# Ensuring minimum standards in reproductive health care

by Sandra Krause

*There is increased awareness that (RH) care is a life-saving necessity in the early stages of an emergency. An evaluation in Aceh has highlighted current shortcomings and the need for greater training and awareness raising.*

Displaced women and girls face heightened health risks, including sexual violence, HIV/AIDS and other sexually transmitted infections, unwanted and high-risk pregnancies, and unsafe abortions. More than 150,000 pregnant women are estimated to have been affected by the tsunami. Fifteen per cent of them, as in all populations, will suffer from unforeseen complications of pregnancy and childbirth and require access to life-saving emergency obstetric care at a time when surviving health workers are likely to lack the most basic materials and supplies.

A decade ago, an inter-agency working group of UN agencies and other international organisations developed the Minimum Initial Services Package (MISP)[1], a set of reproductive health activities and services to prevent and manage the consequences of sexual violence, reduce HIV transmission, prevent excess neonatal and maternal illness and mortality and plan for the provision of comprehensive reproductive health services once a crisis situation stabilises.[2]

Priority MISP activities are:

- identification of lead agency and individuals to coordinate implementation of the MISP
- prevention of sexual violence by ensuring refugee women and girls' participation in emergency assistance provision and distribution, safe access to water, food, fuel and medical care and appropriate camp design
- medical care for all survivors of sexual violence
- prevention of HIV transmission by promoting knowledge about preventing the transmission of infections and ensuring a safe blood supply and condom availability
- reducing neonatal and maternal morbidity and mortality rates by providing clean delivery kits for use by mothers or birth attendants, midwife delivery kits for health centres and establishing a referral system to manage obstetric emergencies
- planning the provision of comprehensive RH services to be integrated into primary health care by collecting background RH data, ordering supplies, identifying service delivery sites and designing and implementing training programmes.

In late February 2005, the Women's Commission conducted an assessment of reproductive health care in Aceh. Within a week of the tsunami, UNFPA (the UN Population Fund) had mobilised technical staff and supplies and fielded RH focal points and essential reproductive health materials and supplies. By late February more than 35 representatives from international, local and national organisations were participating in the weekly meetings of the UNFPA-led RH working group.

The focus in the early days and weeks of emergencies should be on the exchange of information between community members and groups such as midwives, traditional birth attendants (TBAs), community leaders (female and male) and humanitarian actors. UNFPA and WHO had initiated background data collection on the numbers of women of reproductive age, pregnant women and expected deliveries per month and infant and maternal morbidity and mortality. Consultation with women's groups indicated that displaced women were requesting contraceptives. In collaboration with the national family planning association and other agencies, UNFPA was able to quickly mobilise and distribute supplies.

However, UNFPA's implementing partners in Aceh province, although interested in providing RH services to the affected population, did not know the key objectives and priority activities of the MISP. Just over half the humanitarian staff interviewed had heard of the MISP but only a few could accurately describe its objectives and priority activities.

## Shortcomings in MISP provision

Although reports of sexual violence were isolated and did not indicate a widespread problem, humanitarian actors and government staff were not knowledgeable about – or equipped to provide – medical care for survivors of sexual violence. While nearly all international agencies had a code of conduct, none were aware of a reporting mechanism for violations and most had

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*Woman receives mattress and baby clothes for her 6-month-old daughter, Indonesia.*

not shared the code of conduct with local partners. Women and girls expressed unease about sharing accommodation, latrines and showers with strangers and men. There have been few reports of sexual violence but it is still a matter of concern that ministry of health (MOH) staff and humanitarian actors are largely unaware of national and international clinical protocols for rape survivors.

Ten per cent of the 5,500 midwives in Aceh died during the tsunami. To address the resulting gap, 120 midwives from Jakarta were seconded to health centres in Aceh for two- to three-week intervals. Most supplies to support the MISP, such as clean delivery kits and midwife kits for health centres, were available to international agencies within weeks of the emergency. However, some kits, such as the traditional birth attendant (TBA) kits, were not available and in some cases the available supplies had not been distributed from the agencies to pregnant women or TBAs at the field level. Even before the tsunami, community-based midwives reported having limited capacity to provide basic emergency obstetric care prior to transferring patients to the referral hospital for care.

Condoms were not visibly available to beneficiaries in the health centres visited, although one agency had made a point to stock them. Many agencies do not make condoms freely available because they assume, rightly or wrongly, that this would not be tolerated by the Islamic culture and the Indonesian health authorities. Some agencies were not aware of the importance of condom provision. Others were open to the suggestion and were willing to consider making them available to staff as a first step.

Representatives of the MOH and WHO reported significant shortcomings prior to the tsunami in health workers' practice of basic health precautions, such as cleaning, disinfection and sterilisation of medical supplies to prevent the spread of infections, including HIV. Although safe blood transfusion is part of the national protocol, there were doubts expressed by individuals as to whether all blood was screened.

## Conclusion

These findings demonstrate that the presence of a lead agency and designated RH focal points stimulates coordinated RH programming and availability of supplies. Humanitarian actors in Aceh have shown growing awareness of MISP principles and supply kits but few are knowledgeable about the priority RH services intended to prevent excess morbidity and mortality in new emergency settings. The findings underscore the need to provide pre-emergency training on the MISP to humanitarian actors. The Women's Commission has initiated the development of a user-friendly distance learning module and is working to translate it into widely used international languages. It will be available in early September 2005 (email info@womenscommission.org).

The Women's Commission is also urging governments, donors and other humanitarian actors to ensure that the MISP is available to beneficiaries in all new emergency settings. A report, 'Reproductive Health Priorities in an Emergency: Assessment of the Minimum Initial Services Package in Tsunami-affected areas of Indonesia', is available on the Women's Commission's website.[3]

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1. www.womenscommission.org/projects/rh/misp%20index.shtml
2. The MISP is now included in the Sphere Project Humanitarian Charter and Minimum Standards in Disaster Response: www.sphereproject.org
3. www.womenscommission.org/pdf/id_misp_eng.pdf


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