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IMAP Statement on Family planning and safe abortion – the missing components of sexual and reproductive health services in crisis situations

Background

Crises, due to natural disasters or armed conflicts, adversely affect millions of people and large geographic areas, sometimes affecting health and welfare for years after an initiating event. The early impacts may include death, physical injury, and loss of water, food and shelter. The survivors may suffer crisis-generated health problems of a general, psychological and reproductive nature, and thus, sometimes, increase the burden on health systems that may already have been inadequate to respond to existing demands. The people affected by crisis may be foreign refugees or internally displaced persons (IDPs), who may be congregated in camps, or dispersed within a community. The UN's Global Trends 2007 cites 26 million conflict-related internally displaced persons, 12.7 million in Africa. The rarely cited estimate for natural disaster-related IDPs is 25 million. The United Nations High Commissioner for Refugees (UNHCR) cites 16 million refugees, including more than four million that fall under the United Nations Relief and Works Agency (UNRWA) mandate.

The types of crises may vary widely from natural crises such as floods, earthquakes and epidemics to man-made crises such as major industrial accidents, terrorist attacks, civil unrest and war or other armed conflicts. Each type places different demands on the services that can be provided. However, depending on the nature of the crisis, and for the effective implementation of the provision of services, the international humanitarian response can be divided into two main stages: the first, crisis stage, (crude mortality rate > 1:10,000 per day) and the post-crisis or stabilization stage, in which mortality returns to the level of the surrounding populations. During the crisis stage, the safety of both service providers and clients is paramount, and emergency family planning needs are a priority. During the stabilization stage, the full range of services should be made available to the affected community.

The first priorities for many donors faced with an emergency (e.g. national governments, UN agencies and NGOs) are the provision of clean water, food and shelter, but attention to health, including reproductive health, is also critical. To address emergency health care, WHO, UNHCR, UNFPA, UNICEF and the Interagency Working Group (IAWG) have well-developed programmes and guidelines to assist national efforts.[1] They also provide a package for reproductive health in the initial phase of an acute crisis: the Minimum Initial Service Package (MISP). This package can be ordered by any recognized health organization in preparation for, or in response to, a crisis. MISP includes detailed guidance for activities and 13 different RH kits.[2] Information on the kits or assistance with ordering can be provided by UNFPA Staff in Field Offices (in the capital city of respective countries), UNHCR or other UN coordinating agency at country level, agency partners, or UNFPA/HRU.

Reproductive health care is crucial for people caught in a crisis. A high priority should be given to safe delivery and postpartum care for pregnant women, as complications of labour and delivery without adequate care can be life-threatening. During such circumstances, the risks of HIV/AIDS, other sexually transmitted infections (STIs), and unwanted pregnancy also increase due to the lack of contraceptive supplies and a greater incidence of sexual and gender-based violence. There may also be an increased demand for safe abortion and postabortion services due to the violence and major disruption in women's lives. In addition, people may not have access to condoms or other family planning methods and services. When regular contraceptive supplies are disrupted, emergency contraception should be made available to any woman who has had unprotected intercourse.

Prioritizing family planning services during a crisis

Family planning services should form part of comprehensive health care during crisis situations, as the need for them is even greater, coupled with risk reduction behaviour, access to safe abortion (MVA) and the use of procedures for infection prevention. These enable survivors to avoid the increased risks of unplanned pregnancy, unsafe abortion and the transmission of sexually transmitted infections, including HIV. Restoring access to safe, effective contraception protects the lives and well-being of women, children and the wider community, and enables families to manage scarce resources more effectively.

What can Member Associations do?

One of the programme strategies in the IPPF Strategic Framework (2005-2015) is "to improve **access** to appropriate high quality sexual and reproductive health services using a **rights-based approach**". It guides Member Associations (MAs) to "respond to the sexual and reproductive health needs of groups affected by emergency situations resulting from political instability and natural disasters"3 {Access – 6 (e)}. Although we acknowledge that crisis situations require a comprehensive sexual and reproductive health response, this IMAP Statement focuses on family planning and safe abortion services.

Preparation for the provision of effective family planning services for a crisis requires a fully developed policy, appropriately trained staff and a sustainable supply of material and financial resources. It must also be recognized that the infrastructure of the immediate area, or whole region, may be compromised, with severely constrained resources.[4]

All disasters are unique in that the MAs affected have different social, economic, and health contexts. But they share many common elements, and knowledge about these can ensure that the health and emergency medical relief, and limited resources are well-managed. Those worst affected by natural disasters, civil unrest and armed conflicts are increasingly the poorest and most marginalized. Although the timing and nature of crisis situations cannot be accurately predicted, disaster preparedness should form part of responsible planning.

Disaster and conflict preparedness should be included in the policies of Member Associations. Throughout the crisis, safety issues are of the utmost importance. The efficient allocation of services for each stage requires careful planning. During a crisis, Member Associations have an advantage over international relief agencies as they are familiar with the local community. However, Member Associations may be at a disadvantage in an internal armed conflict, depending on whether they are identified with a group involved in the conflict, for example, because of contacts with the government, or the composition of their board. They need to consider whether they would be able to negotiate access to displaced populations.

Prior to the crisis

It is difficult to plan in advance, but there are many things Member Associations can put in place. They should acquire and implement the MISP guidelines for the kits, adapt them for their own location and the types of crises they feel are most likely to occur, and they should then undertake the associated training. They should make provisions to link in with the co-ordination structures (cluster) that the international community will put in place if there is an international relief operation. Clear plans for recovery, in the event that one or more clinics are damaged or wholly destroyed, should be written and distributed. The plans, to be kept at the homes of staff and volunteers, must include methods to maintain or re-establish contact, so as to identify the people and resources available. Good disaster management must link data collection and analysis to the decision-making process.

Needs assessment and logistics

To complement the international response, and ensure a comprehensive reproductive health (RH) response to crises, the Member Associations should design and put in place an appropriate family planning (FP) component based upon the five A's: safe Abortion, Adolescents, AIDS prevention, Advocacy, Access to services. The demand for family planning services is influenced by refugees' pre-crisis attitudes towards, and choices of, modern methods of contraception, and by their current expectations and perceived needs. Other factors that may affect the contraceptive services which can be offered are infrastructure, religious and ethical values, cultural backgrounds and the availability of appropriately trained healthcare providers. Women have an urgent need to continue the contraceptive method they used before the crisis, which should be met as soon as possible.

Planning for family planning service prior to the crisis should start with local information already available from country and regional offices and national programmes. Areas and countries that are potential sources of refugees should also be part of the review; relevant data can be obtained from WHO, UNAIDS and UNFPA. Information should include contraceptive prevalence by method and community attitude towards contraception. A number of factors affect the choice of contraceptive services which may be planned: the original infrastructure, how much of it would be likely to remain, survivors' expectations, perceived needs and demands, religious and ethical values, cultural backgrounds, linguistic requirements for IEC materials, and the availability of appropriately trained healthcare providers.

Having decided the most appropriate contraceptive methods for the acute phase of a possible crisis, the quantities must be planned and the supply chain identified, so that when the need arises, initial stocks can be purchased and a reliable provision ensured for the longer term. Stocks may be sourced through dependable local suppliers or through UNHCR and UNFPA, who can help negotiate large supplies at reduced cost. Stocks must then be procured, an inventory and monitoring system established, a distribution plan agreed and a logistics manager appointed. Existing staff and logistic systems should be used where possible.

Delivery sites and human resources

Decisions should be made in advance, concerning the types of delivery sites that could be feasible in a crisis, for example, schools or offices, with a supply of water. Service providers and volunteers must be made aware of, and contribute to, the preparations for crisis, and the features envisaged for possible disasters specific to the Member Association. Plans must be made for the personnel who will deliver FP/RH, in the initial crisis and the stabilization stages. A list should be prepared, and maintained, to include nurses, midwives or doctors, and lay workers, their crisis skills, or crisis training schedule, and languages (survivors do not always know the language of the host community). Groups or individuals in a community who could assist in the delivery of services should be identified in advance. It should be noted that in some cultures, clients and providers must be of the same sex. Advice about reproductive health services can be obtained from many sources, and family planning can be linked to many services, for example, condoms and information about FP can be made available at food distribution points and within preventive and curative health services.

A reproductive health and FP coordinator should be appointed. This should be in the context of the Health Cluster system, so that the co-ordinator can liaise with, and influence other agencies, NGOs and the community. Evidence from many settings shows that this preparation is critical to a programme's success.

Reproductive health services

These must be decided according to the Member Association's current resources, and planned as sets of services relevant to anticipated crisis scenarios; the essential services should address the following:

- Safeguarding pregnant women includes resources for safe delivery and emergency obstetric services, a capacity for appropriate referrals and transport
- Provision of safe abortions
- Complications of unsafe abortions
- Gender-based violence care: including post-rape care and counselling.

A contingency plan for family planning services must be adaptable, and based upon the resources available:

- Crisis stage contraceptive methods include barrier methods providing dual protection against pregnancy and HIV/STIs: male and female condoms, spermicides, hormonal contraceptives (COC and POP), emergency contraception pills (ECPs), lactational amenorrhoea method (LAM) and injectables. Breastfeeding should be encouraged, rather than the use of the powdered milk contained in relief packages
- Stabilization stage contraceptive methods, some of which require providers with more specialized training, should include the full range of contraceptive services. These include: injectable hormonal contraceptives (DMPA, 'NET-EN', 'Cyclofem'), hormonal implants, IUDs, voluntary male and female sterilization, emergency contraception pills (ECPs), natural family planning methods and LAM.

Materials, protocols and training

To ensure that the IEC/BCC materials routinely used for client counselling remain available during a crisis, extra supplies may be prepared in advance; protocols for family planning consultations should be based on the national guidelines or standards. A programme must be adopted for training anyone likely to be involved in the provision of contraceptives. It should include: technical competence, as well as interpersonal, communication and administrative skills.

Partnerships

Plan and establish partnerships with other organizations that work with the communities likely to be affected, in order to harmonize the relief work, for example, the National Red Cross/Crescent Societies. These organizations are mandated to provide primary health care and other forms of relief in emergencies and are often included in national/governmental emergency plans. Pre-crisis support can also be sought amongst local community, social and religious leaders and women's groups.

During a crisis

Human and material resources

Conduct a roll call of staff and volunteers for reproductive health; check the viability of clinic and outreach facilities, and stocks. Assign the designated staff, recruit providers from the community and ensure that all are trained - replacement or additional providers and volunteers should receive rapid training on site. Some refugees may be healthcare professionals themselves and can contribute their skills to the care of other refugees, providing extra help to overcome any shortages. Set up activities for longer-term training, and ensure they are sufficiently flexible for shifts in crisis conditions.

The original designated delivery sites may have been destroyed or left in poor condition. Refugees/IDPs both in camps and scattered within a community will have RH/FP needs, but providing the services may be more difficult than anticipated. In some situations, mobile health services may be the only way to distribute contraceptives and other reproductive health services to the affected population. Include community, social, and religious leaders, traditional birth attendants (TBAs) and women's organizations before making decisions about the location and timing of services at the health facilities. The refugees/IDPs and host community should also help determine the levels of privacy and confidentiality, to ensure maximum use and the safety of clients, as there may be increased incidence of gender-based violence.

Sustainable RH and FP supplies

If a needs assessment requires updating, or was not conducted before the crisis, the demand for contraceptive services can be gauged by the following activities:

- Assess attitudes and knowledge of providers from the refugee population, including contraceptives that involve traditional methods
- Gather information about the contraceptive prevalence rate in the affected communities (e.g., where they are from, what contraceptives were previously available to them) through sources such as WHO and UNFPA
- IPPF services statistics can be used for estimating the demand for contraceptive services in the affected communities.

Deliver appropriate material supplies for the crisis stage, order replacement stocks and ensure the supply chain functions well. Co-ordinate with national and local programmes, Regional Rapid Response teams and suppliers to:

- Ensure quality of commodities, with Guidelines for drug donations http://www.medsafe.govt.nz/profs/RIss/donations.asp
- Deliver appropriate material supplies for all planned services for the crisis stage and ensure that stocks required for the stabilization stage, such as IEC, can be maintained. MISP kits should be in place or obtainable
- Check the in-country availability and continuity of sustainable contraceptive supplies. It may be necessary to source RH/FP kit contents from more distant suppliers, depending upon the scale of the crisis.

Record keeping

Regular follow-up and the monitoring of clients, plus a general evaluation of service delivery, are essential to check clients' progress and maintain control of logistics and human resources.

During the stabilization stage - comprehensive family planning services

During the second, stabilization stage, MAs should continue the crisis stage procedures, and deliver as many additional FP services as possible, consistent with needs and resource assessment, the availability of commodities, and the skills of the providers. These should also be consistent with follow-up in the country of origin (e.g. there may not be the will or capacity to deal with implants in the country of origin), linked with and/or integrated with other services, wherever feasible.

- Methods include: IUDs, hormonal contraceptive (HC) implants and natural fertility control including the lactational amenorrhoea method (LAM)
- Utilize as many outlets as feasible, such as outreach health posts, health centres and mobile health services, with particular attention to serving refugees/IDPs scattered within the host community
- Serve as many population groups as possible according to need, including women, men and young people
- Link as feasible with a range of other sexual and reproductive health services including: safe abortion, consistent with the country's laws, improved access to emergency contraception, post-abortion care, STI/HIV prevention, treatment and counselling, female genital mutilation (FGM) and fistula care or referral
- Organize the logistic management system (procurement, storage, transportation, inventory and distribution) to

ensure consistent and sustainable supply
- Ensure adequate monitoring/record keeping as this is crucial for the follow-up of clients and to ensure the control and maintenance of resources
- Evaluation should be completed daily in the first stage, and weekly/monthly in the second phase of stabilization, to identify successes, failures and challenges, and to refine plans for future crises
- Restock, as material resources quickly become depleted, and must be replaced as rapidly as possible.
- Report and provide feedback on efforts made to the Regional and Country Offices of IPPF, the local community, the national and international co-ordination structures, and the media. This is vital in the short term to disseminate information on the needs of clients during a crisis and the quality of the response by MAs; and in the long term for future reference, to identify appropriate measures and raise awareness of specific crisis-generated problems.

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Postpartum haemorrhage: prevention and treatment in low-resource settings

Jessica E Morris, Carrine Myer, Suellen Miller

Scope of the problem

The Maternal Mortality Ratio (MMR) is the indicator with the greatest disparity between developed and developing countries. Of the 500,000+ maternal deaths and millions of disabilities recorded in 2005, 99% occur in developing countries, over half of them in sub-Saharan Africa.[1]

Socio-economic, cultural and gender inequities lead to fatal delays for those women who mainly deliver at home with unskilled attendants. These delays explain the disparate maternal mortality rates between high and low resource countries, and between rich and poor within countries. Weak public health systems, unreliable or absent transportation, and local beliefs that contrast with evidence-based practice, are among the many barriers to safe motherhood. The women may also have limited access to family planning, safe abortion services, antenatal care or skilled birth attendance. The high prevalence of malnutrition and stunting, anaemia and parasitic diseases such as malaria, exacerbate these conditions and further complicate pregnancy.

Complications of pregnancy and birth can occur to any woman. Without a skilled attendant, trained to identify complications before they become life-threatening, women in labour face the possibility of severe haemorrhage, sepsis, eclampsia, and obstructed labour. Of these direct causes of maternal mortality, postpartum haemorrhage (PPH), generally due to uterine atony, is the leading cause of death. Without immediate treatment, PPH can quickly lead to shock and death. Obstetric haemorrhage aetiologies also include: genital lacerations, placental abruption, placenta prævia, ruptured uterus, ectopic pregnancies and unsafe abortion.

Despite these challenges to safe motherhood, the prevention and treatment of PPH in low-resource settings is possible.

Treating anaemia

Anaemia in pregnancy is defined as haemoglobin below 11 g/dL.[2] Anaemia affects the majority of pregnant women in developing countries, with rates as high as 89% in India.[3] Parasitic diseases such as malaria and hookworm exacerbate anaemias due to restricted nutrition. Anaemic women are particularly vulnerable to haemorrhage-related morbidity and mortality because they may not tolerate even moderate blood loss. The detection and treatment of anaemia is essential.

Clinical evaluation of the sclera, lips, tongue, gums and fingernail beds is more sensitive in detecting severe anaemia than moderate or mild anaemia. Two simple and inexpensive methods for anaemia testing can be used by health care providers in developing countries – a colour scale and a copper sulphate test.[4] Health care workers can be quickly trained to conduct these tests and interpret the results. Due to the high prevalence of anaemia in low-resource settings, treatment with iron and folic acid is recommended for all pregnant women. Studies are inconclusive on the impact of iron and folic acid on maternal morbidity and mortality, but there is evidence that micronutrient supplementation programmes reduce anaemia.[5]

Providing skilled attendance at birth

Skilled birth attendants (SBAs) are health professionals trained to manage uncomplicated pregnancy, childbirth and postpartum, recognize the early signs of complications, and perform life-saving functions. MMRs are directly associated with skilled birth attendance. Countries with the lowest MMRs report over 98% SBA attendance; those with high MMRs report less than 60% attendance.[6] More SBAs must be recruited and trained: in 2006 it was estimated that no more than 40% of births in the developing world were attended by an SBA, with some rates as low as 10%.[7]

Implementing active management of third stage labour (AMTSL)

AMTSL is defined as the administration of uterotonic drugs at, or within one minute of, the birth of the baby, delivery of the placenta by controlled cord traction and uterine massage. AMTSL reduces both the incidence of PPH and the need for additional uterotonic drugs, intravenous (IV) fluids, blood transfusions, and surgery.[8] There is no consensus on correct implementation of AMTSL, the efficacy of applying AMSTL without uterotonics, and the ability of unskilled providers to implement the steps. Despite these disagreements, AMSTL has decreased the incidence of PPH in randomized clinical trials and has been recommended for all delivering women.[9, 10]

The use of prophylactic uterotonics, especially oxytocin, can significantly reduce PPH;[11] however, several barriers exist to the universal use of oxytocin, as it requires refrigeration and

safe injection capacity. Another effective uterotonic agent is oral misoprostol, a prostaglandin E1 analogue that stimulates uterine contractions; it is easy to store, heat-stable, low-cost, and easy to administer. In a randomized placebo-controlled trial conducted by auxiliary nurse midwives (ANMs) conducting home deliveries, prophylactic oral misoprostol reduced PPH 50% more than the placebo.[9]

Early identification of PPH

One method for early identification of excessive bleeding is the blood collection drape: a calibrated plastic device placed under the woman's buttocks after delivery. Blood collection drapes are more accurate than visual estimation for assessing haemorrhage.[12] However, training in visual estimation techniques improves accuracy.[13] Research in Tanzania found that a *kanga* (a standard size piece of cotton fabric) could be used to detect PPH accurately. Traditional Birth Attendants (TBAs) were trained to interpret two blood soaked *kangas* (500ml) as haemorrhage requiring referral.[14] This method is community appropriate, low-cost, easily comprehensible, and can be adapted to other traditionally used fabrics, in most low-resource settings.

Treatment of PPH

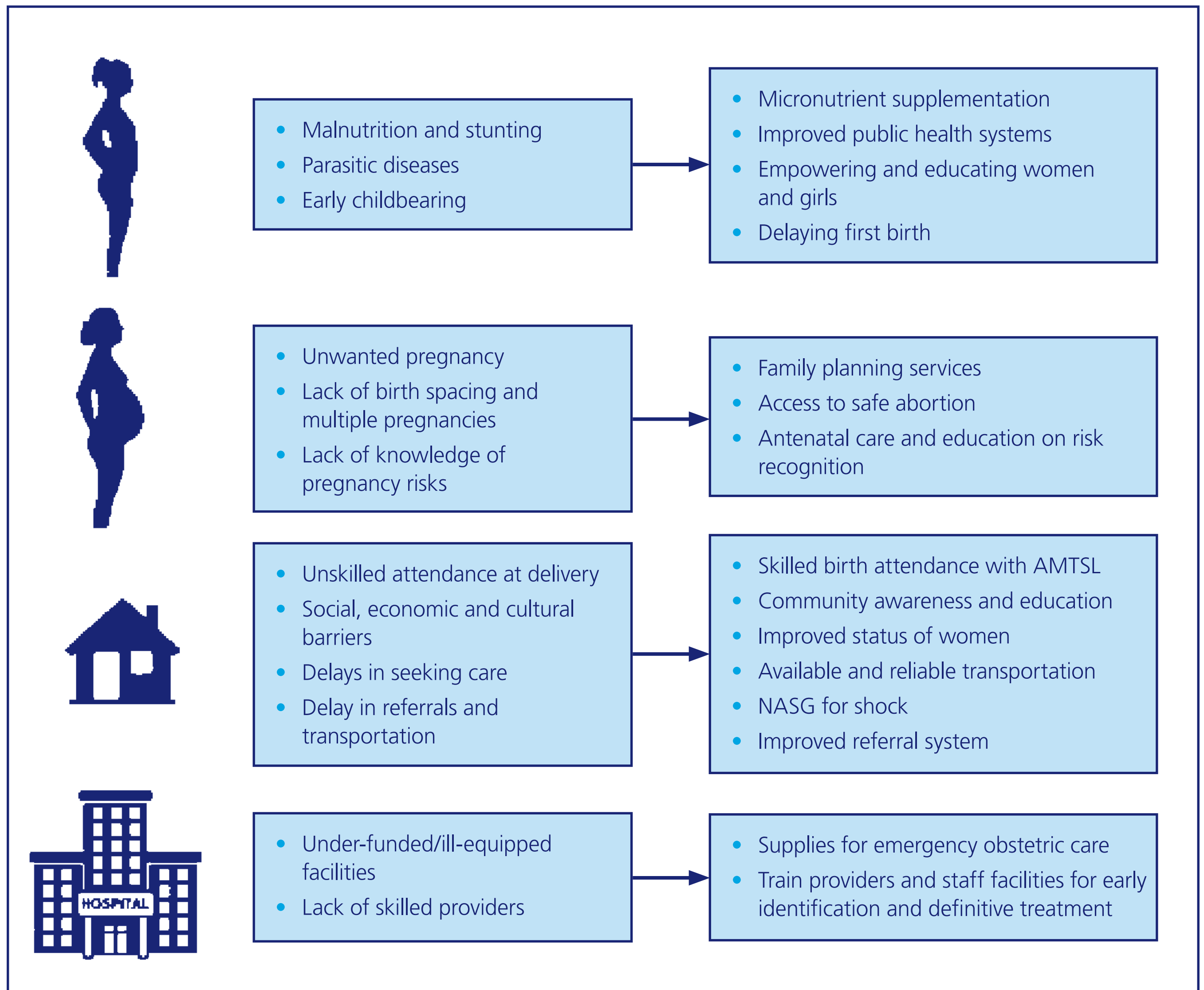
The uterotonics oxytocin and methergine are effective for treatment of PPH when administered parenterally in hospital. Oral misoprostol may be easily utilized in the home or community setting, where refrigeration or safe injections are unavailable. There is community-based evidence that TBAs can use it with minimal training, reducing the need for referrals or IV treatment.[15]

Since the interval between haemorrhage onset and death can be as short as two hours for uterine atony, rapid communication with, and transport to, tertiary-level hospitals is paramount. Maternal deaths can be reduced at village level by introducing simple communication processes (walkie-talkies, radios or cell-phones) and ensuring free, or low-cost, timely transport.[16]

The Non-pneumatic Anti-Shock Garment (NASG) is a first-aid device that can be used before, during and after transportion to a hospital, while awaiting definitive treatment. The articulated neoprene and velcro garment applies circumferential counterpressure to the lower body, shunting blood from the extremities to the vital core organs. Results show promise in stabilizing women with hypovolemic shock secondary to haemorrhage.[17, 18]

These strategies and technologies are most effective as a package or "Continuum of Care Model" (CCM), which emphasizes birth complication planning, routine uterotonic prophylaxis and/or AMTSL, a standardized means of blood loss assessment, availability of the NASG, and systematization of communication, transportation and referral.[19] A CCM is currently being implemented in several states in India and

Figure. Postpartum haemorrhage: predisposing factors and potential solutions



Nigeria by Pathfinder International.

At the referral-level hospital, the package of interventions recommended for definitive PPH treatment includes uterotonic drugs, crystalloid fluid replacement, blood transfusion, manual removal of retained placenta, uterine compression sutures and, if required, hysterectomy. Hospitals must be upgraded to provide, without pre-payment or delay, surgical, anaesthesia, and blood transfusion services at all times. The upgrade includes training for providers, and staffing facilities.

Conclusion

Maternal mortality is a public health crisis for women in low-resource settings. An inclusive, multi-faceted, inter-disciplinary approach is essential for ensuring safe motherhood. Preventative measures such as female literacy and education, empowering women and girls and improving their nutritional status, delaying early childbearing, and providing access to family planning services and safe abortion are major challenges. Pervasive gender inequities, which prevent some women from seeking and receiving care, must be overcome through community awareness and education, and government action. With these wider interventions must come services to reduce unwanted pregnancies, improve birth spacing, and provide antenatal care focused on nutrition and risk recognition for the woman, family and community (see Figure)

Maternal mortality is often a direct function of the quality of health care available,[16] so the implementation of evidence-based strategies and technologies is vital. Skilled attendance at birth remains a key preventative of PPH, and training all levels of birth attendants in AMTSL reduces PPH. Once bleeding has started, immediate diagnosis and response are imperative. The accurate recognition of haemorrhage must be followed by a previously identified referral process, involving rapid communication, transportation and management. New technologies such as the blood collection drape, oral misoprostol, and the NASG may be usefully applied.

Significant investments should be made, to supply all facilities with essential staff, services and supplies. National guidelines and training curricula can assist clinicians in low-resource settings. Economic assistance could ensure the provision of supplies and equipment, and fund further research into new low-cost, high-impact technologies. Clinical solutions must accompany the changes in infrastructure and challenges to the local cultures and customs that put at risk those women who are pregnant and giving birth. With feasible, practical, community-level interventions for prevention and treatment, maternal deaths due to PPH can be reduced.

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