Responding to IDP reproductive health needs

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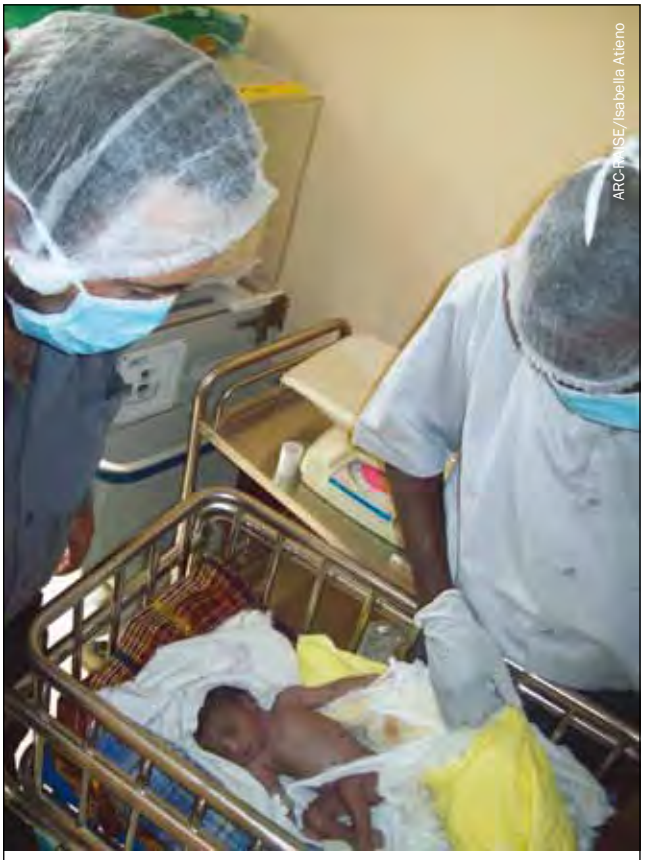
Despite the administrative, logistical, political and cultural challenges of working in Darfur, the Gereida Comprehensive Emergency Obstetric and Newborn Care Centre has made significant progress in a short time.

Following the surge of violence in 2004, more than 2.4 million men, women and children in Darfur were displaced. Several hundred thousand of them fled to the southern Darfur town of Gereida, effectively tripling its population. While living in a camp setting in Gereida, these IDPs (internally displaced persons) had access to a government-run hospital that offered only minimal, often poor-quality reproductive health (RH) services, for a prohibitively high fee. The American Refugee Committee (ARC), a partner of the RAISE Initiative, recognised this vulnerable population's need for free, high-quality, comprehensive emergency obstetric and newborn care (EmONC) and family planning – and decided to construct, outfit and staff a comprehensive EmONC centre.

Access to both family planning and comprehensive EmONC is vital to reducing maternal mortality. Although all women need family planning to time and space their births, this is often even more vital to women who are displaced. Furthermore, family planning is one of the most cost-effective, high-yield interventions available to prevent maternal and child death and disability, infertility and high-risk pregnancies amongst vulnerable women. EmONC refers to the care of women with obstetric complications during pregnancy, and of women and newborns during delivery and shortly thereafter. Comprehensive EmONC includes the ability to carry out surgical interventions (specifically caesarean sections) and blood transfusions, both of which are crucial to managing obstetric complications. When EmONC services are low quality, unavailable or available only at a high cost to the patient, women and newborns die needlessly.



The new EmONC Centre in Gereida provides comprehensive emergency obstetric and neonatal care.

Existing facilities

Prior to ARC and RAISE's intervention, most pregnant women in Gereida delivered at home and many died from potentially treatable complications. In addition, strict national policies prohibiting non-physicians from performing caesarean sections made it difficult to maintain a staff capable of handling complicated deliveries. If no doctor was on duty, women in need of a caesarean section would be forced to travel three hours to reach the nearest EmONC facility. Even if women were able to overcome the substantial financial and logistical obstacles to procuring a vehicle for this journey, the lack of security on the roads posed extra challenges.

In terms of family planning, Gereida's hospital had no designated staff member to ensure the availability of affordable, adequate supplies, or to educate women about them. Although ARC and RAISE saw a tremendous need for these services, what little data existed documented very low demand for family planning without a clear indication of why this was the case. To better understand IDPs' knowledge and attitudes around family planning, ARC conducted informal focus groups. These showed that women wanted to use family planning methods for birth spacing, citing improved health for mother and child and improved economic circumstances as likely outcomes. The major barriers to accepting family planning – for both men and women – were lack of knowledge of methods and ill-informed fears about side effects.

The new EmONC Centre

After months of discussion with the Sudanese Ministry of Health (MoH), the decision was taken to build the Gereida Comprehensive Emergency Obstetric and Newborn Care Centre, to be open 24 hours a day, seven

days a week, with RH services available free of charge to both the IDP and local populations. The doors opened on 28 October 2009, and the facility's first birth took place that same day. With a staff of more than 25, the Centre offers outpatient care, ante- and post-natal care, delivery, laboratory and pharmacy services, an operating theatre, neo-natal care, blood transfusions, latrines and a bathing area. Most importantly, women are now guaranteed qualified staff to assist with obstetric complications at all hours of the day.

In addition to EmONC, the new Centre has had important successes related to family planning. Significant increases in the uptake of family planning have occurred each month since the Centre opened; in fact, the number of new family planning clients has more than tripled since October 2009. The Centre has also hired a full-time RH manager to coordinate supplies and offer good private family planning counselling. Furthermore, the Centre has experienced a marked increase in internal referrals; for example, women who come for post-abortion care (PAC) are now referred to family planning services, where once they might have been overlooked.

Investment in the data collection system has also improved the Centre's ability to evaluate the quality of its services. The system has been entirely updated and staff have been trained in data collection and management. The RH manager now reviews monthly reports with the hospital staff to determine which services are improving and which need further attention.

To better educate the local population about RH, the Gereida Centre has trained several health educators who conduct community-based education sessions about family planning methods and EmONC services. The ARC Gereida team believes that these outreach health educators have played a large role in the increased number of visits to the Centre over the last four months.

The dissemination of information to the local community and the increase in the number of women seeking family planning methods are important successes. To understand the significance of these gains, it is important to examine the challenging context in which they were achieved.

Challenges to service availability

Securing the necessary approvals from government offices, constructing the Centre and ensuring a consistent flow of commodities were each intensely time-consuming. ARC worked in close partnership with the MoH on this project; however, its realisation still took almost two years. Meanwhile, due to logistical complications, ambulances that had been purchased for the Centre sat unused in Khartoum, waiting to be transported to Gereida where the violence continued to escalate and emergency services remained unavailable.

Availability of logistics and supplies:

Notwithstanding the updated logistics system at the Centre, ensuring the flow of necessary supplies – which is absolutely essential – is extremely difficult. Supply orders have sometimes arrived incomplete, or long after stocks have been depleted, forcing ARC to purchase supplementary supplies from various local pharmacies. Because word of mouth is the main driver of patient visits, it has serious implications for maintaining clients' trust if supplies run out; if women cannot consistently obtain the services and supplies they expect, they may influence other clients and potential clients to stop using the Centre.

Government health policy:

The Sudanese MoH has strict guidelines outlining which contraceptive methods may be offered in the country. At this time, contraceptive implants are not recognised, making it illegal to provide them or even to educate patients about them. The MoH is collaborating with the ARC Gereida team to advocate for a change in this policy but IDPs in Gereida currently do not have access to this method.

The MoH also restricts non-physician health workers from providing services when a doctor is not available. According to official policy, only doctors may perform caesarean sections or insert IUDs; however, with proper training other cadres of health workers have been shown to provide such services with error rates as low as those of doctors. This policy, combined with the difficulty of employing and retaining doctors in such remote settings, impacts women's access to care. Given the scarcity of doctors in IDP settings, and women's need for a full range of family planning methods, the need for continued advocacy is clear.

Religious and cultural barriers:

The majority of IDPs in Gereida are practising Muslims and live within a culture where family planning is not universally accepted. Though Islam does not prohibit the use of family planning, traditional methods are considered to be the most natural and are more often acceptable to men. Furthermore, the MoH highly recommends that women be accompanied by their husbands when they go to a facility for family planning. ARC's focus group results were clear: men will be more accepting of the various contraceptive methods if they are educated about them, and if access to family planning is free. Centre staff continue to work diligently to educate the community on the many services they provide and the contraceptive options available.

Looking to the future

In their continued efforts to increase the number of women coming to the Centre for family planning methods, staff members have two main priorities: to advocate to the MoH for adoption of contraceptive implants in the national policy and to continue to send clear messages, via health volunteers and educators, about the Centre's available services.

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