



Reproductive Health Access, Information and Services in Emergencies

The value of rapid RH response

Diana Barnes-Brown

Despite many challenges, life-saving reproductive health care can be effectively mobilised at the onset of crises, even when conditions are far from ideal.

For many years, reproductive health (RH) care was rarely regarded as a routine component of humanitarian medical response. More recently, humanitarian agencies have begun adopting practices that enable the integration of RH care into response strategies but there is still much to be done before RH care provision is considered part of the standard response in emergencies. To facilitate this process, the Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative provides both immediate and long-term assistance to humanitarian agencies working to provide RH services in the field. This article describes three situations in which RAISE has supported emergency provision of RH care at the onset of crises, at project sites in Kenya, Bangladesh and the Democratic Republic of the Congo (DRC).

Kenya

In the wake of the post-election violence and social unrest in Kenya, hundreds of people have lost their lives and approximately 300,000 have been displaced. Access to RH services has been disrupted for many. RAISE is supporting Marie Stopes Kenya (MSK) to work with the Kenya Red Cross Society and other partners to provide vital RH services in camps in Nairobi and in Rift Valley province. Humanitarian agencies are also referring survivors of gender-based violence (GBV) to MSK's centres for emergency medical treatment, including emergency contraception, post-exposure prophylaxis to minimise HIV transmission and treatment for sexually transmitted infections (STIs). Women are now visiting service sites to request contraceptive pills, injectable

contraceptives, hormonal implants, intra-uterine devices and emergency contraception. MSK is also supplying large numbers of condoms. In addition, many expectant mothers in the camps are receiving antenatal care and voluntary HIV counselling and testing services.

Staff have faced a number of challenges in the delivery of these services. One of the main barriers has been the lack of consistent supplies, due to the violence and insecurity. In addition, movement between regions has posed difficulties for MSK staff because of security concerns. Within the camps, insecurity at night makes it difficult and unsafe to respond to emergencies and to ensure that women have access to skilled attendants during delivery. In some camps, the camp organisers are uncomfortable with, or opposed to, the use of certain RH services, such as family planning, and this has been an additional barrier.

Bangladesh

On 15 November 2007 Cyclone Sidr hit the coastal areas of Bangladesh, devastating homes and harvests. By the end of December, an estimated 8.9 million people had been affected by the cyclone – with 3,347 dead and over 563,000 houses destroyed or severely damaged. Maternal health care in the two coastal districts of Borguna and Patuakhali was poor even before the cyclone, with 90% of all deliveries taking place at home and more than 50% of deliveries attended by non-medically trained birth attendants.¹

Save the Children USA used financial support from the RAISE Emergency Fund to implement components

of the Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations² in the wake of the storm. The objectives of the programme are 1) to increase access to skilled birth attendance and to emergency obstetrics care, 2) to ensure that universal health precautions are practised in all health facilities where Save the Children works and 3) to ensure continued availability of family planning methods. Project activities include identification, recruiting and training of Community Health Volunteers; ensuring availability of drugs and medical supplies; registration of pregnant and lactating women; supply of clean delivery kits (with information on how to use them) to women who are visibly pregnant; provision of newborn kits; and provision of transportation for emergency obstetric cases.

The programme had significant success, reaching more than 70% of the target population of visibly pregnant women and providing 6,000 out of a target 8,315 pregnant women with clean delivery kits. Medical supplies and drugs were provided for mobile clinics. In addition, Save the Children was able to mobilise more resources and funding to expand its emergency health response to cyclone-affected areas in Patuakhali and Borguna districts. Although five emergency obstetrics cases were successfully referred for care to the district hospitals, there is still concern that, with so many home deliveries, pregnant women in medical distress may not have full access to referral services and emergency obstetrics care.

DRC

Despite movements forward in the peace process for DRC, North Kivu province remains one of the most unstable and insecure areas in the country. The recent escalation of

fighting in the area is expected to uproot a large number of people. In response, Merlin (UK-based NGO) is using support from the RAISE Emergency Fund to provide RH services to people who have been displaced during intensification of the civil unrest and armed conflict in the region. Specifically, the programme supports two RH objectives: 1) to increase awareness and knowledge regarding the causes, consequences of and appropriate responses to GBV, HIV and AIDS, and other STIs and 2) to increase the technical capacity of Ministry of Health and community leaders in the prevention of and response to these. These activities complement Merlin's ongoing efforts in the management and referral of women with obstetric complications and women in need of family planning services.

Merlin held a series of focus group discussions with men, women and adolescents, which highlighted challenges in identifying causes of GBV and possible support and services for survivors. Both men and women tended to view women as being to blame for sexual violence, due to provocative dress and men's inability to control their sexual urges. Adolescent males reported that rape was a result of girls refusing sex, and some participants in the female focus groups indicated that there should be no interventions to address sexual violence, as drawing attention to the issue would simply result in further violence. The nearest hospital for treatment for survivors of sexual violence was reported as too far away for many women to reach. In addition, the focus group participants asked for family planning and HIV prevention services to be made available at the local health centre. In this case, treating both the causes and consequences of sexual violence has presented a complex set of factors with which field staff must contend.

Emergency realities

None of the challenges presented above are unique to their settings. For example, insecurity can have a major impact on the supply chain, with roads closed, whole regions inaccessible, and raids and looting of hospital pharmacies and other places where crucial supplies are kept. In addition, the imposition of night curfews prevents women being attended during delivery at night and does not allow for referral to EmOC services when an obstetric complication occurs. Coordination of supplies and movement in convoys can help to reduce the risk of ruptures in the supply chain.

In times of conflict, community leaders often act as gatekeepers, with considerable control over which services may or may not be provided, and which agencies or organisations may or may not be providers. As a result, access to RH services may not be allowed – even when providers have the capacity and training to provide them. Working closely with communities and their leaders, as well as with camp organisers, can help ensure that all RH services are available.

Availability of trained and experienced staff is a major challenge for all agencies responding to humanitarian disasters. It has long been recognised that there is a need

for emergency response rosters. However, many of the staff on these rosters may be neither skilled in RH nor aware of the need to provide RH services at the outset. As needs assessment progresses in subsequent stages of projects, it is necessary to supplement gaps in appropriately trained staff as soon as qualified and available candidates can be identified.

Coping with challenges such as those described above provides valuable lessons to be learned. In spite of the difficulty experienced while attempting RH service provision, however, all three sites discussed have succeeded in making services available where they would otherwise have remained unavailable or inaccessible. The process of recording and responding to emerging challenges will help staff and administrators to better understand what is needed to address similar challenges in the future.

Diana Barnes-Brown (db2472@columbia.edu) is Technical Writer/ Editor for the RAISE Initiative. For more information on the RAISE Emergency Fund or referral to partner programme contacts, please contact George Patterson, Grants Manager, at the RAISE Initiative (gp337@columbia.edu).

1. Bangladesh Demographic and Health Survey preliminary report 2007
2. www.rhrc.org/MISP/

Reproductive Health in Emergencies Conference 2008



JUNE 18 - 20, 2008 • Speke Conference Centre
Munyonyo, Kampala, Uganda

Reproductive Health in Emergencies Conference 2008 will bring together a wide range of actors from the fields of reproductive health (RH) in emergencies, global RH, humanitarian assistance and development to contribute to the expansion of comprehensive RH services in crisis settings. Reproductive Health in Emergencies Conference 2008 invites participants to join this important dialogue and help to ensure that refugees and internally displaced persons (IDPs) receive the comprehensive RH care to which they are entitled.

To register, please visit www.RHInEmergenciesConference.org

Organised by the RAISE Initiative in collaboration with the RHRC Consortium

RAISE

RHRC
CONSORTIUM