and structure of the thesis

1.1 Introduction

There are estimated to be 25 million internally displaced persons (IDPs) in the world today due to conflict. 70- 80% of these are women and children.¹ A conflict that have received massive media attention is the conflict in Darfur, Sudan, which have been described as "the world's greatest humanitarian crisis".² It has left over 2 million people internally displaced,³ hundreds of thousands have been killed and renowned organizations such as Amnesty International and Médecins Sans Frontières (MSF) have published reports about the use of rape as a weapon of war in the conflict. A number of organizations are providing health care to men, women and children in Darfur. As more attention is being given to issues related to displaced women's sexual-and reproductive health by the international community and organizations providing health care, the need for independent research on relevant issues becomes even more important. This study represents one of the few attempts to investigate women's reproductive-and sexual health concerns and health services during the conflict in Darfur. This study uses qualitative interviews with internally displaced women and observation of their health services to create a portrait of the current level of available health services. This knowledge is important to offering health care based on the experienced needs and concerns of internally displaced women. It is also an attempt to give voice to some of the women of Darfur, in hope that they will be heard and not forgotten.

1.2 Structure of the thesis

The first section of the thesis will provide background information about various aspects of sexual-and reproductive health and care in addition to information about Sudan, the Darfur conflict and internally displaced persons (IDPs). The next section will review the relevant literature and present a description of the methodology, research findings and a discussion of their implications.

2.0 Reproductive- and sexual health and care

2.1 The concept of reproductive- and sexual health

According to the former Executive director of UNFPA, Dr Nafis Sadik “the concept of reproductive health is one of the landmarks of the 20th century's social history⁴”. At a groundbreaking conference, the International Conference of Population and Development (ICPD) in 1994, a definition of reproductive health, sexual health, reproductive health care and reproductive rights was adopted into the Programme of Action, which was signed by 179 countries. The adoption of these definitions broadened the concepts of reproductive-and sexual health, gave them universal validity and set the standard in the work to improve the sexual-and reproductive health for the world's women and men. The perspective was changed from a narrow attempt at population control to focusing on individual choice and rights within a broader framework of reproductive and sexual well-being.⁵ The widely used definition of reproductive health is worth quoting at length:

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.(Paragraph 7.2⁶)

The definition is broad, and covers a range of factors such as concepts of affection, tenderness, pleasure and equity in intimate relationships. It clearly states that reproductive health is not just a range of physical and psychological conditions. Within this concept reproductive- and sexual health can also be seen as a principle for organizing a set of health services, and a paradigm for social change.

The concept of sexual-and reproductive health is still surrounded by myths and moralistic attitudes about the behaviour of women in issues related to sexuality and reproduction.⁷ It includes both men and women, but is more critical for women as they suffer to a larger extent from diseases related to their reproductive function, in addition to gender based discrimination and assaults occurring worldwide.⁸ Recently there has been an increasing focus to involve men in the work related to reproductive health, but it seems as there is still a long way to go on this issue. Some argue that too much of the work on reproductive health excludes men, and that men and women are presented as opposites standing against each other, instead of focusing on the interaction and dynamic between the sexes.⁹

2.1.1 Sexual health

As a result of the HIV pandemic, increasing rates of sexually transmitted infections globally and an increased focus on prevention of gender based violence, sexual health was included in the ICPD definition of reproductive health. It declares:

*(...) the ability to enjoy mutually fulfilling sexual relationships, freedom from sexual abuse, coercion, or harassment, safety from sexually transmitted diseases, and success in achieving or in preventing pregnancy.*¹⁰

The World Health Organization (WHO) describes sexual health as a condition for reproductive health, which includes unintended pregnancy and unsafe abortion, infertility, aspects of mental health, female circumcision (FC) and the impact of physical disabilities and chronic illnesses on sexual health.¹¹

2.2 Sexual-and reproductive health on the international agenda: reaching a “consensus”

There are many controversial issues related to sexual-and reproductive health which often result in long, and sometimes tedious, debates before reaching a consensus at international conferences.¹² The following quote illustrates some of the main issues, and some of the strongest opponents in the debate against liberal reproductive health policies at one international conference:

At the UN General Assembly special session on children, held in May, 2002, some delegations (Iran, Iraq, Libya, Sudan, the Vatican, and the USA) wanted the phrase reproductive health services redefined to exclude legal abortion; the family characterised as marriage only between a man and a woman; and to include wording that would have recognised a couple's right to information about family planning but not access to contraception.¹³

Some describe this as an ideological battle, and “a conflict between faith and science⁵”. Conservative, and often religious groups are continually fighting against liberals over issues such as condoms, abortion and same sex unions. Strong political forces continue to threaten the advances made at the ICDP. For example, the primary ICPD goal of universal access to reproductive health was excluded from the 2000 Millennium Declaration and from the eight Millennium Development Goals (MDGs), due to “political nervousness”.⁵ This is becoming recognised as a mistake since sexual and reproductive health is essential for achievement of all MDGs.¹³⁻¹⁵

2.2.1 What have been done since the ICPD?

After over a decade since the ICPD in Cairo, many claim that not enough has been done.¹⁴ Critics say that the sexual-and reproductive health promoted in Cairo was too idealistic, and that there has been too much talk but not enough action on the political level in the aftermath of the conference. It has also been claimed that too much of the effort and resources spent on sexual-and reproductive health are focusing on HIV/ AIDS specifically without addressing sexual- and reproductive health more broadly.¹⁶ Some have also blamed the US President George W. Bush, as the US is the leading contributor to the health sector with more than half of the total financial assistance from donors.^{5;14} During his first day in office, the Mexico City Policy (also called “the global gag rule”) was reinstated. This denies financial support to any foreign NGO working with abortion, including counselling and referral for abortion. The decision affected the support to numerous organizations, including UNFPA.^{12;13;16;17} During his presidency abstinence has been promoted as the single most effective way to fight HIV/ AIDS, which is contrary to the current knowledge in the field of prevention of HIV/ AIDS.^{18;19}

However, there have been some improvements since Cairo. The use of contraceptives has increased globally, and infant mortality has decreased to some extent. According to a study conducted by UNFPA in 2004 among the countries that signed the ICPD Program of Action, the general tendency was that the countries had taken full ownership of the ICPD agenda, adopting an incremental approach, setting priorities for action and making broad, multi-sectoral policy interventions. Even though there are great variations between countries, many countries have taken steps to improve the status of women, by increasing their participation in governance, providing education and by adopting legislation to promote women's empowerment.²⁰

2.3 Reproductive-and sexual health worldwide

According to WHO, maternal and perinatal mortality and morbidity, cancers, STIs including HIV/ AIDS, account for 20% of the global burden of ill health for women.

It is estimated that 8 million, of the 210 million women who become pregnant each year, suffer life-threatening complications related to pregnancy. Every minute a woman dies from the complications of childbirth or pregnancy. This adds up to 530 000 deaths each year, 99% occurring in developing countries. Maternal deaths worldwide are most commonly caused by either haemorrhage (post partum haemorrhage accounts for over 25%),²¹ obstructed labour, (pre) eclampsia, sepsis or complications due to unsafe abortion. These are all complications that can be prevented and treated.²² Eighty million women each year have unintended or unwanted pregnancies. Forty-five million of these are terminated each year, 19 million of which are unsafe abortions. This causes an estimated 68 000 women (and girls) to die each year, 13% of all pregnancy related deaths.¹³

The use of contraceptives is slowly increasing in the developing world. However, it is estimated that 201 million women in the developing world have an unmet need for family planning methods.^{23;24}

About 340 million new cases of sexually transmitted bacterial infections occur each year, in addition to millions of cases of viral infections. The latter including five

million new HIV infections, 600 000 are in infants due to mother-to-child transmission. Over one million young women, aged between 15 and 24 are infected with HIV in sub-Saharan Africa. STIs are the leading cause of infertility, most commonly due to lack or inadequate treatment.²⁴

2.3.1 Female Genital Cutting/ female circumcision

Female genital cutting is defined by WHO, UNICEF and UNFPA as “the partial or total removal of the female external genitalia or other injury to the female genital organs for cultural or other non-therapeutic reasons”²⁵. It is practiced in more than 28 countries in Africa, some countries in Asia and the Middle East. An estimated 100 to 140 million girls and women living today are circumcised (half of those are living in Egypt or Ethiopia), and 3 million girls primarily below 15 years undergo the procedure each year. The most severe form is called infibulation which includes removal of parts or all of the external genitalia and stitching/ narrowing of the vaginal opening.²⁵ During delivery deinfibulation might be necessary to prevent obstructed labour, and it is common to reinfibulate the woman after delivery. Some of the immediate complications as a result of FGC are severe pain, haemorrhage and wound infections. The long-term health consequences might be repeated urinary-tract infections, chronic pelvic infections, menstrual and sexuality problems. Some of the obstetric complications are obstructed labour, fistulae and injury to the bladder, urethra or rectum due to deinfibulation.²⁶⁻²⁸

There is a debate about the terminology of the practice. The term female genital mutilation (FGM) is commonly used to refer to the destruction or removal of healthy tissue. The term have been criticised for being too condemning towards a cultural practice, and also that it insinuates evil intentions on the part of those who pursue the tradition.²⁹ In recent years the term Female Genital Cutting (FGC) or Female circumcision (FC) has been used as descriptors considered more morally neutral, which again have been criticised for failing to recognize the injury that is actually taking place, and allowing an alternative term for those who are not against the practice.^{27;29} As FGM is the term most commonly found in literature, I planned the project using the term. However, when I entered into the field I did not feel it was

culturally appropriate to use the term, and used instead female circumcision, which was translated into “tahour” by my interpreter. Tahour is used for both female and male circumcision, meaning cleanliness, which is often understood as religious cleanliness.²⁷ However, in the following discussion, the terms FGC and FC will be used.

2.3.2 Sexual- and gender based violence

In recent times sexual- and gender based violence (SGBV) have received an increasing amount of attention. According to UNFPA:

Worldwide, an estimated one in five women will be a victim of rape or attempted rape in her lifetime. One in three will have been beaten, coerced into sex or otherwise abused, usually by a family member or an acquaintance.(..) Each year, hundreds of thousands of women and children are trafficked and enslaved, millions more are subjected to harmful practices³⁰.

The effect of SGBV on women and girls health include mental health problems, poor reproductive-and sexual health, and a higher risk of acquiring HIV. During armed conflict, such as Darfur, SGBV is often used as a “weapon of war”. There are several reasons for this. A breakdown of social structures, and displacement causes disruption in the support network of women. This might include the loss of family members and community breakdown. When women lack the protection of a man, they are more vulnerable to violence and sexual abuse. In armed conflicts there is often an exertion of political power and control over other communities. When this is combined with a collapse in social and family support structures, coupled with the lack of police protection and security personnel, it also makes women an easy target for sexual violence.³¹ It is a way of undermining community bonds and weakening resistance to aggression, as it may destroy the bonds of family and society. It can also be an expression of ethnic suppression and isolation, or even hate as seen during the civil war in former Yugoslavia and during the genocide in Rwanda in 1994.^{32;33}

2.4 Sexual- and reproductive health care

Sexual-and reproductive health consists of several elements strongly related and affecting each other, therefore services should ideally address all of these elements in combination. Providers of sexual-and reproductive health care deal mostly with women, and promotive and preventive health care are major components.³⁴ According to the ICPD Programme of Action universal access to “safe, affordable, and effective reproductive health care and services, including those for young people⁶” is essential to improving sexual-and reproductive health worldwide. The concept of sexual-and reproductive health care is a comprehensive approach to health needs related to reproduction and sexuality. It “ (...) responds to the needs of women and not only those of mothers⁸”. The core components of sexual-and reproductive health care are illustrated in figure 1 below.

Figure 1: Core components of sexual and reproductive health care^{13;35}

- ❖ Prenatal care, safe delivery, postpartum care, and the management of complications of pregnancy and delivery.
- ❖ Provision of high-quality services for family planning including counselling, information and education.
- ❖ Infertility services
- ❖ Prevention of abortion and management of the consequences of abortion.
- ❖ Prevention and treatment of sexually transmitted infections, including HIV, reproductive tract infections cervical cancer, and other gynaecological morbidities.
- ❖ Promotion, information and education on healthy sexuality, reproductive health and responsible parenthood.
- ❖ Discouragement of female genital cutting and gender based violence.

2.4.1 Antenatal care

The antenatal period is normally defined as the period from conception, throughout the pregnancy and delivery. Antenatal care has three functions: identification of high risk women and referral of these, prevention and treatment of maternal morbidity and maternal health education.³⁶ It is described as one of the “four pillars” of safe motherhood together with family planning, clean/ safe delivery and essential obstetric care. However, evidence suggest that antenatal care does not reduce maternal mortality.³⁷ The frequency of antenatal visits vary, but in many places start as early in the pregnancy as possible, continuing the 4th weekly until week 28, then every two weeks until week 36 and then weekly until labour. Normally this adds up to 12-14 visits. It has been argued that it is not necessary to conduct as many visits when complications are not detected, and that 5 to 7 visits are sufficient. In antenatal care there has also been a tendency to identify high-risk cases, which has been criticised, as complications are in many cases difficult to predict. Instead, basing antenatal care on the fact that there is a risk of complication in every pregnancy might be a more realistic attitude.³⁸⁻⁴² In low income settings the following interventions are known to be effective: iron and folate supplements to reduce anaemia, malaria prophylaxis to prevent severe malaria and anaemia, measuring blood pressure to detect hypertension and pre-eclampsia. In addition, one should also screen for syphilis, gonorrhoea and HIV, provide tetanus immunization and perform a urine test to screen for nephritis, which may cause pre-term delivery.⁴³

2.4.2 Reproductive health services during conflict

In a conflict or emergency, several relevant UN agencies often have a leading role. The coordinating UN body, OCHA often designates NGOs to locations were they are needed. It is then decided what kind of services they will be responsible for providing. In a camp setting the Sphere Guidelines are used as a tool to calculate the amount of what is needed, such as latrines, hand pumps, etc. It is also a guide to what kind of services should be available which is used as a framework by all agencies providing services in camp settings. It outlines what health services should be provided, but does not deal with reproductive health services in

particular, only stating “People have access to the Minimum Initial Service Package (MISP) to respond to their reproductive health needs”. The MISP was published in 1999 as part of a field manual for reproductive health in refugee situations and is a set of recommendations for providing sexual-and reproductive health services in emergency camp settings.⁴⁴ It includes universal precautions against HIV/ AIDS, the availability of free condoms, clean delivery kits for home deliveries, and midwife delivery kits, among other things. In addition to the services provided by NGOs according to the Sphere guidelines, UN agencies such as UNICEF, UNHCR and UNFPA may provide additional services. For example, UNFPA may provide delivery kits, condoms or treatment for certain STIs as seen at the study site in Darfur.

3.0 Background: Sudan, Darfur and IDP's

3.1 Sudan

Figure 2: Map of Sudan⁴⁵



Sudan is geographically the largest country in Africa. Stretching from the Arab countries of north Africa to the Sub-Sahara countries, Sudan is a multi- ethnic country with diverse cultures and traditions.²⁷ Agriculture employs 80% of the work force, with cotton, sesame, livestock/meat and gum accounting for most of the export earnings. The official language is Arabic. The country is a former British colony and gained it's independence in 1956. Out of the 37 million people in Sudan, 70% are Muslim and 5% are Christian.⁴⁶ Simplified, the south consists mainly of Christians from what may be described as African tribes, their culture and lifestyle being similar to neighbouring countries in east Africa.²⁷ The north is mainly Muslim dominated with a majority of Arab tribes with a culture resembling other countries in Northern Africa and the Middle East. Following independence the country has been governed by an Arab elite in Khartoum, with an increasingly

strong Islamic influence. Sharia law was implemented in 1983. The country is headed by president Omar el-Bashir.⁴⁷

Since the country gained its independence, there have also been growing tensions and conflict over resources, which have led to racial division between Arab and African groups.⁴⁷ The south's struggle against the oppression of the government in Khartoum have been the source of Africa's longest civil war, from 1955 to 1972 and continuing from 1983 to 2005.⁴⁶ As a result of the civil war in South Sudan, and the conflict in Darfur, Sudan has the highest number of IDPs in the world, an estimated 5 million people.¹

3.1.1 Reproductive health indicators Sudan

According to UNFPA, 75% of all Sudanese women have had at least one antenatal visit by skilled personnel during pregnancy. However, the maternal mortality in Sudan is estimated to be 590 deaths per 100 000 live births. Total fertility rate is 4.8 lifetime births per woman. Only 7 % are using a modern contraceptive method, and it is estimated that 29% have an unmet need for family planning. There seems to be a need for more education on issues related reproductive health, as only 12% of the women between 15 and 24 years know that using a condom prevents the transmission of HIV.⁴⁸ In 2004, maternal mortality in Darfur were 600 per 100 000 women.⁴⁹ It is estimated that 45% of women of childbearing age still remain without safe motherhood services (prenatal, delivery, and postpartum care) in the country.⁵⁰ In a recent study conducted among IDP's in south Darfur, ninety-six percent (1219 of 1266) used either the natural (rhythm) method or no form of contraception. The mean number of pregnancies was 6. Fifty-eight percent of the respondents (723 of 1236) reported that prenatal care was accessible for all pregnancies. However, the mean number of pregnancies receiving prenatal care was only 1.4%.²⁸

It is estimated that around 89% of all Sudanese women have undergone female genital cutting (FGC). Infibulation is the predominant form of circumcision in the country.^{28;51;52} In a quantitative study from 2006, conducted in the Nyala Province

of south Darfur, 84% of the women interviewed reported having undergone circumcision.²⁸

3.1.2 The Darfur conflict

Darfur is located in western Sudan with approximately seven million inhabitants. The region lacks basic infrastructure, there is an absence of basic services, few employment opportunities, and a general proliferation of small arms. The main ethnic groups are the Fur, after whom the region is named, and the Arab Baggara. Ethnic conflicts between settled farmers (principally people of the Fur, the Zaghawa and the Masaleit tribes) and “Arab” pastoralists have been common for centuries in Darfur. During the 1980s and ‘90s these conflicts intensified, aggravated by draught and the influx of arms from wars in neighboring countries.^{2;53}

In early 2003, a rebellion was carried out against the Arab-led Sudanese government claiming discrimination and a lack of resources in the region. Behind it were militants from several African tribes in Darfur, in particular the Fur and Zaghawa, and the two local rebel groups - the Justice and Equality Movement (JEM) and the Sudanese Liberation Movement/Army (SLM/A). Their demand for greater autonomy and more political power in Khartoum seemed to be inspired by the achievements of the southern Sudan in the north-south peacetalks that same year. In response, the government started a campaign of aerial bombardment in addition to ground attacks by Arab militia, known as the janjaweed, which targeted civilians of the same ethnicity as the rebel groups. The government-supported Janjaweed are accused of committing major human rights violations, including mass killing and gender and sexual violence.⁵⁴⁻⁵⁷

In May 2006, a peace agreement, the Darfur Peace Agreement (DPA) was reached between the government and one of the rebel groups - a faction of SLM/A led by Minni Minnawi. The other SLM/A faction and the JEM refused to sign it. The DPA was criticized of having major defaults, such as no clear plan for the disarmament of the Janjaweed. Only a short period after the DPA was signed,

fighting continued. The US, the European Union and other European countries wish to replace the African Union (AU) force with a hopefully more effective UN force. This has been strongly opposed by the Sudanese Government, but a hybrid AU/ UN force might be accepted due to massive international pressure in the future.

Out of the 7 million living in Darfur, 4.1 million people have been affected by the conflict.⁵⁰ Over two million people are displaced from their homes living either in IDP camps or moving to other villages within Darfur. In addition, 250,000 have become refugees in Chad.⁵⁸ It is estimated that 400,000 people have died as a result of the conflict.⁵⁹

3.2 Internally displaced persons (IDPs) worldwide

IDPs are persons or groups of persons who have been forced or obliged to flee or leave their homes or places of habitual residence as a result of, or in order to avoid, the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters.⁶⁰ They have not crossed an internationally recognised state border, and are therefore not protected by international laws and conventions like refugees. There is an estimated 25 million IDPs in the world due to conflict, and 70- 80% of these are estimated to be women and children.¹ Half of the world's IDPs live in Africa, and Sudan has the largest number of IDPs in the world with 5 million. Other countries with large IDP populations include Colombia, Iraq, Uganda and the Democratic Republic of Congo (DRC).

According to the Internal Displacement Monitoring Centre, 15.6 million IDPs are exposed to serious threats to their physical safety. The national government has the primary responsibility for the security and well-being of the IDPs in their country. This makes them particularly vulnerable, as the state's government is in most cases either unable or unwilling to provide for their basic needs. Many of these countries, such as Somalia, Colombia, the Central African Republic or the DRC are among the poorest in the world. In some cases, the government is

creating the displacement and preventing the IDPs from being assisted by NGOs. Countries where the government is involved in deliberately displacing people, providing limited or no humanitarian assistance and also hindering international humanitarian access to displaced populations include Sudan (Darfur), Israel (the Palestinian Territories), and Sri Lanka.¹ Due to the large number of IDPs in the world today, the UN organization providing humanitarian assistance to refugees UNHCR have recently started to increase its work directed at IDPs.

4.0 Literature review

While planning the study, prior to the fieldwork, a literature review was carried out to identify knowledge gaps. It focused on the following: the effects of conflict on health and on issues related to women's health such as fertility, safe motherhood and the use of family planning methods, in addition to STIs and HIV/ AIDS.

Throughout all stages of the research process literature have been consulted, and the literature review have been modified according to the changes in the study.

After returning from the fieldwork section 4.3 about reproductive health services during conflict was added.

4.1 Armed conflicts and health

Most of the studies concerning displaced people (both IDP's and refugees) are conducted after the displaced individuals have migrated to a western country, or are in the post-emergency phase of a conflict. A meta analysis on refugees and mental health might explain why there is so little research-based evidence on this large and complex group of people:

Research on refugee mental health is fraught with practical obstacles. Populations are often physically, linguistically, and culturally inaccessible to researchers, and humanitarian aid usually has higher priority than scientific investigation. Studies are often exploratory and methodologically compromised, and the specificity of local circumstances makes it difficult to draw generalized conclusions⁶¹.

Research papers, critical reviews and meta-analyses indicate that displaced people have less favorable health outcomes compared to the host community. This includes both mental disorders and physical health. A meta analysis on mental health and displaced people found that over half of the sample adhere to the diagnosis of post traumatic stress disorder (PTSD) or severe depression.^{62;63} Only 2% of the studies in the meta analysis were conducted in Africa, and as noted "at present, the global distribution of refugees is not adequately represented in the mental health literature⁶¹".

4.1.1 The effect of armed conflict on women's health

Studies conducted among displaced in Rwanda and Afghanistan show that women have a variety of health concerns. In the study conducted in Afghanistan, women described several physical conditions, such as musculoskeletal pain, gastrointestinal symptoms, gynecological symptoms and chronic headaches.⁶³ In the study from Rwanda several physical concerns was mentioned such as headaches, backaches and respiratory congestion. As data on the same population before becoming refugees, as a comparison group does not exist, it is difficult to determine whether these concerns are caused by the conflict or the displacement. Poverty was mentioned as the most significant issue to affect the women's health, in addition to lack of freedom and control of one's own life. The women also expressed concerns related to reproductive health, contracting STIs, miscarriages, and lack of decision regarding contraception.⁶⁴ A qualitative study conducted in South Sudan concluded that reproductive health issues were important to the population affected by conflict. Miscarriages were the most commonly mentioned problems in reproductive health followed by sexually transmitted diseases and problems in childbirth, and infertility.⁶⁵

4.1.2 Fertility, safe motherhood and family planning

Conflicts might cause a temporary decrease in fertility due to malnutrition, stress, trauma and displacement in the emergency phase of the conflict. To replace those who are deceased or feared to become lost, there is also a need for women to increase fertility. A review of literature indicates that there is no common fertility pattern among displaced women and that fertility even during conflicts and displacement are affected by social and demographic factors among other things.⁶⁶ Most of the literature on reproductive health indicates that:

Refugees' status with respect to fertility, family planning and safe motherhood is largely determined by factors similar to those in settled populations. Social and demographic factors, such as age, socioeconomic status, education and urban or rural residence, as well as access to services, rather than refugee or displaced status in itself, appear to influence fertility desires and health behavior with respect to these reproductive concerns.⁶⁷

A retrospective study of data collected from over 600 000 forced migrants living in 52 post emergency phase camps in 7 countries shows how the reproductive health outcomes were better in refugees in the post emergency phase compared to host community and country of origin.⁶⁸ The area where there seems to be the greatest discrepancy in services is family planning. This is due to the lack of availability of methods and the performance of health care providers on the matter. Most literature indicates that the displaced, regardless of their lack of knowledge about contraceptives, still express a strong interest in and need for family planning and contraceptives.⁶⁹

4.1.3 STIs and HIV/ AIDS

Little is known about the relationship between HIV/ AIDS and IDPs. Organizations such as UNAIDS claim that IDPs do not have a higher prevalence of HIV compared to the general population.⁷⁰ But armed conflict may lead to increased spread of STIs including HIV, due to migration and power issues. Access to condoms might be scarce and the collapse of health systems during conflict leads to minimal prevention, treatment and care. Research has also shown an increased HIV prevalence among uniformed personnel, such as soldiers and peacekeeping forces. This is a group that may contribute to the spread of the disease by having sexual intercourse with civilians in the various areas where they work. As mentioned in section 2.3.2, armed conflict is often connected to the collapse of traditional norms regarding sexual behavior and sexual violence may be used as a “weapon of war”. Women may also be forced into exchanging sex for money, food or protection. This will increase the risk of STI and HIV exposure and the risk of being infected. Women are in general thought to have higher risk, biologically, of acquiring HIV.^{71;72} In addition, during rape, due to increased risk of bleeding and tearing of the genital area, women are more likely to be HIV infected than during voluntary sexual intercourse.³¹

4.2 Women and health in Darfur

Most of the literature related to women and health in Darfur is produced by NGOs.^{56;73;74} In 2005, UNFPA and UNICEF conducted a study focusing on the effects of conflict on the health of women and girls in Darfur, using focus group discussion with men, women and children in various sites. Among the issues the women mentioned were miscarriages, excessive bleeding, physical injuries and disabilities caused by beatings or running long distances fleeing from attacks. STIs, fistula, and other damage to vaginal, and urinal passages, malnutrition, psychosocial disturbance and nightmares were also reported. Sexual abuse had resulted in the destruction of the victims genitals; perpetrators circumcised them with knives even though their tribes did not practice circumcision. A majority of the women reported that most rape incidents occurred when they went to fetch firewood. The women also said that the health care available was not enough to cater for their needs.⁷⁵ A quantitative study among displaced in the Nyala province in south Darfur found that women's health needs remained largely unmet. Sixty-eight percent used no form of birth control and 53% reported at least one unattended birth. A total of one third of the respondents met the criteria for major depressive disorder.²⁸

4.3 Reproductive health services during conflict

The existing literature on reproductive health services in camp settings, primarily consists of studies or reports published by NGOs or UN agencies. A review conducted by the Inter-agency Working Group on Reproductive Health in Refugee Situations (IAWG) found that, overall, services related to safe motherhood are available and widely used. This includes antenatal- and postpartum care, post-abortion care and care during labor and obstetric emergencies. However, there was a need to improve the skills of health care workers and provide them with written clinical guidelines covering all services included in safe motherhood. Services for the treatment and prevention of STIs (including HIV/ AIDS) were of various quality, and the availability of family planning methods were in some places lacking. This was related to the limited selection of methods, lack of sensitization to the community about family planning, and stock shortage.⁷⁶

In 2004, the IAWG conducted an evaluation of reproductive health services globally. It seemed to indicate that the services provided for refugees are better compared with those provided to IDPs. The evaluation found that reproductive health services in post-emergency camps are sufficient compared to camps during conflict, and that the treatment for STIs was inadequate. There were also recommendations to improve case referrals and emergency obstetric care.⁷⁷

5.0 Justification for the study, hypothesis, research question and objectives

5.1 Justification for the study

Women's reproductive health during conflict has received an increasing amount of attention in recent times. However, the research conducted on the health of internally displaced persons in general and women in particular, is minimal compared to the large number of people. As more attention is being given to issues related to displaced women's sexual-and reproductive health by the international community and NGOs, the need for independent research on relevant issues becomes even more important. Only a few studies have investigated issues women's sexual-and reproductive health concerns and health services during the conflict in Darfur. This study therefore represents one the first attempt to gather information directly from internally displaced women about their sexual- and reproductive health care needs and their experiences with the available services. This knowledge can be valuable in terms of offering health care based on the experienced needs and concerns of the women. Hopefully, the new knowledge derived from this study can be used to improve the health services provided, and to generate hypotheses for future research in the field. This research has implications not only for the women in camps in Darfur, but may also be used to improve health care delivery to women living in similar conditions elsewhere.

5.2 Hypothesis, research question and objectives

Hypothesis

Women in Darfur have reproductive-and sexual health concerns that are important to them, for which there is limited health care available.

Research question

- How do the services available to women affected by conflict, cater for their sexual-and reproductive health concerns?

General objective

- To acquire new knowledge about how women's sexual-and reproductive health concerns are catered for by the health services available during conflict.

Specific objectives

- To explore women's experiences of safety and/ or danger in their lives
- To explore quality issues in the availability of family planning methods.
- To explore quality issues in the antenatal-, delivery- and postpartum care.
- To explore women's perception of the health care available.
- To identify recommendations for improvements and/ or changes of the health services.

6.0 Methodology, study setting and sample

6.1 Research methodology and approach

When deciding what method or methods to be used for data collection in a study one those that result in the richest data based on the research questions of the study.⁷⁸ As the study aims at understanding phenomena and explore issues related to the reproductive health and health services of women affected by conflict, a qualitative approach was chosen. As the study does not aim to establish correlation or representativeness for a larger population, quantitative research methods were not applicable. This chapter will explain how the qualitative research methods, namely interviews and non- participant observation, have been used. In addition to a description of the sample, the recruitment and the study setting.

6.2 Data collection strategies

As the study aims at investigating both issues related to women's sexual-and reproductive health according to the women themselves and quality issues in the health services delivery, two data gathering techniques were chosen, interviews and non- participant observation. Two groups were interviewed, namely health care workers and women using the health services and non-participant observation was conducted at various sites. This was done in the attempt to obtain data from a wide range of sources and in this way approach the phenomena under investigation from various, yet complementary angles to get a broader perspective and a more complete view. Using two or more methods allows the researcher to counterbalance the weaknesses and biases of the individual methods. This is called triangulation and is also used to increase the validity and credibility of the findings.⁶³

6.2.1 Interviews

The interviews with the health care workers were non-structured and did not follow an interview guide, but instead more general topics for each interview. As the health care workers had various experiences and worked within different areas, I

interviewed them to obtain background information about the health services, their comments on what I observed or issues raised during the interviews with the women. The interviews were conducted in English without interpreter, except for one. The interviews lasted from 20 to 30 minutes.

The interviews with women in town and in the camp were conducted with the use of an interview guide (appendix 1 & 2). It consisted of key words and a few questions, starting with background information and previous life experiences and continuing with issues related to delivery as this is something that most women find easy to talk about. Later questions asked specifically about STIs, family planning and FC and the use and perception of the health services. I always ended the interview with the question “do you have any questions for me?” which I found to be a good way to bring closure to the interview. It also revealed other concerns the women had, and I got the opportunity to speak more freely. In addition it often ended the interview less abruptly and more positively. It also allowed the informants to ask me questions and freely direct the conversation according to their interests. The interviews lasted from 35 minutes to one hour.

6.2.2 Non- participant observation

Observation is useful to experience activities directly and record your own perceptions and also to conceptualise statements and actions with individuals over time.⁷⁹ The objective during observation was to record women’s health concerns, how these were addressed by the health care workers, what kind of treatment they got, the interaction between the health professionals and the women and also the daily life in the health facilities. During the observation I would take notes in a mix between English and Norwegian (the latter for confidentiality reasons), which would be elaborated at the end of each day, and written into the computer. The observation included:

- Medical Assistant (MA) and midwife in the mobile clinic.
- Medical Doctor, MA and midwife in the rural hospital.
- MA and midwife in the camp
- Midwife in the clinic in town

In addition I went to several clinics in the area around town to observe what kind of services were available. Total time of observation was 60 hours.

When planning the study, I had developed a list of issues that I wanted to obtain data about through observation of the health services. During the fieldwork, several additional issues were added.

6.3 Study setting

6.3.1 Darfur Emergency Response Operation programme

When the conflict in Darfur broke out in 2003, Norwegian Church Aid (NCA), Action by Churches Together (ACT) and Caritas networks decided to respond with humanitarian aid through a joint Darfur Emergency Response Operations (DERO) programme. As NCA have been working in Sudan since the 1960's it was decided that the organization would have the legal responsibility for the programme. In consultation with the UN coordination mechanisms in place in Darfur, areas of operation were decided in South and West Darfur. The programme has its main office in Nyala, a support office in Khartoum and three field stations located in Zallingei, Garsilla and Kubum. The activities are carried out in cooperation with three local partner organizations, namely Sudan Social Development Organisation, Sudan Council of Churches and Sudan Aid. Thirty international and 350 local staff members provide services within the areas of shelter, water and sanitation, nutrition, distribution of non-food items, education, agriculture, psychosocial support, protection, advocacy, primary health and promotion of public health. The humanitarian response is estimated at 500 000 IDP's and members of host communities, around 7% of the total population of Darfur.⁵³

6.3.2 Kubum town

Kubum is located in the southwestern region of Darfur. According to OCHA,³ 5563 people live in the town, mainly in huts. They are mainly of Arab tribes, primarily the Benihalba tribe. After attacks in the nearby town of Aratala, and surrounding villages, several IDPs of Fur tribes moved to Kubum town and settled in the camp right outside of town when this was created in late 2003.

There are several open wells in town in addition to hand pumps. Some houses have generators, whereas firewood is most commonly used for cooking. There are three schools and one primary health clinic. There is one mosque for the primarily Muslim people. Most people earn their income by agriculture, and selling things at the market. Throughout the conflict there have been no attacks in town.

Kubum is one of the four field stations for NCA/ ACT- Caritas operations in Darfur. NCA is supporting the clinic in the camp, in Kubum town in addition to villages and towns nearby, 12 in total. NCA is the only NGO working in the Kubum area.

6.3.4 Kubum Clinic

The clinic in town consists of one area for nutrition and one building with an office and one room with two beds for deliveries. The clinic has a stock of essential drugs such as folic acid, antimalarials and antibiotics. A majority of the staff are midwives. The services are free.

6.3.5 Kubum rural hospital

The rural hospital was built by NCA in 2004 (see appendix 6 for picture). It is located approx. 3 km outside of Kubum town. At the time of visit there was one doctor working there, several medical assistants, midwives, nurses and traditional birth attendants (TBAs). They have laboratory equipment (though no laboratory technician at the time of the fieldwork), delivery room, and one room for surgery.

The IDPs do not have to pay to use the hospital, whereas the host community members pay for the services.

6.3.6 *Kubum IDP camp*

The IDP camp is situated right outside of town. It was created in 2003, and 2208 IDP's live there.³ They are mainly from Fur tribes and come from an area around the town of Artala, which was attacked by (allegedly) Janjaweed three years ago. People work by cultivating land and selling things at the market. IDP children go to school in town.

6.3.7 *The clinic in the camp and community centre*

There is one primary health clinic in the camp (see appendix 6 for picture) and one community centre. The clinic in the camp consists of one area for nutrition, one for health education, a small dispensary and an area for examination and one for deliveries. The services are free. The community centre is under the psychosocial, protection and peace building (PPP)-programme. The psychosocial activities consists of four parts; income generating activities, adult education, capacity building (awareness raising in the community) and counselling either in groups or individually. At the time of visit women made and sold bread at the centre, there was a kindergarten on the premises and women came for adult education. As part of the peace building part, there was also a workshop for people in the camp about UNHCR, the rights of refugees and IDP's among other things.

6.4 *Sample*

6.4.1 *Displaced and host community women*

As for most qualitative research, the sampling can be described as purposive. It implies that the informants are chosen because of some shared characteristics that will illustrate a feature or process in which the researcher is interested.⁸⁰ In this research project the characteristics and inclusion criteria were the following: being

a woman in the reproductive age span, between 15 and 49 years⁶⁸ and being affected by the conflict in Darfur, primarily by being displaced. Variation within the sample was also chosen deliberately to get a contrast so that the data obtained would cover a broad spectrum of perspectives. This was achieved by variation in age, level of education, occupation, and number of children and living either in the IDP camp or in town. The original plan was only to interview women living in the camp, but it was more difficult to arrange for the interviews there, so interviews were expanded to women living in town.

6.4.2 Sample size

As there is little knowledge in the field of reproductive health and IDPs, it was decided that the sample size between 10-15 would be enough to provide new insights and data in this area. However, the size of the sample should be determined by achieving "theme saturation". This means that no new data would emerge by conducting further interviews with additional informants.⁸¹ This was the goal of the researcher, and interviews were conducted until she felt this stage was reached after 14 interviews. The sample consisted of women ranging between 17 and 49 years of age and living as IDPs in the camp or in town respectively. It also consisted of women who could be described as host community, meaning that they were not displaced and lived in the town prior to the conflict.

6.4.3 Health care workers

Additional interviews with 6 health workers was conducted to obtain background information about the health services and also to get their opinion on issues raised during the interviews. The health care workers were of various ages, 3 being male and 3 female. One was a medical doctor, two were medical assistants, two were midwives and one was trained in social sciences

6.5 Sample Recruitment

6.5.1 In town

The informants in town were recruited in various ways. Since the interpreter knew some of the women in town, we started with the ones the interpreter considered to be most willing to answer my sensitive questions. After one interview the informant followed us to her friend so we could ask her if she wanted to participate. Another time one woman saw us coming and asked if she could be interviewed. We went from home to home, sat down with the woman, gave a brief introduction to the study and asked if she wanted to participate. If she accepted and agreed to do the interview there, we started the interview directly afterwards.

6.5.2 In the camp

I was allowed to conduct interviews in the camp by the camp leaders on the condition that one of the leaders attended the interviews. He was a registrar at the health clinic and seemed to have a good relationship to the people in the camp. Throughout the process, he expressed that he liked that the study was being conducted and thought it was needed. As he knew most of the people in the camp, I described the inclusion criteria and he took us from one eligible informant to the next. It seemed very arbitrary which household he chose, and sometimes there were no women where we stopped, so we went to the next. In the beginning I was very sceptical to the fact that one of the leaders in the camp was recruiting informants and attending the interviews, especially considering the issues I wanted to discuss and the fact that he was a man. But as discussed in section 6.11, the participants did not seem to mind that he was there, and the interview setting was relaxed and positive.

One informant from the camp was withdrawn from the study. She gave her consent to participate in the study, but seemed uncomfortable answering questions and had a dismissive body language. The interview was terminated after only a few questions, and the data obtained have not been used.

6.5.3 *The health care workers*

The health workers were recruited on the basis of the work they did. It was relevant to interview those who worked directly with the women being studied and who provided health care to them. Most commonly, it was the health care workers who I followed during observation.

The informants did not receive any material or financial compensation for participating in the study.

6.6 *Interview setting*

6.6.1 *Camp and town*

We conducted the interviews in the afternoon before dinner, a time of the day when the women were considered to have the most time to sit down with us. It was important that the women felt comfortable with the place where the interviews took place. All the informants expressed that it was best if the interview took place in their home, probably for practical reasons. Except for one interview where we sat inside the hut, we sat on rugs outside the hut. As I was operating the digital recorder I had to sit quite close to the interpreter, as it was at times quite noisy around us and I wanted her voice to be audible on the recorder.

6.6.2 *Distractions during the interview and lack of privacy*

Most of the time there was children around, and some times the women holding one of their children or lactating during the interview. People were coming and going, guests came over to greet us and children were playing around us. During three of the interviews, the informant had a female friend around, and they would start to discuss the questions among themselves before the informant answered. In the beginning I was concerned about this lack of privacy, and how freely the informant felt in terms of speaking her mind. But the fact that the informants seemed at ease and willingly answered all the questions, even regarding sensitive

issues, made me think that it was not limiting their responses. In fact, an isolated interview setting might have seemed strange to these women as they rarely experience any real privacy. If things got too noisy, I asked the children around us to leave, but more commonly, the woman asked the children to leave if a sensitive topic was raised.

6.6.3 Health care workers

The setting for the interviews with the health care workers were somewhat private, during their working hours in the health care facilities. They were not arranged in advance, but occurred by me starting to ask about issues relevant to their work that I had observed, or that had been discussed during the interviews.

6.7 Setting of non- participant observation

6.7.1 Observing the work of the midwives

In the clinic in the camp and in town, I observed antenatal examinations, as this was the work that the midwives did in the clinics. I sat on a chair next to where the midwife was sitting, and when she got up to perform an abdominal examination I followed her. I observed what kind of data they collected about each woman (weighing, measuring the blood pressure or conducting an abdominal examination), if they gave the women any drugs, if they referred them when they detected something abnormal, how much time they spent with each woman and how they communicated with them. The observation was conducted without an interpreter, which limited the data collected. Some communication was done in a mix of (limited) Arabic and English.

In the rural hospital, I observed the midwife when something out of the ordinary happened with one of her patients and not when she was conducting antenatal examinations. I only observed her during one pre-term delivery, and when she referred some of her patients to the medical doctor (as I was primarily observing his work at the hospital).

6.7.2 Observing the work of the medical doctor and medical assistant

At the rural hospital, I was mostly observing the medical doctor (MD). When he did not have any patients, we would go to one of the medical assistants (MAs) offices and observe their work with the MD (who spoke English) translating for me. I also observed the work of the MAs in the clinic in the camp and the mobile clinic. Both of the MAs spoke English. I used to sit either next to the MA or in the MD's office, in a chair behind the patient. The patients looked curiously at me when entering the room, however, no one expressed any dislike for me being there. The MA/ MD would take the patients illness history, and then turn to me to translate and also add the diagnosis and treatment. Similar to the interviews, various people came and went when the patient was sitting there. Often other health care workers would come in to listen and make a comment to either the patient or the MA/ MD and then leave. My main objective during the observation of the MA/ MD was to observe what kind of concerns women had, the treatment they got, and the interaction between the health professional and the woman.

6.7.3 Being “a fly on the wall”

Since I was dependent on the translation from the MA/ MD, it was difficult not to affect the situation that I was observing. After spending days seeing the same person treating patients I often found it difficult not to get involved in diagnosis and treatment of the patients. Sometimes the MA/ MD would give me the patient's symptoms and then look at me in a questioning way, as if for me to say the diagnosis if it was an "easy" one like as malaria. Sometimes I also asked the MA/ doctor questions related to the treatment or diagnosis, but I tried to do this in a curious manner and not in a way that would indicate a questioning of their judgment.

6.8 Lack of data on relevant issues

As a broad spectre of issues was covered during the interviews, the amount of data obtained varied greatly depending on the issue. In some cases I had expected to get more data, but had to realize that it was not possible.

Throughout the interview, I often followed up with questions so the informants would elaborate their answers. However, I found it difficult to get very long answers and narratives from the informants. There might be several reasons for this. First of all, I did not get a direct translation from my interpreter when the informants gave long answers, but a summarized version, as it was impossible for the interpreter to remember word by word what the informants had said. Secondly, my questions were specifically related to the issues that I wanted to discuss, and in some cases did not invite the informant to answer more in-depth, for example, by asking “could you tell me about a time you visited the midwife?” In addition, some of the issues discussed during the interviews were not issues the informants were used to talk about. This was especially true for the topics related to violence, FC, STIs and the use of family planning. These were also issues where I did not want to make the informants uncomfortable by talking about something they did not want to talk about, so I did not probe too much into these issues. The fact that the informants did not give long answers might also be related to the fact that they are not used to talking very much about themselves and their private health concerns. An example of this reluctance to elaborate was seen while observing the women when they had a consultation by a health care worker. They were very brief explaining their health concerns and did not elaborate on their problems.

The women living in the camp gave more incoherent and at times contradicting answers compared to the women in town. Their answers about their lives before the conflict and how things had changed were the most elaborate. This might give an indication of how important this is to them, and how much being displaced affect their current lives. I got shorter answers from the women in town, compared to the camp. These were the first interviews conducted and my probing skills were not fully developed until later interviews in the camp.

It was interesting to see how certain issues became more prominent than expected, whereas others were only touched upon briefly during the interviews. As a result, I removed one objective about STIs. Few informants had something to say about the issue, and those who did said they had heard about it, but had not seen it. First I thought that the informants said that because it was embarrassing to talk about STIs. But as one health care worker pointed out, it might be also that it is rarely diagnosed either due to lack of knowledge from the health care workers or because they do not want to treat it. This might make it unknown in the community. One of the issues that received more attention than originally planned was female circumcision (FC). The initial interview guide contained very few questions about it. However, when I came to the field this complex issue became so interesting that I started to elaborate the questions about it, as the consequences of the practice affected so many aspects of the women's health.

6.9 Validity of the findings

As a researcher it is important to keep in mind what might affect the responses of the informants, as they may be influenced by a number of issues. They might say what they think the researcher wants to hear, or something that will give a good impression of them. In relation to the data collected for this study, there are several issues that should be commented. One is FC. Both governmental and non-governmental organisations work against the practice in Sudan.^{27;82} Included in this work is awareness rising among midwives and TBAs. The health care workers interviewed might know that performing the procedure is not approved of, and will therefore be cautious about what they are saying about it. An example is one health care worker in the camp, who gave contradicting views on the practice. The informants might also pretend to be against the practice, if they know that white people are against it. Another issue was the degree to which the informants felt comfortable saying negative things about the health services. They might have felt pressured to say something positive about the health care if they thought I was working for the DERO programme. They might also answer according to norms in society, for example opposing women of using contraceptives without the approval of their husbands. I used interpreters connected to NCA, and in the camp we were

assisted by a register in the clinic. This might have affected how comfortable the informants felt saying negative things about the staff. In terms of the non-participant observation, my presence might have changed the behaviour of the health care workers and their patients. The health care workers might have tried to improve their performance and the patients might have become less talkative or be more obedient.

In the following it will be described how I tried to address these issues. This is related to how I presented myself as a researcher, and the training and performance of the interpreters

6.10 Position as the researcher

When using qualitative research methods, the researcher is in it self a research tool. Reflexivity at every step of the research process therefore becomes important. The researcher's preconceptions, previous qualifications and experiences will impact and affect the research process and the outcome of the study.⁸³

I was 25 years old at the time of fieldwork, which made me feel fairly young, both compared to the informants and the field workers. As I have only been working as a registered nurse at a major hospital in Oslo with infectious diseases, I had no work experience from conflict settings. I think the advantage of my young age and inexperience was that it made people more eager to help me (and also since I did not try to hide the fact that I needed help). My lack of experience working in conflict settings was a disadvantage because I did not know how I would react to the experiences I got in the field, and might also react more strongly compared to someone who was used to the setting. On the other side, I did not have any preconceptions about the situation, or how things were "supposed to be". I was also not familiar with the norms of the fieldworkers, and this was challenging at times. For example, the international staff thought I was spending too much time and being too friendly with the local staff, which I felt was natural since I was dependent on them to give me access to the field.

I did not have any professional attachments to NCA or any of the partner organizations, which I also made clear to the informants and the fieldworkers. It was important for me to be an independent researcher, and that my findings would not be biased by my own personal feelings for or against NCA.

6.11 Interpreters

Due to my lack of knowledge with the Arabic language and the culture in Darfur, I used three interpreters for the interviews. Due to practical reasons it was not possible to find one for the entire fieldwork, since I wanted a female interpreter and there were few females working in Kubum who also spoke sufficient English. The role of the interpreters were to interpret as accurately as possible the communication between my self and the informant, to clarify misunderstandings and to provide me with additional knowledge about the local culture that would help me get a deeper understanding of what the informants were saying.

The first interpreter was 28 years old and worked at the NCA office in Nyala as a health educator. She had completed two years of nursing school. She had previously lived in Kubum for one year, but was from Nyala where she lived now. The woman who interpreted the interviews in the camp was 49 years old, lived and worked as a midwife supervisor in Kubum. She was from South-Sudan. The third was only used for one follow-up interview with one of the informants. She came from North-Darfur, but lived in Kubum where she worked with administration in the DERO office. All the women were frequently used as interpreters by the NCA office.

All three interpreters were trained. First we went through all the questions and I explained why I asked them, and then we went through issues such as confidentiality and the importance of interpreting exactly what the informant was saying. As all had previous experience in interpreting, we did not practice the actual interpreting. After the first interview with all three, I let one of the

international staff, who also spoke Arabic, listen to parts of the interviews to assess their abilities to interpret correctly. He confirmed in all cases that they did. During the process he and three Sudanese listened to some of the interviews to make sure that the interpretation was correct. They were both informed about the necessity for confidentiality related to the interviews, and they accepted this. After three months in Sudan I learned some basic Arabic and was, in some cases, able to tell what the informant was saying and that the interpreter was translating correctly when listening to the interviews.

The interpreters were women, which was one of my criteria, as people who knew the community said that the women would be more comfortable talking about their health issues with another woman. However, during the interviews with the IDP's one of the male leaders of the camp who also worked as a register in the clinic in the camp, was present. I was reluctant to have him with me, but was relieved when it did not seem to bother or make the informants unable to talk about sensitive issues. One of the reasons might be because they knew him as a health care professional. A few times during the interviews, he had to translate from Fur to Arabic, as my interpreter did not speak Fur. The current thinking in the literature seems to indicate that using research assistants/ interpreters of the opposite sex when discussing sensitive issues might not affect the informants' ability to speak openly about these issues. According to Svanemyr, this may be due to the abnormality of the interview setting which might loosen or change social norms and replace these by others.⁸⁴

Two of the interpreters also had work experience within the health sector, one was a health educator who had done two years of nursing school, and one midwife. This meant that they, to a certain extent, were used to talking about women's health, and familiar with medical terminology. None of the interpreters were of the same tribe as the informants, namely Fur and Benihalba. It was not mentioned by the informants or the interpreters that this was a problem.

6.12 Discussing sensitive issues during interviews

When planning my project, there were several topics that I wanted to discuss such as FGM, STIs and the use of family planning methods. But I did not know if it would be possible to raise these issues. During the interviews, I tried bringing up the issues that I knew might be sensitive after creating a setting where I felt it was appropriate. I started with background questions about the informant's family and work, where they gave birth and so on. When I entered into more sensitive issues I always started by asking "is it okay with you if I ask about family planning (or FC, violence, STIs etc.)". All the informants said yes. Sometimes I generalized the questions by saying "we know that many women have experienced violence, do you know of any?" or "people have told me that..". I also chose interpreters keeping in mind that they had to be someone who dared to ask these kinds of questions, and would do it in a way that did not offend the informants. In terms of the difference in educational level within the sample (see table 1 in section 7.2), it seemed that the women with the higher education were more willing to talk about sensitive issues. The interpreter I used for the interviews with host community decided that we should try to find teachers and health workers as these women were educated and would be more open to talk about reproductive-and sexual health issues. Her insight was correct, later we interviewed some women with a lower socio- economic background, and they generally seemed more reluctant to discuss sensitive issues.

When entering into sensitive issues during the interviews, one of the most difficult things was to understand what we were actually talking about. Often when we entered into issues such as FGM or STIs both the informant, the interpreter and myself talked about it without saying the actual words, which sometimes made me wonder if we *were* talking about it. Below is one example from one of the first interviews conducted where we talked about STIs:

Informant: no. they will not think you are a bad person because of syphilis, just normal because they think this is a disease, not bring it by..

Researcher: so they will not think it is..

Informant: they have found easy treatment for this syphilis and gonorrhoea.

(woman living in town, nr. 3)

Gradually, as I became more confident discussing sensitive issues it became easier to address it in a way that did not offend the informants and also made it clearer to me that we were talking about it.

6.13 Conducting fieldwork in a different culture

Even though I came to Darfur with some background knowledge about the history and culture of the area, I did not feel I had enough background knowledge that would help me in my daily interaction with the community. When I got to know the local people I tried to learn as much as I could from them about the local customs. As long as it did not conflict with my own personal values, I tried to do what the locals were doing. I ate with them (and in the same way, by not using my left hand) and tried to dress somewhat similar to them by wearing loose fitting clothes with long sleeves and trousers or skirts. I also wore a headscarf every time I went outside, as this was the custom for women. I learned basic Arabic, to be able to greet fieldworkers and informants, and carry out some conversation.

Before, during and after the fieldwork I was in contact with Sudanese people and people with local knowledge from Darfur, in addition to other Muslim people. They provided knowledge about cultural issues related to what I experienced or my findings which helped me to understand it better.

I entered the field and expected everything to be completely different from the world I was used to. And in many ways it was. But during the fieldwork I also experienced similarities, such as the human reactions to events in life. Findings can easily be biased by the researcher's expectation that everything is going to be different from what one is used to, and also prejudice about the culture. A number of research papers give examples of this occurring, when western researchers conduct research in developing countries. According to Silverman, this prevents the researcher from "observation of what people are actually doing, then one may find certain common features between social patterns in the West and East⁸⁵". It may be argued that this issue does not receive enough attention, as it may severely damage the quality of the research performed in developing countries

creating "more of the same" kind of knowledge. An example of this might be seen when research is conducted in cultures where men exert control over women. In some cases it seems as though the researcher forgets that it does not necessarily mean that ALL women in that community are controlled by men, and therefore does not present findings of the opposite experience.

6.14 Conducting field work during conflict

The fieldwork was conducted during a time of armed conflict. This made things somewhat different from conducting fieldwork during peacetime. For a researcher it is challenging primarily because the security situation changes rapidly, and can make it difficult to carry out a research project as planned in advance.

Due to the constant change of the security situation, it was not decided until I came to the DERO office in Nyala where in Darfur I would collect data. These decisions could not be made in advance, but instead from up to date information about the situation in the areas where the DERO programme was carried out. During the period of fieldwork the security situation changed gradually for the worse with increasing episodes of violence in major towns and attacks on NGO offices and vehicles. There was a constant possibility of being evacuated out of the field and as a result, I collected what I considered to be the most important data first which was the interviews. Even though Kubum area was considered peaceful, it caused without doubt an additional amount of psychological strain to collect data in an area of conflict, because I knew that the situation could change quickly for the worse.

Spending time collecting data during a conflict is challenging from an ethical point of view. In a place where many people are in a desperate situation, humanitarian assistance and emergency relief seems more important than a research project. Many times during the fieldwork I felt as a nurse that I should spend my time working in the health facilities instead of collecting data, as this would have benefited the people more.

6.15 Data analysis

Like most qualitative research, some of the data analysis occurred simultaneously with the data collection. At the end of each day field notes were elaborated upon and typed into the computer. Interviews were then transcribed as soon as possible after the interview was finished, but only my questions and the interpreted answers, as no one in Kubum had the opportunity to transcribe the informant's answers in Arabic. To organize the data and obtain an understanding of themes and categories, I read and reread notes and the transcribed interviews throughout the fieldwork. As interviews were transcribed from the English interpretation of the answers, I did not analyse the interviews according to the language used or word-by-word. Instead I focused on the general impression I got from what the informant was saying. For example, whether the informants were positive or negative about the health services. Many themes were already identified in the interview guide such as antenatal care, disease history, perception of the health care, STIs, FC etc. I used these as headings and put the statements and my comments where I found them most appropriate. I also made some new headings when a theme occurred often, such as miscarriage. I made a summary of the general impression of each category and quantified certain things, such as how many had undergone an abortion, used contraceptives etc. Most of the categories emerged into several sub-categories which were used for the interpretations. These steps of analysis were partially based on Kvale's methods of analysis, particularly meaning condensation and meaning categorization being relevant.⁸⁶

When analysing qualitative data it is possible to use computer software such as NUDIST N6. The program may assist in organizing data into themes and categories. As the amount of data collected for the study felt manageable without "assistance" from the computer programme, it was decided not to use it.

6.16 Dissemination of findings

Preliminary findings of the study have been distributed to several people primarily working within the DERO programme or NCA. This includes the DERO director and health programme manager, the NCA Resident Representative in Sudan, the NCA special advisor on gender and development, the NCA program co-ordinator Eastern Africa and the head of division for Eastern Africa, South and South East Asia. The summary of preliminary findings has been delivered in written form.

On the 26. September 2006, preliminary findings were presented to the Technical Advisory Committee, Epidemiological Laboratory (Epi-Lab), Khartoum.

The researcher has also met with representatives from Norwegian Ministry of Foreign Affairs to present some of the main findings of the study and experiences from the fieldwork.

The findings related to psychosocial interventions and the community centre was presented at the conference "Cope with Crisis" 27. April 2007 in Oslo.

6.17 Ethical clearance and approvals

The study was ethically reviewed, and approved by a committee at the Institute of General Practice and Community Medicine, University of Oslo. In Sudan, the study was ethically cleared with relevant authorities (see appendix 4 and 5).

The supervisor reviewed and approved the research protocol, and an external censor reviewed the methodology and approved it.

Permission to collect data in Darfur for the study, with assistance from NCA was granted in writing from the DERO support office in Khartoum, and by e-mail from the NCA resident representative in Sudan and the DERO director in Nyala.

6.17.1 Informed consent

According to the Declaration of Helsinki regarding all research involving human subjects, informed consent should always be obtained for all participants in a study.⁸⁷ As most of the informants were illiterate, it was decided that it would be obtained orally. To ensure that consent is given without any form of persuasion, one witness should be present. In the IDP camp, one of the camp leaders was attending the interviews, and was also the witness that consent was given without any form of pressure. However, it may be argued that he might have exerted pressure on the women to participate in the study, but this did not seem to be the case. During the interviews with the host community, there was no witness in addition to the researcher and the interpreter since I did not want an additional person to come with us as a witness. Instead it was considered that the interpreter was in a position to prevent any pressure being put on potential interview objects to participate in the study. First of all, she was not paid for interpreting, which meant that she did not have to be subordinate to the researcher in any way. Secondly, she knew and had a good relationship to the community and would protect the women from exploitation. The participants were informed about the purpose of the study, risk and benefits and also their right to withdraw at any time without consequences, refuse to answer any questions and withdraw consent for the use of their data. They were also informed about their right to refuse the use of the digital recorder, that their names would not be written down anywhere and that the researcher and interpreter would ensure their anonymity in any way they could.

Informed consent was not obtained during observation for all the patients that were consulted by the health care workers, as this would be practically impossible. The health workers agreed that I could attend the consultations, and in certain cases they would explain who I was and the purpose of my study when the patient entered the room. When they did not it was often because there was no time, or the patient started the consultation without asking about me.

6.17.2 Confidentiality

The participants names were not written down, or even asked for during the interviews. The researcher identified the participants by memorized interview numbers. The interpreters and also those who listened to the interviews to verify the interpretations had to confirm verbally that they understood the concept of confidentiality and that they would not publicly discuss anything related to the research. When writing up the thesis, I tried in every way possible to keep the informants' statements anonymous.

Throughout the fieldwork I took notes and wrote down my observations in Norwegian, as no one (that I am aware of) knew the language. The notes would therefore not make sense if others read them. The data collected were kept in a secure place the whole time, and will be destroyed after this paper is disseminated.

6.18 Timeframe of the project

The initial planning of the project and a literature review was carried out from January to May 2006. The data was collected between August 2 and September 20, 2006 in Darfur, Sudan. The analysis was conducted and findings generated from December 2006 to May 2007.

7.0 Results

7.1 Introduction

This section will present the findings of the study. It will start with some of the characteristics of the sample, and also some of the differences within the sample. It will then continue with the informants' life before the conflict and the psychological effects of violence and traumatic experiences, before entering into the health services, antenatal health and care, female circumcision, contraceptives and lastly other factors affecting the women's health.

7.1.1 Clarifications

R = Researcher

T = Interpreter

I = Informant

7.2 Differences in the sample

The study included six displaced women living in an IDP camp, three displaced women living in Kubum town (hereafter called “town”) and five women living in town as part of the host community. Table 1 shows some of the socio-economic characteristics of the sample:

Table 1: Socio- economic characteristics of the women interviewed

	Displaced women living in the camp (n= 6)	Displaced women living in town (n= 3)	Women living in town (n= 5)
Age average (min- max)	32 (23- 40)	24 (17- 30)	38,4 (35- 42)
Number of children average (min- max)	5 (2- 11)	4 (1- 8)	5 (3- 8)
Marital status	all married	all married	all married
Tribe	Fur	Fur	Benihalba
Work	All work at home, 3 work seasonally cultivating other people's land and 1 works occasionally in the health sector.	All work at home	4 work in the public sector, 1 does not work.

From the figure above, one can see that there are both differences and similarities between the women living in town and the IDP women. During the interviews, I noticed that the women did appear to be different. It was partially related to the desperate situation that the IDP women, especially those living in the camp, were in. In addition, the women were from different areas, of different tribes and spoke different languages. It also appeared that the women of the host community in town had more education than the displaced women. A result was that the displaced women did primarily domestic or agricultural work, whereas four of five women in town had a job in the public sector, and three had higher education. One informant living in town said it like this:

The women in town are coming from a different environment; the level of education is high. The women in town are civilized. The IDP women do not have education and have not had the same standard of living.

(Women from the host community, nr 3)

It appeared that the displaced women had less access to education in the villages where they were from, compared to the women in town. One of the displaced women was asked if she could read and write. She answered that she had learned it in primary school but had not used it since, so she had forgotten it. She also said that she wanted to continue her studies, but had to start working to support her family instead.

There was a perception among the women in town that the displaced did not have any problems because the NGOs were supporting them. It is however, unclear if the woman quoted below were talking about the IDPs in Kubum or in Darfur in general:

I: they have severe malnourished and acute jaundice sometimes. In the past they have these diseases. But now they are happy.

R: they are ok now. Why are they better now?

I: because of all the NGOs, they have concentrate for the drugs, doctors..

R: they are getting what they need to improve their lives?

I: yes.

(Women from the host community, nr 3)

But some also felt sorry for the displaced people who had to flee their homes and leave everything behind. One woman in town talked about how she had let one

displaced family stay in her garden after they had fled, before the camp was established. She had seen the desperate situation that they were in, and how they did not have the essentials for their daily lives:

When the woman was going to deliver, they put this cloth for her. There is nothing. Just this top (pointing at her top, she is wearing traditional Darfur outfit) and she is delivering there on the ground. Without anything.

(Women from the host community, nr 2)

One IDP woman living in town was asked about how she felt living in town, and what she thought the people in town were thinking of her being displaced:

R: do you feel very different from the people around here?

I: yes. A lot of differences.

R: but do you feel that they look at you in a negative way because you are an IDP?

I: no, the relationship is good between us.

(Displaced woman living in town, nr 8)

It is worth mentioning that the interpreter during this interview was herself a woman living in town, and that this might have affected the informant's response. When asked, several of the informants from the host community said that the major difference in their life after the displaced came, was that prices on the market had increased.

7.3 Loosing everything

All the displaced women in the camp described the life in the village as carefree compared to the life in the camp which was marked by struggle for survival.

All the displaced women described a happy life in the village they came from. They remembered a life of self-sufficiency and at times also indulgence, having plenty of "everything". Then the rebels came (described by one informant as Janjaweed):

We where happy in the village. Everything was free. I was cultivating in the village. We are not happy now because everything is taken away from us. We ran away because there was a war. We had everything at home, here they have nothing.

(Displaced women living in the camp, nr 2)

When the attack came, there was no time to bring anything with them, and they arrived in the camp empty handed:

If you are staying at home and someone come with a gun, you will be afraid and you will run. They have taken everything from me, even the animals. If you have to run you will leave everything at home.

(Displaced women living in the camp, nr 3)

In the initial phase after coming to the camp, they received food and "non-food items" such as plastic sheets for the huts from the NGO working in the camp. That was three years ago, and now the IDPs are now expected to manage for themselves. This was a major concern:

When we came here, we found that NGOs were helping us, brought us food and everything was fine. Now it is finished. Plastic sheets for the rain, no more food. Everything is finished. I have no job.

(Displaced women living in the camp, nr 1)

In the village, they had managed without money as they were self-sufficient. Now they needed money to buy things at the market. To get money they had to work, which was difficult to find. The rainy season was occurring during the time of the interviews, so some of the informants worked for people of the host community, to cultivate their land. The atmosphere in the camp was tense and the people living there were frustrated because of their situation. They were talking of leaving the camp, and going to one where they were given more. All the women I interviewed in the camp said they were happy to see a white person, because that meant they would be given something.

Throughout the interviews with the women living in the camp, it was also discovered that some things were improved living in the camp compared to the village. They had easier access to clean water, as there were many hand pumps in the camp. And they had a health clinic nearby, in comparison to the village where there was none.

7.4 Psychological effects of the conflict

The displaced women had experienced traumatic events before they had to flee their village. This was still affecting their lives, their mental state and their interaction with the people around them.

Several informants told stories similar to this one:

One day I went cultivating and I saw four planes. While we were taking our things to run away, one of the planes shot in the middle of my village. Some people were killed and 50 houses were burned. While the rebels were busy burning houses, or shooting someone, we found a chance to take our children and run away from the village.

(Displaced women living in town, nr 8)

Three years after the displacement their experiences were not forgotten. Losing loved ones was particularly difficult:

I am always thinking about my relatives. Some of them died in the conflict, many of the things we faced.

(displaced woman living in town, nr 8)

The same informant also mentioned the effects of the traumatic experiences on her mental state:

We go out and do our things but we are not happy. We can laugh and talk to others, but we feel that it is not good.

(displaced woman living in town, nr 8)

Her sister was attending the interview, and this is most likely the reason why she used the term “we”. The informant thought it was best to talk to relatives about what had happened because the people from the host community who lived around her, would not understand her experiences:

Before we were living in our houses, and we had things in our hands (meaning money). And when we have lost that, sometimes we sit together and talk about what we have lost. We can only talk to our relatives. We live among other people now, so we can chat with them, but we cannot give the secrets, we cannot talk about what we have in our hearts..

(displaced women living in town, nr 8)

It was obvious that the women found it very difficult to talk about this issue. A Sudanese, not from Darfur, working with psychosocial interventions said it was difficult to get the displaced women to talk about their experiences as an outsider. He explained that the people living in the camp had particular difficulties talking about the issue. This may be related to what the informant above described as being different from the others due to their traumatic experiences.

7.5 Experience with violence

All the women both in the camp and in town reported feeling safe in their daily lives. The displaced women reported being afraid of attacks when they lived in the village, and described taking precautions to protect themselves from violence. Half of the women in the camp said they had heard about women who had experienced sexual violence.

Several of the women in the camp told stories similar to the informant below about the fear of violence while they were living in the village:

We were afraid. Even though you were at home, we had to go outside to get firewood, and sometimes there would be people with guns there threatening us, maybe you would be killed. Nobody was supporting us. But here, we are safe because there are soldiers here.
(IDP woman living in the camp, nr.2)

Most of the women had stayed indoors to try to be safe, as the attack happened outside. During the follow-up interview with one of the informants, she explained how the community had tried to protect the women against violence. After hearing about incidences of violence against women in areas around the village, and also seeing men with guns running towards them when they went out to collect firewood, the men in the village had decided that the women should no longer go out to collect firewood and that it should be bought in the market instead.

There were mixed responses to the question about whether the women in the camp knew of any women who had experienced sexual violence. It was confirmed by three that they had heard of it occurring, whereas three said they had not. One informant gave an indication that this was a major issue:

There are some women, that there are many women who have experience with violence.
(IDP woman living in the camp, nr.1)

One of the health care workers working with psychosocial interventions, like trauma healing, in the camp said the community was very conservative. It was difficult for the women to be open about this issue because there was so much

stigma attached to being sexually abused. However, one informant stated that the community's perception had changed after the conflict started:

If a woman had sexual contact before she got married and it was shown that she had been with a man before, she was considered not to be a good woman. But after the conflict nobody is blaming the women, because they know it is because of the attacks.
(displaced women living in town, nr 8)

The informants gave contradicting answers when I asked if they knew any women who had experienced sexual violence. Those who did know were always quick to add that they had only “heard about it, but not seen it”. However, I got the impression that they had thought about it, and what would happen to the woman after such an experience. One informant said the victim would be sad and that it was important that she got the support of her husband, whereas another said the victim would need time in a hospital to regain her health.

7.6 The community centre

A majority of the informants in the camp had been to the community centre. With one exception, all reported that it had been a positive experience. However, they could not continue to go there, as they had to spend their time taking care of the children or to look for work.

The informants explained how they had come to the centre and been told that they could do whatever they knew how to do. This could be sewing, mending or making henna painting. One informant liked being at the centre because she could do something she liked to do, but also because of the people who worked there, and the civilised way people interacted with each other:

It is good, because when you go there, they give you an experience how to sew, how to mend, you talk as a person in the town. It is good.
(IDP woman living in the camp, nr 5)

One of the informants living in town stated that the women in town were more educated and had a higher standard of living than the displaced women. The displaced woman quoted above seem to indicate that she regained some of the

confidence she might have lost when becoming displaced, by doing something she could master. However, her situation made it difficult to spend time there:

I went there, they asked me what do you want to do? The second time they gave me henna painting. And those who know sewing have been doing that there. But I stopped after three times .I stopped because no one is here helping me with the children. When I come home from the community centre I have nothing to give to the children. I would go if I could get some money there. But you have to work there, and then nothing. Nothing to eat.

(IDP woman living in the camp, nr 3)

All the women reported that they stopped going after a few times. They explained that they could not spend time there without getting some compensation in the form of food or money. They were worried about how to feed their children and felt that they should spend time looking for work instead of spending time at the centre. As mentioned in the introduction to the community centre, there were income-generating activities at the centre, but it appeared to be on such a small scale that it could not benefit all the women who visited the centre.

Only one informant said she did not like the community centre. She explained that it was because she did not know how to do any of the things that the women were doing there.

7.7 The health services

The informants expressed that they were happy with the health services available to them. All reported having used the services, receiving treatment and that the health care workers did a good job. However, most of the informants had suggestions for how it could be better. During observation it became clear that there was room for improvement from the health care workers, especially with regard to the diagnosing of patients, health education and attitudes towards patients.

7.7.1 Opinions about the services

All the informants both in town and in the camp said the treatment they got in the clinics or at the rural hospital was good. The displaced compared it to the village where they had limited access to health services. Several of the informants described how they went to the health facility and the staff asked them about their health concerns and gave them drugs.

R: what do you think about the clinic in the camp?

I: It is good. Before, if I got sick only God could help me. But now if I get sick I can go to the clinic and get medicine. If I go, they will ask "what is your condition?" or, "what do you need?" And if I describe signs and symptoms, they give me medicine.

(Women living in the IDP camp, nr 4)

When asked what was good about the clinic most answered that the staff was good and "had good experience". Only three out of the 14 informants said they had any concerns related to their health when asked. All had used the health services for various health concerns in the past and without exception gotten some form of treatment, which was considered to be effective:

R: did you get any treatment?

I: I found a treatment. They have given me drugs.

R: do you think it helped?

I: yes.

(Displaced woman living in the camp, nr 4)

Another informant felt she got particularly good care by the medical doctor:

I will go to the doctor, and he will treat me, like give me an injection. He is good like that.

(Women living in town, nr 5)

In general, the informants were positive about the health care workers, saying that they had "good experience".

In most cases it did seem like the health care workers cared about their patients and tried to provide something extra when it was considered necessary. At times patients approached the health clinic with symptoms that could be categorized as psychosomatic. In these cases the health care workers gave out drugs to patients even though they could not find anything wrong with them, because they said it

would make the patients feel better. One health care worker said he did not charge for his services if he knew that the patients did not have the money to pay.

7.7.2 The health care delivery

The informants had several suggestions about how the health services could be improved, but it was questionable to what extent this was taken into consideration. There seemed to be a need to improve the practice with regards to information and education given to the individual patient as part of the consultation.

When asked, most of the informants had suggestions for how the health services could be better. More staff, more equipment and more drugs were frequently mentioned. Several of the informants living in town mentioned that there should be more health education related to nutrition, especially after delivery. Some of the midwives had samples of grains and legumes in their offices, but it was rarely seen that these were used for educational purposes. Three of the women in town also mentioned that there should be improved facilities for deliveries in the clinic. However, one informant did not think that the women's concerns and suggestions were taken enough into account when developing the health services:

I: when the services are implemented, they (the NGOs) do not listen to the women.

R: they do not listen to the women?

I: no. We have problems and we have needs like this (we where talking about contraceptives) and nothing is done about it.

(woman living in town, nr.5)

Often when the informants told me about their experiences with the health services, it seemed that they had difficulty knowing what kind of health care worker had taken care of them, what kind of drugs they had been given and in some cases, even what their condition was. This could be due to the practice, as was seen during the observations of the health care, where the health workers failed to introduce themselves with name and title, and only rarely explained the drugs they prescribed to the patients, or informed them properly about their disease. One example of this was an informant with heart disease:

R: does she have any other diseases?

I: there is a kind of disease. I have swelling in the body, oedema. If it starts I am not supposed to eat, all the body will pain, and I have to go to the clinic and they will give me medicine. More than three or four days until it is better again.

R: have they told you what kind of disease it is?

I: it is kind of disease, where you are not to eat too much salt or too much meat.

R: heart disease?

T: yes.

(Women living in IDP camp, nr 2)

It is also not clear how long the effects of the treatment lasted. Some informants first said that they had gotten better, but later in the interview revealed that there were still some problems. This was often associated with chronic pain as a result of either complication during delivery, pelvic inflammatory disease after delivery or generalized pain in the abdomen.

7.8 Antenatal care

All the informants reported going to antenatal visits during pregnancy, and some even went more than what is considered to be necessary. However, the observed antenatal examinations were of questionable quality and did not adhere to guidelines for antenatal care.⁸⁸

7.8.1 The use of antenatal services

For the displaced, there had been limited access to antenatal care in the village they came from. One woman explained how she had gone from the village where she lived to another town over 100 km away to attend an antenatal visit. However, most of the displaced informants said they had not attended antenatal visits until they came to the camp.

There was no antenatal care in my village. When (I was) pregnant in the camp I went every month to the midwife.

(Woman living in the camp, nr.1)

The displaced women said having access to antenatal care was the major difference between being pregnant in the camp compared to the village. It was obvious how important the antenatal visits had become to the women:

R: what is the main difference between giving birth in the village, and giving birth in the camp?

I: there is a difference. in the village, you cannot go to antenatals, so no one will make sure that the child is okay and is positioned right in the womb. here, you have to go. and if the child is not positioned right, the midwife will give you medicine and check. here there is a midwife, in the village there is nowhere to go for antenatals.

(Woman living in the camp, nr.4)

One informant explained that it had taken her a while to get used to attending antenatal visits. During the first pregnancy in the camp she had not gone as frequently for antenatal visits as she did during the later pregnancies, simply because she did not know that pregnant women were supposed to attend antenatals. Some women, both in town and those living in the camp, reported going weekly during the last two months before delivery and monthly before this. This was also mentioned by other displaced informants.

7.8.2 Antenatal examination

From observing a number of antenatal visits conducted by three trained midwives, it is unclear how skilled they are in detecting "high risk cases" and referring these. It also varied to what extent they were following procedures for antenatal examination.

The three midwives observed performed the antenatal examination in very similar ways. First, they would take the patient's history, writing it into a notebook. Then the patient would be asked to step on a scale, and the midwife would record the patient's weight. Then the midwife would perform an abdominal examination, and at the same time observe mucosal linings, the palm of the hand and nail beds for signs of anaemia. They would also examine the patient's nipples for signs of mastitis and palpate the thyroid gland for signs of goitre. During the abdominal examination, they would place their ear on the abdomen to listen for the foetal heartbeat, only one used the midwife stethoscope. They would then palpate the abdomen to feel the positioning of the foetus. Finally, they would give the patient drugs or refer them when this was considered necessary. During the visit there was little talk between the patient and the midwife, except when the midwife asked

for the patient's background information. Only a few times did the midwife show samples of grains and beans to educate a patient about nutrition.

7.8.3 Quality issues related to antenatal services

One of three midwives measured blood pressure on her patients. There was not taken any blood- or urine samples from the women as part of the antenatal services. The latter might be related to the lack of lab facilities at the health facilities. All of the midwives conducted a physical examination of the abdomen, before week 32. The midwives themselves did not comment on the extent to which they were following procedures for antenatal care, or give any explanation to why this might be lacking.

When they gave pregnant women drugs this was most commonly Vitamin A, Folic acid or iron supplements and in rare cases paracetamol, if the pregnant women experienced pain.

Some women were referred by the midwife to the MA or medical doctor. At the rural hospital, the midwife would accompany the patient to the medical doctor and assist him during the examination of the patient and provide background information. The MA's and medical doctor seemed concerned about not prescribing drugs that might harm the foetus to pregnant women. On several occasions the health care workers were debating among themselves, or stating what drugs were the right ones, when prescribing to pregnant women.

7.8.4 Postpartum care

Some of the women interviewed had gone to vaccinate their infants at the clinic, and two reported also weighing the baby. There was no difference in the occurrence of these visits between the town and the camp. The midwives confirmed that women did not come to the clinics for a medical check-up for their infant after giving birth. It was only when the baby got ill that it was brought to the

clinic. Some of the most common symptoms of the children who was taken to the clinics were cough, fever and diarrhoea in addition to what appeared to be ear, skin or eye infections.

One midwife stated that prenatal visits were not a routine for women, such as the antenatal visits. However, if she heard of a woman having delivered, she would visit and observe the infant. On one occasion it was observed that another midwife did this. She was informed that a woman had given birth during the night when she came to work in the morning. She looked at the infant, talked to the mother and looked for signs of inflammation of the umbilicus.

7.9 Complications during pregnancy

Despite attending, in some cases quite frequently, antenatal visits a majority had experienced feeling ill and also complications during pregnancy.

All informants who reported feeling ill during pregnancy also said they had mentioned this during antenatal visits. In all cases the woman had received some form of treatment:

There was a problem because I had pain and was sick, every time I had to go to the midwife. Every time I went to the clinic the midwife had to supply me with medicine.

(IDP woman living in the camp, nr 2)

Even though this was the first time some of the women had access to antenatal care, the same informant said that the problems had started to occur after she became displaced:

There was no problem when I was at home. When I came here I was suffering with every child. Pain, back pain, pain in the stomach.

(IDP woman living in the camp, nr 2)

A midwife working at the clinic in town said they often discovered that the foetus was positioned wrong during abdominal examination. An informant in town had experienced this:

When I was pregnant with the twins, they were coming with their.. The girls stand and the boy was upside down. They transferred me to Nyala, but I was not be able to go because of the situation that I have said to you (lack of money).

(woman living in town, nr. 5)

Even though there was a medical doctor working at the rural hospital, if a woman needed caesarean section, she had to be referred to another town. The medical doctor referred some patients for caesarean section. The patients were referred to a public clinic, where they had to pay for the health services. It is not known how many of the referred women ended up having the procedure.

7.9.1 Miscarriage

Several of the informants asked about complications during pregnancy mentioned miscarriages. Four of the eight informants living in town had experienced a spontaneous abortion. All aborted at home without any medical assistance. Half of those experienced chronic pain in the abdomen after the abortions.

The women who had miscarried had all done so at home, and said that nothing had been detected during the antenatal visits. It seemed that most of the miscarriages had happened after multiple pregnancies:

During the first pregnancies I did not feel any bad health, but the last I was expecting twins and they died because I was bleeding.

(Women living in town, nr 3)

Excessive vaginal bleeding (post partum hemorrhage) after delivery or miscarriage was also a concern seen during observation. Some of the women were given antibiotics, iron or folic acid whereas others were told to come back later, to see if the bleeding had decreased.

My last question during the interviews was always if the informant had any questions for me. In town, several of the informants had questions related to miscarriages. These were related to the pain they experienced afterwards, and if there were anything to be done to prevent miscarriage from occurring. One

informant was a 30-year old woman with 8 children who had undergone an abortion 3 months earlier. She was now 50 days pregnant and wondered what she could do to prevent another abortion.

The women living in town, both from the host community and displaced, frequently mentioned miscarriage. The issue was not raised as frequently among the women in the camp. One health care worker confirmed that there seemed to be fewer miscarriages in the camp compared to the town, and suggested that the women in the camp were stronger physically as they had limited access to health services in the past.

7.9.2 Loosing a child

The women who had experienced a miscarriage were not asked how they felt about loosing a child. But two episodes gave an indication how difficult this was for them. One happened during the antenatal visits in the camp. One woman kept coming and the midwife conducted the same examination of her as with all the other women. After the woman was gone the midwife told me that the fetus was dead. This had been explained to the woman several times, but the woman kept coming for antenatal visits. The midwife indicated that she did not understand why she did this. The other episode occurred at the rural hospital. A woman 7 months pregnant came to the doctor due to vaginal discharge. The doctor confirmed that the woman was in pre-term labour. The woman delivered at the hospital, but unfortunately the newborn died within an hour after the delivery. Afterwards, the female relatives burned incense, and the woman was lying in bed holding her dead child, crying for a long time.

7.10 Circumcision related to the assistance during delivery

It varied to what extent the informants had experienced complications while giving birth as a result of FC. Unexpectedly, there was also a clear division between the women in the camp and the women in town with regard to their use of a traditional

birth attendant (TBA) or a relative for assistance during labour, which may be related to the type of circumcision the informants had undergone.

A TBA had assisted all the informants living in the camp during childbirth. The women in town, both displaced and women from the host community reported being assisted by relatives, most commonly their mothers. Even though this was not specifically asked about, one can assume that the displaced women in the camp had undergone infibulation since all the informants mentioned the issue of obstructed labour if the TBA was not there to assist. As the displaced women and the women in town are two different tribes with different cultures and norms, it would be natural that customs varies some with regards to what type of circumcision is performed. However, this does not explain why the displaced women living in town, who were from the same tribe as those living in the camp, would use relatives and not a TBA.

7.10.1 Consequences of female circumcision during delivery

In total, half of the informants said they had experienced problems as a result of circumcision, while the other half said they had not. It appeared that most of the women who did experience problems were infibulated, and that obstructed labour was a fear for them:

There is a problem with circumcision. When the child is coming, unless they harm and cut you, the child will not get out. If you come into labour and there is no midwife... you will die.
(IDP woman living in the camp, nr 1)

One woman had experienced the consequences of infibulation during delivery:

During the last birth I was suffering. It was dangerous for me to give birth, because the child could not get out. There is no way for the child to come out. The TBA helped me. After delivery I was suffering. A lot of pain.
(IDP woman living in the camp, nr 6)

One of the health workers interviewed said that the main reason for obstructed labour in the area is infibulation. Of those who did not report any problems, two informants explained that it was because the TBA was there to help.

Some of informants also reported reinfibulation by the TBA after the delivery. After one delivery it was observed that the midwife did stitch the woman afterwards. It is unclear however, if this was due to circumcision or if it was needed after the delivery for natural reasons. When asked, one TBA said that they were only stitching the women after delivery for natural reasons.

One might question the validity of the midwife's and TBA's answers related to circumcision, as the Sudanese Government have gone out publicly to condemn it, and said that health care workers should not perform it. It was confirmed by other health care workers, and also seen during interviews with midwives that they made contradicting statements about circumcision.

7.10.2 Perceptions about circumcision

The respondents were mixed regarding performing circumcision on their daughters.

R: when she said that she does not want her children to be circumcised, is that something she has agreed with her husband, something they have decided together?

5: the eldest one, she have made circumcision, but the little one, she will not circumcise.

(Woman living in the camp, nr 5)

Some were against it because they had experienced the consequences of the procedure themselves. However, there were informants who expressed negative attitudes towards circumcision, but still said they would circumcise their daughters. The reason was that they considered it to be a tradition. They explained that they would not perform the infibulation, that they had undergone themselves. Instead they described a less severe form, something "very small", and the interpreter indicated dots with her finger. During several of the interviews this was described as the "normal type" and infibulation as the "severe type". One informant was clear that she did not want to circumcise her daughters, even though this was not something she could decide:

*R: how do you feel about circumcision, if you have girls will you circumcise them?
6: circumcision is bad, and I will not make circumcision for my children.
R: is it your decision to make?
6: I do not think so, but I will not like to circumcise my children.
R: do you think that will be taken into consideration when a decision is made about it?
6: the circumcision that has happened is the one of long ago. But the ones now will not do it to their children.
R: the new generation will not do it at all, or only the less severe one?
6: they will not do it at all.*

(Woman living in the camp, nr. 6)

From the statement made there seem to be a change in attitude about both infibulation and FC in particular. Even though the majority of the informants did not oppose it, several mentioned that infibulation was not as common as previously as before, and that more women were against the practice. However, the study did not investigate to what extent this view applied to men, who often make the decision regarding FC.

7.11 The use and perception of contraceptives

There was a clear difference between the displaced and the host community women with regard to the use of contraceptives. The displaced women did not seem interested in using it. However, there had been a demand for it at the clinic in the camp. Among the host community women, some had used oral contraceptives and they seemed in general more positive towards the use.

7.11.1 In the camp

There seemed to be several reasons why the women in the camp were more negative towards the use of contraceptives. One was related to the conflict and repopulating the community:

I do not like it because many of us have died. Many men, women and children at the time of war. I do not like family planning.

(Displaced women living in the camp, nr 2)

Another was linked to religion, and that this was in the hands of God:

R: Have you tried to control or plan when to get pregnant?

I: no, I dislike it. I would like to increase..

R: can you say a little bit more about that?

I: I will not stop until God stop me, I will not stop delivering.

(Displaced women living in the camp, nr 6)

However, the health care workers interviewed, who worked in the camp said that there were people asking for it. They said that men had come on behalf of their wives, couples came together or the woman came alone. It seemed that the midwives and TBAs were most commonly asked about it. There was no injectible or oral contraceptives available in the clinic (where all the drugs are free), and the only way to get it was to buy it at the market. As the people living in the camp barely had money to buy food, this was not an option for them. When asking people at the administrative level of the program why contraceptives were not available in the clinic in the camp, there did not seem to be a clear answer. One explanation was that it was due to the financial support the program received from several catholic NGOs who have a policy against providing contraceptives. It was also said that people who asked for it should be referred to the rural hospital where all services and drugs were free for IDPs. None of the people who had asked for it in the camp had been referred to the rural hospital, which was 7 km from the camp.

7.11.2 In town

The host community women were either saying that they wanted to use it, but could not afford to buy it, or that they had used it at some point to space between babies, after discussing it with their husband:

I agreed with my husband to take it. When I decided to take it before, I agreed with my husband, and I got it from the hospital.

(Women living in town, nr 5)

Later in the same interview it turned out that she had not got it from the hospital, but instead bought it from the midwives who where buying it at the market for the women who wanted it. This was verified by several midwives in later interviews as a common practice. One informant from the host community, said that some

women discussed using contraceptives with their husband, whereas others used it without them knowing about it. Another said that if that happened it was reason enough for the husband to divorce her, and that is why the husband always had to come with his wife to the clinic if she wanted contraceptives. The health care workers interviewed did not seem to agree, and said that they would prescribe contraceptives to any women who asked for it, even if she came alone. The latter was confirmed during observation.

7.12 Other forms of family planning

Three other methods of family planning were mentioned during the interviews with the host community women in town. One was 40 days abstinence from sexual intercourse after delivery, which is a Muslim tradition originating from the Qur'an and the Hadith. One informant pointed out the contraceptive effect of breastfeeding, but she could not understand why she had become pregnant so soon after the last child, since she was breastfeeding the child for over a year:

I did not get any menstruation cycle before, when I was breastfeeding. But now it is.. get menstruation cycle when I was breastfeeding the last one. What is the problem?

(Woman living in town, nr 1)

It seemed that the women were breastfeeding their child even after one year. However, soon after birth they started to give the infant small amounts of water and milk. This might have had severe consequences for the child as the water is often contaminated, causing most commonly diarrhoeal infections in the child. It also decreases the contraceptive effect of breastfeeding. Another informant mentioned the use of the rhythm method, indicating the use of “safe” periods to have intercourse during the menstrual cycle.

7.12.1 The use of condoms

As there were no male informants in this study, there is little data about men's perception about the use of condoms. Some of the clinics had been given condoms as part of family planning kits from UNFPA. They were on display,

however, when the health care workers were asked if men wanted to know more about the use of condoms, they just laughed and said no. Condoms were not sold in the shops in the area. Sensitization about condoms had been part of a workshop in HIV/ AIDS awareness. The health workers reported that the men had showed no interest in learning about the use. It is notable, however, since men's decision not to use condoms may also have grave consequences on their female sexual partner(s).

7.13 Treatment of STIs (sexually transmitted infections)

Even though one woman said that some went as far as to Nyala to get treated when they could get treatment in Kubum, having an STI was described as a “normal disease”. It was explained that because of the NGOs in the area, it was not problem to receive treatment for an STI. Syphilis and Gonorrhoea were the only two STIs mentioned by the informants. During observation one patient received treatment for an STI and there seemed to be no issues related to this event.

One of the health workers said that there were confirmed cases of syphilis in Kubum town. Another said that the reason why so few were diagnosed with an STI was due to a lack of knowledge among the health care workers in diagnosing cases. It was commonly heard that people were having sexual relationships outside of marriage. One also pointed out that the town is situated close to the border of both Chad and the Central African Republic, and there are a lot of people doing trade, or working as drivers, in the neighbouring countries. They might have sexual intercourse in these areas where prevalence of STI's including HIV/ AIDS might be higher and then spreading it into their community. HIV/AIDS was not mentioned by any of the informants, including the health care workers. There had been conducted one awareness workshop in town about HIV/ AIDS, but it did not seem as there was a priority to follow up these kind of educational efforts. Therefore, its absence from the interviews might be related to lack of knowledge about the disease.

7.13.1 Knowing someone with an STI

To address the issue of STIs the informants were asked if they knew of anyone who had an STI. None of the informants knew of anyone in specific. One of the women living in town explained that it was because the women she knew did not have sexual relationships outside of marriage, which was the way the informant, believed that one could get an STI. Instead, having an STI seemed to be related to other people:

There is some tribe here, some nomad tribes who have syphilis, like you Norwegians (laughing) (the researcher had after being asked, told the informant that one of STI's prevalent in Norway was syphilis⁸⁹)

(Woman living in town, nr3)

The nomads were believed to have STIs because they did not seek medical assistance to get the disease treated. Three displaced women said they had heard about someone with an STI:

I have heard (about it) when I was in the village, not in the camp. Long ago, before the conflict. And I did not see it.

(Woman living in camp, nr. 4)

When the informants said that they had not “seen” it, they used the same phrase as when they said that they had heard of women experiencing violence. It is unclear if this is a way of distancing themselves from the issue, as it in some ways rules out any follow-up questions, or if it was a way of explaining something they have heard vaguely, like a rumor. It might also be a result of my formulation of the question about STIs, as it was not open-ended (“do you know anyone with an STI?”), and that the informants might have said more about it if the question was formulated differently.

7.14 Lack of access to food

A particular concern for the women living in the IDP camp was their lack of access to food. Rations from the NGO had stopped, as it was expected that the IDPs could manage themselves. The only food that was given out was the food supplements handed out by the visiting nutrition team twice a week to malnourished children

below five years. During observation, especially during antenatal visits, there were clear signs of malnourishment of the pregnant women. All the pregnant women observed when being weighed at the antenatal visits in the camp were severely underweight, women 35-40 weeks gestation weighing less than 40 kg. The midwife indicated to me that she was upset about this, and the fact that there was nothing she could do about it. Many also showed signs of malnutrition like iodine deficiency, having developed goitre, in addition to the large number of pregnant women being anaemic or showing signs of vitamin A deficiency. One woman said:

I was sick, during pregnancy in the camp, but we had nothing to eat so I had to go and work for the people.

(Woman living in the camp, nr 3)

One of the women living in town and working in the health sector also mentioned that this was a concern for the pregnant women she had seen in her work:

R: do you see a lot of problems, related to malnutrition in pregnant women?

I: yes

R: what kind of problems?

T: malnutrition. Severe malnutrition.

I: Sometimes when I was working with them, the pregnant women, the haemoglobin was 30%. Some of them have died.

(Woman living in town, nr. 3)

A displaced woman compared being pregnant in the camp to the time before the displacement when things were better:

After delivering the first one in the village I had a lot to eat after delivery, this one in the camp, I have nothing to eat.

(Woman living in the camp, nr 6)

7.15 Economy

The lack of money was seen as a major obstacle to good health among the women in the study.

One informant living in town commented on the importance of having money for women's health:

I: a lot of women are not working and going to the market and selling something and many are staying at home. Sometimes women cannot find work. Like me, I have two girls. One is studying in Khartoum and the other is sitting at home because she is not be able to go to school (due to lack of money). Income would be good for women.

R: they would be healthier if they had work?

I: yes.

The statement also indicates how money is affecting the level of education available to young women, which in turn affects their health.

Lack of money to pay for health services (before they were taken over by DERO from the government and became free) or drugs was mentioned by some of the informants. One woman had experienced that the clinic did not have the drugs she needed, so she would have to buy them at the market instead:

I was going to the hospital, the last time, they gave me the drip, and it is free. But I had to have some drugs, they said to me, "we haven't, you have to buy". I had to buy it, and since we did not have any money, I did not get it.

(Displaced woman living in town, nr 6)

In addition to having to walk long distances to get to the health facility, lack of money seemed to be one of the greatest obstacles to access to health care. As seen in the quote above, it seemed primarily related to drugs, as accessing the health services was free. In principle, so are the drugs, but from the narratives of the informants and also observation, the amount of drugs is limited and there seemed to be occasional logistical issues. During the six weeks of fieldwork, some clinics did not have drugs except nutrition supplements and some only had the most essential drugs. According to the health care workers the situation had been like that for a month. This was due to an administrative error, and the drugs finally came just as I left. Transport in an area like Darfur is not easy. The NGOs need to apply for travel permits from the government, which in some cases are both difficult and time-consuming to obtain. In addition, during the rainy season the roads are destroyed by flood, and big trucks might be stuck for weeks on end on the way to their destination unable to go anywhere.

7.16 Summary

This chapter has looked at the data collected through observation and interviews with women affected by conflict and health care workers. It has been focused on health services related to women's reproductive health and women's health in general. These issues will be discussed in the following chapter.

8.0 Discussion

8.1 Introduction

The objectives of this study were to gain increased knowledge about women's reproductive health during conflict, to assess the health services directed at their reproductive health and to use this knowledge to investigate how the services might be improved. This chapter will discuss the main findings of the study, and how they inform the current literature in the field. According to the specific objectives of the study, the following key issues will be discussed: the informant's experience with safety and/ or danger, health care issues related to maternal health and family planning and the informants perception of the health services. These issues will be discussed in relation to the health services and how these could be improved or changed. Finally, women's access to health services will be discussed within the framework of women's reproductive rights.

8.2 Past experiences to violence or threat of violence

As told by the displaced women, having to flee was due to sudden attacks on their villages and not a planned move as a result of prolonged insecurity. Even though none of the informants explicitly said they had experienced direct violence, it is without doubt that the threat of violence had been experienced as great. They knew that sexual- and gender based violence (SGBV) happened, and did what they could to protect themselves including staying inside the village, preferably indoors and not go out to collect firewood. This is supported by numerous reports stating that women in Darfur are the most likely to experience violence when they are collecting firewood.^{56;75} The traumatic experiences in the past were not forgotten. Three years after she had to flee from her village, one informant said that she was constantly thinking what had happened and about the loved ones that she had lost in the conflict. One can only imagine what kind of effects these experiences have on the women's mental health. A study conducted among displaced women living in camps outside Nyala in 2005 found a prevalence of major depression of 31%.²⁸ This indicates the importance of including mental health in the services provided to displaced women.

8.3 How being displaced affected their current lives

Loss is a word that may describe how being displaced had affected the women's current life. They have lost their home, income, belongings, loved ones, a sense of belonging and their self-esteem. They have lost the life that made sense. This is also found in other studies conducted on displaced populations, where a high number of the respondents report feeling useless and having lost their sense of worth.⁹⁰ According to literature, sudden displacement in combination with reoccurring losses, makes it even more difficult to cope with a new life situation.⁹¹ It seemed that the displaced women living in town felt even more lost in terms of getting support from people around them, as the host community could not identify with their experiences. One informant said that she could only talk to her relatives about her feelings, because they had experienced the same as her. This is common to people who have experienced trauma they feel is so terrible that they cannot tell others, except someone who have similar experiences. However, the study conducted among IDP's in Nyala found that 98% of the women meeting the criteria for major depressive disorder thought that counselling provided by international NGO's might be useful for them.²⁸ It seems that a psychosocial intervention that might be useful for the women in the IDP camp in Kubum is creating women's groups. This would be groups organized by the women themselves and would be a way to empower women in terms of allowing them to take part in developing interventions to meet their needs. These groups would provide an environment where the women talk about their traumas together, have their feeling and memories confirmed by the others in the group and also feel solidarity from taking part in a group.

8.3.2 The community centre

As seen in the socio-demographic characteristics of the sample in table 1 in section 7.2, there are differences between the women from the host community and the IDP's with regards to educational level. With one exception, all the women from the host community had a job requiring higher education. One informant from the host community mentioned the difference in educational level between the displaced and those living in town. It was also something the informants in the camp mentioned when they described what they liked about the community centre; the people there

acted and talked in a civil and educated way like they did in town. Another reason why the centre was popular was because the women could spend time doing something they were competent in, and felt confident doing. On arrival, the informants had been told that they could do whatever handcrafts they knew how to do at the centre, like sewing, mending and making henna painting. This is in line with crisis interventions, where the goal is to recapture aspects of life before the crisis. This may increase the user's sense of coping and coherence by practicing skills she already knows how to do. It may also help to re-establish a sense of normality.^{92;93} As only one of the informants expressed that she did not like the community centre, most of the women liked spending time there. However, they could not "afford" to go there more than a few times, as they had to attend to more urgent matters like taking care of their children or trying to get casual labour. The women's major concern was that they were spending time at the centre without getting anything for their families to eat in return. It is a paradox that the women could not do this one activity that they seemed to like, because the basic needs of their family were not provided for. It might therefore be recommended that income-generating activities at the psychosocial centre should be strengthened and enforced as this might make it more accessible and convenient for the women to use.

8.4 Quality issues in the primary health care delivery

The ICDP's Platform of Action demand that health services are accessible, affordable, acceptable and convenient to all users.⁶ This is obviously related to situation and context, but should be a goal that all health care providers and implementers strive for. In the setting studied in Darfur, accessibility would imply that the health services are within reasonable walking distance from where the women live. The walking distance from the camp to the rural hospital is estimated to be about 1,5 hours. To a community that strives to find the means for survival, health services are affordable when they are free of charge, which they were. The only thing that was not free was the drugs that were not available in the clinics, and had to be bought at the market. Acceptability implies that there are culturally acceptable

services for the beneficiaries and that they have a certain level of quality. There were no indications that the services studied were against local customs and norms.

However, it seemed that with the exception of antenatal care, reproductive health services were not prioritised. There was limited management of complications during pregnancy and delivery, limited services for family planning, no interventions directed at preventing abortions, no sensitization, promotion or education about sexual- and reproductive health, or FC or SGBV. The impression was that many of the issues related to reproductive-and sexual health were considered to be too sensitive to address. This included the use of contraceptives, prevention and treatment of STIs and FC. It is true that there are many sensitive issues related to the topic. However, the interviews conducted with the women both in the camp and in town demonstrate that it is possible to talk to women about these issues, and also that women are concerned about them. A study addressing reproductive health among men in other low-income countries also concluded that the informants were open to talk about it, contrary to expectations.⁹⁴

One way to involve the community in Kubum in discussions related to reproductive- and sexual health is through religious- and community leaders. As mentioned in section 6.5.2, the camp “sheik” (leader) who was present during the interviews in the camp said he thought it was important that sexual-and reproductive health issues were addressed. When community leaders have this perception of the importance of reproductive health, it makes it easier to enter into a dialogue about what kind of interventions could be implemented to improve women’s reproductive health.

8.4.1 Recommendations for improvement of the health services

Considering the limited health services available, especially to the women living in the camp, it was surprising to find that they were pleased with the services. The health care workers were frequently mentioned as a positive factor. Studies suggest that the quality of reproductive health services not only affects women’s use of them, but also influence reproductive health outcomes.⁷ Interestingly, when asked what could be improved, the women in the camp who were suffering from malnutrition,

answered that there should be more equipment and furniture in the clinics, whereas several of the women in town mentioned nutrition as an issue that should receive more attention.

The health workers suggestions for the improvement of health services were to increase the supply of drugs and materials used for examinations and deliveries. As there seemed to be a lack of adequate equipment for obstetric care at the clinics in addition to logistical issues in the delivery of drugs, improving this part of the health services should be prioritised. Research suggests that the health care workers frustration with the lack of essential supplies might affect their interaction with patients seeking care.³⁸

8.4.2 Monitoring and evaluation

Monitoring and evaluation is an essential component of any project or program. It gives an indication of how things are progressing, and what aspects needs to be improved. In the clinics in Kubum, weekly reports where filled out with extensive information about diagnoses of patients, maternal morbidity and mortality etc. There are however, reasons to question the validity of these reports. There were numerous examples of errors when the reports were filled out by the health care workers, for example by continuously filling out the wrong diagnosis. This makes it difficult to “trust” the results and use them to improve the services. Obtaining accurate data is important not only for improving health services, but also for providing evidence of the devastating and in some cases fatal consequences of inadequate health care. This appears to be an issue for improvement in similar conditions elsewhere as well. According to the Inter-agency Working Group on Reproductive Health in Refugee Situations (IAWG) data collection methods relevant to reproductive health should be improved.⁷⁷

8.4.3 Sexual- and reproductive health education and information

From what has been discussed above, it seems that the lack of health education and information is a major inhibitor to improving the sexual-and reproductive health of the women in the study. This is related to spacing of children, use of family planning methods and various aspects of nutrition. The findings demonstrate that the women have an interest in obtaining information about these things. It would therefore be recommended that the health education and information efforts are increased and maintained. In this area the midwives can play an important role. Almost all women attend antenatal visits where they would be receptive to health information. Women would also provide the information, which would be an advantage. By involving community leaders, it might also be possible to find other arenas where one could provide information and education related to sexual- and reproductive health in a culturally appropriate way. This could be at the community centre, where workshops are often held. As this is a place popular to women, one could develop peer education on issues that the women wanted to gain increased knowledge of. The women in the camp seemed to some extent to admire the women in town. As more of the women there had a higher level of education, it might also be possible to use some of them as tutors and "role models". As adult education is already a part of the activities at the community centre, reproductive-and sexual health education and information could be included into the curriculum. Religious leaders can also play an important role in changing people's attitude and behaviour. As it is equally important to include men in the sexual-and reproductive health, religious places might be an area where they could obtain some of this awareness and participation.

8.5 Antenatal care

The antenatal services were used frequently by all respondents during pregnancy. There are several issues worth discussing in relation to the antenatal examinations performed by the midwives. First of all, it is unclear how much the women benefited from the antenatal visits. The time spent with each woman was approximately five minutes. Blood pressure was only measured by one of the midwives, and the abdominal examinations seemed random and unfocused. As mentioned in section

2.4.1, screening for pre-eclampsia by measuring blood pressure is an important procedure conducted during antenatal visits, due to the severe consequences this might have for the pregnant women and foetus if left untreated. On the positive side, the midwives referred what they considered to be high-risk women to the MA. One can also assume that there were positive psychological effects of the antenatal visits for the pregnant women who had limited access to antenatal care in the past. Studies indicate that displaced women living in camps have better pregnancy outcomes compared to the host community, due to more and better access to health care provided by NGOs.⁹⁵ Luckily, there is a shift away from providing services to only one group of a community, such as displaced living in a camp, as this might create tensions among those who are excluded. It was obvious that the health services in Kubum were aimed at being equally directed towards women, both IDPs and those from the host community.

Other studies investigating the quality of the work performed by midwives in conflict settings have not been identified. But studies from other low-income settings suggest that the quality of antenatal care varies greatly.³⁷ This important aspect of women's reproductive health should be investigated further.

8.5.1 Referral and obstructed labour

The informants had experienced several complications related to pregnancy and birth. These were complications during pregnancy and delivery, including miscarriages and complications due to FC.

The MAs working in the camp were not observed referring patients further in the system, for example to the medical doctor at the rural hospital, which was the procedure in complicated cases. The medical doctor who had only treated a few patients referred from the camp confirmed this. At the rural hospital it was frequently seen that the midwives and MAs referred patients to the medical doctor who was working on the premises.

Regarding FC, it was clear that the women knew the risk of obstructed labour due to infibulation. One had even herself experienced the traumas it may cause. This may be one of the reasons why several of the informants claimed that only less severe forms of FC were performed now.

It did not seem that the risk of obstructed labour was in itself considered to be a cause for referral. It was surprising to find that the medical doctor did not perform caesarean sections. As obstructed labour is common in the area due to infibulation, this should be a life-saving procedure he was trained to do. It may be that one of the reasons was that assisting during delivery is considered primary to be a woman's job, performed either by the midwife or the TBA. They assisted in the best way they could during an obstructed labour, and only received assistance from the medical doctor in rare cases.

8.5.2 The use and practice of TBAs

It seemed that since the TBAs were available and the women used them for the deliveries at home, it was not necessary to have midwives available at night when most of the women deliver. It might be worth mentioning that the TBAs in this study were women from the community had undergone some training and were paid for their services. After much debate, WHO have decided that TBAs are not a sufficient substitute for a midwife, and studies indicate the use of TBAs does not reduce maternal mortality.³⁹ It has therefore been an international goal to attain universal skilled attendance during every delivery. Practically, in rural and low-income settings like Darfur, this seems unrealistic. As stated by Austveg, it is a fact that the TBAs are present at a considerable amount of the deliveries in low income countries.⁹⁶ Building on the capacity of TBAs is recommended by the Inter-agency Working Group (IAWG) on Reproductive Health in Refugee Situations.⁷⁷ One would therefore argue that by acknowledging the work conducted by TBAs in Kubum, and including them in staff training and awareness raising one might be able to improve and change some of the malpractice performed by TBAs.

8.5.3 Miscarriage

Several of the women interviewed had experienced a miscarriage. The term miscarriage is used, as the women did not give any hints to self-induced abortions. On the contrary, they seemed saddened that they had lost their foetus. In low income settings there are several reasons why women miscarry. It may be a result of malnutrition, especially iodine and vitamin A deficiencies that were frequently observed in the health care facilities. Other reasons for miscarriage are anaemia or other health concerns, physiological stress, hard physical work, untreated infections in the mother, lack of spacing between pregnancies, the mother being either very young or at the end of the reproductive age span, etc.⁹⁷ The women included in the study had all experienced some of the factors mentioned above. However, it was difficult to find accurate data on the number of miscarriages for several reasons. First of all, a majority happen at home. It is only when the informants had experienced complications later that they had visited the health clinics. Secondly, in countries where self-induced abortion is illegal, it might be difficult to distinguish between self-induced abortions and miscarriages.

One of the complications after a miscarriage is infection. If left untreated this may cause infertility. This issue receives far less attention than other issues related to women's reproductive health. During the fieldwork, several women got treatment at the rural hospital for primary or secondary infertility. This may also be a result of untreated UTIs or pelvic inflammatory disease, which is common in low-income settings.

Several of the informants had questions for me about how to prevent miscarriage or the treatment of complications related to miscarriage. It seems to be a need to educate the women and their spouses about what might be done to prevent miscarriage. This should include the importance of adequate nutrition and spacing between pregnancies.

8.6 Nutrition

As mentioned in the findings chapter, the low nutritional status of pregnant women, especially in the camp, was unexpected. One presumes that a minimum level of nutrition is provided for in a camp setting during conflict. However, previous studies also indicate that malnutrition and providing enough food is a major concern for displaced women living in camps.^{64;98;99} Some argue that by making life too comfortable for the displaced in the camp, for example by handing out food, the displaced will not return home even if the security situation improves. However, the informants expressed a strong desire to go back to the village the moment it became safe, even if that meant not having access to the same services as in the camp. This has also been confirmed by other studies.¹⁰⁰

During the antenatal examinations, a majority of the women received Vitamin A, Folic acid or iron supplements. However, due to the fact that a number of women were severely underweight, it should be expanded to include women into the feeding programme. During the fieldwork, this only included children below five years. It is common sense, however, that by providing food supplement for pregnant women malnourishment of the expected child may be prevented. It has even been indicated that “the long-term health of adults is influenced by their weight at birth and may depend on the quality of nutrition enjoyed by their mothers¹⁰¹”. It should also be an argument for considering including pregnant and lactating women in the feeding programme that women do not use other services such as the community centre, and seem less concerned about their own health in general when they can not provide the basic needs for their families. Providing adequate food supplies for women during conflict was also recommended by Ellen Johnson Shirleaf and Elisabeth Lehn, in their report to the UN “Women, War and Peace” on women’s role in peace building and how conflict affect women, which received massive international attention.⁹⁸

As mentioned by some of the informants, education about nutrition would be useful to integrate to a larger extent as part of the perinatal health service. This should include what nutrients are important during pregnancy and while lactating and how this affects the mother and child.

8.7 Postpartum care

The women interviewed had not attended postpartum visits, except for vaccinating the baby. As the women did not come to the clinics with their newborns, it was left to the midwives in the clinics to visit women who had delivered which was only observed once. According to WHO, 50% of maternal deaths occur after delivery, which indicate the importance of an assessment conducted by a trained TBA or midwife within the first 24 to 48 hours after delivery.⁴⁴

During the antenatal visits in the clinics, the women should be encouraged to attend postpartum visits. In addition to examine the mother and child, the midwife should during these visits provide information and education about breastfeeding, nutrition and the spacing of pregnancies.⁴³

8.7 The use of family planning methods

This section will focus on the informants' experiences and perception of the use of family planning methods. Among the informants, various explanations were used to argue against the use, and there were differences between the women of the host community and the displaced women regarding their perception and use of methods.

The women in town were in general more positive towards the use of oral or injectible contraceptives, which were the only two methods available. The women living in the camp said they did not like it. This was either because they wanted to repopulate the community since so many had died in the conflict, or because “they would have as many children as God wanted them to have”. Both of these explanations are found in the literature.¹⁰²⁻¹⁰⁴

It has been seen that the level of literacy influenced reproductive health choices, and the use of contraception.¹⁰⁵ All the women from the host community who supported the use of contraceptives had a profession requiring higher education and a paid job. A study indicated that women with basic education more frequently use modern methods of contraception.¹⁰⁵ The informants living in town, who were positive towards the use, stated that it was not to prevent any more pregnancies, but instead

to space between the pregnancies. Even though all the informants who had used contraceptives had agreed to do so together with their husbands, there were stories about women using it without their husbands knowing about it. This is consistent with findings from the study conducted in Iran.¹⁰⁴

The use of relatively ineffective family planning methods such as the rhythm method indicates the need to increase the availability and affordability of effective methods. One example was the frustration of one informant who thought that she would not get pregnant while lactating. She could not afford to buy contraceptives, and ended up getting pregnant against her will while lactating her youngest child. The fact that people in the camp had asked for methods of family planning, should be an argument for including oral and injectible contraceptives in the drugs available in the camp. When organizations only provide limited reproductive health services, it becomes random what kind of reproductive health services the displaced in camps receive depending on the organization administering the camp.¹⁰⁶ The MISRP recommended by the Sphere Guidelines and adopted as a framework for provision of reproductive health services in emergency settings, clearly state that methods of contraception should be available and affordable. The unmet need for methods of contraception is also found in the literature. A study conducted among displaced women living in camps outside Nyala in 2005 found that 96% of the women in the study used either the rhythm method or no form of contraception. Nineteen percent of the informants expressed a desire to use a method of family planning.²⁸

The health care workers were positive towards increasing the availability of contraceptives. One health care worker commented the severe results he had seen on the health of women having pregnancies with too short intervals. One woman living in town told the story of how midwives brought women oral contraceptives they had bought at the market. The story gives an indication that midwives try to assist the women so that they can use modern contraceptives. The story also gives reason to believe that there is still a negative perception in the community towards a woman using it, thus limiting the ability to buy it herself.

8.8 The position of women influencing their reproductive health

It appears that a major influence on the reproductive health of the women in the study were factors that may be described as external forces. The women were constantly dependent on others to make decisions which directly affected their reproductive health. This is a global phenomenon related to the inferior position of women, which affects the poorest women in the world most severely.

A major obstacle to reproductive health is inequality. The burden of reproductive-and sexual ill-health is greatest in the world's poorest countries and among the poorest of the poor. According to the UNFPA, there is no other area of health which presents as large disparities between rich and poor, within and among countries. One example often used is maternal mortality, where 99% of the cases occur in developing countries.³⁰ In addition, the global discrimination against women and girls include lack of opportunities of education for girls and employment of women, lack of financial means and being economically independent. It is also related to the lack of legal frameworks to protect women and promote their rights, or the lack of will to develop such laws.

Inequality also influenced the reproductive health of the women in this study and the lack of decision-making power that the women have on issues related their own health is striking. The important decisions about their health were, to a large extent, made by other people. It could be the husband deciding if she can seek health care or if she can use contraceptives, the family deciding if she would be circumcised and the NGOs and health care providers deciding what kind of health care she is going to get, the quality of it and what kind of services she will have access to. The extent to which this was the case seemed to vary in relation to the informant's socio-economic status. This study indicates that those with the lowest level of education, no work or means of income were the most vulnerable in terms of lack of decision-making power.

In the following section, the concept of women's reproductive-and sexual rights will be discussed in relation to how this framework may be used to improve the health services for the women in the study.

8.9 Reproductive- and sexual rights

Reproductive rights encompass human rights and consensus documents related to areas of sexual reproduction. According to the Platform of Action at the ICPD in Cairo human rights of women “includes the right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence⁶”. It includes the right to reproductive health services and information and also freedom from sexual abuse or harassment and the ability to enjoy mutually fulfilling sexual relationships.¹⁰⁷ In addition to the Universal Declaration of Human Rights, the Convention on the Elimination of all forms of Discrimination against Women (CEDAW), the Rights of the Child and the International Covenant on Civil and Political Rights are some the most important international human rights instruments relevant to women’s sexual and reproductive rights. However, there are many controversies connected to the use of the term reproductive rights:

Worldwide, issues related to reproductive rights are some of the most vigorously contested, regardless of the population’s socio-economic level, religion, or culture¹⁰⁸.

It is, for example, commonly perceived as being synonymous with the legalization of abortion.

The human rights can be separated into the categories seen in the following table 2.^{107;109} It is important to stress, however, that the table only points out of some of the rights that are relevant to reproductivity and sexuality, and it is not exhaustive. Some of the rights and their use in practice can be applied in several categories below, but are only mentioned once.

Table 2 Human Rights Reproductive rights Women in Darfur

<p>Life, survival, security and sexuality</p>	<ul style="list-style-type: none"> - The right to life and survival - The right to liberty and security of the person. - The right to be free from torture and from inhuman and degrading treatment 	<ul style="list-style-type: none"> - Ensuring that women go through pregnancy and childbirth safely, e.g. by providing emergency obstetric care and treatment of unsafe abortion. - To reduce violence against women, including FC. - To ensure respect for human rights of people living with HIV/ AIDS. 	<ul style="list-style-type: none"> - Limited access to emergency obstetric care. - Less than optimal antenatal care - No military present so that IDP women are protected against SGBV in the villages they are from. - No protection or prevention from FC.
<p>Reproductive self-determination and free choice of maternity</p>	<ul style="list-style-type: none"> - The right to decide the number and spacing of one's children. - The right to private and family life 	<ul style="list-style-type: none"> - Safe, effective, acceptable methods of family planning are accessible, affordable, acceptable and convenient. - Choice of termination of unintended pregnancy. - Prevention and treatment of STI's that cause infertility. - Protecting the confidentiality of patients seeking reproductive health services. - Both partners consent freely to marriage. 	<ul style="list-style-type: none"> - Unaffordable methods of family planning. - No medical options for termination of pregnancy (against the law) - Receive treatment for STI's and infertility.
<p>Health and the benefits of scientific progress</p>	<ul style="list-style-type: none"> - The right to health and health care. - The right to benefits of scientific progress. 	<ul style="list-style-type: none"> - Ensuring availability, accessibility, acceptability (being ethically and culturally appropriate) and quality of health services. - Ensuring affordable health services. - Providing access to drugs. 	<ul style="list-style-type: none"> - Affordable health services, but unaffordable drugs (IF they are not available in the clinics who are often out of stock) - Limited number of family planning methods available. - Health services do not address important health concerns (e.g. nutrition)
<p>Non-discrimination and due respect for difference</p>	<ul style="list-style-type: none"> - The right to non-discrimination. 	<ul style="list-style-type: none"> - Ensuring equal access to health care without discrimination due to sex, sexual orientation, marital status, age, race. - Prevent discrimination of women in matters of education, politics, economy or due to marital status, age, race among other things. 	<ul style="list-style-type: none"> - Victims of harmful practices such as FC and SGBV due to gender. - Lack of decision-making power over own reproductive health.
<p>Information, education and decision-making</p>	<ul style="list-style-type: none"> - The right expression, to receive and to impart information. - The right to education. - The right to freedom of thought, conscience and religion. 	<ul style="list-style-type: none"> - Fully informed consent based on adequate information and education. - Freely available information about reproductive health and rights and related policies and laws. - The freedom from compulsion to comply with laws designed to uphold religious doctrines. - Establish programmes to keep girls in schools. 	<ul style="list-style-type: none"> - Inadequate health information and education. - denied free contraceptives on religious grounds?

The concept of human rights have been criticised for being a western concept, focusing too much on the individual and not taking the community into consideration. In Africa, several African human rights instruments have been developed. The protocol to the African Charter on Human Rights and Peoples' Rights on the Rights of Women in Africa deals explicitly with health and reproductive rights of women. This includes the right to fertility control and family planning education, and the right to be protected from HIV/ AIDS.¹¹⁰ As of 2005, only 15 African states had ratified the Protocol. Sudan has not signed it.

8.9.1 Reproductive rights as a framework to improve services

The following section will describe how the findings of the study about women's reproductive health and available health services may be adopted into the framework of women's sexual-and reproductive rights. In line with the focus of the study, issues related to the delivery of health services have been chosen as examples of areas where women's sexual and reproductive rights are not met. Suggestions will also be made for how the health services may be improved using a human rights perspective. Due to limitations, only specific issues relevant to the findings of the study will be mentioned. Issues such as reproductive rights in relation to adolescence or access to safe abortion will not be dealt with in particular.

8.9.2 Materializing sexual- and reproductive rights

There has been an increasing pressure on NGOs to integrate reproductive rights into all areas of their work, including conflict settings. According to UNFPA:

*Safeguarding reproductive health and rights in humanitarian emergencies is fundamental to saving lives and laying the foundation for gender equality and sustainable development when stability returns.*¹¹¹

The reproductive rights of the women included in this study are violated in several ways. These breaches are active violations when women are victims of SGBV and passive when they do not receive adequate health services to provide for their

reproductive- and sexual health needs. This is not uncommon for women in similar conditions,²⁸ and CEDAW states that “special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups, such as migrant women, refugee and internally displaced women¹¹²”. In areas such as Darfur, where women’s rights are violated in almost every aspect and women are not in a position to claim their rights, the challenge lies in transforming the idealistic rhetoric of sexual-and reproductive rights into specific actions and attainable goals that can be carried out in the field.

8.9.3 The right to education and information

The informants stated a desire to obtain more health education and information, and this was also a missing part of their health care delivery. The women obtained inadequate information and education about their own health status and treatment, but did not expressly ask that this be improved. However, there was an expressed wish to learn more about nutrition during pregnancy and while lactating. As several of the informants argued that they opposed the use of family planning methods because they wanted to repopulate the community, the health education should still include the dangers of frequent pregnancies with too short intervals. The health education should also include sensitization of the community about STIs, the use of condoms and other contraceptives and other issues related to sexual behaviour. The fact that it is a right to obtain reproductive health information and education should make it easier to justify the inclusion of improved health education about these issues into the health programme. Obtaining health information and education is also a precondition for being able to make informed decisions about one’s own health and consent to the medical treatment one is given. Informed consent includes the right to freedom of thought, the right to equality and to be free from all forms of discrimination and the right to health.¹⁰⁷

The right to information and education about harmful traditional practices, such as FGC seems necessary, as the practice was still highly prevalent in the community. Performing FGC is an additional breach of the liberty and security of the person which also include unsafe abortions and GBV.¹¹³

8.9.3 The right to decide the number and spacing of one's children

Having access to safe and effective contraceptive methods is part of the right to life and the right to health. However, few of the women in the study were in a position to control the spacing and number of their children. This was due to their inferior position to their spouses on the issue, cultural norms related to the use of contraceptives, and the lack of family planning methods provided by the health services. The right to decide the number and spacing of one's children should ensure that the health services provide safe, effective, acceptable methods of family planning that are accessible, affordable, acceptable and convenient, according to the ICPD Program of Action.⁶ This right is breached when women without money, such as those included in the study, have to pay for contraceptives. When it is argued that contraceptives are not provided due to religious affiliation of an organization this is an additional breach of the right to freedom of thought, conscience and religion. It is also a breach of the right to scientific progress when women are only offered a limited number of family planning methods, for example oral and injectible contraceptives.^{107;114}

8.9.4 The right to health and health care

Women have a right to health and health care. This includes the right to control one's health and body, in addition to accessibility and availability of acceptable health care. Observations of the health care provided in the study indicate that there is a need to improve the health care that is delivered. This is specifically related to antenatal care. When women face the risk of dying during pregnancy or birth due to lack of health services or inadequate care, it is also a breach of the right to life. The ICPD Program of Action, para 7.2⁶ clearly states that there should be "access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant". This implies access to skilled personnel who are delivering health care according to international guidelines and are who are trained in performing basic and life- saving procedures. If this is not the case, it is an additional breach of the right to protection, information and education as well as the right to equality and freedom from discrimination.¹⁰⁷ It can also be argued that by excluding severely

under-weight pregnant and lactating women from feeding programs their right to life, right to health and freedom from discrimination is being breached.

9.0 Conclusion, limitations and recommendations

9.1 Concluding remarks

Reproductive-and sexual health and rights are a vast and complex area. It is linked to other issues in society such as the extent to which women are in a position to make decisions about their own health, and have access to health services that cater to their health concerns. The burden of diseases related to women's sexual-and reproductive health is massive. Despite the fact that so many of these can be prevented and treated, there are not enough resources allocated to improve the reproductive health and health services. The poorest women are the ones that are the most severely affected, yet there remains little knowledge about their sexual-and reproductive health. This thesis is focused on the health services women receive during conflict. Most of the women included in the study are in a desperate situation, severely affected both physically and mentally by the conflict. They have particular sexual-and reproductive health concerns that need to be addressed by the health services. The health services directed at their reproductive health include the very basic elements of reproductive health care. However, they are inadequate in terms of maternal care, reproductive health education and information and lack the accessibility of effective and affordable methods of family planning. The findings further demonstrate how the lack of adequate nutrition affects the utilization of health services by women and show the importance of including pregnant and lactating women into the nutrition programme. The observation of the health services has shown that procedures and guidelines for the health care workers should be strengthened and enforced. The fact that women in the IDP camp had limited access to family planning methods is a breach of international guidelines for provision of reproductive health services to conflict affected, and should receive attention. Overall, women's sexual-and reproductive health could be improved by providing information and education on issues women find relevant. Some of these have been identified in this study and include nutrition, how to prevent miscarriage and effective

methods of family planning. This work should build on the experiences of the community and be carried out in collaboration with community-and religious leaders. Finally, this study and its accompanying data highlight the importance of using a human rights perspective which focuses on women's sexual and reproductive rights. Ideally, these findings illustrate how one can improve health services and influence decision- makers to include all aspects of women's sexual-and reproductive health into policies and programmes.

9.2 Summary of recommendations

Table 3

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|---|
| <ul style="list-style-type: none">❖ Strengthen and enforce psycho-social interventions such as income-generating activities and women's groups.❖ Provide information and education about reproductive-and sexual health issues with particular focus on nutrition during pregnancy and while lactating and spacing between pregnancies.❖ Make contraceptives available in the clinic in the camp.❖ Reinforce procedures for antenatal examination.❖ Increase postpartum visits.❖ Reinforce procedures and increase staff knowledge about emergency obstetric care.❖ Include malnourished pregnant and lactating women in the nutrition programme. |
|---|

9.3 Limitations of the study

As previously mentioned, reproductive-and sexual health in general and in conflict in particular, is a vast field. As the study objectives of this project were also quite broad, this did not create enough in-depth data. Several important aspects of the informant's reproductive-and sexual health, were only touched upon briefly. HIV/AIDS, issues related to adolescents and reproductive health and self-induced abortions are some of the issues that have not been dealt with in particular.

One could also argue that since men play such a large part in women's reproductive and sexual health, they should also have been involved. Critics might argue that the study is one-sided from the women's point of view.

As with all studies using qualitative methods, the most important limitation is its external validity. The data can only yield interpretations relative to the populations under study, and is not generalizable to a greater population.⁴⁰

9.4 Future research

There are several issues that would be interesting to investigate further. Perhaps with continued research and attention, the IDPs in Darfur as well as individuals in similar circumstances will receive the comprehensive sexual-and reproductive health care services they deserve. Some of these are:

- Men's perception of the use of condoms.
- Prevalence of STIs in the community
- Prevalence of infibulation among women and girls (including change of practices and differences over time)
- Number of stillbirths, abortions and maternal deaths in the community.
- Prevalence of malnutrition, anemia and vit A deficiency among pregnant women.
- Quality of antenatal examinations performed by midwives.
- Issues related to the reproductive health of adolescence during conflict.

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Appendices

Appendix 1: Interview guide IDP's

- **Background**

How old are you?

who did you live with?

What do you do here in the camp?

Tell me about your life before you came here.

Have your life changed in any way due to the conflict?

- **Health**

Where did you give birth to your children?

Who assisted you?

Antenatal visits

Visits after birth?

Have you given birth while in the camp? What is the difference between that and at home?

Have you ever experienced problems during pregnancy or birth?

Any other diseases

Problems related to female circumcision.

Have you ever tried to plan or control when to get pregnant?

Have you heard of anyone with an STI?

- **Health care**

Have you used it?

What for?

Did you like what they did to you at the clinic?

Do you have any suggestions to changes and improvements in the health services provided?

Have you attended the community center? What do you think about it?

- **Experience with violence**

Do you feel safe in the camp?

Do you know of any women who have experienced violence?

Appendix 2: Interview guide host community

- **Background**

How old are you?

Who did you live with?

What do you do?

- **Health**

Where did you give birth to your children?

Who assisted you?

Have you ever experienced problems during pregnancy or birth?

Antenatal visits

Have you ever experienced any sexually transmitted infections? Received treatment?

Any other diseases

Problems related to female circumcision.

- **Health care**

Have you used it?

What for?

Opinions about the service.

Do you have any suggestions to changes and improvements in the health services provided?

- **Experience with violence**

Do you feel safe in town?

Have your life changed in any way due to the conflict?

Appendix 3: Request for participation

Consent will be given orally with one witness present.

My name is Sara Rivenes and I am a registered nurse. Currently I am studying International community health in Norway and this research is part of the study. I want to find out about displaced women's health and the health services in this camp. I would like to ask you some questions about your background, what you think about living in this camp, having children, and your health concerns. I am also interested in what you think about the health care available in the camp, and if you have any suggestions for improvements. This information may be used to improve the health care provided here, and in similar conditions elsewhere. I am an independent student, not hired by any of the organizations working in this camp and do not receive any money from them for conducting this research. I am doing this out of my own professional interest.

The interview may take up to 1 hour. I am interested in your health concerns, and how living in the camp affects your health. There are no right or wrong answers, and whatever you say will have no consequences whatsoever. It will also not effect the health care you receive in the camp. You do not have to discuss issues that you do not want to and you may end this interview at any time.

You may withdraw for the study any time along the study process, and do not have to give reasons for doing so, and there will be no consequences of doing so. You may also refuse the use of a tape recorder, and we will take notes instead.

Our discussion may come to focus on private matters but it is important that you know your identity will be treated with confidentiality and the information that you provide will be used for the purpose of this study only. Your name will not be written anywhere and will never be used in connection with any of the information you tell me.

Appendix 4- Ethical approval University of Oslo



UNIVERSITY OF OSLO
FACULTY OF MEDICINE

To the relevant authorities

**Institute of General Practice and
Community Medicine**
Section for International Health
P.O. Box 1130 Blindern
NO-0318 Oslo

Date: June 23rd 2006
Your ref.:
Our ref.:

Telephone: + 47 228 50 640
Telefax: + 47 228 50 607
E-mail: g.a.bjune@samfunnsmed.uio.no
URL: www.med.uio.no/ism/inthel

Ethical Review

Investigator's name: Rivenes, Sara

Title of the project: The effects of conflict and displacement on women's reproductive- and sexual health in Darfur, Sudan

Due to a re-organization in the Norwegian system for ethical review of research students' projects involving a second country, the project proposal has not been subject to a national review process this year.

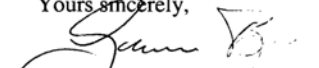
The students have filled in the ordinary national form for ethical review of research projects involving human subjects and supplied the protocol for their project. A group of experts (medical research ethics, medical anthropology and clinical medicine) in our department have read the applications carefully and made their comments. The investigator's project is found to abide to international regulations, and the comments (below) are to guide the investigators to clarify, elaborate or modify some point(s) before they apply to their national authorities. In case there are such comments in this letter, the investigator's application will be corrected accordingly.

Comments of the reviewers:

The persons who are invited to participate as informants must be informed that they can refuse the use of tape recorder if this makes them uncomfortable or withdraw from the study without any consequence if a tape recorder must be used.

The project leader/student should state whether there is not any local or national institution or authority that need to approve the study or be informed about it.

Yours sincerely,


Gunnar Bjune,
Professor International Health
Head of M.Phil. education in International Community Health



M.PHIL PROGRAMME
INTERNATIONAL COMMUNITY HEALTH
FACULTY OF MEDICINE
UNIVERSITY OF OSLO, NORWAY

Appendix 5- Ethical approval Epi- Lab, Khartoum, Sudan



The Epidemiological Laboratory (Epi-Lab), Sudan
A Collaborative Centre of the HSA/WHO

Sara Rivenes
Colletts gate 11B
0169 Oslo
NORWAY

Khartoum, 29. September, 2006

Clearance certificate for conducting medical research in Sudan

The project "How do the services available to women affected by the conflict in Darfur, cater for their reproductive- and sexual health concerns?" whose Principal Investigator is Sara Rivenes, has been granted ethics clearance to be conducted in Sudan.



Prof. Asma El Sony
Head of Scientific activities
Epi Lab
Khartoum, Sudan

+249 183 224496

P.O. Box: 12810