RAISE Reproductive Health Access, Information and Services in Emergencies

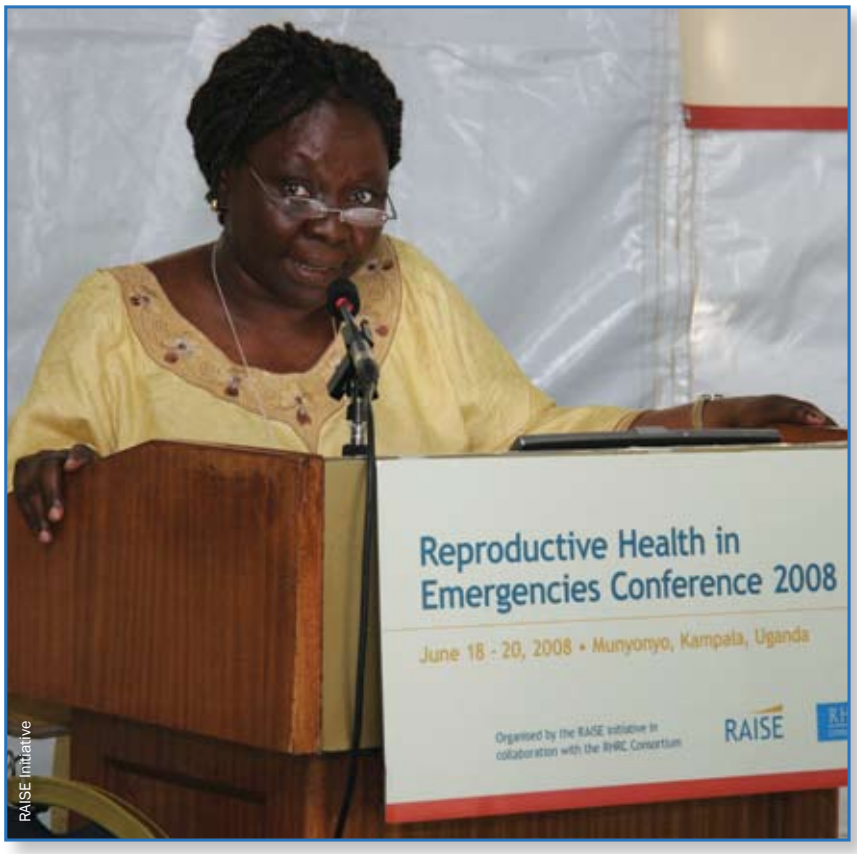
Reproductive health in emergencies: new initiatives, renewed commitment

Claire Tebbets

Reproductive Health (RH) in Emergencies Conference 2008 was held 18-20 June in Kampala, Uganda, to address current RH issues in emergency settings and to contribute to the expansion of comprehensive RH services in such settings.

The conference, a joint venture between the Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative[1] and the Reproductive Health Response in Conflict (RHRC) Consortium[2], was the third in a series of conferences dedicated to the topic of RH in humanitarian emergencies.[3] It brought together 485 professionals from the fields of RH in emergencies, global RH, humanitarian assistance and development from more than 50 countries worldwide.

There was a strong Ugandan presence at the conference, with more than one-quarter of participants attending from host country organisations. Uganda itself has a significant population of internally displaced persons (IDPs); recent estimates place the number at nearly one million. Thirteen presentations targeting issues of RH in conflict-affected areas of the country allowed Ugandan and international colleagues alike to address current challenges and opportunities in the field.



Dr Grace Kodindo addressing the conference.

"Make no mistake – reproductive health care saves lives and changes lives. It re-asserts the dignity of those from whom fundamental reproductive rights and human rights have been stripped." Therese McGinn, Director, RAISE Initiative

Outcomes

Throughout the conference, plenary and panel speakers echoed the sentiment that IDPs and refugees must be included in the planning and implementation of services. Additionally, the following key themes emerged from conference discussions:

1. Improving maternal health remains a priority. To this end, field staff must ensure access for all women to emergency obstetric care (EmOC), family planning, post-abortion care and safe abortion where legal. Such services are often not prioritised in emergency settings – but can be. Pentecostal Mission Unlimited Liberia reported positive results of a community-based family planning programme; in a region with a recent history of conflict, the programme has been successful in increasing contraceptive prevalence.[4]

2. Globally, sexual violence persists in conflict and disaster settings. Psycho-social support and clinical management of sexual violence, including availability of emergency contraception, post-exposure prophylaxis for HIV

IUD and implant demonstration.

and sexually transmitted infection treatment, are critical elements of gender-based violence response and should be launched in the early stages of an emergency. The public health community also needs to increase its commitment to the prevention and treatment of HIV and AIDS, services frequently overlooked in crisis settings. In the Central African Republic, the International Rescue Committee (IRC) found that, despite obstacles, coordination between primary health care teams and psychosocial teams can be established for successful implementation of confidential, safe and measurable response to sexual violence in the early stages of an emergency.[5]

3. Both relief and development organisations should prioritise capacity building and collaboration

New and under-utilised technologies

In addition to traditional panels, poster presentations and roundtable discussions, a new feature of RH in Emergencies Conference 2008 was a demonstration of new and under-utilised technologies. Participants visited 15 displays featuring hands-on exhibits, audio and video presentations, and discussions with experts. There they learned about – and practised using – tools and technologies useful for field practitioners working in RH in emergency settings, including the following:

US-based NGO PATH has developed two new contraceptives: a new female condom designed with extensive input from users,[9] and a next-generation diaphragm, designed for greater comfort and ease of use than previous models.[10] PATH has also developed a number of medication technologies, including single-dose Nevirapine applicators mothers can administer at home to prevent mother-to-child transmission of HIV.[11]

In the field, Marie Stopes International (MSI) staff use Marie Stopes Ligation (MSL), or minilaparotomy for tubal ligation, a tool valuable in emergency settings because it can be provided in low-resource settings and by a trained mid-level provider (where allowed by law). To facilitate the success of the procedure in such settings, MSI has also developed an MSL kit – containing all necessary equipment – that can be easily sterilised in an autoclave.

While certain comprehensive EmOC services can be provided only at the referral level, basic emergency obstetric and neonatal care (EmONC) services can be provided locally in low-resource settings. IRC has demonstrated the efficacy of this approach with displaced populations in Sudan, Pakistan and Liberia. With trained staff, the seven basic EmONC signal functions (administration of parenteral antibiotics, administration of uterotonic drugs, administration of parenteral anticonvulsants, manual removal of placenta, removal of retained products, assisted vaginal delivery and neonatal resuscitation) can be provided within a primary health care centre setting.

A new motorcycle ambulance suitable for use over rough terrain is now being put into service in countries such as Zimbabwe, Malawi and Uganda in order to transport patients, including women with obstetric emergencies, from remote settings to facilities equipped to provide lifesaving care.[12]

At the RAISE Eastleigh Training Centre in Nairobi, health workers receive clinical training in RH in order to improve the quality of care provided in refugee camps and hospitals in Kenya. During the conference, centre staff demonstrated correct insertion and removal techniques for contraceptive implants and intrauterine devices, using anatomical models (see photo above).

Human resources

Weak health systems are a threat to the health of women and their families in low-resource settings throughout the world. This is especially true in emergency settings where health facilities are often understaffed and unequipped – if not lacking altogether. These conditions pose serious challenges to the provision of good RH services.

One solution proposed in recent years is the utilisation of mid-level providers to offer essential services. In countries like Mozambique, Malawi and Tanzania, assistant medical officers, clinical officers and surgical technicians are carrying out procedures previously done only by physicians. In these countries, mid-level providers are performing the majority of Caesarean sections at district hospital level, among other procedures. In addition to offering both a cost-effective solution to a lack of human resources and improved staff retention rates over physicians, the quality of care provided by mid-level providers is equivalent to that provided by physicians.[13]

Recruiting and retaining health workers has proven challenging in northern Uganda, where those working in conflict zones often lack the training to provide quality RH care. In response, Pius Okong, President of the Association of Obstetricians and Gynaecologists of Uganda, suggests that associations of health care professionals should establish emergency response teams equipped to organise RH services in crisis settings, as well as create a database of local providers trained in RH care in emergency settings, in order to facilitate a rapid response.[14]

with local actors. Dr Fred Akonde, of RAISE and Marie Stopes Kenya, reported that one of the main challenges in implementing RH services in crisis settings is the lack of training among field staff. Through his work at the RAISE Eastleigh Training Centre in Nairobi (see box opposite), Dr Akonde has shown that competency-based training for health workers can improve the quality of RH care provided in such settings.[6]

4. Strengthening health facilities and systems is essential to the provision of quality RH services in emergencies. Two crucial components of this process are strengthening the human resource sector (see above) and improving logistics and supply management.

Expert opinion: Dr Grace Kodindo

"In the West, one woman in 2,800 dies as a result of pregnancy or childbirth. In Chad, that number is one in eleven. The situation can be yet worse for refugees and IDPs. The solution is clear: we need stronger health systems and increased access to good quality RH care.

Basic technology available in the West since the 1950s is lacking in many developing countries, contributing greatly to health disparities. Blood transfusions, Caesarean sections and essential drugs like antibiotics, magnesium sulphate and oxytocic drugs can make all the difference. In many places I visit there is no functioning health system – not even a blood bank. Haemorrhage is one of the primary causes of maternal death; a woman can die in as little as two hours from blood loss. We need blood banks and other basic care, together with appropriately trained staff, to be available to all women in our countries.

We also need to increase health care coverage, especially in rural areas. In such areas, health centres can function well without a doctor or a specialist, or even a fully trained midwife. Mid-level providers can offer the basic care needed at the local level and refer complicated cases to higher-level facilities."

Now an advisor to the RAISE Initiative, Dr Kodindo is a leading expert in the organisation and implementation of RH services and the improvement of EmOC services in order to reduce maternal mortality.

"Now we must accelerate efforts to scale up reproductive health services for refugees, displaced persons and people affected by disasters." Thoraya Obaid, Executive Director of UNFPA, in a statement written for RH in Emergencies Conference 2008

5. Numerous challenges confront both supply chain and transport management in crisis settings, ranging from organisational capacity to national policies.

6. Within the already vulnerable populations of refugees and IDPs, youth and other under-served groups, such as sex workers, are especially at risk; particular attention must be paid to their RH needs. To this end, Save the Children has developed an adolescent RH service package for RH managers and health workers to address adolescent RH needs in humanitarian emergencies.[7]

7. The public health and development communities must make better use of data.[8] It is vital to collect good quality data and use it to improve service delivery and programme management in emergency settings. Data can act as a powerful tool for advocacy and must be brought to policymakers, donors and programme staff.

"Though I am somewhat overwhelmed by the scope and the amount of work yet to be done to improve the health of women in crises, I am leaving with energy and commitment to ensure that the news is better next time we meet!" Conference participant

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1. www.raiseinitiative.org
2. www.rhrc.org
3. The fourth conference will take place in 2011. For more information about RH in emergencies and the programme and abstracts of the 2008 conference, see www.raiseinitiative.org
4. RH in Emergencies 2008 Book of Abstracts, p13: www.raiseinitiative.org/conf2008/
5. Abstracts, p71 6. Abstracts, p7 7. Abstracts, p40
8. See RAISE article 'Challenges of collecting baseline data in emergency settings', FMR29 www.fmreview.org/FMRpdfs/FMR29/68-70.pdf
9. See www.path.org/projects/womans_condom.php
10. See www.path.org/files/TS_update_silcs.pdf
11. See www.path.org/files/TS_update_nevirapine.pdf
12. See www.eranger.com
13. More information available through Health Systems Strengthening for Equity at: www.midlevelproviders.org
14. Abstracts, p66