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Reproductive health services for refugees by refugees: an example from Guinea

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The need to involve refugees in their own reproductive health (RH) services has long been recognised, but there is a lack of published examples describing how this can be achieved collaboratively between refugee initiatives, UNHCR, bilateral development organisations and international relief agencies. This paper outlines the work, outputs and lessons learnt of the Reproductive Health Group (RHG), an organisation of Liberian and Sierra Leonean refugee midwives and laywomen providing RH services to fellow refugees in Guinea's Forest Region between 1996 and 2000. Working as part of the Guinean health system, RHG midwives and community facilitators helped make the RH services in their region the most effective in Guinea at the time. Looking at RHG's achievements, the challenges it faced and partly overcame, it is argued that refugee organisations can plan and implement RH services for refugees where UNHCR and its international partners ensure that they receive funding and technical assistance.

Keywords: capacity development, NGOs, post-conflict situation, STIs, refugees' reproductive health

Why reproductive health services for refugees matter

It was the 1994 Cairo International Conference on Population and Development that focused international attention on the particular reproductive health (RH) needs of refugees or internally displaced people. Ever since, the topic has steadily gained in prominence (Palmer et al., 1999). In 1995, an Interagency Working Group (IAWG) on reproductive health for refugees was founded, comprising over 50 international agencies active in the field of emergency aid, committed to developing models of reproductive health care provision for populations affected by conflict. An interagency field manual, *Reproductive Health in Refugee Situations*, was agreed upon and published in 1999 (UNHCR, 1999).

At that conference, donors, policy makers and field actors acknowledged the right of vulnerable groups, including refugees, to comprehensive RH services. However, much still needs to be done to ensure that refugees can actually attain them. In times of conflict, the breakdown of social structures, traditions and rituals regulating gender relations under peaceful conditions has a severe impact on the lives of refugees. Increased levels of sexual violence, transactional sex for material or financial gain, the loss of traditional sources of sex education for youngsters, cramped living conditions in refugee camps and the sheer boredom of camp life all contribute to changes

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in refugees' sexual behaviour and, consequently, increased need for accessible and acceptable RH services (Khaw et al., 2000; Krause et al., 2000).

The IAWG field manual underlines the importance of refugees' involvement in their RH programmes at all stages. More broadly, active participation by disaster-affected populations in the assessment, design, implementation, monitoring and evaluation of assistance programmes has become codified in one of the key standards formulated by the Sphere Project (Sphere Project, 2004). Yet, although the principle is widely accepted, operationalisation in humanitarian interventions proves to be difficult (ALNAP, 2003). In the health sector, participation is often limited to training and employing health workers from the local population by international humanitarian organisations. It is rare that individual local health workers and other national staff start organising themselves, for instance into a national non-governmental organisation (NGO), to provide services to the population they belong to. An interesting exception has been the establishment of a range of local health NGOs in Afghanistan during the years of conflict (Palmer et al., 2006). However, such NGOs will be in need of financial support and technical assistance in particular related to organisational management.

This paper documents the experience of the Reproductive Health Group (RHG), an organisation of Liberian and Sierra Leonean refugee midwives and laywomen, active in Guinea between 1996 and 2000. The information presented in this paper is primarily based on the personal experience and observation of four of the authors (Anna von Roenne, Franz von Roenne, Sarah Kollie and Yaya Swaray) who played an active role in supporting the RHG, the first two as employees of the German Development Cooperation Agency (GTZ) and the last two as RHG coordinator and youth programme officer, respectively. In addition, data will be used from a programme evaluation in 1998 of RHG's activities, an analysis of the amount and types of contacts and services provided by RHG staff as recorded on monthly 'tally sheets' during 1999, and the results of a large-scale survey of RH knowledge, attitudes and behaviour conducted in 1999 by RHG, assisted by GTZ and the Antwerp Institute of Tropical Medicine (Chen et al., 2008; Howard et al., 2008).

How the refugee crisis arose, and what it meant for the health system in Guinea's Forest Region

Since 1989 brutal civil conflicts in their home countries have forced many people from Liberia and Sierra Leone to seek refuge in neighbouring countries. In 1993/1994, at the height of the crisis, Guinea accommodated a population of over 600,000 refugees (World Refugee Survey, 1996), mostly in its Forest Region bordering those countries. Whilst many Liberians returned home following the elections in 1997, the upsurge in rebel violence in Sierra Leone in 1998 brought a new major influx of refugees. In February 1999, the Forest Region's Kissidougou and Guéckédou districts hosted a refugee population of 329,479 (UNHCR–Guinea, 1999).

In the late 1980s, when the refugee crisis set in, the Guinean health services had only just begun to recover from the effects of the disastrous economic and political conditions characterising Guinea at the end of Sekou Touré's regime in 1984. Service utilisation was very low and the vaccination coverage had plummeted below five per cent (van Damme, 1998). In 1986, Guinea's new government initiated major health sector reforms, following UNICEF's Bamako initiative. Bilateral and multilateral co-operation agencies were invited to help Guinea's Ministry of Health develop health services in the various regions.

In the Forest Region, Médécins Sans Frontières (MSF), Mission Philafricaine and GTZ had just launched their district development programmes when refugees started to arrive, from 1990 onwards. To respond to the refugees' health needs, the Ministry of Health set up the '*Programme d'assistance aux réfugiés Libériens et Sierra Léonais*', which soon became an integral part of the existing health system. Refugees were treated free-of-charge by the Guinean health services, and these were reimbursed by the United Nations High Commissioner for Refugees (UNHCR) on a fee-for-service basis.

Although the integration of development cooperation and refugee assistance that evolved in the Forest Region had numerous catalytic effects on Guinea's health sector development, the Guinean population, Guinean health workers and the refugees had their grievances: while the first complained that only refugees were treated free-of-charge, and the health workers saw their workload double, many refugees questioned the quality of the services they were offered. Family planning, for example, a service many Liberian and Sierra Leonean women had used in their countries of origin, was only introduced to Guinean health centres from 1992 onwards. In his analysis of medical assistance to refugees in Guinea from 1990–1996, van Damme (1998) writes that 'ANC [antenatal care] attendance was close to 100 per cent for Guineans, but only between 11 and 42 per cent for refugees', and that '. . . in 1994, only 0.75 per cent of women between 15 and 44 years used family planning offered in health centres. . . Between 10 and 30 per cent of users were refugees. It is possible that refugee women—and maybe Guinean women as well—preferred to use "unofficial", and unregistered, services by refugee midwifes, as they did for ANC' (p. 182).

These 'unofficial' services by refugee midwifes were the beginnings of a refugee self-help organisation aiming to improve the reproductive health services available to refugees. How this initiative started, developed and ended, together with lessons that can be drawn from it, is the subject of this article.

How the Reproductive Health Group started and evolved

Among the Liberians and Sierra Leoneans that took refuge in Guinea there were also many nurses and midwives. As professionals in their field, they were acutely aware of the limited number of health facilities, the language barrier between Guinean staff and refugee clients, and the complete lack of essential RH services for refugees, such as family planning (FP) or treatment and prevention of sexually transmitted

infections (STIs). To avoid unwanted pregnancies some refugee women ventured risky, long walks to Sierra Leonean health posts just behind the border to receive the contraceptives they were familiar with. Others, who could afford it, bought self-prescribed contraceptives on the market place or came to see refugee nurses in 'private practice', seeking advice on alternative methods of contraception, such as identifying 'safe' days in the menstrual cycle, or requesting abortions of unwanted pregnancies. Resolved to improve this situation, a number of refugee nurses in the Guéckédou and Kissidougou districts decided to found the Reproductive Health Group.[2] With initially limited funding from the German government, they started in 1995 to provide information and advice about FP and STI/HIV prevention to refugees in the larger camps. In 1996, the initiative obtained official NGO status and project funding by the German government for a three-year term.

Following an agreement with the district health office and UNHCR, RHG seconded refugee nurses to all health facilities used by refugees. Here they worked under the Guinean heads of service, usually male nurses, providing safe motherhood services, FP, and STI prevention and treatment to refugees and Guineans alike. To build the capacities of its own nurses and their Guinean counterparts, RHG conducted a series of training workshops in FP, antenatal care (ANC) and STI management. The joint trainings, the sharing of the increased workload and the refugee nurses' greater experience in RH service provision all contributed to continuous improvements in the districts' RH services, which were reflected in UNHCR's and the district health services' monthly monitoring reports.

In addition to the services it provided at the health facilities, RHG also trained and supervised members as *reproductive health facilitators*. These were refugee laywomen who promoted RH at the community level, providing condoms and spermicides and referring individual clients to their midwives and nurses. By involving motivated refugee women from all walks of life in their work, RHG made sure that its messages were spread throughout the community and it provided both a small income and a shared purpose to women in considerable need of both.

By early 1998, RHG's contribution to the region's reproductive health services was widely recognised and respected, particularly because RHG was run and managed by refugees themselves. And yet, there were growing concerns amongst UNHCR and GTZ staff about the management and the handling of funds by the two self-appointed male RHG coordinators. In April 1998, GTZ commissioned an external evaluation of RHG, including a financial audit and interviews with field workers, supervisors and administrative staff. The interviews showed that the female field workers no longer trusted them as coordinators of the organisation's activities and finances and felt unsupported by them. They were unaware of their rights and duties as members of RHG and of any ways in which they could hold their coordinators accountable. The financial audit showed that resources had been misappropriated, leaving field workers unpaid and the supervisors unable to go on supervision tours. As a consequence, GTZ suspended its cooperation with the RHG coordinators and suggested that a general assembly of all RHG members be called. The members'

assembly elected the two nurse supervisors, who had supported them throughout, as their new coordinators. At a planning workshop of RHG, their Guinean counterparts and GTZ, a number of democratic reforms were initiated, including the definition of members' rights and duties, such as monthly membership fees, annual general assembly meetings, the establishment and quarterly meetings of a board of governors, and the formulation of conventions with the Guinean district health office and GTZ. The new RHG management also requested GTZ to provide ongoing technical advice to help them establish organisational and management routines, and GTZ appointed one of the authors (Anna von Roenne) as part-time technical advisor who worked with the group until 2001.

Following these reforms, RHG's output increased in terms of the number of clients served, couple-years of protection (CYP)[3] and contraceptive prevalence of their target group. Overhead and recurrent costs were markedly reduced, and RHG's relationships and collaboration with the district health administration, GTZ and its own members improved. Top-down decisions were replaced by discussions and often heated debates within RHG as well as with its sponsors and partners. However, RHG had established itself as a crucial player in the health sector. A World Health Organization consultant evaluating RHG's work in December 1999 summarised in his report:

> *Maybe RHG is not unique but it is rare to find an organisation of refugees with so much clout and organisational strength. RHG represents the ideal situation whereby refugees participate in their own health care and in this instance it may well represent 'best practice' worth of intensive study for possible replication in other settings* (Msuya, 1999).

Which services did RHG provide and who benefited?

From the end of 1998, RHG nurses and facilitators registered every client contact on a 'tally sheet', specifying the client's nationality, sex, age group and the services provided. The sheets were checked by RHG supervisors, then entered into a database and analysed by the RHG health information officer. These service output data, together with UNHCR census figures and data from a cross-sectional survey undertaken by GTZ and the Antwerp Institute of Tropical Medicine on the refugees' reproductive health knowledge, attitudes and behaviour (Table 1), allowed estimating the coverage of RHG services provided to refugees (Table 2).

Beneficiaries

Together with their Guinean counterparts, RHG's 36 nurses and 75 facilitators provided RH services in 23 refugee camps and to refugees and Guineans attending the 28 health facilities throughout the refugee zone of the Guéckédou and Kissidougou districts, including the district hospital. Camps and health facilities were located up to 90 kilometres away from Guéckédou town, and could only be reached by dirt roads

Table 1 Population data for refugees with access to RHG services, Guéckédou and Kissidougou districts, Guinea, 1999

	Parameters		Data source
[1]	Total refugee population in areas served by RHG	291,721	UNHCR refugee census 1999 for Guéckédou and Kissidougou districts (UNHCR–Guinea, 1999)
[2]	Proportion of females in refugee population	50.0%	Howard et al. (2008)
[3]	Proportion of Sierra Leonean women aged 15–49 in 2000	45.7%	World Population Prospects http://esa.un.org/unpp/ (accessed 6 November 2007)
[4]	Proportion of female refugees 15–49 eligible for family planning*	41.2%	RHG survey, 1999
[5]	Crude birth rate in Sierra Leone (births/1,000 population), 1995–2000	47.1	World Population Prospects http://esa.un.org/unpp/ (accessed 6 November 2007)
[6]	Total female refugee population	145,861	[1] × [2]
[7]	Female refugees 15–49	66,658	[6] × [3]
[8]	Female refugees 15–49 eligible for family planning	27,463	[7] × [4]
[9]	Expected deliveries per year in refugee population	13,740	[1] × [5]/1,000

Note:
* Excludes women who want to become pregnant or who are pregnant, breastfeeding, infertile or abstain from sexual intercourse.

Source: authors.

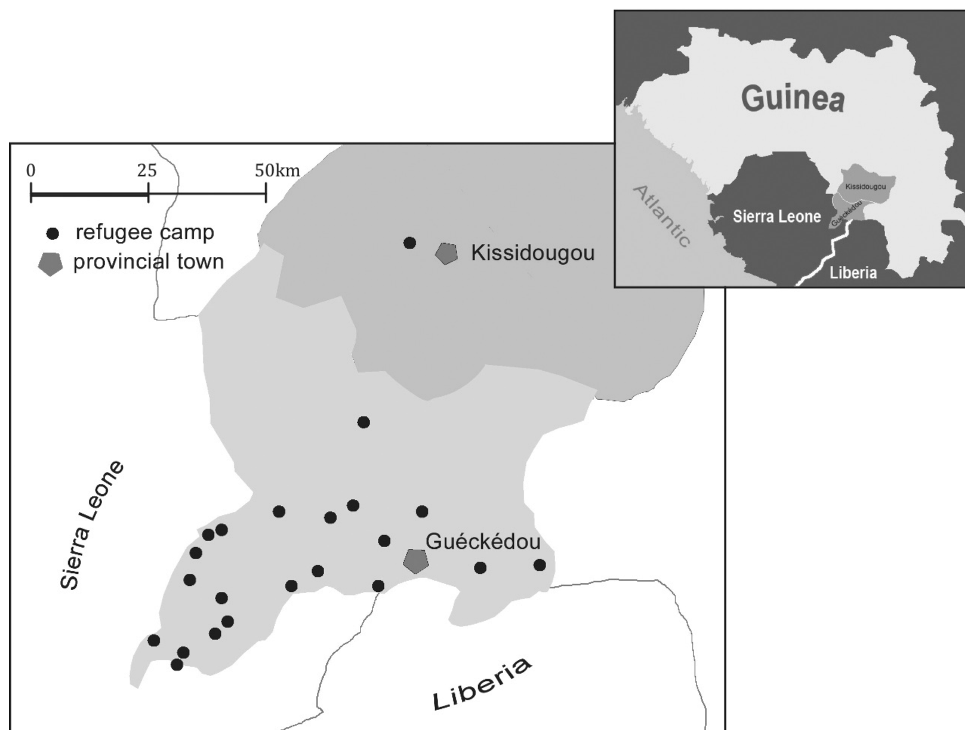
Table 2 Main services provided by RHG to refugees and the local population, service coverage for refugees, Guéckédou and Kissidougou districts, Guinea, 1999

	Refugees	Local population*	Total
Contacts of RHG midwives with any clients 15–49	60,063	25,563	85,626
contacts with female clients 15–49	57,214	25,429	82,643
contact per woman 15–49	0.86	–	–
Antenatal care, all contacts	25,300	19,867	45,167
Antenatal care, first contacts	7,480	6,409	13,889
coverage (% of expected deliveries)	54%	–	–
Deliveries with skilled birth attendant	3,344	1,069	4,413
coverage (% of expected deliveries)	24%	–	–
Post-natal care	1,683	774	2,457
coverage (% of expected deliveries)	12%	–	–
Family planning, all contacts	32,906	4,550	37,456
Family planning, first contacts	9,604	1,248	10,852
Family planning, couple-years of protection**	4,635	680	5,315
coverage (% of eligible women)	17%	–	–
Contacts of RHG facilitators for counselling (individual or group)	64,982	17,274	82,256

Notes:
* Coverage for the local population has not been calculated in cases where there is no figure provided, because of the unknown denominator.
** Couple-years of protection (CYP): sum of method specific CYPs, which are calculated by multiplying the number of dispensed units of contraceptives with a factor representing the average duration of protection conveyed by each unit (0.25 for injectable contraceptives, 0.0763 for packages of oral contraceptives, 2.5 for IUDs, 0.01 for a condom, 0.01 for a spermicide).

Source: authors.

Figure 1 Map of refugee camps in the Guéckédou and Kissidougou districts, Guinea, 1999



Source: authors.

in poor condition (see Figure 1). The refugees living in the areas with access to RHG's services numbered 291,721: a quarter of them lived in the towns, and three-quarters in camps (RHG operational data based on UNHCR–Guinea (1999) refugee census; see Table 1).

Safe motherhood services

In 1999, RHG midwives had 45,167 ANC contacts (25,300 refugees [R]; 19,867 Guineans [G]) (see Table 2); of these, 31 per cent (R 50 per cent, G 32 per cent) were first contacts. 24 per cent of pregnant refugee women delivered at a health facility assisted by RHG midwives, while most of the others presumably had home deliveries under less safe and hygienic conditions.

Fifty-six per cent (R 50 per cent; G 72 per cent) of those who delivered with RHG assistance came back for a post-natal consultation. This comparatively small proportion prompted RHG to intensify their efforts to persuade women to attend this service.

Family planning

RHG nurses provided FP at all RHG-served health facilities and at various outreach clinics. Methods included oral and injectable contraceptives, intra-uterine devices

(IUD), spermicides and condoms. In 1999, RHG nurses registered a total of 37,456 FP contacts (32,906 R; 4,550 G). Seventy-one per cent of them (R 71 per cent; G 73 per cent) were follow-up contacts, compared to 56 per cent in 1998, when many Sierra Leonean refugees had newly arrived. The relative increase in follow-up contacts suggests that more and more of RHG's clients had become permanent FP users. The marked difference in use of the service by refugees and Guineans may be due to the higher acceptance and utilisation of FP among refugees, and to Guinean clients possibly preferring to attend Guinean FP providers.

Over the year, RHG midwives distributed contraceptives equivalent to 5,315 CYPs (4,635 R; 680 G). Injections made the greatest contribution with 70 per cent (R 69 per cent; G 79 per cent), followed by oral contraceptives with 25 per cent (R 26 per cent; G 19 per cent). The small contribution of IUDs with four per cent (R 5 per cent; G 2 per cent) is explained by the high prevalence of STI—a contraindication—in women requesting them. For refugees, the estimated family planning coverage was 17 per cent (see Table 2).

The results of the 1999 survey showed that the contraceptive prevalence among refugees in the organisation's catchment areas—that is, the percentage of refugee women of reproductive age (15–49) who did not wish to become pregnant and who used a modern FP method—was markedly higher (25 per cent; Howard et al., 2008) than the national Guinean average (5 per cent) reported in the *Demographic and Health Survey Guinea 1999* (Macro International, 2000). Higher demand and improved supply may both have contributed to higher contraceptive prevalence in RHG's catchment area.

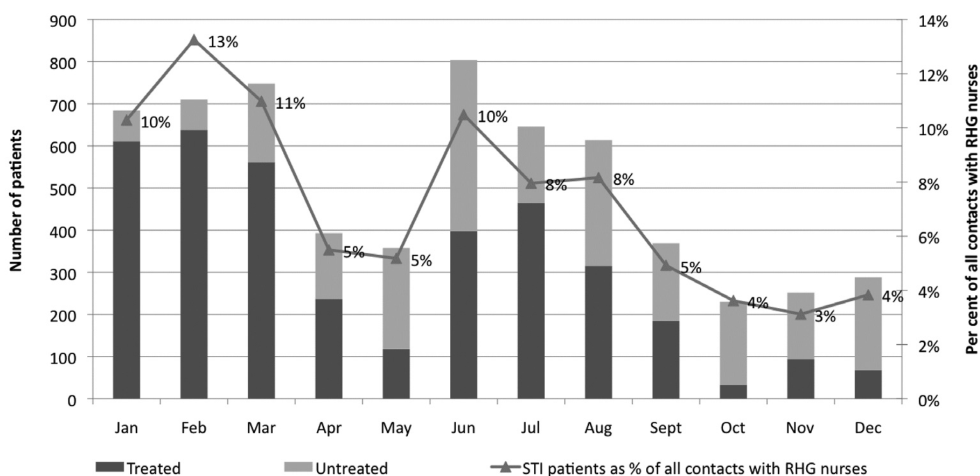
STI identification and treatment

At the end of 1998, all RHG nurses and their Guinean counterparts were trained in STI management following a *syndromic approach*. The International Rescue Committee funded some of these workshops and provided three-months' supply of anti-STI drugs to various health posts. However, the nation-wide chronic shortages of anti-STI drugs remained a very serious challenge for RHG.

The need for effective STI treatment was underlined by the results of the 1999 RHG survey (Chen et al., 2008): 27 per cent of the refugees interviewed reported to have experienced genital ulcers, genital discharge or both during the past 12 months. When women who had experienced only discharge were excluded, the alarming figure of 18 per cent remained. However, the survey also suggested that RHG clients, when compared to non-RHG clients, knew more about STI and their prevention, and reported more appropriate behaviour when perceiving STI symptoms on themselves.

In 1999, RHG nurses identified 6,096 STI patients, representing seven per cent of all contacts. Figure 2 shows how the number of STI patients, and the proportion of all RHG contacts attributable to STI were highest when suitable antibiotics for STI treatment were available. It is likely that RHG nurses were less inclined to diagnose STI when they were unable to treat them, and that STI patients were less motivated

Figure 2 Number of STI patients identified by RHG nurses in 1999, differentiated in those who received treatment and those left untreated due to lack of drugs



Source: authors.

to seek treatment from health facilities when they did not expect to find there the necessary medication.

Community-based counselling and distribution of contraceptives

The RHG facilitators formed the link between community and health facilities. They took advantage of all kinds of contacts and group gatherings to provide information and advice on RH and to distribute condoms and spermicides. They encouraged pregnant women to attend ANC, couples to use FP, or those experiencing STI symptoms to seek treatment together with their partner. Where necessary, they accompanied anxious first-time clients to their midwife colleagues at the health facilities. Working in local teams with the RHG midwives allowed them to follow up patients in the community and to remind women to get their next supply of contraceptives or to attend their ANC appointments.

In 1999, the facilitators had 87,260 individual contacts with community members, equivalent to an average of 112 contacts per month per facilitator, and 44 per cent of these were with new clients. For 94 per cent of clients the facilitators provided counselling, for 37 per cent they provided counselling followed by referral to a health facility, accompanying half of these 37 per cent to the health facility. Six per cent of clients requested condoms or spermicides without counselling.

Throughout 1999, facilitators easily distributed all condoms and spermicides supplied to them by the district pharmacies, amounting to 1,158 CYP. Given the continuous high demand, this figure could have been much higher had more condoms and spermicides been made available. One reason for the district health services' reluctance to provide more contraceptives or STI drugs to RHG providers was the considerable delay in reimbursement of services delivered to refugees by UNHCR.

Drama groups and youth-oriented activities

RHG used drama, music and traditional dances to attract large audiences in camps and towns, enabling them to reach groups who were less interested in talking with facilitators, namely young people and men. In 1999, 14 RHG drama groups of young refugees, often supervised by RHG facilitators, conducted regular performances spreading RH messages to audiences of several hundred refugees.

Since March 1999, RHG organised weekly 'Youth Nights' at the RHG central office in Guéckédou town. RH-related videos were shown followed by discussions and presentations by nurses and facilitators. Drama groups gave performances and there were quizzes and competitions on RH questions as well as music and dancing. What began with just 20 to 30 youngsters quickly grew to events hosting approximately 300 young people each time.

How did RHG change RH provision and coverage for refugees?

The Guinean health services' ANC coverage (first ANC visits) for refugees before RHG became involved is estimated at 'between 11 per cent and 42 per cent' at different sites (van Damme, 1998, p. 182). In contrast, in 1999, RHG reached an ANC coverage of 54 per cent for refugees in their catchment area (Table 2).

According to van Damme (1998), '0.75 per cent of women between 15 and 44 [used] FP services offered at health centres' of whom 'between 10 and 30 per cent were refugees' (p. 182). In contrast, RHG's data from 1999 show that RHG providers met 17 per cent of FP needs among refugees (Table 2).

Resources needed to make RHG work

Human resources

RHG's core staff were its 36 nurses and 75 facilitators. These were managed by the coordinator and her deputy, four supervisors (who ensured monthly supervisions to all nurses and facilitators throughout a large catchment area), a youth coordinator, a data administration officer and a financial clerk.

Responding to the management team's request in August 1998, GTZ appointed a part-time technical advisor (Anna von Roenne) who assisted in the development of information systems, organisational tools, training modules, reports and proposals. The local UNHCR medical coordinator advised RHG on medical issues and helped coordinate RHG's activities with other actors in the refugee health sector.

Finances and equipment

The German government financed RHG between 1996 and 2000, covering most RHG workers' remuneration, training organised by RHG, overheads and recurrent costs as well as materials and equipment, including two pick-up cars and motor bikes

for the supervisors, three computers, two printers, a power generator for office operations, and a mobile generator for events in the camps. From 1999, the American Refugee Committee (ARC) took on funding the remuneration of 15 of the 75 facilitators as well as RHG nurses' and facilitators' participation in training workshops organised by ARC. Including these contributions, the financial support to RHG in 1999 amounted to an equivalent of USD 164,350.

RHG members themselves contributed a minimum of four per cent of their monthly remuneration as membership fees to their organisation's funds. These contributions were not used to cover running costs but meant to help start RHG activities in the members' countries of origin. They were used to cover the costs for registering RHG in Liberia and in Sierra Leone in 2000 and 2001, respectively.

How the RHG story ended

After the 1999 regional peace accord, there were hopes that the political situation in Sierra Leone would stabilise and the Sierra Leonean refugees began to prepare for their return. Instead, in the second half of 2000, rebel activities extended into Guinean territory and directly affected the refugees. In September, rebels began shelling and vandalising Guéckédou town and refugee camps, including hospitals, health centres and health posts throughout Guéckédou and Kissidougou districts. RHG members, like their fellow refugees, had to flee once more, across the border to Liberia or towards the Guinean capital some 800 kilometres away, or to hide 'in the bush'. The RHG office was destroyed and looted and one of the RHG cars was stolen. All expatriate staff evacuated to the Guinean capital, where, eventually, many members of the RHG management team arrived and established a crisis committee to ensure RHG's further operations.

Following these events, based on the notion that the existing refugee camps had provided bases for the rebels, UNHCR began to establish new, larger camps, located further away from Guinean cities and borders. This ended the integration of services for Guineans and refugees: each larger camp received its own health post, and UNHCR entrusted international NGOs such as MSF or ARC—so-called implementing partners—with running them. At the same time, the German government discontinued its financial support to RHG, as its bilateral refugee RH programme had reached its scheduled end. While the German government continued to provide humanitarian assistance to refugees in Guinea, focussing on improving road and camp infrastructure, this aid was no longer part of the long-term German–Guinean development cooperation, and could therefore no longer be included in the health sector cooperation. For RHG this meant that they now had to compete with very experienced international NGOs for UNHCR funding.

Throughout 2001 and 2002, RHG tried to convince UNHCR and the international implementing partners that it had the institutional capacities and the human resources to become an implementing partner itself for reproductive health services. The UNHCR office in Guinea rejected this on the grounds that there were 'already

too many implementing partners' (personal communication with Anna von Roenne) and that 'local NGOs' could not obtain this status. RHG then suggested to several international implementing partners that they subcontract the RH part of their commissions to RHG, given that RHG facilitators and nurses had provided exactly these services to the same refugees for the past four years. In some cases, the international NGOs agreed to pay RHG for nurses and facilitators 'lent' to them, yet none of them was prepared to reimburse RHG's organisational costs (overheads). These international NGOs simply needed staff and did not recognise the added value of having an effective, independent refugee organisation manage and provide the RH services for their own community.

Most RHG nurses and facilitators who had stayed in Guinea worked under RHG as long as they could. When RHG could not pay them for several months and international NGOs offered them individual work contracts for higher salaries, they gradually moved over to them. However, most of them stayed in touch, always ready to return to the organisation they had taken such pride in as soon as new funding would become available.

Following the rebel incursions in 2000, a number of Liberian RHG nurses and facilitators returned to Liberia where they reassembled and gained a number of contracts as RHG Liberia, the sister organisation that RHG Guinea had registered in the previous year. In the same vein, RHG's Sierra Leonean vice-coordinator registered RHG Sierra Leone in 2001 and a number of returnee midwives and facilitators joined her in seeking new tasks and funding for the rebuilding of reproductive health services in their country.

What was special about RHG and what can we learn from it?

Key lessons from this Guinean example are:

- first, that it is possible to have RH services planned and implemented by refugees for refugees;
- second, that to accomplish this, organisations of refugee health workers require sustained funding and technical assistance;
- third, that international humanitarian organisations, like UNHCR and major NGOs, pay insufficient attention to the potential benefit of supporting local NGOs; and
- finally, that technical assistance should prioritise monitoring and evaluation to ensure programme effectiveness as well as organisational development, which can strengthen democratic procedures and accountability in refugee organisations.

The reorganisation of refugee camps that followed the rebel incursions of the year 2000 put an end to an exemplary model of RH service provision in long-term refugee situations. The above account shows how, in this model, refugee health workers were responsible for all aspects of their RH programme, including management,

planning, and monitoring and evaluation. In addition to building on, and strengthening, their coping skills and self-esteem, this represented capacity development for the rebuilding of health systems in the refugees' countries of origin.

On a less positive note, the RHG experience highlights that UNHCR and international NGOs are not always willing or able to involve refugee organisations in the provision of services for them. This may in part be due to practical concerns and bureaucratic hurdles, but it is at odds with UNHCR and others' explicit commitment to involve refugees in planning and provision of their reproductive health services.

The hiring and training of refugee health workers by international NGOs does contribute to individual capacity building of those health workers. However, supporting, in this case, midwives to organise themselves to run an organisation adds another dimension to capacity building (Lauten, 2007). As was the case for the health sector examples from Afghanistan (Palmer et al., 2006) and Guinea with RHG, grooming local NGOs during conflict periods may have a positive effect during the post-conflict phase. It provides an example of how relief can be linked to development and is in line with recently formulated principles for delivering health services in fragile states and difficult environments (Oswald and Clewitt, 2007).

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2 The first initiative was called the Women's Working Group. In 1996, when registered as an NGO, it became the Regional Working Group. In 1998, the newly elected coordinators renamed it the Reproductive Health Group to underline their new beginning.

3 Couple-years of protection (CYP) are the estimated duration of protection provided by contraceptive methods based on the quantity of all contraceptives sold or distributed free of charge. They are calculated by multiplying the quantity of each method with a conversion factor representing the duration of contraceptive protection per unit of that method. The CYP for each method are then summed up to obtain an overall CYP estimate.

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