HEALTH CLUSTER

OUADDAÏ AND WADI FIRA, CHAD

# The Minimum Initial Service Package for Sexual and Reproductive Health

## PROCESS EVALUATION

JUNE 2025

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# Abbreviations and Acronyms

| | |
|---|---|
| **ANC** | Antenatal care |
| **ARVs** | Antiretrovirals |
| **BEmONC** | Basic emergency obstetric and newborn care |
| **CEmONC** | Comprehensive emergency obstetric and newborn care |
| **CHW** | Community health worker |
| **CNARR** | National Refugee Resettlement Commission (Commission Nationale pour l'Accueil et la Réinsertion des Réfugiés et des Rapatriés) |
| **COUSP** | Public Health Emergency Operations Center (Centre des Opérations d'Urgence de Santé Publique) |
| **DOSSMF** | Directorate for the Organization of Health Services and Financing Mechanisms (Direction de l'Organisation des Services de Santé et de Mécanisme de Financement) |
| **DMPA-SC** | Self-injectable contraceptive (Subcutaneous Depot Medroxyprogesterone Acetate) |
| **DSR** | National Reproductive Health Department (Direction de la Santé de la Reproduction) |
| **EC** | Emergency contraception |
| **EmONC** | Emergency obstetric and newborn care |
| **FGD** | Focus group discussion |
| **GBV** | Gender-based violence |
| **HFA** | Health facility assessment |
| **HIV** | Human immunodeficiency virus |
| **IAWG** | Inter-Agency Working Group for Reproductive Health in Crises |
| **IARH** | Inter-Agency Reproductive Health kits |
| **IOM** | International Organization for Migration |
| **IPV** | Intimate partner violence |
| **IUD** | Intra-uterine device |
| **KAP** | Knowledge, attitudes and practice |
| **KI** | Key informant |
| **KII** | Key informant interview |
| **KMC** | Kangaroo mother care |
| **LBW** | Low birth weight |
| **MISP** | Minimum Initial Service Package |
| **MOH** | Ministry of Health |
| **MVA** | Manual vacuum aspiration |
| **NGO** | Non-governmental organization |
| **PAC** | Post-abortion care |
| **PEP** | Post-exposure prophylaxis for HIV |
| **PLWHIV** | People living with HIV |
| **PMTCT** | Prevention of mother-to-child transmission of HIV |
| **PN-PTME** | National PMTCT program (Programme National de Prévention de la Transmission du VIH/SIDA de la Mère à l'Enfant) |
| **PPA** | Provincial pharmacy store (Pharmacies Provinciales d'Approvisionnement) |
| **PSLSH/IST** | Sectoral Program to Fight against AIDS, Viral Hepatitis, and STIs (Programme Sectoriel de Lutte contre le SIDA, hépatites virales et infections sexuellement transmissibles) |
| **SRH** | Sexual and reproductive health |
| **SRHR** | Sexual and reproductive health and rights |
| **STI** | Sexually transmitted infection |
| **TBA** | Traditional birth attendant |
| **UNFPA** | United Nations Population Fund |
| **UNHCR** | United Nations Refugee Agency |
| **USG** | United States Government |
| **WASH** | Water, sanitation and hygiene |
| **WHO** | World Health Organization |

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# Executive Summary

This evaluation assessed the implementation of the Minimum Initial Service Package (MISP) for sexual and reproductive health (SRH) in response to the Sudanese refugee crisis in Eastern Chad. With over 800,000 new arrivals since April 2023, the evaluation focused on eight refugee camps across Ouaddaï and Wadi Fira provinces—each with population sizes rivaling Chad's largest cities. We used a mixed methods approach: interviews with 16 NGO/UN key informants, 9 health facility assessments and 10 refugee focus groups.

While the existing humanitarian infrastructure enabled a rapid SRH response early on in Chad—including the deployment of experienced midwives and provision of Inter-Agency Emergency Reproductive Health Kits by UNFPA—severe shortages of trained staff, inadequate facility infrastructure, competing priorities, limited community outreach and funding cuts have severely strained the humanitarian response. This has resulted in ad hoc coordination—particularly at the field level, where SRH coordination has been absorbed into broader health cluster meetings. Funding cuts have led to facility closures, staffing reductions, and stockouts, threatening sustainability amid a growing refugee population.

## What is the MISP?

The **Minimum Initial Service Package (MISP) for SRH in Crisis Situations**, developed by the Inter-Agency Working Group on Reproductive Health in Crisis (IAWG), comprises the *minimum*, lifesaving sexual and reproductive health needs that humanitarians must address at the onset of an emergency (within 48 hours wherever possible). It includes six key objectives: 1) coordination, 2) preventing sexual violence, 3) reducing HIV/STI transmission, 4) preventing unintended pregnancies, 5) ensuring safe childbirth, and 6) planning for comprehensive SRH services. The MISP provides a roadmap for communities to deliver critical care in crisis while laying a foundation to transition to a more comprehensive suite of SRH services (ideally within 3 to 6 months) as communities recover.

Most **health facilities** (8 out of 9) operated 24/7 with at least one midwife, solar power, water, and free services for refugees and host communities. However, staffing was inadequate for the case load. While midwives generally supported SRH and reported providing MISP services, only 41% had MISP training, and just 27% demonstrated adequate SRH knowledge. Some newly posted midwives lacked essential SRH skills, raising concerns about recruitment and oversight.

- Most health facilities offered **clinical management of rape,** including emergency contraception, post-exposure prophylaxis for HIV, and referrals for psychosocial support, although trained psychosocial and case management staffing was inadequate. Follow-up of referrals was weak. Gender-based violence (including intimate partner violence) was widespread and underreported, according to refugee focus groups, with limited access to justice and comprehensive care.
- Health facilities had basic infection control infrastructure and offered **HIV/STI services**, including ARVs, but shortages of HIV test kits constrained access to prevention of mother-to-child transmission. Condoms, though available, were limited to distribution at the health facility, reducing access. Refugees expressed confusion about local HIV prevalence and treatment options.
- **Basic emergency obstetric and newborn care (EmONC)** was widely available, but comprehensive EmONC and care for low birth weight infants were limited to referral hospitals, often located far from the camps. Challenges included shortages of trained midwives, referral delays, and reduced training due to funding cuts. Refugees reported long distances and high cost of transport as a reason for relying on home births. In a few camps, refugees reported dissatisfaction with the maternity services.

- **Contraceptives** were widely available in health facilities, but stockouts of popular methods were common. Midwives supported access to contraception, but training gaps and USG funding cuts affected provision. Refugee women supported contraception despite stigma and mixed perceptions from the male population.
- **Post-abortion care** was generally available, but **safe abortion care** was largely absent due to legal ambiguity and a lack of training. Refugees reported that unsafe abortions were common, driven by stigma, fear, and lack of access.

Despite the early availability of supplies to implement the MISP, continued refugee influxes, limited storage, and last-mile delivery challenges have led to frequent **supply** stockouts, especially of contraceptives, and concerns about future procurement—especially following USG funding cuts.

Long distances and transport costs, and overcrowding at facilities also hindered **access to services**. Services are expected to become even harder to access during the rainy season as flooding limits travel.

Opportunities remain to deepen refugee involvement, clarify abortion laws and reduce stigma. **Community engagement** is critical to make sure that refugees understand when and how to access care. However, at present, broader efforts to engage communities at scale in normalizing SRH are minimal.

Refugee **community health workers** (CHWs) and maternity assistants played a vital role in bridging health services and refugee communities. They supported health education, referrals, and maternity care—often acting as trusted liaisons due to shared language and cultural familiarity. However, their impact was constrained by low incentive pay and staffing reductions due to funding cuts, which limited outreach and follow-up capacity. Health facilities had an average of 15 CHWs, but this was inadequate for camp populations exceeding 30,000 people.

In Chad, key informants still described the response as feeling like an emergency. While the MISP was implemented relatively quickly, growing refugee arrivals and recent aid cuts have eroded service delivery. The main barriers include shortages of qualified midwives, inadequate supplies, weak coordination and insufficient community engagement. Strengthening midwife capacity, securing sustainable funding and improving supply chains are critical for maintaining lifesaving SRH services.

This evaluation underscores the importance of effective implementation of the MISP in Chad, which is a critical lifeline in crisis settings—laying the foundation for restoring sexual and reproductive health services, safeguarding women's rights, and ensuring access to the full scope of care they need.

## Priority Actions

### The country health cluster and SRH working group should:

- Improve coordination at provincial and district level. As the SRH working group lead, UNFPA should designate someone in each province (or ideally district) to be responsible for ensuring that SRH is discussed in Health coordination meetings if a separate SRH group doesn't make sense

### Implementing partners and governments should:

- Improve integration of clinical services with case management services for GBV survivors, including tracking of completed referrals
- Recruit additional qualified midwives appropriate for the increasing client load and ensure adequate BEmONC training, including all signal functions, for all midwives to reinforce treatment of most obstetric complications at health center level given delays with referrals
- Strengthen supply chain for contraceptives, including timely and correct procurement, to reduce stockout
- Ensure good quality non-judgmental PAC services are available at all heath facilities and implement innovative strategies to increase access to safe abortion care, including harm reduction strategies to provide information on correct dosage of misoprostol to use.
- Engage in health system strengthening, including strengthening the capacity of relevant governmental institutions

### Donors should:

- Require and ensure sufficient budget for MISP implementation and hold implementing partners accountable for all MISP objectives

# 1. Introduction

The Minimum Initial Service Package for Sexual and Reproductive Health in Crisis Situations (MISP) is a set of priority lifesaving sexual and reproductive health (SRH) services and activities to be implemented at the onset of every humanitarian emergency to prevent excess SRH-related morbidity and mortality. Over the past 25 years, the MISP has become a minimum standard in humanitarian response, and it is therefore imperative that its content reflects current evidence and best practice, and that a formal process evaluation be undertaken. Informal reports from recent responses suggest that the delivery of SRH services has become disorganized, deprioritized, or even arbitrary, amidst some global restrictions on women's health and empowerment. As SRH needs within the humanitarian sector continue to grow, the humanitarian community needs learnings and consensus on how to direct limited funds so as to have greatest impact.

## 1.1 Overview of sexual and reproductive health in Chad

Chad faces substantial SRH challenges, with one of the highest maternal mortality ratios in the world at 748 maternal deaths per 100,000 live births [1]. According to the World Health Organization (WHO), a 15-year-old girl in Chad faces a one in fifteen lifetime risk of dying from maternal causes. With low modern contraceptive prevalence of 8.6% [2], Chad has high unmet need for contraception. In 2019 31.0% of married women and 64.5% of unmarried women of reproductive age reported an unmet need for contraception [2]. In addition, Chad has a severe shortage of qualified health workers, with 0.6 per 1000 population in 2019, well below the WHO norm of 4.45 per 1000 [3]. These health system issues are chronic due in part to Chad's limited resources, with only 4.5% of the national GDP allocated to the health sector in 2018 [4]. In 2022, Chad committed to increasing the budget for health to 15% of the State's general funding [3]. While no formal SRH working group exists similar to the one that is part of the humanitarian response, SRH issues are discussed among MOH Office of Reproductive Health and partners in the triannual meetings of the *Plateforme SRMNIAN*, joint national platform for coordinating and monitoring interventions related to reproductive, maternal, newborn, child and adolescent health and nutrition in connection with the Global Financing Facility.

Chad's overall HIV prevalence is 1.6%, with an estimated 69,000 women over the age of 15 living with HIV in 2024 [5]. To combat HIV, the Government of Chad launched the Prevention of Mother-to-Child Transmission of HIV (PMTCT) Programme in 2005. This initiative aims to prevent HIV transmission during 3 critical stages: pregnant, childbirth, and breastfeeding, and completely eliminate mother to child transmission by 2030 [3,6]. Chad is also actively working to address gender-based violence (GBV) and has adopted the National Gender Policy in 2017 [7] and the National Action Plan for Women, Peace, and Security in 2023 [8], which outlines strategic priorities for protecting women's rights and strengthening prevention and response to GBV.

Chad has signed, but not ratified, the Maputo Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa [9]. In 2002, the Government of Chad passed Reproductive Health Law 006 that guarantees an individual's right to SRH regardless of age or marital status [10,11]. Although this law permits safe abortion when necessary to save a woman's life or protect her health, the decree of application was only passed in 2018 by the Council of Ministers and awaits the validation and signature of the President and the penal code has not been updated [12,13]. Guidelines for providers have not yet been developed meaning that safe abortion is still largely unavailable. Despite these legal advances promoting SRH and rights (SRHR), implementation remains inadequate. This gap between policy and practice leaves health providers without clear guidance and limit access to essential SRH services. To address these critical issues, the Government of Chad committed to reduce maternal mortality to 564 maternal deaths per 100,000 live births and expand comprehensive emergency obstetric and newborn care (EmONC) by 2030 [3]. The Government made a commitment to FP2030 to increase contraceptive prevalence to 22% and ensure that "all Chadians and refugees who have found asylum in Chad will have access to family planning services at any time and anywhere, and exercise their sexual and reproductive health rights through a system resilient and equitable health system, with the full participation of the community for sustainable development" [14].

## 1.2 Humanitarian context in Chad

Chad is facing multiple humanitarian crises: the Sudanese refugee crisis on the Eastern border, Boko Haram attacks and internally displaced populations in the Lake region, and conflict and instability in the Central African Republic on the southern border. In addition, climate change causes increasing drought, flooding and food instability in Chad. This evaluation focused on the Sudanese refugee crisis in the East.

Chad remains the second most affected country by the Sudanese crisis after Egypt, hosting 31% of Sudanese refugees, with thousands of new arrivals each week [15,16]. Chad already hosted over 400,000 Sudanese refugees who fled 2003 Darfur violence. Humanitarian needs in the refugee camps surged after violence resumed in Sudan in April 2023, bringing more than 800,000 new refugees as of August 2025 [17]. The National Refugee Resettlement Commission (CNARR), UNHCR, and IOM have been relocating the influx of Sudanese refugees from several border entry points to existing and new camps across four provinces in Eastern Chad: Ennedi Est, Ouaddai, Sila, and Wadi Fira, the vast majority of whom are in Wadi Fira and Ouaddaï [17]. More than 150,000 new refugee arrivals have been registered through mid-August 2025 [18]. The continuing influx has put immense pressure on limited national resources overwhelming the capacity of the much smaller local population. For example, the population of Iridimi refugee camp (90,981) would make it the fourth largest city in Chad. UNFPA estimates there were 1,265,000 women of reproductive age and 219,170 pregnant women in the camps in August 2025 [19].

## 1.3 Minimum Initial Service Package (MISP) for Sexual and Reproductive Health

In order to provide effective SRH services to populations in crises, the MISP was established by the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises as a set of priority activities to be undertaken in a coordinated manner by trained staff at the onset of an emergency. When implemented in the early days of an emergency, the MISP is intended to save lives and prevent illness, especially among women, newborns, and girls. The MISP includes priority actions and guidelines to: 1) ensure SRH coordination; 2) prevent and respond to sexual violence; 3) prevent transmission of HIV and other STIs; 4) prevent excess maternal and newborn morbidity and mortality; 5) prevent unintended pregnancies; 6) plan for comprehensive SRH to be integrated into primary health care; and 7) ensure safe abortion care to the full extent of the law (see MISP Reference for more information).

To support implementation of the MISP, UNFPA designed a pre-packaged set of Inter-Agency Reproductive Health (IARH) Kits that contain essential medicines, supplies, and equipment. The IARH Kits are intended for the early stage of an emergency as the contents of the kits are designed for three months and for a particular number of people. The IARH Kits have been formulated so that each kit responds to the priority activities of the MISP, such as rape medical treatment kits, blood transfusion kits, clean delivery kits, and midwife delivery kits.

# 2. Purpose and objectives of the evaluation

The MISP process evaluation was conducted in June 2025 in Eastern Chad, which hosts 1.4 million refugees, over 800,000 of whom arrived since the resurgence of violence in Sudan in April 2023. The evaluation focused on the response to new arrivals since 2023 in the Ouaddaï and Wadi Fira provinces, which, at the time, were receiving the largest influxes of refugees.

The objectives of this evaluation of the MISP were to:

- assess the extent to which the MISP has been implemented.
- identify the availability, accessibility, and use of MISP services.
- describe the facilitating factors and barriers to the implementation of MISP activities and services.

# 3. Methods

## 3.1 Study design

The evaluation used a mixed methods approach consisting of key informant interviews with NGO and UN staff, health facility assessments, focus group discussions with refugees, and review of service delivery data. The team visited 8 refugee camps in Ouaddaï and Wadi Fira provinces that hosted new arrivals. Six were new camps; two were extensions added to existing camps (Farchana and Milé). The population sizes of six of these camps places them among the top 10 largest cities in Chad, meaning they dwarf the local population.

**Table 1**

**Refugee camps visited**

| **Ouaddaï** (n=653,900) | **Refugee Population** | **Wadi-Fira** (n=263,789) | **Refugee Population** |
|---|---|---|---|
| Aboutengue | 46,680 | Iridimi | 90,981 |
| Allacha | 47,522 | Koursigue | 13,106 |
| Arkoum | 50,131 | Milé | 61,946 |
| Farchana | 32,225 | Touloum | 56,611 |

Data source: Ajala platforme de coordination de la réponse à l'urgence (August 2025)

## 3.2 Data collection procedures

### 3.2.1 Key informant interviews

Key informant interviews (KII) were conducted with a purposive sample of key stakeholders engaged in SRH-related programming and service delivery in the selected camps and in overall coordination. 13 interviews were conducted with 16 key informants (KIs) who managed health, SRH and/or GBV programs (Table 2). The SRH/Health KIs represented 3 INGOs, while the GBV KIs represented 2 local NGOs. We also interviewed SRH/Health and GBV KIs at 2 UN agencies. Most interviews were conducted individually in the participant's office or other private location they selected. Two interviews were conducted in a dyad and triad. In addition, the team held a few short discussions with staff at a few additional NGOs.

**Table 2**

**Number of key informants interviewed**

| | **SRH/Health** | **GBV/Protection** |
|---|---|---|
| UN | 3 | 3 |
| NGO | 6 (1 national) | 4 (all local) |
| **Total** | **9** | **7** |

### 3.2.2 Health facility assessments

Nine health facility assessments (HFAs) were conducted in 7 health centers, 1 health post and 1 hospital located in or near the camps to assess the availability, accessibility, quality, and utilization of the SRH clinical services of the MISP. A new (less than one month) health post was also visited in Iridimi but not formally assessed given its still transient nature and temporary staff. This health post did, however, have a midwife who provided antenatal (ANC), emergency contraception (EC) and post-exposure prophylaxis for HIV (PEP) to rape survivors, syndromic STI diagnosis and management but no contraception or safe delivery care.

Facility assessments were completed on paper forms. The hospital and health post were NGO facilities. All of the health centers were Ministry of Health (MOH) facilities supported by NGOs. In some cases, health centers were built inside the refugee camps and were largely NGO staffed and run but had an MOH facility director, while other MOH health centers were located in villages near the camps. Notably, some of these facilities experienced increased capacity due to the humanitarian response. In Koursigue, for example, the MOH health center nearest the new camp recently expanded their staffing and hours to be 24/7, with UN and NGO support, after the arrival of the refugees. MOH-built health centers were traditionally quite small, only 2-3 rooms, so most needed construction to increase the size to accommodate the increased population. One health center visited in Arkoum camp was new as of May 2025; previously, it had been a temporary health post to alleviate overcrowding at the nearby MOH health center.

Twenty-one female midwives and one male nurse completed a knowledge, attitudes and practice (KAP) assessment on a tablet using KoboToolbox. Eighteen providers worked in seven of the visited camps (the remaining four worked in other camps not visited but whom the team found at an NGO office for a training). In three of nine assessed health facilities, midwives did not have time to complete the assessment tool due to a high number of clients. A midwife in a very new health post also completed an assessment, although given the lack of infrastructure and permanence, the health post was not formally assessed.

### 3.2.3 Focus group discussions

Ten focus group discussions (FGDs) were conducted with 15-45 year old female (n=6) and male (n=4) refugees in six camps, for a total of 100 participants. Participants were identified by community health workers; in most cases, a convenience sample of community members meeting the age and sex criteria who were at or near the health facility were selected. FGDs were primarily held at the health center, in a quiet location.

## 3.3 Data analysis procedures

KIIs and FGDs were audio recorded with participant consent. KII recordings were transcribed and reviewed by the evaluation team. FGD recordings were transcribed in teams of two: local colleagues translated from Arabic into French for a partner who typed up the translation. Transcripts were reviewed and coded by MISP objective and cross-cutting themes. The evaluation team summarized the findings under each theme for the report. Facility assessment data were reviewed on paper forms and summarized in tables. The provider KAP data was imported into SPSS for analysis using frequencies.

## 3.4 Ethical considerations

At the time of the interview or focus group, the interviewer read an information sheet about the study that provided a clear and concise presentation of the key information about the evaluation. After reviewing the information sheet with the participant, the interviewer obtained verbal informed consent from all participants. Interviews and focus groups were audio recorded with participants' consent. Transcripts of the interviews and focus groups contained no personal identifying information. The evaluation received approval from the Institutional Review Boards of Columbia University, the International Rescue Committee and the Chadian Ministry of Health.

# 4. Results

The MISP Process Evaluation findings are presented in the following sections:

1. MISP awareness and knowledge
2. Objective 1: Coordination of the MISP
3. Overall health facility infrastructure and functioning
4. Objective 2: Prevent and manage the consequences of sexual violence
5. Objective 3: Prevent the transmission of HIV and other STIs
6. Objective 4: Prevent excess maternal and newborn morbidity and mortality
7. Objective 5: Prevent unintended pregnancies
8. Objective 6: Plan to integrate comprehensive sexual and reproductive health into primary health care
9. Other priority of the MISP: Safe abortion care to the full extent of the law
10. Facilitating factors and barriers to the implementation of the MISP
11. Additional concerns among Sudanese refugee population

## 4.1 MISP awareness and knowledge

Most KIs suggested that MISP was introduced early in the crisis, even if not fully implemented immediately. Most were aware of the MISP, primarily because many of them currently or previously worked for one particular NGO that prioritizes SRH. Indeed, many referenced the trainings or MISP information they previously received when employed with this specific INGO . The GBV KIs were less likely to have heard of MISP. Several other factors were noted as contributing to MISP awareness:

- Trainings: UNFPA organized two MISP trainings in 2025 for district medical officers and NGO staff. These trainings included an orientation to the IARH Kits, their content and how to order them. One NGO staff member also mentioned attending a MISP training organized by UNFPA and MOH in 2021.
- Previous exposure: KIs referred to the rapid deployment by UNFPA of 'humanitarian midwives' who had substantial experience working in Eastern Chad and who knew MISP. Several NGOs that were already providing comprehensive SRH services in existing refugee camps were able to draw on their existing services and staff in the new emergency response.

## 4.2 Objective 1: Coordination of the MISP and related activities

The coordination of SRH and GBV services faced substantial challenges due to systemic gaps and funding constraints. The SRH working group, led nationally by UNFPA, was reactivated in 2024 in response to the new emergency in Sudan. The national working group has Terms of References and meets monthly in N'Djamena. UNFPA, however, lacked dedicated staff at the field level, leading to ad hoc coordination efforts. At local or provincial level, due to limited staff and competing priorities, the decision was made to not establish a separate SRH working group, leaving the Health Cluster as the only body responsible for discussing SRH coordination. Few NGOs had separate SRH managers, so the same Health manager would attend both Health and SRH meetings. In some locations, Health and Nutrition were also merged as well. Previously UNFPA led SRH sub-cluster meetings in Adré until their focal point departed. UNFPA deployed a senior midwife in Abéché for coordination which they acknowledged was a bit far to effectively fill this role, so she focused more on managing supplies with occasional missions to the field. UNFPA coordinated with UNHCR health staff, who they believed did promote SRH. Health cluster meetings were held monthly at provincial level, and more frequently (usually bi-monthly) at district level. These meetings were MOH-led, but with substantial support from WHO, UNHCR and other NGOs.

> *And [coordination of] sexual and reproductive health is practically non-existent. It is not very active because there are no meetings. Health meetings – yes; nutrition meetings – yes. But focused solely on reproductive health – no. There is no technical group like that or any coordination on SRHR, even though this package is offered; there is no coordination at that level.*
>
> **KI, HEALTH/SRH NGO**

A GBV/Protection subgroup existed, led by UNFPA, at provincial level. However, it often operated without consistent participation from health actors, as staff were frequently too overburdened to attend meetings. District level GBV/Protection meetings occurred under the leadership of UNFPA or the local GBV/Protection partner. An INGO that previously filled this role closed operations earlier this year after the loss of United States Government (USG) funding, and a local NGO subsequently hosted these meetings. Participation by health partners was limited.

### 4.2.1 Inter-Agency Emergency RH (IARH) Kits and other SRH supplies

Most NGO KIs mentioned that they received IARH kits. UNFPA delivered 175 IARH kits to the Eastern provinces in 2024; the largest number were related to maternity care and contraceptive implants (Annex). In the first 5 months of 2025, they delivered 74 kits, over half of which were for maternity care, including clean delivery kits, as well as post-rape treatment and STIs. Despite consistent availability early in the crisis, UNFPA was unable to keep up with the continued large influxes of refugees in 2025 and expressed concern about 2026. UNFPA also described use of Provincial Pharmacy Stores (PPA) to preposition kits, though these were based in the provincial capitals which are not closest to where the need was. These PPAs are government entities, so sometimes lacked sufficient space to store kits as they also held WHO and other medical supplies, including UNFPA-supplied contraceptives. Last mile delivery was described as a challenge, e.g. moving the kits from the PPAs to the camp health facilities, particularly given the lack of storage space in the camps. UNFPA stored more kits in N'Djamena, and sent them out when ordered, so they went directly to the health facility or NGO partner.

UNFPA's senior midwives routinely followed up with NGOs to ask about Kit utilization, and whether they used all of the contents. They identified some issues, for example when the Kit itself had a 2027 expiration date, but some products inside the kit had earlier expiration dates. UNFPA was working on a study of Kit utilization.

In addition to the IARH kits, UNFPA's development arm also provided contraceptives. The ordering process for these was different than for the Kits – they had to originate from the health facility to the PPA, via the MOH District office.

A few KIs referenced a need to improve or better support health centers' logistics and ordering systems to prevent delays. However, everyone – KIs and refugees - described frequent stockouts of contraceptives, particularly the most popular methods (injectables and implants). Some KIs reported that the quantity of contraceptives that District MOHs received from UNFPA ran out quickly.

Most KIs said they obtained HIV testing kits and ARVs for PMTCT and for people living with HIV (PLWHIV) from the District MOH. Although most described minimal problems with ARV supplies, a few mentioned running out of HIV tests given the high numbers of ANC clients in the camps.

While UNFPA acknowledged placing a large order for IARH kits in 2024 which helped meet the need in 2025, they were concerned about procurement for next year given the recent USG funding cuts. This presents a substantial problem given that kit availability already isn't meeting the demand of the continued rising numbers of refugee arrivals. Some KIs did mention pursuing international procurement processes due to lack of local sources, but described these as subject to long delays in receiving supplies.

## 4.3 Overall health facility infrastructure and functioning

All assessed health facilities, except the health post, functioned 24/7 with at least one midwife and one nurse present at night (Table 3).

- All had some form of solar power, with the health post reporting outdoor solar lights only, and 2 health centers reporting functional solar power only in the maternity. The hospital also had a generator.
- Health facilities reported receiving water deliveries from WASH partners. Two reported occasional shortages, while the others said their water supply was sufficient as health centers received priority regarding the camp water supply. All health facilities had sex segregated toilets for patients.
- The health facility directors said the number of health workers was insufficient for the client load.
- Eight health facilities had a mean 15 CHWs per health facility. The hospital had more community agents across multiple categories (health promoters, CHWs and TBAs).

- Health services were free for all clients, although some mentioned a US$0.20 fee for a notebook (personal medical record) on their first visit. In one camp served by an MOH health center that was newly supported to serve the refugees, some refugees referred to being asked to pay for care if they hadn't yet received their official refugee card. However, health facility staff reported that services were free for both refugee and host populations.
- All health facilities reported access to an ambulance via telephone, though they were sometimes based at other health facilities or camps and used by several partners. Ambulance services were free for all, refugees and host community members, with the exception of referral to tertiary care. While transport to the tertiary level (e.g., in Abéché) was provided free for refugees, host community members were asked to pay.

The distance to referral hospitals ranged from 10 to 50km. For many camps, the road to the referral facility traversed wadis (dry riverbeds) which would fill up during rainy season making access even more difficult.

The majority of midwives who completed the KAP assessment reported providing MISP services in the last 3 months, and having been trained to provide them (see Figures under each objective). Only 41% reported receiving specific training on MISP. Most midwives had attitudes towards SRH that would lead to good quality service delivery with 77% responding favorably to 75% or more of the 20 attitude statements. However, only 27% correctly answered more than half of the 18 knowledge questions. The lack of well-trained midwives was a substantial gap which will be described further in the next sections. In one assessed health center, the two midwives present seemed completely unprepared for their role and said this was their first posting after finishing midwifery school. They reported being unable to provide most SRH services beyond ANC and short-acting contraceptives (they were not asked to complete the KAP assessment). The Health coordinator for the NGO supporting this health center (who was himself new to his organization) described his frustration at the lack of qualified midwives there. When probed, he said the midwives were recruited by the District MOH, which received funding to pay them from a UN agency – a process in which the funders had little input to ensure minimum standards.

**Table 3**

**Health facility infrastructure (n=9)**

| | |
|---|---|
| Functions 24/7 | 8 |
| At least one qualified provider on site during the night and on weekends | 8 |
| Functioning power supply | 8 *(mostly solar)* |
| Functioning water supply | 9 *(primarily delivery)* |
| Toilets for patients, separated by sex | 9 |
| Ambulance transportation available | 9 |
| Sufficient health workers for client load | 0 |
| Average number of CHWs per facility | 15 *(range 10-24)* |

### 4.3.2 Community participation in service delivery

Refugees were engaged in health care in three main ways.

- Each health facility had a **community management committee** (*CoGes*) made up of refugees (and host population for health facilities located outside the camps). However, in existing camps, these committees were dominated by refugees who arrived before 2023, leaving newer arrivals under-represented.
- Most health facilities reported engaging refugees as **assistants in the various health center services**. All assessed health facilities had refugee midwives or trained traditional birth attendants (TBAs) working in the maternity. All were referred to as 'matrons', but some were likely qualified midwives. Both KIs and refugees indicated the presence of trained clinicians among the recent refugee population, which generally had a higher education level than earlier arrivals. One KI specified that in their health center in an existing camp that also had new arrivals, they made an effort to recruit refugee staff from among both the old and new populations. Refugee staff were paid an 'incentive' rather than a salary which the refugees complained was too low. KIs suggested that these refugee providers were a good liaison between the health facility and the community, and more successful at communicating with the refugees.

- All NGOs recruited refugee **community health workers (CHWs)**, some evenly split between men and women, but often majority female. CHWs, who were generally supervised by health facility staff, provided health education, including SRH, and visited pregnant women and malnourished children to encourage them to go to the health facility. Most respondents said the numbers of staff and CHWs had decreased this year due to funding cuts despite the increased population size.
- A few KIs and refugees referenced toll free numbers or boxes where refugees could submit complaints or concerns about services or programs that were regularly reviewed.

### 4.3.3 Access to SRH services

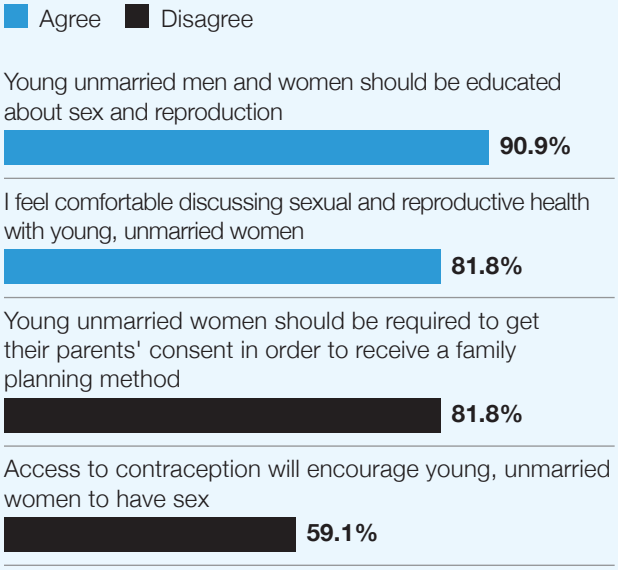
Both KIs and refugees described long distances to the health facility. Refugees repeatedly emphasized the long distances and transport costs as barriers to access to care. Auto rickshaws were seen as expensive (US$2-10 depending on distance), but few other transport options existed. Some refugees described delays with care seeking until a condition became serious. NGOs have introduced mobile clinics or health posts in the larger camps to reduce the distance people needed to travel, but these were more limited in the services they provided. Some NGOs reported recently ending some of these due to funding cuts, while others had very recently set up temporary health posts that were not yet fully functional. It was unclear how coordinated these efforts were as one health post we visited was located near a health center, rather than further away. Most KIs and refugees said that access issues were likely to increase with the coming rainy season – particularly for secondary care - as the roads from some camps to the nearest hospital were impassable after a heavy rain.

Some refugee women spoke of disrespectful treatment from midwives and long waits at the health facility. They also raised concerns about reduced staff and lack of medicines in a few camps. Men added frustrations with ambulance delays and high transport costs, emphasizing that services did not meet their needs. Refugees in a few camps were unaware that the health center functioned 24/7, although most knew that a provider was available at night and on weekends even if the facility was closed for routine consultations. One health center in particular received many complaints about its limited functioning hours although staff at the facility said it was open 24/7. Language barriers and lack of confidentiality were mentioned a few times. Women said they were not always understood by midwives, while men echoed concerns about poor communication and a lack of trust in staff. While most refugees expressed good treatment by providers, those in two camps expressed concern about the midwives' competency and skills. Refugees of both genders stressed that community education is primarily focused on women, leaving men uninformed about SRH.

Midwives at all health facilities said they provided contraception to any adolescent, although midwives at one health center seemed less comfortable with this and said the adolescents preferred condoms. However, only 41% of midwives who completed the KAP assessment correctly identified that all reversible contraceptives were appropriate for adolescents. Midwives also reported mostly favorable attitudes towards adolescent SRH (Figure 1). While some community education targeted adolescents, youth groups or adolescent specific activities had not been established in the new camps. Some adolescents and midwives expressed concern about confidentiality or their ability to access services without being seen by other refugees. In all health facilities, contraception was provided in the maternity, which made unmarried adolescents feel less comfortable going.

**Figure 1**

**Midwives' attitudes towards adolescent SRH (n=22)**



Few efforts were mentioned to improve access for people with disabilities. Some ramps at entrances were seen in older health facilities, but in most cases, people with disabilities had to depend on their family members to help them access care. A camp president mentioned that some refugees who were injured or disabled during their flight from Sudan lacked care. No mention of outreach or services to people of diverse gender identities was mentioned.

## 4.4 Objective 2: Prevent sexual violence and respond to the needs of survivors

Most of the assessed health facilities provided clinical management of rape services, including provision of EC and PEP (Table 4). Health facilities reported minimal stockouts of these supplies. The health post, which did not provide GBV services, referred cases to the nearby health center instead, while the midwives at one health center said they lacked training. All health facilities had private rooms – usually in the maternity – to see survivors although that room was usually used for all SRH consultations. Midwives referred clients for psychosocial or case management support either internally within the health facility, or externally to a partner organization. Referrals for safe abortion services were nearly nonexistent, as legal exceptions (e.g., to save a woman's life) were rarely applied. Many of the GBV cases were among women who had been raped weeks or months earlier – especially during their flight from Sudan - with no opportunity for EC or PEP.

Referral systems between GBV case management and clinical services were weak, although protocols and referral forms existed, with limited follow-up on whether survivors accessed medical or psychosocial care after a referral. KIs reported a lack of trained psychosocial support and case management staff for the increasing numbers of refugees. For example, a camp often had only a few case managers to serve all GBV clients. In general, they reported that Chad had a lack of skilled psychosocial support staff. The abrupt closure of the Lead GBV NGO following USG funding cuts was also still being felt as responsibilities were slowly transitioning to a local NGO.

The majority of midwives reported providing clinical management of rape services in the last three months (Figure 2). For example, 73% disagreed or strongly disagreed with the statement "Sexual violence doesn't count if it's between two people in a committed relationship".

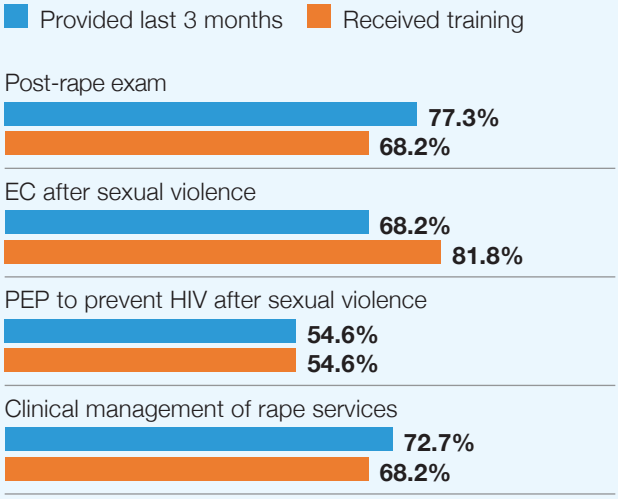
**Table 4**

### Clinical management of rape services available (n=9)

| | |
|---|---|
| GBV services provided in this health facility | 7 |
| *Main reason GBV services **not** provided* | *Lack of training (1), refer to nearby facility (1)* |
| Emergency contraception (EC) | 7 |
| Post-exposure prophylaxis (PEP) for HIV | 7 |
| Antibiotics to prevent sexually transmitted infections (STIs) | 7 |
| Treatment of injuries | 7 |
| Referrals for protection/psychosocial support | 8 |

**Figure 2**

### GBV service provision and training (n=22)



Few organizations offered comprehensive GBV services. One-stop centers providing medical, psychosocial, and legal support (*Centres Intégrés de Services Multisectoriels*) were set up in Abéché and Adré, though their distance from refugee camps limited accessibility. Staff said transportation support was available but the refugees were unaware or found it inadequate. Protection mechanisms, such as safe housing, were absent, leaving survivors dependent on temporary relocation by UNHCR. Legal pathways existed but were underutilized due to stigma and procedural delays.

Community engagement efforts included CHWs conducting education about GBV and referring cases for care, with KIs reporting that inconsistent messaging across organizations and funding shortages limited their impact.

Refugees described GBV as a persistent and serious issue. Both men and women reported that women and girls were attacked outside the camp, particularly when they left to collect firewood. Some refugees mentioned hostility from the local community driving some of the attacks. Some FGDs reported that violence inside the camps was also a problem. Some participants said GBV was worse in the past or for new arrivals, but others insisted it remained common.

Refugees emphasized that rape survivors rarely received justice or adequate care: cases were hidden due to shame, fear of damaging marriage prospects, or because security authorities were seen as ineffective. In some cases, a woman or girl may go the health facility but not tell the midwife what happened; some may feel more comfortable disclosing the rape to a refugee matron who speaks her language.

Both men and women acknowledged that intimate partner violence (IPV) also occurs in the camps, driven by economic stress, including food shortages, and gender inequities. Women spoke of men demanding their wives' earnings, sometimes responding violently if refused. Some survivors seek help, though IPV was largely hidden.

## 4.5 Objective 3: Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs

Health facility staff described adequate infection prevention procedures, including autoclaves for sterilization of equipment and incinerators to burn medical waste (Table 5). Although all reported the availability of PEP for GBV clients, only 5 reported its use for occupational exposure (though some were unsure). However, only half of health facilities reported they had adequate supplies for infection prevention given the high client load. The one assessed hospital located in a camp reported providing blood transfusions, although KIs reported that safe blood transfusion was available only at the referral hospitals.

**Table 5**

**Infection prevention (n=9)**

| | |
|---|---|
| Autoclave | 9 |
| Incinerator | 9 |
| Sharps separated / sharps boxes used | 9 |
| Blood transfusion | 1 |
| Post occupational exposure treatment for staff | 5 |
| Adequate supplies for infection prevention (self-reported) | 5 |

HIV and STI services were largely available (Table 6). All health facilities reported having male condoms, ARVs and prophylaxis for opportunistic infections for PLWHA as well as ARVs for HIV-positive mothers and their newborns for PMTCT. In one health center, despite availability of ARVs, two new midwives said they lacked training and skills to provide PMTCT. In some health facilities, condoms were only available in the maternity, while others said they were available in all consultation rooms. Syndromic diagnosis and management of STIs was available. Six health facilities reported having a laboratory, one of which shared a lab technician with another health center; two health centers said they could perform rapid tests only.

HIV testing kits frequently ran out due to high numbers of ANC clients, though ARVs remained generally available. Health facility staff and KIs reported that ARVs and HIV test kits were supplied by the MOH.

**Table 6**

**HIV/STI services (n=9)**

| | |
|---|---|
| Male condoms available | 9 |
| Female condoms available | 7 |
| ARVs available for continuing users (PLWHA) | 9 |
| Co-trimoxazole prophylaxis for opportunistic infections for PLHWA | 9 |
| ARVs given to HIV+ mothers for PMTCT | 8 |
| ARVs given to newborns born to HIV+ mothers in maternity | 8 |
| Syndromic diagnosis and management of STIs | 9 |
| Laboratory available | 6 |

Many sexual violence survivors sought care too late for effective HIV prevention measures. STI services relied on syndromic management, with partners often reluctant to participate in treatment. Women reported difficulties getting male partners to seek STI treatment. Some refugees arrived already aware of their HIV-positive status, having initiated treatment in Sudan, while others learned of their status in Chad.

Most refugees reported knowledge of HIV and STIs, including prevention and the importance of treatment. Some women admitted not knowing much, while others said they were informed through past education campaigns in Sudan. A strong theme was uncertainty about HIV prevalence and treatment. Some were unsure whether HIV was common in the camp. Most acknowledged testing was available but believed treatment was not, though some had heard otherwise. Both genders expressed confusion about where exactly to access treatment, suggesting a need for further community education.

Women and men complained that condoms are now scarce — previously accessible via CHWs but now only at health facilities. Men added that distribution should be discreet, as many fear stigma if seen asking for condoms. Both genders stressed a need for wider, more private access. Some stigma was noted. Women frequently blamed men for transmission, citing polygamy and extramarital relations, while men framed the issue in terms of general risk.

## 4.6 Objective 4: Prevent excess maternal and newborn morbidity and mortality

Overall safe delivery care and basic emergency obstetric and newborn care (BEmONC) was available in the camps (Table 6). All 9 health facilities conducted safe deliveries, and most provided 6 of the 7 BEmONC signal functions (assisted vaginal delivery was the exception). The two health facilities that did not provide BEmONC - one was a health post that lacked sufficient infrastructure, and in the other, the midwives lacked training - referred cases to nearby BEmONC health centers or the referral hospital. Staff at all assessed health facilities except the health post said at least one midwife present 24/7, although refugees in a few camps were unaware of this. All health facilities could call an ambulance to refer cases for cesarean section and blood transfusion as well as for low birth weight infants. Although the one assessed hospital provided blood transfusions, it lacked an operating theatre. A hospital in a camp not visited provided CEmONC for most camps in Ouaddaï. Otherwise, cases were referred to the nearest district hospital, many of which received some NGO or UN support. Many KIs described the overall weakness of the national health system and the need for additional support for CEmONC. Previously, many health facilities provided mama kits (eg, clean cloths to wrap the baby, mosquito net, etc) to women who delivered at the health center; these supplies were mostly no longer available at the time of the evaluation. Health facilities largely provided essential newborn care, although only the hospital treated low birth weight babies; all other facilities referred these cases.

Midwives largely reported providing and having training on BEmONC, including post-abortion care (PAC) (Figure 3). One NGO was organizing an EmONC training that very week, and midwives present for that training completed the KAP assessment, which may have overestimated these findings.

Multiple KIs described that in the early days of the current crisis, experienced midwives were sent to the reception sites and delivered babies there if there was no time to refer them to a health facility. One midwife talked about quickly identifying and briefly training TBAs to recognize danger signs, providing them with clean delivery kits and giving her mobile number in case of problems before health services were established.

**Table 7**

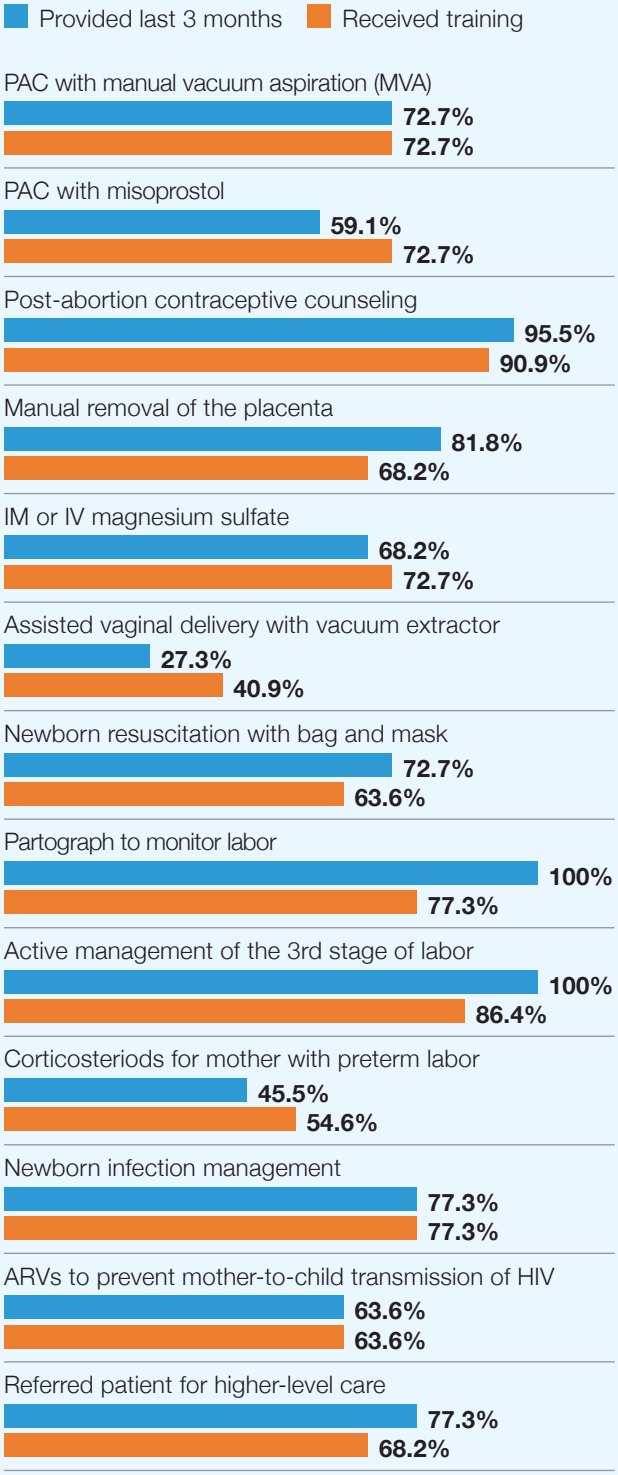
## Provision of Delivery and EmONC services (n=9)

| | |
|---|---|
| Normal deliveries performed | 9 |
| Parenteral antibiotics | 8 |
| Parenteral uterotonics | 7 |
| Parenteral anticonvulsants | 7 |
| Manual removal of placenta | 8 |
| Removal of retained products | 7 |
| Assisted vaginal delivery | 1 |
| Neonatal resuscitation with appropriate bag and mask | 7 |
| Caesarean section (CEmONC) | 0 |
| Blood transfusion (CEmONC) | 1 |
| Newborn care | |
| Support for immediate & exclusive breastfeeding | 9 |
| Prevention of infection (cleanliness, hygienic cord cutting and care, eye care) | 9 |
| Newborn infection management | 7 |
| Thermal care (including immediate drying and skin-to-skin care) | 8 |
| Management of low birth weight (LBW)/ preterm babies/kangaroo mother care (KMC) | LBW 1, KMC 4 |

The most frequently cited challenges with respect to maternal mortality were insufficient resources for the size of the population. The increasing numbers of refugees meant more women delivering babies, and more women with obstetric complications. However, only one ambulance served several health centers, and sometimes several camps. The distances to referral facilities were sometimes far. Providers reported sometimes waiting for an ambulance that was elsewhere which increased the delays in women reaching CEmONC. Others described the weak phone network delaying their calls for an ambulance. Midwives reported occasional delays in obtaining consent from the woman or her family for the referral. The coming rainy season will introduce further delays as the wadis (dry riverbeds) fill up and prevent timely travel.

**Figure 3**

## Basic EmONC, PAC, safe delivery and essential newborn care provision and training (n=22)



> *Now it's going to rain. That's why I accelerated this training so that the midwives on site could first master BEmONC... If, during this BEmONC, they already have this and they are on site, and there is a wadi, at least we will have someone who can do something to save the woman's life while the wadi subsides. But if we leave them like that, I think we will have a lot of deaths.*
>
> **KI SRH/HEALTH, NGO**

Most KIs and facility heads mentioned insufficient numbers of midwives for the population size, meaning they were overwhelmed in some camps. Data reported by UNFPA-supported midwives showed 14,650 deliveries in the first 6 months of 2025 in Eastern Chad compared to 16,750 in 12 months of 2024. Several KIs described recent funding cuts that further reduced the number of midwives, and attributed increased maternal mortality to this. UNFPA midwives reported 23 facility-based maternal deaths in Jan-Jun 2025 compared to 30 for all of 2024. In addition, new midwives arrived with insufficient skills and required additional training. NGOs sought funding, or called on UNFPA, to organize BEmONC training for their midwives. In the absence of funding, some provided on-the-job coaching with manikins and supervision to increase the midwives' skills. Refugees in two camps expressed frustration with midwives' lack of knowledge and competency. All health centers visited had refugee matrons - it was unclear how many were trained midwives from Sudan versus TBAs.

> *Now, is the number [of midwives] sufficient? No. We are not covered... It is UNFPA that helps us with senior midwives who have a lot of experience... So yes, there are qualified people, there are some, but there aren't enough. Because, you see, here they have five midwives, no, six midwives for a population of 56,000 people. And so, if one goes on leave, or two go on leave, they are left with four for 56,000.*
>
> **KI HEALTH/SRH, UN**

Both refugees and KIs mentioned that the refugees often arrived in communities with their own matrons and preferred delivering at home - particularly those who lived far from the health facility or had difficulties traveling at night. Some refugees said that matrons were present in each bloc to assist with home deliveries. All KIs said their CHWs provided education on identifying danger signs in pregnancy and encouraged health facility delivery. But they acknowledged that the number of CHWs had decreased due to funding cuts and were insufficient to adequately follow up with all pregnant women in the camps.

Both male and female refugees voiced frustrations about the long distances, lack of transport, and gaps in maternity services. Men emphasized the lack of facilities inside camps, particularly at night, noting that women sometimes delivered en route to hospitals. Women highlighted that midwives were not always available, ambulances arrived late, and many maternal deaths occurred while waiting.

> *But most women give birth at home because the center is very far from our camp, and our husbands don't have the money to take us to the center to give birth. Sometimes when we give birth at home and there are complications, they take us to the hospital.*
>
> **FEMALE REFUGEE**

While some refugee women said they preferred home births, citing distance, cost, lack of transport, and poor treatment at health centers, others noted that women went to health centers, particularly if complications arose, though experiences there were mixed. Some praised the care and availability of medicines, while others complained of neglect, disrespect, and lack of confidentiality. Refugee men similarly acknowledged both home and facility deliveries, emphasizing that poverty often drove choices.

Refugee men and women reported maternal and newborn deaths in the camps, though frequency estimates varied. Groups in newer camps, especially those who described the health facility as inadequate, described frequent deaths, while others said they were rare. Mama kits, once provided, were now inconsistent - further reducing the incentive to deliver at the health facility. The highest number of complaints about maternal deaths and incompetent midwives was in the camp served by the health center with highly inexperienced midwives.

## 4.7 Objective 5: Prevent unintended pregnancies

Contraceptive methods were widely available in the assessed health facilities (Table 8). The self-injectable (DMPA-SC) was available at several health facilities but none said they sent women home with additional doses to inject herself. All except one health facility reported that all methods were offered to adolescents. One health post, where the midwives seemed less comfortable with contraception, suggested that adolescents preferred EC or condoms. Several KIs described the lack of skills among new midwives with respect to long-acting reversible contraceptives, and the need for additional training. Several expressed a desire for UNHCR or UNFPA to organize this.

**Table 8**

### Provision of contraceptive methods (n=9)

| | |
|---|---|
| Male condoms | 8 (1 stockout) |
| Female condoms | 8 |
| Oral contraceptive pills | 9 |
| Emergency contraceptive pills | 8 |
| IUDs | 9 |
| Injectable contraceptives | 7 (2 stockout) |
| Implants | 7 (2 stockout) |
| All contraceptive methods offered to adolescents | 8 |

Midwives who completed the KAP assessment reported provision and training on long-acting reversible contraceptives (Figure 4).

Midwives likewise had largely favorable attitudes towards contraceptive access, with slightly less agreement when it came to men's role (Figure 5).

Despite this widespread availability, many health facilities reported problems with stockouts. Two health centers reported current stockouts of the most commonly used methods: injectables and implants, and one was stocked out of male condoms. Some KIs described receiving insufficient supplies from UNFPA, while UNFPA also described difficulties with last mile delivery. Some KIs

**Figure 4**

### Contraceptive service provision and training (n=22)

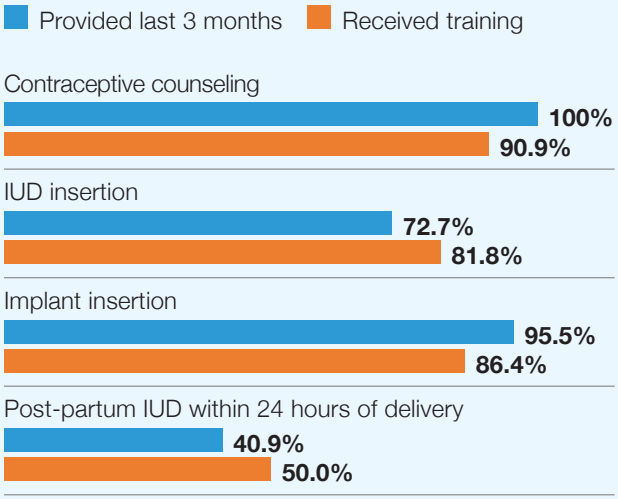
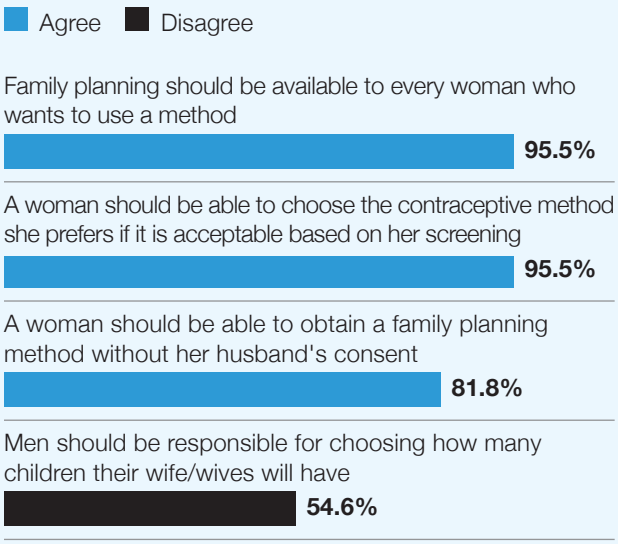



**Figure 5**

### Favorable attitudes towards contraception (n=22)



described a lack of knowledge of the process to order contraceptive supplies which needed to originate at the health centers and pass via the District MOH to UNFPA (for regular supplies, not IARH kits).

> *For reproductive health services, especially in camps, the biggest problem is with family planning supplies, or rather the quantity we receive, which is often low. And at the national level, we cannot purchase these supplies either, except through international orders. So for some projects, we can buy them for a while before they run out. But the quantity we receive from UNFPA, through the health district, is small, and we run out of it in no time. Above all, the most commonly used methods are in short supply.*
>
> **KI HEALTH/SRH, NGO**

Many KIs mentioned that contraceptive service delivery, and especially contraceptive supplies, was highly impacted by the recent USG funding cuts. UNFPA had substantial BPRM funding for contraception that was cut. Since contraception was not considered a 'life-saving' service, organizations that received USG funding scrambled to identify internal or other funding to cover contraceptive services.

Some KIs described contraception as taboo in the community. CHWs provided some community education about contraception. A few described incidents where a woman received a contraceptive method, but her husband complained and brought her back to remove it or threatened the midwives who provided the method. In more established camps, male CHWs focused on educating men about contraception to reduce this problem.

Most refugee women said that contraceptive services were available, with the exception of one camp where both men and women said the contraceptives at the health center were only for 'show' – for visitors or for educational purposes – but not to give to women (this camp was served by the health center with highly inexperienced midwives). Stockouts of some methods – usually injectables or implants - were major complaints.

Refugees' perspectives on contraception revealed sharp contradictions between and within genders. Women strongly expressed the need for contraception, linking it to safety in childbirth, preventing the burden of repeated pregnancies, and protection from controlling husbands. They said husbands viewed them as objects and refused contraception, leaving them continuously pregnant. Some women reported secretly accessing methods at markets or through health workers to hide use from their husbands, while others described a need to convince their husbands or bring them to the health facility so the midwife or matron could explain the benefits. Others described husbands who had been educated and now support contraception, even accompanying wives to the health center.

Men expressed more mixed views. Some argued contraception should be a couple's decision and resented midwives discussing directly with their wives. A few men believed contraception undermined morality, especially for adolescents, while others acknowledged it was necessary given the hardship of camp life. Some noted that in polygamous households, contraceptive use by one wife could cause conflict if not all wives used it. Yet other men admitted contraception was essential to avoid constant pregnancies when men spent all their time at home. Some men expressed a desire for education focused on them rather than only on women, although they also acknowledged that they were less likely to be found at home.

In short, women were generally supportive of contraception despite barriers, while men were divided — some opposed on moral or cultural grounds, others recognizing its practical necessity.

## 4.8 Objective 6: Plan to integrate comprehensive SRH services into primary health care

When asked about the transition to comprehensive SRH, many KIs referred to the fact that the refugee influx continued to increase and thus they considered themselves still in the emergency response phase. Existing health facilities were currently overwhelmed; some organizations were looking to set up new health facilities, or increase capacity at existing ones, to ensure access and reduce overcrowding. Recent funding cuts – resulting in fewer staff and supplies - combined with the increasing numbers of refugees threatened progress towards a transition to more comprehensive services. One GBV/Protection respondent described the futility of a recent protection assessment when many refugees still lacked shelter or adequate food, water and sanitation.

> *It's still difficult to talk about protection to someone who is hungry and thirsty and needs a home. … We all know that if we had responded to basic social services, the risks of people being exposed to the highest levels of vulnerability would have been reduced. But we are in a context where basic social services are virtually non-existent….It's like it's an exercise that we do just to say we've done it. Everything [the problems] there is huge… So [they ask] are the shelters safe? But people don't even have shelters, and you check to see if the shelters have light, if they're well ventilated?*
>
> **GBV/PROTECTION KI**

Others described weaknesses in the national health system, particularly with respect to human resources. Some UN KIs described seeking development funding to support health system strengthening in the East. But funding cuts plus the continued influx of refugees made a full transition to comprehensive SRH difficult.

Despite this, some transition to comprehensive had already begun, particularly where NGO-supported health facilities existed before 2023. Antenatal and post-natal care were widely available. Contraceptive education was provided, though the number of CHWs was inadequate. However, a robust community education and outreach campaign, including adolescent-focused activities, was yet lacking for new arrivals. Although it was unclear if patient-initiated HIV testing was available, provider-initiated testing was.

## 4.9 Additional priority: Provide safe abortion care to the full extent of the law

Post-abortion care (PAC) was available in 7 of 9 health facilities, all of which also provided post-abortion contraception (Table 9). The two health facilities not providing PAC reported a lack of training or equipment, e.g. manual vacuum aspiration (MVA) kits and misoprostol. Safe abortion care was mostly not available. One organization acknowledged providing medication abortion in some health facilities, with expatriate staff, and mostly under the radar. Midwives at two health centers within referral distance of one of these NGO's facilities said they referred abortion clients to them.

**Table 9**

**Provision of comprehensive abortion care (n=9)**

| | |
|---|---|
| Postabortion family planning | 7 |
| PAC with MVA | 6 |
| PAC with misoprostol | 6 |
| SAC with MVA | 0 |
| SAC with medication | 1 |
| Referrals for safe abortion care (if don't provide) | 2 |

*2 health facilities provided no post or safe abortion care due to lack of training and supplies.

Most KIs and providers referred to abortion as illegal in Chad, although a few mentioned a 'process' to obtain approval for an abortion via the Ministry of Health or of Justice. Chad's Reproductive Health law 006 permits abortion to save the health or life of the woman or in cases of fetal anomaly; however the guidelines to implement this law have not been put in place. Although some were unaware, many KIs said that abortion was common in the camps, though no data were available. They were only aware of the cases that came to the health facility to seek care for complications. Several described sexual violence survivors and adolescents as the ones who seek abortions.

Both refugee women and men in most camps acknowledged that abortions were common in the camp, usually carried out in secret, often with matrons' assistance or drugs from local drug sellers, and sometimes with dangerous methods or incorrect dosages. Women described abortion as a response to unwanted or dangerous pregnancies, particularly when women were already caring for infants, when pregnancies resulted from rape, or when young unmarried girls became pregnant.

> *There are some [abortions] in the camp, sometimes after rape, and others because the girl is not yet married, and the parents think it's shameful for them, so they prefer that their daughter aborts.*
>
> **FEMALE REFUGEE**

> *Just yesterday, a girl had an incomplete abortion and was brought here to the center for treatment. Since the prices of products have fallen, the abortion rate is very high.*
>
> **FEMALE REFUGEE**

Women highlighted the desperation behind these choices, noting the shame of unmarried pregnancies and the risks of repeated childbearing. Men, while less detailed, agreed that many abortions occur because women were "always pregnant" due to a lack of contraception.

Some said women with complications would eventually go to the health center, but others described deaths, infertility, and untreated complications when survivors avoided the health center out of fear. Both women and men highlighted the dangerous, clandestine nature of abortion in the camps.

## 4.10 Facilitating factors and barriers to the implementation of the MISP

### 4.10.1 Facilitating factors

While KIs described the challenging environment in which they worked, a few facilitating factors were mentioned. KIs believed the existing presence of humanitarian infrastructure and NGOs in the East permitted a rapid response. UN agencies and NGOs were able to quickly second staff to the border areas, and mobilized resources for mobile clinics and referrals to existing health facilities. They were able to quickly deploy experienced midwives who had worked in Eastern Chad to reception sites to support pregnant women. Given the long history in the area, many midwives had both good SRH and humanitarian experience. KIs also described the ability of UNFPA to quickly provide IARH kits as helpful. Some also referenced the provision of HIV tests and ARVs by the MOH. UNFPA staff believed the presence of the provincial pharmacies in the relevant provinces helped facilitate Kit deliveries to the region.

### 4.10.2 Barriers

KIs described a number of barriers to successful MISP implementation. Most frequently mentioned were concerns about human resources, particularly the number and capacity of midwives. Most KIs mentioned that the shortage of midwives for the size of the refugee population, for example, six midwives at a health facility that served 56,000 people. The shortage was related, in part, due to funding cuts for the humanitarian response. But, several also referred to severe weaknesses in the midwifery education system in Chad, with many newly trained midwives requiring substantial training to adequately provide SRH services.

Some KIs described limitations in the Chadian health system that hindered their ability to quickly implement MISP, and a need for health system strengthening. For example, existing MOH health facilities had only two or three rooms for all health services, making it difficult to provide adequate privacy for SRH services. Several reported a lack of hospitals with equipped operating rooms and equipment for cesarean sections. Many reported transport barriers where too few ambulances were available given the population size and distances to secondary care facilities.

Another barrier related to limited funding was the need for more community mobilization. The number of CHWs was insufficient for the population, for example, 10 CHWs to cover health (not only SRH) education and outreach for an entire camp of 30,000 people. Both KIs and refugees described a need for increased community mobilization and more CHWs to reach the increasing population. Improved community mobilization activities would build trust with the health facilities and reach people who lived furthest from the health centers.

Finally, KIs described the uncertainty around funding and short-term projects combined with continued influxes of new arrivals hindering their ability to plan and avoid gaps in services. For example, a few organizations were using internal funds to implement health posts or mobile clinics to improve access for refugees located far from existing health facilities while they sought longer term funding. While these short-term interventions filled an important gap, it was unclear how long they would function. The overall uncertainty around continued funding as well as substantial USG funding cuts impeded critical SRH service delivery.

Many KIs raised the issue of USG and other funding cuts in 2025, and their important impact on SRH. Many described reductions in the numbers of midwives which resulted in increased maternal deaths. Abrupt stop-work orders meant closing health facilities with no warning which also damaged trust with the refugee community. Budget reductions meant pulling back to the essentials. Reduced staffing meant few NGOs had SRH-specific staff. UNHCR and UNFPA both lost substantial funding that funded health service delivery,

supplies and medications. KIs attributed the closure of mobile clinics, health posts, and suspension of plans to upgrade and equip the maternity at an MOH facility serving a vastly increased population to the funding cuts. Funding for contraceptive methods and services was a particular concern. While several KIs described how they were pulling together small amounts of internal or external funding to fill the gaps for now, they worried about next year when UNFPA, for example, would receive no USG funding.

> *It's true that the reduction in nursing staff, midwives, and matrons is one of the difficulties. In the maternity ward, there are three midwives, which is frankly not good.*
>
> **FEMALE REFUGEE**

## 4.11 General concerns among target population

Refugees also raised concerns beyond SRH. Both men and women spoke about lack of housing for new arrivals, food shortages, malnutrition, and, in one new camp, unfair aid distribution. Women highlighted the heavy workload placed on them, while men complained that NGOs ignore men's needs, offering them neither jobs nor support. Adolescent girls expressed frustration with menstrual hygiene challenges, limited school access due to water collection duties, and lack of secondary education in the camps. Several complained about being asked to perform work, e.g. community education, for little or no compensation.

## Limitations

The assessment team was hosted by an active SRH Working Group member which managed health facilities in many camps in the two provinces before 2025 (when UNHCR transferred some to a different NGO). Many of the visited health facilities were currently or previously managed by this NGO which prioritized SRH so we may have overestimated MISP implementation. Similarly, many KIs working for other NGOs were former staff of this NGO. While was is good to see that they brought this SRH knowledge with them, we may have overestimated MISP knowledge. No MOH referral hospitals were assessed. The teams did not visit Adré where many organizations are based, and some coordination activities are centered. The provider KAP assessment tool was quite long, so some midwives were rushed completing it as they needed to get back to their patients which may have affected their comprehension of some questions, resulting in lower knowledge scores. Some could not take the time complete it, including two newly qualified midwives at one health center who reported a lack of training for most services during the facility assessment. Many of those who completed the assessment worked at health centers with strong SRH services suggesting an overestimate of overall midwives KAP.

# 5. Conclusions and recommendations

Chad is experiencing multiple humanitarian crises on three borders in addition to environmental stressors caused by climate change. The Chadian health system was already weak with severe shortages of qualified health personnel. Overall, MISP appeared to have been implemented relatively quickly when the emergency began in 2023. The presence of multiple humanitarian organizations and staff in the region following the 2003 Darfur crisis enabled them to quickly pivot to respond to the new emergency. Existing health facilities serving refugee populations provided a broad range of SRH services. However, the continuing (and increasing) influx of refugees has hindered MISP implementation as well as the transition to comprehensive SRH. In addition, the response in Chad was severely impacted by USG funding cuts this year – with multiple NGOs and UN agencies reporting lost funding. This has resulted in a substantial decrease in the number of program staff, midwives and CHWs as well as the closure or termination of mobile clinics – at a time when the number of refugees has substantially increased.

## Recommendations

### Objective 1: MISP Coordination

#### GOVERNMENT OF CHAD

- Strengthen coordination at the district level in partnership with humanitarian community
- Strengthen both primary and secondary level health services in districts that have received large influxes of refugees to improve healthcare for both refugees and host population

#### UNFPA

- Improve coordination at provincial and district level. As the SRH working group lead, UNFPA should designate someone in each province (or ideally district) to be responsible for ensuring that SRH is discussed in Health coordination meetings if a separate SRH group doesn't make sense

## Priority recommendations

1. Improve coordination at provincial and district level. As the SRH working group lead, UNFPA should designate someone in each province (or ideally district) to be responsible for ensuring that SRH is discussed in Health coordination meetings if a separate SRH group doesn't make sense
2. Improve integration of clinical services with case management services for GBV survivors, including tracking of completed referrals
3. Recruit additional qualified midwives appropriate for the increasing client load and ensure adequate BEmONC training, including all signal functions, for all midwives to reinforce treatment of most obstetric complications at health center level given delays with referrals
4. Strengthen supply chain for contraceptives, including timely and correct procurement, to reduce stockout
5. Ensure good quality non-judgmental PAC services are available at all heath facilities and implement innovative strategies to increase access to safe abortion care, including harm reduction strategies to provide information on correct dosage of misoprostol to use.
6. Strengthen the capacity of relevant governmental institutions for health system strengthening

## Objective 2: Prevent and manage the consequences of sexual violence

### UN/NGOs

- Improve coordination between SRH and GBV actors
- Improve integration of clinical services with case management services for GBV survivors, including tracking of completed referrals
- Improve safety around the camps, particularly for women and girls who leave the camp to seek firewood.
- Promote awareness of the availability of confidential GBV services, including both health and case management services, emphasizing the importance of seeking health care within 72 hours of an assault
- Engage men to improve safety and reduce IPV incidence among women and girls
- Establish One-stop centers or other safe spaces for women and girls in the camps to enhance accessibility (rather than the provincial capital)
- Recruit and train additional psychosocial and/or mental health specialists

## Objective 3: Prevent the transmission of HIV and other STIs

### MOH/UN/NGOs

- Ensure sufficient supplies of gloves and other infection prevention supplies for the increasing client load
- Make condoms available throughout health facilities, including the toilets, as well as supply CHWs with condoms to increase discreet access

## Objective 4: Prevent excess maternal and newborn morbidity and mortality

### GOVERNMENT OF CHAD

- Invest in midwifery education to increase the number of well-trained and qualified midwives
- Improve CEmONC capacity in each district to reduce the distance travelled to referral sites

### MOH/UN/NGOs

- Ensure adequate BEmONC training, including all signal functions, for all midwives to reinforce treatment of most obstetric complications at health center level given delays with referrals
- Recruit additional qualified midwives appropriate for the increasing client load
- Strengthen maternal and perinatal death surveillance and response to address increased maternal and newborn mortality
- Increase the number of ambulances given the population size to reduce referral times for obstetric emergencies
- Engage with the matrons in the blocs furthest from existing health facilities to determine their capacity as TBAs or trained midwives. Consider providing clean delivery kits and training them to quickly recognize complications and refer cases to the health facility.
- Strengthen local transport options to encourage women to come to the health facility, for example, by paying a local donkey cart driver which could also be an income generating option for refugees
- Increase access to and uptake of interventions that can be safely delivered in the community, reducing the burden on health facilities when appropriate care can be safely delivered at community level, for example, kangaroo mother care for LBW babies and distribution of misoprostol for prevention of post-partum hemorrhage

## Objective 5: Prevent unintended pregnancies

### GOVERNMENT OF CHAD

- Strengthen supply chain for contraceptives, including timely and correct procurement, to reduce stockouts
- Integrate DMPA-SC and other self-administered contraceptives into community health care norms and standards

### UN/NGOs

- Improve supply system for contraceptives, including timely and correct procurement, to reduce stockouts
- Identify local and/or regional suppliers of contraceptives to avoid delays in international procurement
- Train and equip CHWs with pills, EC, DMPA-SC, condoms for community-based distribution – particularly in blocs furthest from the health facilities
- Train women who choose DMPA-SC to self-inject and provide additional doses

## Additional priority: SAC

### GOVERNMENT OF CHAD

- Clarify and streamline the process to provide safe abortion within the law

### MOH/UN/NGOs

- Advocate for the full implementation of SAC as written in the 006 Reproductive Health Law, especially the president's signature on the decree of application and development of guidelines for providers.
- Implement innovative strategies to increase access to safe abortion care, including harm reduction strategies to provide information on correct dosage of misoprostol to use
- Ensure good quality non-judgmental PAC services are available at all heath facilities
- Ensure the population are aware of PAC services and their confidential nature to encourage utilization

## Objective 6: Plan to integrate comprehensive sexual and reproductive health into primary health care

### GOVERNMENT OF CHAD

- Strengthen health system capacity at district and provincial level to serve both the Chadian host population and high numbers of refugees
- Strengthen pre-service midwifery training to increase the number of well trained midwives

### UN/NGOs

- Engage in health system strengthening, including strengthening the capacity of governmental institutions: Public Health Emergency Operations Center (*COUSP, Centre des Opérations d'Urgence de Santé Publique)*, National Reproductive Health Department (DSR, Direction de la Santé de la Reproduction), National PMTCT program (*PN-PTME, Programme National de Prévention de la Transmission du VIH/SIDA de la Mère à l'Enfant*), Sectoral Program to Fight against AIDS, Viral Hepatitis, and STIs (*PSLSH/IST, Programme Sectoriel de Lutte contre le SIDA, hépatites virales et infections sexuellement transmissibles*), Directorate for the Organization of Health Services and Financing Mechanisms (*DOSSMF, Direction de l'Organisation des Services de Santé et de Mécanisme de Financement*)
- Identify reliable and diversified funding to support SRH service delivery, especially contraceptive services in the absence of USG funding
- Increase the capacity of existing health facilities, and increase the number of SRH service delivery points to meet the needs of the increasing population size and distances in the camps
- Increase the number of trained midwives in health facilities
  - Given the higher education levels among newly arriving Sudanese population, increase efforts to recruit and train midwives from among the refugee population to increase staffing. Those who are trained midwives and demonstrate their qualifications should be empowered to function as midwives rather than as TBAs.
- Provide training and supportive supervision on key SRH services, like BEmONC, clinical management of rape, post-abortion care and long-acting contraceptives
- Improve the overall supply and supply chain procurement and management, to prevent stockouts and ensure last mile health delivery of SRH supplies (including contraception)
- Increase community mobilization activities to better engage with and inform new arrivals

# Annex 1

## Number of IARH kits delivered by UNFPA for Eastern Chad response

| | | No. kits 2024 | No. kits Jan-May 2025 |
|---|---|---|---|
| Kit 2 | Clean delivery | 14 | 18 |
| Kit 3 | Post-rape treatment | 8 | 10 |
| Kit 4 | Oral and injectable contraception | 10 | 7 |
| Kit 5 | Treatment of STIs | 16 | 10 |
| Kit 6A | Clinical delivery assistance – midwifery supplies | 12 | 11 |
| Kit 6B | Clinical delivery assistance – midwifery supplies | 20 | 9 |
| Kit 7A | IUD | 14 | 0 |
| Kit 7B | Contraceptive implant | 50 | 0 |
| Kit 8 | Management of complications of miscarriage or abortion | 8 | 3 |
| Kit 9 | Repair of cervical and vaginal tears | 13 | 0 |
| Kit 11 | Obstetric surgery and severe obstetric complications | 7 | 6 |
| Kit 12 | Blood transfusion | 3 | 0 |
| | **Total** | **175** | **74** |

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