Section 5

Assessment of changes over time within agencies / institutions involved in Reproductive Health Services for refugees and internally displaced persons

This component of the Inter-agency Global Evaluation of Reproductive Health Services for Refugees and Internally Displaced Persons was undertaken by Ms Carla White, Consultant, The Women's Commission for Refugee Women and Children

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Appendices*

Appendix 1: Survey Sample: List of Organizations and Key Respondents
Appendix 2: Survey Questionnaire

* The appendices are available on a CD-ROM containing the report and other documents related to the evaluation.

Executive summary

This report presents a combination of quantitative and qualitative data to describe how reproductive health in refugee situations (RHR) has evolved within and among organizations over the past decade. It also provides a description of current programming and operations of organizations involved in RHR. The intended outcome is greater understanding of the progress organizations have made thus far, and the ongoing challenges to performance and institutionalisation, as well as to suggest future directions.

The study methodology entailed questionnaire development followed by an e-mail survey of key informants working in organizations with known involvement in RHR within the last decade. The final sample consisted of 30 of the original 46 organizations identified, including 12 International NGOs, three with RH as their primary mission, eight academic/research institutions, five multi-lateral/UN affiliated agencies and five Governmental agencies; three US, one European and one Japanese. Key informants had worked an average of 4.7 years in their current RHR capacity, and an average of 7.2 years total in RHR related positions.

The major concepts investigated by this study were defined largely in the terms of reference developed by the Evaluation Steering Committee. The survey topics include: programming components; organizational operations; policies; RH training and capacity building; technical assistance; resource tools; financial and staff resources; and collaboration between agencies.

Overall, 73% (n=22) of the sample report significant changes have taken place in their RHR programming and/or operational working areas since 1995. Eighty-two percent (n=18) of these organizations describe RHR growth in their organization, while 18% (n=4) describe either stagnation or reduction.

Respondents report that expansion of information and new developments in technical components have engendered more programmes that address a wider scope of RHR components. They also cite the introduction of a rights-based approach integrated into the organization and programming, and an increasing emphasis on integrating RH into primary health care programmes at the outset of emergencies, including the use of MISP and provision of RH kits. There is also an increasing programme focus on HIV/AIDS and STIs, which is noted by some, to draw effort away from other components.

Approximately half of organizations reporting significant growth indicate that RHR has reached the point of integration into the formal structure of their organization. Providers of direct services report that integration is also occurring within health care delivery and multi-sectoral service delivery approaches. Respondent ratings of "perceived value of RHR to the mission of your organization" indicate there has been an appreciable rise in institutional endorsement of RHR since 1995.

Yet there is simultaneous concern expressed that RHR will only be sustained in their organization if funding remains available and new donors are identified. Fifty percent (n=15) of the sample reported that recent political/policy changes had seriously affected their RHR action agenda or implementation. Components such as EC, PAC, adolescent RH and many FP efforts were affected. In this political climate,

support from private donors was perceived as reduced in these programming areas as well.

The continuing viability of RHR is seen to depend heavily on a positive external policy environment, yet endorsement by internal policy seems of lower priority; only 43% of sample organizations have written internal policies that specifically validate RHR in their institution. This is, however, a significant positive change, since prior to 1995 only one organization in the sample had written RHR policy guidelines.

Analysis of programming in the RHR components shows they are fairly evenly distributed across organizations, although intensity of effort varies among them. Organizational support for STIs and HIV/AIDS is broadest and strongest, while male involvement, EC and female genital mutilation (FGM) show lower organizational involvement, and very low intensity of "work effort". Anti-retroviral treatment (ART) receives the least support of all measured components.

Operational working areas are also spread fairly evenly among organizations. The distribution ranges from two thirds or more of organizations engaging in training and research, to less than half engaging in policy activities. The area of service delivery receives the greatest relative "work effort" with nearly three quarters of engaged organizations ranking it as "high". In contrast, while more organizations engage in monitoring and evaluation and research, the "work effort" allocated is much lower. Less than one third of organizations engaged in monitoring and evaluation and research rank these areas "high" in terms of "work effort".

To address the greater demand for more comprehensive and technically focused programming, respondents say they need more frequent and specific training to build skills and capacity among staff members. Survey results show that 73% of organizations are engaged in training and that the thrust of these efforts is aimed primarily at field level staff. Training targeted to RHR policy makers, current organizational managers, or to future leaders, is a relatively minor part of overall efforts.

There is universal agreement that more data based evidence is needed to improve programme management and demonstrate effectiveness, especially for funding purposes. Despite the 57% of organizations reporting involvement in research, only a minority of these were able to furnish expenditure information of any kind. In the small amount of data furnished, RHR research expenditures showed quite large increases between 1995 and 2000. Between 2000 and 2003, research expenditure data shows more variability; larger organizations continuing to increase while smaller organizations decreased.

Currently, technical assistance (TA) is a working area for 50% of the sample. Among these organizations it represents an area of relative importance with TA "work effort" ranked as "high" in over half of this group.

An examination of organizational use of major RHR resource materials revealed that the *Reproductive Health in Refugee Situations Field Manual* is by far the most frequently used document of those assessed, with 68% of respondents rating its use at ten or more times. Other resources with high use are the two Sexual Violence guidelines (UNHCR 1995 and 2003), Guidelines for HIV Interventions (UNHCR, WHO and

UNAIDS), and RH Needs Assessment field tools (Reproductive Health Response in Conflict (RHRC) Consortium).

Examination of changes in budget and staffing data over time yielded results consistent with the qualitative findings described above, although only one-third of organizations were able to provide data that tracked RHR expenditure specifically. Overall organizational expenditure showed strong increases in nearly every reporting organization between 1995 and 2003, with the strongest growth in the earlier time period between 1995 and 2000. The pattern of RHR spending shows a strong parallel upward trend during this first period. Between 2000 and 2003, there is more variability with 40% of organizations reporting a downward trend in RHR expenditure but since these findings derive from such a small proportion of the sample they may not be representative.

Overall, 68% of respondents report significant increases in collaboration / linkages in their programming initiatives since 1995. Collaboration, assessed for programmes between 2001 and 2003, was found to occur across a wide variety of different types of organizations, most frequently between international NGOs and local NGOs. The most common form of collaboration, cited as 30% of total responses, is sharing of resources such as office space, equipment and materials. Collaboration in the form of meetings and working groups comprise another third of the total citations. These three forms of informal collaboration account for 61% of all collaboration efforts cited.

Many respondents credit working groups, especially the IAWG and the RHRC Consortium, as primary facilitators of interaction, partnerships, sharing of resources and designation of responsibility across members. On a rating scale of one to five with five being the highest, The “Positive impact of the IAWG on the RHR programme activities of this organization” was rated 3.1 for 1995, and 3.9 for currently. These ratings indicate that the perceived positive impact of IAWG on organizations has grown over this time period.

Collaboration, whether formally planned or as a response to field contingencies, is viewed as a mechanism that enhances both learning opportunities and programmatic effectiveness. Partnership and linkages improve efficiency, reduce duplication and amplify individual strengths through joint efforts. The growing collaboration reported by the majority of organizations is therefore direct evidence of IAWG achieving one of its main objectives. Burgeoning collaboration is also indicative of stronger inter-institutional support and higher quantity and quality of RHR work.

Since 1995, improvements have occurred in all RHR programming and working areas, technical support and RH strategy. There have been increases in the size and scope of RH programmes with respect to gender-based violence (GBV), EmOC, HIV / AIDS and RH needs of youth. Yet as the size and scope of programming has enlarged, the majority of organizations feel their work is hampered by too short and inconsistent funding for programmes and, frequently, too few technical staff to support all of their functions.

Nearly all organizations in the sample found it difficult to provide retrospective information about RHR expenditure and staffing, and most were unable to provide current expenditure because systems are not in place that allocate and track RHR funds separately. Organizations need to institute systems that routinely identify and

track RHR budgetary and staffing data to validate its importance and further its institutionalisation.

There is overwhelming evidence that collaboration and exchange among RHR organizations has escalated since 1995, due in large part to the vital roles played by the IAWG and the RHRC Consortium, as well as other key groups. Encouraging new partnerships to draw on the increasing interest and expertise of academic and development organizations will expand the base of support of RHR and facilitate a smoother transition from emergency situations to longer-term development assistance.

Toward this objective, the IAWG should consider developing an Outreach / Membership Committee to initiate and oversee proactive engagement of peripherally involved organizations, and raise awareness throughout the larger community, especially toward potential new entrants in the field. It would also establish and oversee a central repository / database to contain membership information, reports, and documents relevant to the operation of the IAWG and the field of RHR.

Organizations report widespread use of the Internet to access RHR materials from a large number of websites. The IAWG should consider invigorating and transforming its **refugee** listserv as a powerful agent for RHR networking, dissemination of information and ongoing discussions. A moderated listserv forum could raise and spread awareness of new developments in the different aspects of RHR, attract more interest and bring in a wider community, and strengthen affiliations within this group. It could also provide support to developing sub-groups within the larger IAWG membership, based on regional or technical commonalities.

Respondents voice concern with a variety of implementation issues, and some concerns are so widespread that they bear repeating. A dearth of all forms of data, surveillance, monitoring and evaluation remains an intractable problem. Despite emphasis on tool development and expert efforts, collection of data in the field is poor and requires further simplification of systems and formats, and better technical support. The related need for more in-depth research on the elements of RHR is also widely expressed, especially more information about successful models and best practises.

Another broad concern is the need for more capacity building with local NGOs and organizations' own staff. More investment is needed to attract and keep female field workers to provide support in culturally sensitive programming areas. Programmes in GBV, STIs and HIV / AIDS especially require staff with specific skills and training to achieve good quality, comprehensive programmes. In all areas, but especially those requiring highly technical skills, it continues to prove a challenge to identify and to develop competent staff.

The strength of evidence shows that RHR has evolved and matured, carried forward by the collective efforts of a vested group of professionals and workers collaborating across a diverse spectrum of organizations. Despite some significant threats, it remains a resilient force within the larger humanitarian assistance community. In all likelihood, the demonstrated trends of growth in technical expertise, collaboration, programme activities and institutionalisation will continue apace for most involved organizations. New organizations that join this effort will increasingly strengthen

the foundation of the RHR cadre and add to overall productivity. Finally, the continuing leadership, advocacy and support of major institutions will remain a keystone to advancement of RHR in situations of crisis and conflict throughout the world.

Introduction

1. In support of the Inter-agency Global Evaluation of Reproductive Health Services for Refugees and IDPs, the Women's Commission for Refugee Women and Children undertook an assessment of changes over time within agencies / institutions involved in reproductive health for refugees and IDPs, which was the fifth component of the Global Evaluation.

2. Worldwide, the organizations working in RHR are diverse in size, perspective, mandate and platforms of action. For the majority, their involvement in RHR is tangential to their overall mission and represents only a minor fraction of their total programme effort. Many of these organizations tend to focus and work in a subset of the component areas that comprise the realm of RHR. This specialization has advantages as each entity contributes to the common goal, working from within its own realm of expertise, as implementer, advocate, researcher and trainer. An important objective of this study then, was to document the attention organizations give to each component of RHR, and the different types of work they do, and provide comparisons of work effort allocated to each over time. It was also important to document collaboration among organizations involved in RHR, with respect to how it has originated, the nature of linkages and its implications for RHR, including an assessment of the positive impact of the IAWG on organizations. In addition, the study examines data on changes in organizational expenditure and patterns of RHR staffing since 1995.

3. Due to the unstable and hardship conditions of complex emergencies, it is often very hard to identify, place and maintain staff, and likewise for them to carry out essential RH functions in a coordinated and skilled manner. Training, technical assistance and research are realms most often used to improve performance and build capacity. This study documents types of RHR training and technical assistance, as well as changes in research investment.

4. The study also assesses changes in selected field-level implementation issues: the use of a "focal point"; capacity building and the competence of field staff to deliver the components of RHR; and the comprehensiveness of field programmes, for both range of components and integration of target groups.

5. In summary, both quantitative and qualitative findings are presented to describe the current work of organizations involved in RHR, and how this has evolved over the past decade. There is discussion of significant external and internal factors that affect the ability of organizations to create, strengthen and expand RHR in the context of their mission.

6. This report is intended to foster greater understanding of the progress made thus far, underline ongoing challenges to performance and institutionalisation, and suggest future directions. Hopefully, the IAWG members and other readers will reflect on the nature of the RHR work and investment made to date, and use these findings to inform, direct and spur on future planning and action.

Conceptual framework and methodology

Methodology and sample characteristics

7. The study methodology included questionnaire development and survey of key informants working in organizations with known involvement in RHR within the last decade. A sample of 46 organizations meeting this criterion of RHR involvement was generated by the IAWG Evaluation Steering Committee (listed in Appendix 2). Thirty of these organizations are members of the IAWG or have had some association. This original sample included 18 international NGOs, four with RH as their primary mission; thirteen academic/research institutions; eight multi-lateral /UN affiliated agencies, and seven governmental agencies, including three US, two European, one Canadian and one Japanese.

8. The IAWG Evaluation Steering Committee also suggested a key informant for each organization, based on that individual's professional experience and working relationships (listed in Appendix 2). Each identified key informant received an e-mail letter explaining the purpose of the evaluation and requesting his or her participation in the study. A second e-mail letter gave more detailed information and instructions. This letter included a request that key informants confer and consult with their RHR colleagues in their organization so as to obtain the most complete history and representative perspective possible in their answers, and to make use of their organization's documentation wherever possible.

9. All study materials, including two preceding letters and the questionnaire itself, were distributed and returned via e-mail (with the exception of one hard copy faxed back from Ethiopia). The data collection process took place over a three-and-a-half month period from mid-December 2003 to the end of February 2004. Follow-up telephone calls and e-mails were employed to increase the rate of compliance. A total of 30 questionnaires were completed and returned, representing a return rate of 65%. Reasons for not returning the questionnaire were: 3 - too busy; 1- survey was too long; 1- no longer doing RHR work; 2- unable to finish in time, while the remaining 9 never replied so their reasons are unknown.

10. The final sample of 30 organizations is composed of 12 international NGOs, three with RH as their primary mission, eight academic institutions/research, five multi-lateral/UN-affiliated agencies and five governmental agencies, including three US, one European and one Japanese (listed in Appendix 2). Key informants in the final sample had worked an average of 4.7 years in their current RHR capacity, and an average of 7.2 years total in RHR-related positions.

Questionnaire development and content

11. The individual concepts investigated by this study were largely defined by the terms of reference for Evaluation Component 5: Study of RH Organizations. The Evaluation Steering Committee had proposed the study topics to include:

- organizational operations;
- policies;

- budget and finance;
- programming components;
- technical assistance; RH training;
- technical resources;
- collaboration between agencies;
- lessons learned and;
- future priorities.

These concepts formed the foundation of the investigation.

12. This study also drew on a more theory-based approach embodied in a landmark background paper, The Emerging International Policy Agenda for Reproductive Health Services in Conflict Settings, published in *Social Science and Medicine*, in 1999. This paper proposed six specific criteria as indicative of whether an issue is on the international relief policy agenda:

- increases in international conferences;
- policy documents and strategic plans;
- financial and human resources;
- number and rate of publications;
- emergence of new NGOs.

13. The paper also proposed three parameters to indicate the likelihood that a policy will be implemented: legitimacy, feasibility and support.

14. On the basis of their analysis, the authors concluded that these criteria and parameters are critical to the emergence of reproductive health for conflict-affected populations, and that, while RHR is on the policy agenda of relief organizations, "there remain significant impediments to effective implementation." Criteria and parameters proposed by this research are incorporated into the current investigation.

15. Thirdly, a review of all the final reports available from the IAWG annual meetings (1996-2002) as well as other selected documents and reports was conducted to ensure that there were no gaps in the enumerated universe of concepts to be investigated. This review crosschecked concepts that were underlying objectives and actions stated in these documents against the concepts represented by questionnaire items.

Questionnaire format and types of measurement

16. The questionnaire format consisted, in part, of short answer and semi-structured, open-ended questions that produced qualitative, comparative information. Each item investigated a concept, criteria or parameter from those enumerated above,

using a longitudinal perspective. Most frequently, the respondent was asked to describe a concept at two points in time, "currently", and at the baseline time period "1995," marking the beginning of the RHR movement and the IAWG. In open-ended items, the respondent was asked to cite the nature of changes in the concept and to comment on "why" these occurred, and any impact they have had on the organization's RHR agenda.

17. The questionnaire also contained a number of items that generated quantitative data allowing for comparisons between variables. A large, multi-part item documented current organizational involvement in RHR technical components and working areas. Respondents were also asked to rank the amount of work effort of his/her organization with respect to each technical component and programming area. Seven subjective rating scales assessed perceived changes in RHR organizational capacity and attitudes since the baseline time period of 1995. Data on organizations' financial and staffing resources were collected for three points in time: 1995, 2000 and 2003 (or 2002, depending on availability).

18. During development, the instrument was subjected to extensive review. The conceptual content and structural format of the questionnaire items were evaluated by experts in RHR and technical design and revisions were incorporated based on this input. Finally, a draft was shared with the Evaluation Steering Committee for its comments and suggestions, prior to pre-testing and finalization. The study questionnaire is included in Appendix III of this report.

Findings

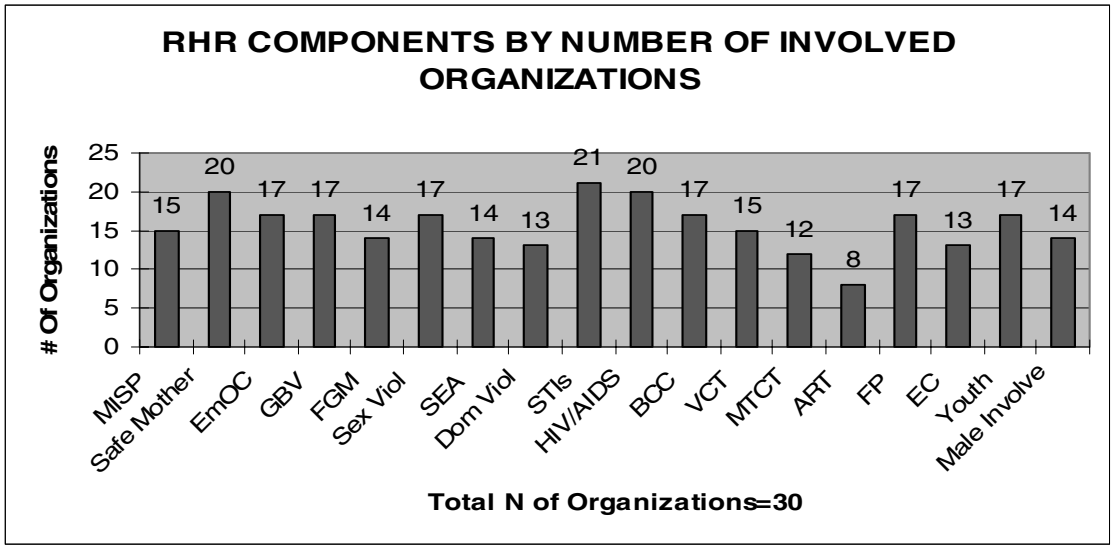
Documenting RHR organizations and their output

19. This section documents the allocation of current programming efforts by sample organizations across RHR technical components. It also presents the relative "working effort' invested by organizations in each RHR technical area, ranked as high, medium or low. Comparable data measures are also presented for the operational working areas of organizations.

Current programming in the RHR components

20. RHR spans a large number of technical components. The following chart shows the percentage of organizations that currently work in each measured component of RHR.

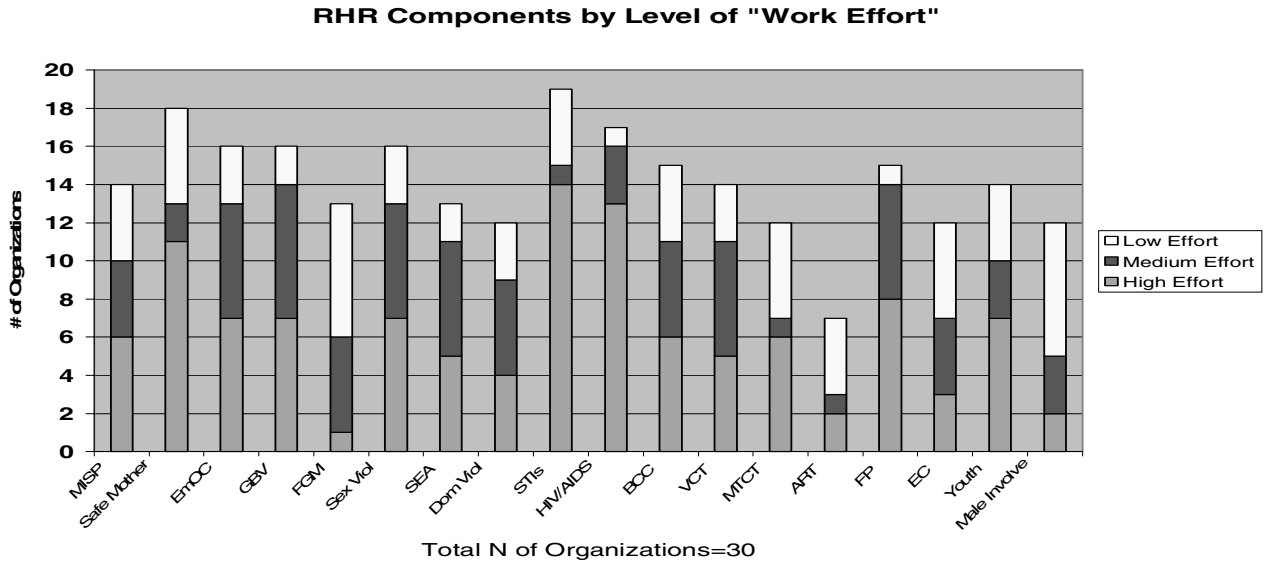
Chart 5.1: PHR components by number of involved organizations



21. The distribution of organizations working in each RHR programme area varies from a low of eight in the area of anti-retroviral treatment (ART), to a high of 21 in the area of STIs. The components of safe motherhood, EmOC, gender-based and sexual violence, STIs, HIV/AIDS, behaviour change communication (BCC), FP and youth programmes are supported by more than half of all organizations. Female genital mutilation (FGM), sexual exploitation and abuse (SEA), domestic violence, mother-to-child transmission (MTCT), EC and male involvement are supported by fewer organizations.

22. Each organization allocates its effort according to its own priorities. Chart 2 below shows the current levels of "work effort" organizations allocate to each RHR component, ranked by respondents as low, medium or high. The height of each bar shows how many organizations work in that component, while the subsections composing each bar show the relative levels of organizational "work effort."

Chart 5.2: PHR Components by Level of "Work Effort"



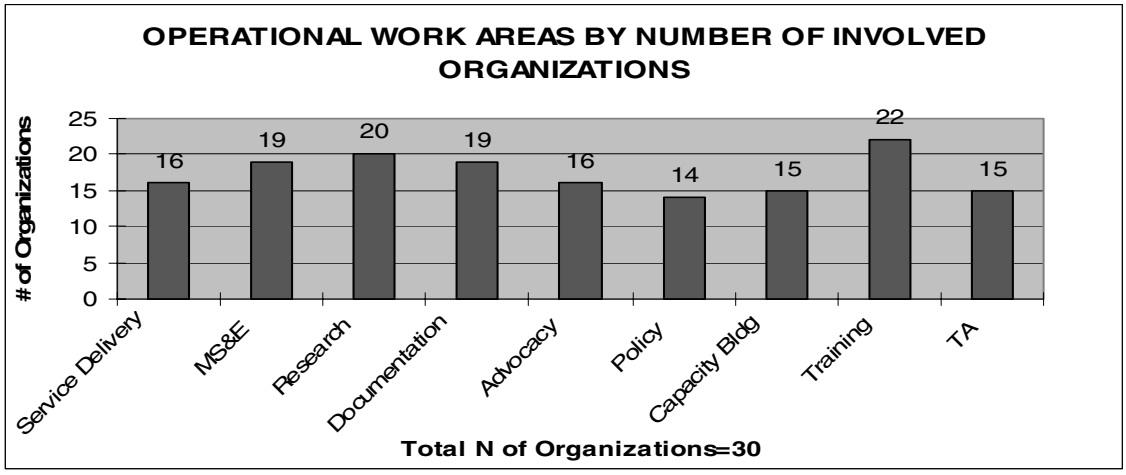
23. Three technical components, HIV/AIDS, STIs, and safe motherhood have the greatest frequency of organizational involvement, and also rank highest in terms of level of allocated 'work effort', 76, 74 and 61% respectively with 'high' rankings. Conversely, ART is the least frequently worked in component, and also has the lowest "work effort". Generally, "work effort" appears to parallel organizational involvement. That is, higher frequency of involvement is associated with higher 'work effort' and lower frequency of involvement with lower "work effort".

24. It is notable that male involvement, EC and FGM are relatively low on frequency of involvement and very low on "work effort" received. "Work effort" is cited as high by only one organization working in FGM, two organizations working in male involvement, and three organizations working in EC. (Note: the slightly smaller number of organizations in Chart 2 compared to Chart 1 is due to respondents not ranking some components.)

Current operational areas

25. RHR organizations have different operational work areas, depending on their individual mandates and size. Chart 3 below shows the frequency with which organizations operate in each work area.

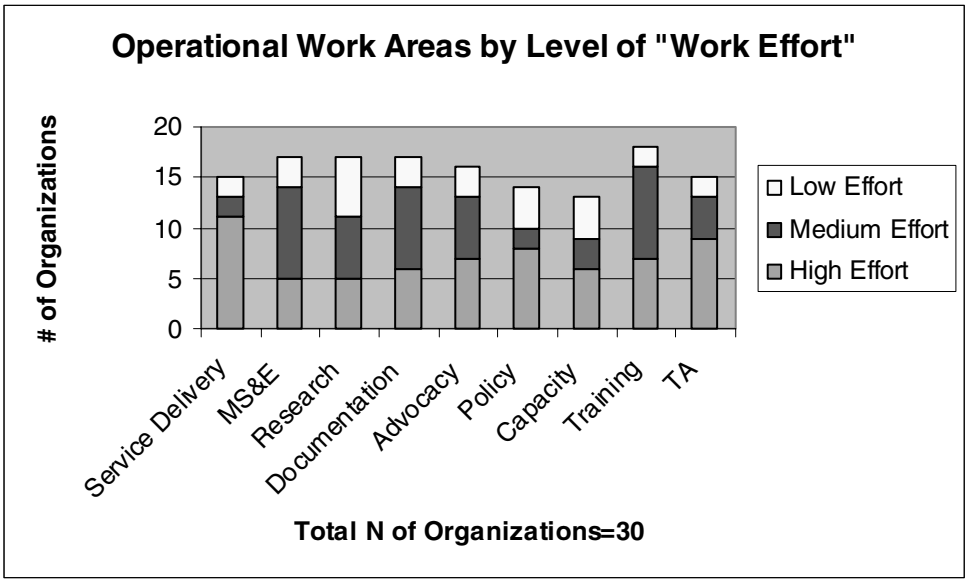
Chart 5.3: Operational Work areas by Number of Involved Organizations



26. Chart 3 shows that the distribution of operational work areas is spread fairly evenly across organizations. Training is the most common operational working area, with over 73% of organizations (n=22) engaged, while 'policy' at 43% (n=14) is the lowest. Research, with two thirds of organizations engaged (n=20) is also a working area of high involvement. Chart 4, which follows, adds important information to the interpretation of these findings.

27. Respondents were asked to rank the level of "work effort" that their organization allocates to each of their working platforms, with 1=high, 2=medium and 3=low. Chart 4 below shows the current operational work areas of RHR organizations by level of "Work Effort." The height of each bar shows how many organizations work in each area, while the subsections composing each bar show the relative "work effort" organizations put into that component.

Chart 5.4: Operational Work Areas by Level of "Work Effort"



28. Although as demonstrated in Chart 3, operational work areas seem to be distributed fairly evenly across the sample of organizations, there is much more variability with respect to "work effort" accorded to each. Service delivery receives 'high' rankings for "work effort" by the most organizations in the sample (n=11), while monitoring and evaluation, and research received the fewest 'high' rankings on "work effort" (n=5). Documentation and capacity building also receive relatively low rankings; less than half of organizations working in these areas rank their "work effort" as high. (Note: slightly smaller numbers of organizations in Chart 4, compared to Chart 3 are due to respondents not ranking some areas.)

Specific indicators

29. Although peripheral to the organizational scope of this evaluation, data was collected in the form of ratings of change for several programming elements of special interest.

30. Comprehensiveness of field programmes is rated from 1=low to 5=high, for two points in time, retrospectively for the baseline in 1995, and currently. The statement "This organization successfully integrates most components of RHR into its refugee programmes" showed average ratings of 2.4 for 1995 (n=8) and 3.7 currently (n=14). This finding illustrates the belief that programmes today are substantially more comprehensive than they were a decade ago.

31. There is recognition of the importance of designing programmes that are sensitive to the needs of sub-groups within refugee populations. The statement, "This organization's RHR programming incorporates awareness of the needs and desires of both men and women, and youth" is rated from 1=low to 5=high, for two points in time, retrospectively for the baseline in 1995, and currently. The average rating for 1995, 3.0 (n=11) compares to an average rating of 3.8 (n=16) currently. The longitudinal change across the two measures implies that respondents believe their

programmes are somewhat more targeted toward these sub-groups today, as compared to 1995.

32. In the early part of a crisis there are immediate needs that must be met to reduce mortality and morbidity, particularly among women. The study examines the degree of organizational endorsement of the MISP in the sample. The statement, "MISP should be implemented as a basic response in the initial phase of a crisis" is rated from 1=low to 5=high for the point of view of the organization. MISP receives an average rating of 4.7 (n=20) for currently, demonstrating a strong endorsement of MISP in the sample. The rating for 1995 was lower at 3.8 (n=5) but it may be less reliable as it is based on so few responses.

33. The objectives of the MISP include identifying an organization(s) or individual(s) to facilitate coordination and implementation of the MISP, a role frequently referred to as a "focal point". Survey respondents were asked if their organization routinely identifies an RH Focal Point in their field response, and, if yes, whether that person participates in inter-agency coordination meetings.

34. Thirty-three percent of organizations (n=10) report routinely designating a "focal point" in their field response. However, many organizations marked this as "not applicable" since they work very little, or not at all at the field level. Other RH service delivery organizations integrate refugees into their general service delivery and therefore may be less likely to identify this role in their response to this broader audience. Still other providers that target refugees may integrate RH into their larger package of services, and assign RH coordination as part of the duties of general health coordination function.

35. Confounding this situation further, the definition of "focal point" seems to vary by organization and situation. Some organizations identify "focal points" located at field-level, while others identify a headquarters-based "focal point" for RH, with responsibility for overall RHR coordination. This ambiguity confounds the survey question regarding focal point participation in inter-agency meetings. Some respondents interpret this to mean meetings at field-level, while others interpret it to mean international-level conferences. "Focal point" is used by some respondents to designate a position solely charged with RHR coordination, and by others when these duties are one of many functions provided by a staff member.

36. In addition to these issues of role definition and function, there is the cost of maintaining RHR "focal points" to contend with. A respondent from a large organization without focal points comments that it was:

> *"not clear who takes "possession" of the overall RH theme. It has been impossible for a single person to coordinate all RH issues throughout the organization and there will be financial problems setting up a network of "focal points" in the organization."*

37. Although the MISP receives clear and strong endorsement in principle, in practise, there is variable utilization and commitment to its essential implementer, the "focal point".

RHR organizational evolution

38. This section examines the perceived changes that have taken place in organizations with respect to RHR programme activities, operations and institutional changes. Qualitative data, numerical and rating scales are presented as evidence of these changes.

39. Overall, 73% (n=22) of the sample report that significant changes have taken place in their RHR programming and/or operational working areas since 1995. Eighty-two percent (n=18) of these organizations describe RHR programming and operations as growing in their organization, while 18% (n=4) report either stagnation or reduction.

Nature of organizational changes

40. Respondents report the growth of RHR in their organizations as a significant increase in activities and an expansion of programmes that address a wider scope of RHR components. Other changes describe the introduction of a rights-based approach in the organization, and as a principal integrated into programming. A third theme is that organizations are responding to increases in RHR information, and that new developments in technical components have engendered more programming in those components. A fourth change is increasing emphasis on integrating RH into primary health care programmes at the outset of emergencies, and the use of MISP and provision of RH kits. Finally, there is more programme focus on HIV/AIDS and STIs, which is seen by some to draw effort away from other components.

41. The following comments drawn from the survey illustrate common themes:

> *"[There is] a stronger policy focus on humanitarian assistance, particularly the fight against HIV/AIDS, improvement on gender equality and improvement of adolescent sexual and reproductive health and rights."*

> *"Our focus has changed from advocating general refugee health care to more specific advocacy on the technical components. Ongoing field assessments and research have led to documentation in specific gaps in services, and the focus on population groups to meet their specific needs and advocate for their participation in meeting their RH needs."*

> *"I think that the level of interest and activity in the area of RHR has increased over the last 5-10 years as a result of more information and advocacy. It appears more now in programmes, on conference agendas and in the literature. People here seem to be thinking of it more and including it in their work more."*

> *"Organization is now implementing, VCT and MTCT programmes that were not there in 1995. Change from a focus on HIV in 1995 to a variety of projects on all areas of RHR, especially emphasizing this year in advocacy work."*

Reasons for organizational changes

42. Respondents attribute these changes occurring in response to a number of factors including: world events and local demand; a growing base of RHR information and

resource tools; leadership and staff interest in RHR, stronger organizational endorsement; and alterations in availability of funding due to political changes. The following comments attest to underlying reasons why RHR has become a greater part of the working agenda of their organizations.

> *"ICPD and then involvement in IAWG and the development of the Field Manual increased our involvement."*

> *"Organizational leadership has recognized the need for RH ….Executive Board has endorsed ….our mandate in this area and ...Humanitarian Response Unit was created in 2001 and made part of the Office of the Director in 2002."*

> *"An increased focus on the technical areas of EmOC, EC, STIs and HIV/AIDS in refugee /conflict- affected settings comes from the recognition that they remain underdeveloped to support the provision of good quality comprehensive RH services."*

> *"Over a five-year period, we had designated staff to work in RHR areas at HQ and in the field and this constant presence and support helped to begin a process of institutionalisation of RHR efforts."*

> *"Technical and programmatic developments within the field of humanitarian assistance and RH, e.g., MISP, EmOC."*

43. For the 18% of organizations that report a reduction in RHR work, respondents say that RHR evolved as a lower priority of their organization, reflected in reduced funding.

> *"Worked stopped because insufficient funds secured to continue this work; not a priority of our key donors."*

Implications of organizational changes

44. Approximately half of the organizations reporting significant growth indicate that RHR has reached the point of integration into the formal structure of their organization. Providers of direct services report that integration is also occurring within health care delivery and multi-sectoral service delivery approaches. Yet there is simultaneous concern that RHR will only be sustained in their organizations if funding remains available and new donors are identified. They note the influence of policies, both external and internal to their organization, and how these, as well as economic factors could threaten the gains made thus far.

45. Given these caveats, there is evidence that RHR is now institutionalized in a number of organizations and this in turn has created greater demand for more comprehensive and technically focused programming. There is a recognized need for more research, capacity building and training to fortify these RHR structures. The comments below articulate these conclusions, and highlight factors seen as critical to the continued institutional strengthening of RHR.

> *"RHR activities have been built into the formal structure, promoting sustainability and likelihood of continuing support. However, this remains dependent on outside funding sources."*

"More support: issuing policy document, some more financial support."

"RHR is now included in course curricula, staff have written more about it and there is project development."

"RHR is an integrated part of the work of the organization. Changes in focus are indicative of increased institutional capacity and support for the work undertaken."

"RHR is integral part of … organizational structure, programme guidelines and policies, and in resource allocation. Increased commitment to address the needs across the organization. This is reflected by increased number of programmes and increased number of staff, both at HQ and in the field."

"Increased demand for human and financial resources to go beyond general awareness raising to support the development of technical resources and local capacity to complement advocacy."

"Over a five-year period, we had designated staff to work on RHR areas – at HQ and in the field and this constant presence and support helped to begin a process of institutionalisation of RHR efforts within (the organizations)."

46. A preponderance of qualitative data indicates that over the last decade, the evolution of RHR has realized a larger and stronger presence of RHR activities in most organizations in the sample. In some, RHR has reached a level of integration and prominence to be considered institutionalized. Respondents were asked to evaluate the degree to which this process has taken place within their own organization by rating the "Perceived value of RHR to the mission of your organization" from 1=low to 5=high, for two points in time, baseline in 1995 and currently. The rating for 1995 is 2.8 (n=15), compared to the rating of 3.8 (n=22) currently. In conjunction with the commentary, this finding supports the conclusion that the RHR function is accorded substantially more recognition and status in sample organizations today in than in 1995.

External and internal policy changes

47. As discussed earlier, favourable global attitudes and RH policies set the stage for fast tracking RHR. From 1995 to 2001 the U.S. government provided very strong economic and institutional support that helped to establish policy, resource tool development and partnerships. However, fifty percent (n=15) of the sample reported that recent political / policy changes had seriously affected their RHR action agenda or implementation. Components such as EC, PAC, adolescent RH and many FP efforts were affected. In this political climate, support from private donors was perceived as reduced in these programming areas as well. The following comments reflect this effect:

"Funding decrease on FP, while increased demands occurred in the field, affect the work of the organization.

…changes at the political level have required the home office team to commit greater resources to be spent on "advocacy" activities rather than on technical assistance to field projects."

48. As discussed above, the continuing viability of RHR is seen to depend heavily on a positive external policy environment, and organizations are sensitized to changes in external policy that constrain their ability to work. Yet there is less concern or attention to the existence of internal policies that specifically validate RHR within these institutions. Forty-three percent (n=12) of the sample reported that their organization has a written policy or guidelines, or other official support, such as a Board mandate for RHR, compared to only one organization in 1995. Four of these organizations reported adoption of a policy between 1994 and 1999; six between 2000 and 2003, while one organization indicated that it is now in the process of RHR policy development. Organizations with a written internal policy made few comments regarding its effect, although a few respondents mentioned that a written internal policy for RHR provided more internal credibility and direction.

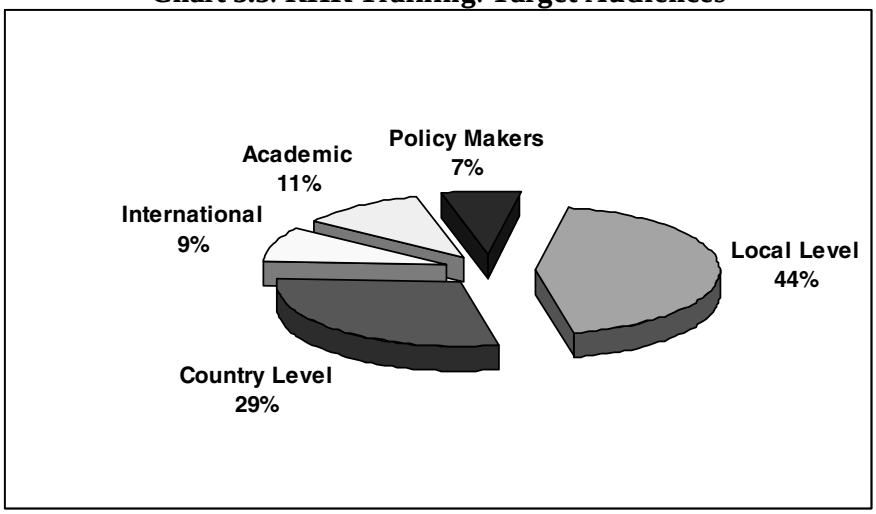
RHR operational working areas

Training and capacity building

49. Currently, training is the most widespread working area with 73% (n=22) of organizations reporting involvement. The breakdown of this group engaged in training is: 32% research institutions (n=7), 23% multilateral organizations (n=5), 36% international NGOs (n=8), and 9% U.S. government (n=2). Although many organizations are involved, only 39% rank it high with respect to "work effort", 50% rank it medium, and 11% consider their "work effort" as low. (See Chart 4 above.)

50. Training content in RHR can be very diverse, but the goal is always to build the capacity of the target audience. Organizations provide training based on the perceived needs and benefit accrued, relative to their RHR programme interests and their own areas of expertise. RHR Training, categorized by target audience, is summarized in Chart 5 below, as a function of the total survey responses.

Chart 5.5: RHR Training: Target Audiences



51. Chart 5 aggregates all enumerated responses into five conceptually separate categories of training "target audience". It shows that in-country training audiences, especially those at the local level, account for the majority of training, with 73% of total responses. The data does *not* measure actual numbers of trainings, but it is

useful to describe, in a general sense, the relative allocation of different types of training. The data imply that most RHR training efforts focus on persons in the field. Training efforts targeted to graduate students represent a small but significant organizational investment in future leaders and a means to further institutionalisation of RHR. Training to policy makers, while clearly important in the long-term, appears as only a very small part of overall effort.

52. Training can be used to improve staff understanding and performance in their programmatic duties, or to promote and educate about a new topic or approach. Many respondents articulate the need for more specific training in the components of RHR, and focus on improving the skills of implementers at or near the field level. Chart 5 illustrates the dominant training orientation of organizations to field-level.

53. Concern with the need for more and better field-level training is also demonstrated in other survey evidence. "Competence of field personnel to address RHR issues" was rated by respondents from organizations with field-level experience, using a scale of 1=Low to 5=High, for two points in time, retrospectively for 1995, and currently, to assess changes over time. The average rating score for 1995 is 2.4 (n= 10), while the average current rating is 3.7 (n=17). These data indicate the perception of a moderate positive change in staff competence over this time period, with room for more improvement. Respondent comments echo this finding, that while there has been some improvement in on-site implementation, more is needed.

> *"Huge need for training in RHR, human rights and reproductive rights, gender for all stakeholders involved in RHR programmes."*
>
> *"Need….capacity building, ongoing training of health workers and staff in other sectors such as protection, community service, programme, etc."*
>
> *"Lack of staff competence, especially on issues such as HIV/AIDS. Better training, supervision and technical support is required. More technical advisors are needed to ensure consistent strategies and programme quality."*

54. Both quantitative and qualitative findings acknowledge the importance of more capacity building. They also demonstrate the plurality of training efforts aimed at field-level audiences. The long-term benefit of investing in training efforts targeted to holders of roles in RHR policy making, organizational management, as well as future leaders, is outside the focus of many organizations that engage in training.

Technical assistance

55. Currently, technical assistance (TA) is a working area for half of the organizations in the sample (50%, n=14). The TA provider group consists of five research-focused institutions, three multilateral organizations, two RH organizations, three RHR service delivery organizations and one refugee-focused organization.

56. In this group, TA represents an area of relatively high work effort. Two thirds (66%) rank TA work effort as high, 22% medium, and only 12% rank it low. The content of this technical work, not surprisingly, reflects the technical expertise resident in the provider organizations. Thus academic and research organizations provide TA in assessment, monitoring, evaluation, and dissemination, while clinical

TA is provided by organizations with an RH medical/technical orientation. Organizations that provide integrated, multi-sectoral service delivery provide both general managerial and financial assistance as well as TA in the components of RH, frequently focusing on EmOC, STIs, HIV/AIDS, Youth and MISP. In an effort to improve the availability of TA, a database of RH specialists and the creation of a stand-by arrangement system has been established by UNHCR.

Research

57. Respondents were asked to document the annual RHR research expenditure of their organization for the baseline year of 1995, 2000 and 2003 (or 2002 if 2003 not available). Few were able to furnish financial information at this level of desegregation, and only 23% of the sample (n=7) reported data for two or more points in time. Of these seven organizations, five with larger budgets all report strong growth in research expenditure, with most increase in the period from 1995 to 2000. Four organizations experienced very large overall increases in research expenditure (e.g., from $50,000 in1995 to $1,100,000 in 2000 and 2003), while a fifth reported an increase from $0 in the years 1995 and 2000, to $80,000 in 2003.

58. By contrast, research expenditure in the other two reporting organizations with smaller RHR budgets showed large decreases relative to their size. One dropped from $15,000 in 1995 to $0 in 2000 and 2003, while the other initially increased from $0 in 1995 to $89,000 in 2000, and then dropped back to $10,000 in 2003.

59. Trends shown by such a small sample with such large variability may not be representative, and clearly need substantiation by further investigation. Nonetheless, this data showing increases in research expenditure is consistent with other commentary attesting to the increased availability of research data.

60. Despite the wide recognition of the value of research findings for both programmatic direction and fund raising, research endeavours are often complex and challenging to execute, with a relatively long time frame for results. Moreover, RHR research may cover topics that are sensitive in many cultural contexts, which requires more preparation and slower approaches at the community level. Potential donors are aware of these issues and may be hesitant to fund smaller organizations or those with shorter track records. In times of less economic buoyancy, all organizations will find more competition for shrinking resources, an effect exacerbated in the area of research.

RHR technical resources

61. Since 1995, a significant amount of organizational effort has been invested in the development of materials that serve to define the topics and content of the RHR sector, the principles of action that underlie it and practical tools to guide, train and educate practitioners. The most comprehensive document, *Reproductive Health in Refugee Situations; an Inter-agency Field Manual*, is the result of extensive efforts by many organizations working through the IAWG. The “Bible” as one respondent refers it to, has been the basic document of the RHR sector and is available in six languages.

62. Over time, many other resource documents for use in conflict situations have been produced, but it is unknown to what extent these are widely known, pertinent and practical, or actually used. Unfortunately, few respondents took advantage of the opportunity to comment on document utility, although it was noted that having a tool on CD-rom increased its usefulness to carry when on mission. Table 5.1 below presents information in regard to the frequency of organizational use of some of the better-known resource materials. The five categories of "use" are from Lowest, 1-2 times, to Highest, over 10 times. It is important to note that "use" may refer to implementation in the field, as a resource for teaching or personal education.

Table 5.1: Use of Major Guidelines, Protocols and Documents

Resource Documents	**USED 1-2 TIMES**	**USED 3-6 TIMES**	**USED 7-10 TIMES**	**USED MORE THAN 10**	**# OF RESPON-SES**
Sexual Violence Against Refugees: Guidelines on prevention and response; UNHCR, 1995.	10%	29%	10%	**52%**	N=21
Guidelines for Prevention and Response: Sexual and Gender-based Violence against Refugees, Returnees and Internally Displaced Persons; UNHCR 2003.	14%	18%	18%	**50%**	N=22
Guidelines for HIV Interventions in Emergency Settings; UNHCR, WHO, UNAIDS, 1996.	26%	17%	**30%**	26%	N=23
Guidelines for HIV/AIDS Interventions in Emergency Settings; IASC, 2003.	27%	20%	20%	**33%**	N=15
Reproductive Health in Refugee Situations: an Inter-agency Field Manual; UNHCR, 1999.	20%	4%	8%	**68%**	N=25
Refugee Reproductive Health needs assessment field tools; RHRC, 1997.	30%	26%	9%	**35%**	N=23
Reproductive Health Kit for Crisis Situations: UNFPA, 1998; revised 2002.	26%	21%	21%	**32%**	N=19
One-Day Awareness Raising Module: introduction to reproductive health issues in refugee settings: CARE/RHRC, 1998.	20%	**53%**	20%	7%	N=15
Raising Awareness for Reproductive Health in Complex Emergencies: CARE/RHRC, 2003.	31%	**46%**	15%	8%	N=13
A Five-Day Training Programme for Health Personnel: reproductive programming in refugee settings; CARE/RHRC, 1998.	20%	**33%**	33%	13%	N=15
Moving from emergency response to comprehensive reproductive health programmes: A modular training series; CARE/RHRC, 2003.	**38%**	**38%**	13%	13%	N=8
Reproductive Health during Conflict and Displacement: A guide for programme managers; WHO, 2000.	41%	**29%**	12%	18%	N=17
RHR Consortium Monitoring and Evaluation Tool Kit, Draft for Field Testing, Feb. 2003.	**50%**	29%	0%	21%	N=14

63. As shown in the table above *Reproductive Health in Refugee Situations; an Inter-agency Field Manual* is the most frequently rated document (n=25) and receives the highest "use", with 68% of respondents rating these documents as used ten or more times. The two sexual violence documents (UNHCR) are rated as highest "use" by 50% or more of respondents. *Guidelines for HIV Interventions* (UNHCR, WHO and UNAIDS), and *RH Needs Assessment Field Tools* (RHRC Consortium) also receive frequent use. The data reflect the intuitive finding that the more specific the subject matter of a document, the more circumscribed its use.

64. This survey does not provide information regarding the actual distribution or availability of these documents, guidelines and tools, either in hard copy or on the Internet. However, in response to a question regarding use of the Internet, 62% of respondents (n=18) report they use it to access RHR materials and information. Four most frequently mentioned sites are:

www.rhrc.org; www.who.int; www.unhcr.org; www.unfpa.org.

65. The following (listed below in no particular order) are also cited as useful reference sites: www.cdc.gov; www.apha.org; www.forcedmigration.org; www.unaids.org; www.engenderhealth.org; www.interaction.org; www.ippf.org; www.fhi.org; www.globalhealth.org; www.reliefweb.int; www.alanguttenmacher.org; www.ipas.org; www.safemotherhood.org; www.irc.org; www.jsi.org; www.worldbank.org; www.developmentgateway.org; www.pathfinder.org; www.genderandaids.org; www.popinform.org; www.jhuccp.edu; www.icrc.int; www.savethechildren.org; www.medline.org; www.womenscommission.org; www.rhgateway.org; www.haph.harvard.edu/grh/index.html; www.reproline.jhu.org; www.cedpha.org; http://cpmcnet.columbia.edu/dept/sph/popfam/amdd/; www.astra.org; www.cpc.unc.edu; www.familycareintl.org; www.msi.org. www.raisingvoices.org; www.sigi.org; www.endvaw.org; www.figo.com

RHR organizational resources

66. The productivity and growth of an organization is strongly related to its fiscal and human resources. The study examines quantitative data to measure trends in both of these resources. In addition, respondents were asked to comment if their organization had faced any financial constraints that seriously affected the action agenda or implementation of their RHR activities. They were also requested to indicate and comment on any active efforts since 1995 to increase or attract new resources for RHR work. The information provided to these inquiries is summarized and discussed below.

Annual expenditure trends over time

67. Annual expenditure is measured at three points in time, baseline in 1995, 2000, and 2003 (or 2002 if 2003 not available). Two different expenditure variables are tracked; expenditure of the entire organization and expenditure specific to RHR. The purpose of the entire organization budgetary data is to provide a standard for growth/shrinkage, against which the RHR expenditure trend can be compared.

68. Unfortunately, most organizations did not provide expenditure figures or estimates for these time periods, either because there is no earmark or mechanism to track RHR funding separately in their programmes, or they do not have easy access to retrospective budgetary data, or both. Thirty-seven percent (n=11) were able to provide data for at least two points in time. Due to the partial nature of the data collected, caution should be used when generalizing these results to the entire sample.

69. In the period 1995-2000, 75% (six of eight) of reporting organizations experienced large increases in overall organization expenditure, with rates of growth ranging between two and eight times. One organization held stable across the period, and one large agency reported a significant decline. Across this period, 88% (seven of eight) of organizations reported even greater relative increases in RHR expenditure, from two to 28 times. One respondent, who did not provide figures, reported that RHR growth in this period was "exponential." Thus, from the baseline period to 2000, overall organizational growth was high, and RHR growth even higher.

2000-2003 In this period, 10 organizations reported overall organizational expenditure data for two or more points in time. Seventy percent (n=7) approximately doubled their expenditure, showing growth, but at a slower pace than in the prior period. Two organizations reported stable expenditure, and one large organization experienced a mild decrease. In contrast to this general upward trend, RHR expenditure decreased in four organizations between 20 and 100%, three organizations held stable, while four reported expenditure increases. Thus, from 2000 to 2003, overall organizational growth continued to grow at a slower rate, while in more than half of these organizations, RHR expenditure stopped growing or was reduced.

70. Although the two data periods are not exactly equal in size, and the few organizations that supplied the information tend to be larger, the quantitative trends described are consistent with qualitative information provided by respondents.

> *Securing funding for RHR activities has been difficult over the past few years. In addition, the length of most funding cycles makes it difficult to build the trust and approach sensitive RHR topics within the allotted time frame.*

71. In summary, the trend of overall expenditure shows strong increases in nearly every reporting organization between 1995 and 2003, with the strongest growth in the earlier time period. In contrast, while the pattern of RHR spending shows a parallel strong upward trend in the first period, after 2000, there is more variability, with 40 percent of organizations reporting a downward trend in RHR expenditure.

72. The small size of data does not justify estimating the size of changes in expenditure. Nor should this variation be attributed solely to changes in political will, since reduced availability of funds arises from a constellation of factors that include economic cycles and other external events, including the number, size and prominence of crises that arise.

73. Seventy percent (n=21) of respondents indicated that "financial constraints had seriously affected the action agenda or implementation of RHR activities." And virtually all of them (n=20) indicated that their organization had made active efforts

since 1995 to increase or attract new resources for RHR." One international NGO stated the following:

> *"Since 1998, we have annually approached different donors, foundations, USAID in East Africa and the EU for continued funding. We did not succeed in any of our numerous attempts (we estimate that eight of our attempts involved developing concept papers of proposals."*

> *"Fundraising, continuous. Important to note that RH matters are integrated into (organization) programmes, and there are few stand-alone RH programmes. An integrated approach seems to work better in terms of successful fundraising."*

RHR Staffing Trends Over Time

74. RHR staffing changes are measured at the same three points in time, baseline in 1995, 2000 and 2003. As with expenditure, many respondents did not provide specific numbers, especially for retrospective data. However, almost half (n=14) reported data for at least two points in time. The data demonstrate staffing trends somewhat similar to those found for expenditure. A high proportion of organizations, 86% (n=12) report rather large relative increases in RHR staff across the entire period from 1995 to present, while 14% (n=2) report reductions.

75. Unlike the trend identified in the expenditure data, where more increase is realized in the first period, RHR staff growth is more even across time, with less slow down between 2000 and 2003. For example, between 1995 and 2000, the smallest staff increase is from 1 to 2, while the largest is from 5 to 30. Between 2000 and 2003, the smallest increase in staff is from 1 to 2, while the largest is from 51.5 to 87.75. The two organizations that saw staff reduction were small. One programme went from 1 RHR staff member in 1995, to 1.5 in 2000 to 0.5 in 2003. The other programme started with 2 RHR staff in 1995, dropped to 1 in 2000, and then to 0 in 2003.

76. The range of current RHR staff in this group of fourteen is large, from 2 to 87.75. Despite the identified trend of consistent growth in staff over the entire period, respondents voice a common concern about the need for more technical personnel, and as noted earlier, the need for more field-level staff to provide a stronger coordination function.

Collaboration among RHR Organizations Since 1995

77. All major RHR work originates in a relatively small number of diverse organizations, characterized by differences in corporate and ideological cultures, mandates, purpose and technical working areas. The continuing growth and provision of good quality RHR services globally is intertwined with how successfully these organizations collaborate and achieve synergy.

78. The survey examines collaboration in several ways. In one item respondents were asked to explain the nature of changes in organizational cooperation and collaboration since 1995, how these changes occurred and their outcomes. Overall, 68% of those responding to this item (n=15) report increases in

collaboration / linkages in their specific programming initiatives. The origins of these inter-connections, their nature and their effects are described below.

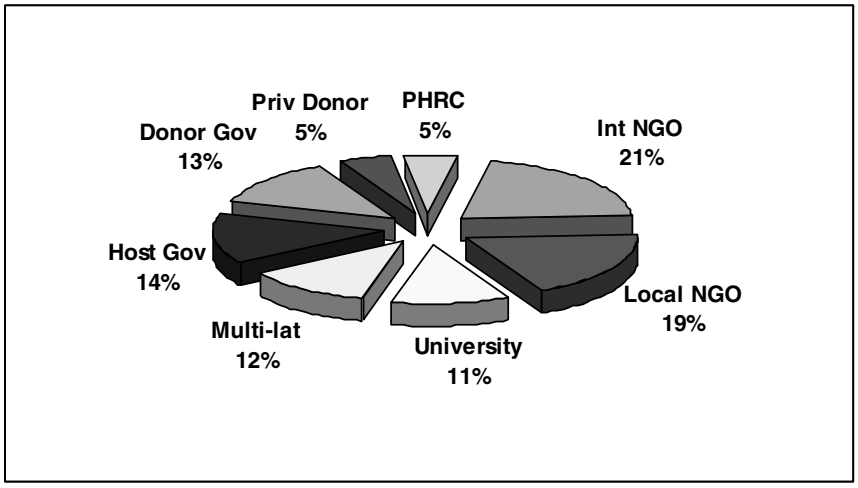
79. Many respondents credit working groups, especially the IAWG and the RHRC Consortium, as primary facilitators of interaction, partnerships, sharing of resources and designation of responsibility across members. Through symposiums and meetings, the IAWG and RHRC Consortium bring together a critical mass of individuals to strategize, plan and set working objectives that further their involvement and expand the range of RHR organizational activities and areas. These groups foster personal relationships and leadership, and lead to joint initiatives, often wider in scope than could be undertaken by a single organization.

> *The establishment of IAWG which helped not only in promoting RH for refugees but also in strengthening RH services in refugee situations. More organizations and refugee communities have become involved in RH and HIV/AIDS issues.*

80. The "Positive impact of the IAWG on the RHR programme activities of this organization" was rated by respondents from 1=Low to 5=High, at two points in time, retrospectively for the baseline period 1995, and currently. Positive impact of the IAWG received a rating of 3.1 for 1995 (n=9) and 3.9 currently (n=16). These ratings indicate that the positive impact of IAWG has grown over this time period, although most respondents did not rate the early impact of the IAWG, and just over half rated its current impact.

81. The study also examined current types of collaborating organizations, based on information given by respondents about linkages in their major recent RHR programmes.

Chart 5.6: Recent Collaborating Partners



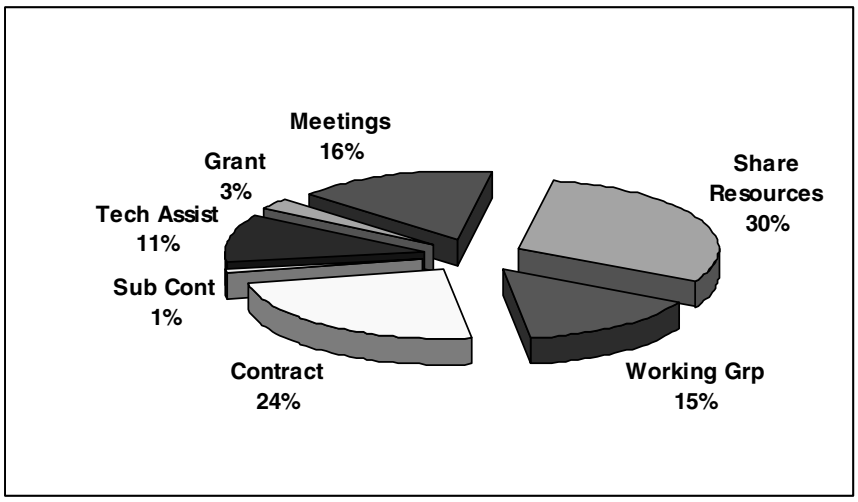
No of organizations =22
Total # of types of collaborating partners =209

82. The data in chart 6 show recent collaboration (for programmes between 2001 and 2003) occurring across a wide variety of different types of organizations, most frequently between International NGOs, and local NGOs. (Note that respondents

were asked to indicate types of collaborators in each programme, so this data should be interpreted as indicative of relative, rather than total instances of collaboration.)

83. Chart 7 below presents the nature of these collaborations/linkages between organizations, as measured by frequency of enumeration.

Chart 5.7: Forms of Collaboration



No of Organizations =21
Total # of responses =149

84. Chart 7 shows the most common form of collaboration is 'sharing of resources' such as office space, equipment and materials. Together with 'meetings' and 'working groups', these three forms of informal collaboration account for 61% of overall responses. The mechanism of 'contracts' at 24% is the most commonly cited formal linkage.

85. While coordination and linkages develop from networking opportunities and staffing structures such as 'focal points', for some organizations establishing linkages is a foundation of their working philosophy. Many service delivery organizations define participation and linkages across many levels as essential to programme success and sustainability. For these organizations, collaboration with communities with organizations at local, regional, national and international level is intrinsic to their operational fabric.

86. Collaboration, whether formally planned or as a response to field contingencies, is undoubtedly viewed as a positive mechanism to enhance effectiveness and raise awareness of various aspects of RHR. Partnership and linkages can improve efficiency, reduce duplication and amplify individual strengths in joint efforts. The growing collaboration reported by the majority of organizations is therefore indirect evidence of stronger institutional support and higher quantity and quality of RHR work.

> *"Increases in collaboration are due to field demand, networking at country and HQ levels and due to increased exchanges between universities and the NGO sector in the past few years. Also attendance at IAWG meetings has been a positive factor."*

Lessons learned, recommendations and future directions

87. Since 1995, improvements have occurred in all RHR areas, technical support and RH strategy. There have been increases in the size and scope of RH programmes with respect to EmOC, HIV/AIDS and RH needs of youth. Moreover, there is overwhelming evidence that collaboration and exchange among RHR organizations has increased since 1995, due in large part to the vital roles played by the IAWG and the RHRC Consortium, as well as other key groups. Acknowledging these many substantive achievements in RHR, and with expectations that the size and scope of their programming will continue to grow, the majority of organizations also feel their work is hampered by too short and inconsistent funding for programmes and, frequently, too few technical staff to support all of their functions.

88. Nearly all organizations in the sample found it difficult to provide retrospective information about RHR expenditure and staffing, and most were unable to provide current expenditure because systems are not in place that allocate and track RHR funds separately. The paucity of disaggregated budgetary data for RHR makes it almost impossible to monitor these changes over time in any systematic way, or to establish an institutional record. Perhaps most significantly, the absence of this data undermines efforts to establish RHR as a priority within the organization itself. Improvement in systematic identification and collection of RHR budgetary and staffing data within organizations would help to raise the profile of RHR, validate its importance and further its institutionalisation.

89. The growth in collaboration through a variety of exchange mechanisms among RHR organizations over the past decade provides momentum for increasingly ambitious and extensive activities to promote greater connections and inclusion. Encouraging new partnerships that draw on the increasing interest and expertise of development organizations will expand the base of support of RHR and facilitate a smoother transition from emergency situations to longer-term development assistance. The various academic centres and institutes throughout the world, some of which already have programmatic involvement related to refugees and health, should also be actively engaged.

90. To facilitate this goal, the IAWG should consider developing an Outreach Committee that would initiate and oversee activities related to inclusion and membership. The Outreach Committee would take responsibility to seek out and engage peripherally involved organizations, and raise awareness throughout the larger community, especially toward potential new entrants in the field. It might also establish and oversee a central repository/database to contain membership, reports, documents and other information relevant to the operation of the IAWG and the field of RHR.

91. Organizations report widespread use of the Internet to access RHR materials from a large number of websites. However, none refer to **refugee**, an unmoderated listserv created by the IAWG that is primarily a vehicle for infrequent announcements (there are 66 subscribers). The IAWG should consider invigorating and transforming the **refugee** listserv as a powerful agent for RHR networking, dissemination of information and ongoing discussions. A moderated listserv forum could raise and spread awareness of new developments in the different aspects of RHR, attract more interest to engage a wider community, and strengthen affiliations within this group.

92. Respondents voice concern with a variety of implementation issues, and some concerns are so widespread that they bear repeating, although they are somewhat tangential to the scope of this study. A dearth of all forms of data, surveillance, monitoring and evaluation, remains an intractable problem. Respondents report that despite emphasis on tool development and expert efforts, collection of data in the field requires further simplification of systems and formats, and better technical support. A more fact-based approach will improve system performance and identify priority interventions. Data is also intrinsic to credibility, and organizations unable to demonstrate programme outcomes and impact are at a severe disadvantage when competing for donor funds. A related need for more in-depth research in the elements of RHR is also widely expressed, especially more information about successful models and best practises.

93. Another shared concern is the need for more capacity building with local NGOs and organizations' own staff. There is a critical need for more female workers in the field to provide support in culturally sensitive programming areas. Programmes in GBV, STIs and HIV/AIDS especially require staff with specific skills and training to achieve good quality, comprehensive programmes. In all areas, but especially those requiring highly technical skills, it continues to prove a challenge to identify and to develop competent staff.

94. On balance, it is important that the reality of these ongoing challenges does not focus attention away from the major positive thrust of this report. Essentially, since 1995, a nexus of RHR organizations, working both individually and collaboratively, has amassed substantial expertise and implemented critical activities and services across a spectrum of technical components. Moreover, throughout this time there has been building recognition and support, institutionalisation both within and without, of RHR as a critical part of humanitarian efforts. The primary specific objectives of the IAWG, the development and dissemination of an Inter-agency Field Manual and the fostering of greater collaboration among all partners have been attained and progress continues on many other fronts toward the overall goal of strengthening RH services in refugee situations.

95. In conclusion, rapid, enthusiastic growth of RHR was ignited by strong commitment from key humanitarian actors, spurred on by the IAWG and the RHRC Consortium, and has been carried forward by the collective efforts of a vested force of professionals and workers collaborating across a diverse spectrum of organizations. Although output and impact have expanded, RHR work is still limited to a small contingent within the larger humanitarian assistance community.

96. In all likelihood, the demonstrated trends of growth in technical expertise, collaboration, programme activities and institutionalisation will continue apace for most involved organizations. RHR has evolved and matured and, despite some significant threats, it remains resilient. Major service delivery providers to refugees and other conflict-affected populations will continue their efforts to integrate and expand RHR within the health sector. Others not targeted specifically to refugees will continue to contribute from their respective areas of specialization. As new organizations join this group, they will increasingly strengthen the foundation of the RHR cadre and add to overall productivity. Finally, the continuing leadership, advocacy and support of major institutions will remain a keystone to advancement of RHR in situations of crisis and conflict throughout the world.