

Minimum Initial Service Package (MISP) access to displaced people of Pakistan based on Sphere Standards and Indicators

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Abstract

Objectives: To evaluate people's access to priority reproductive health services of the Minimum Initial Service Package at the onset of emergency.

Methods: The descriptive cross-sectional study was carried out at the Jalojai camp for internally displaced people in Pakistan from January to July 2010. A customised structured questionnaire was used at the household level, and a semi-structured questionnaire at the health facility level. Purposive sampling was done at the household levels and all four health facilities in the camp were included in the study. SPSS 17 was used for statistical analysis.

Results: At the household level, 23 women constituted the sample size. Of them, 20 (87%) knew about delivery service, while 14 (70%) of them women reported no antenatal care at the health facilities. Five (23%) women had problems in using delivery and antenatal care at the health facilities. Of the respondents 20 (87%) answered that no health personnel had visited them for checkup during pregnancy or for follow-ups. Knowledge of postnatal care services was reported by 10 (43%), while 18 (78%) women had not received Clean Delivery Kits. None of the health facilities at the camp was aware of the Minimum Initial Service Package.

Conclusion: Reproductive health is still a neglected area in Jalojai camp. Steps should be taken at the facility level to educate the health personnel about the requirements and standards set by Sphere and its implementation in disaster-hit communities.

Keywords: Minimum Initial Service Package, Disaster, Sphere standards and indicators, internally displaced people, Emergency situation. (JPMA 63: 1027; 2013)

Introduction

Reproductive health is not merely the absence of disease and infirmity, but is a state of complete physical, mental and social well-being. Every year, 585,000 deaths occur in women due to pregnancy-related causes.¹ According to Reproductive Health Response in Crisis (RHRC) consortium, approximately 98% maternal and 99% neonatal deaths occur in developing countries where basic healthcare services are not accessible to people.² In Pakistan, every year 400,000 infants and 16,500 maternal deaths occur.² With effective and affordable measures, more than 80% maternal deaths can be avoided. The massive displacement of 2.31 million people in Pakistan's Khyber Pakhtunkhwa (KP) province and the Federally Administered Tribal Areas (FATA) left men, women and children in an urgent need of basic medical care, food rations, reproductive healthcare, safe supply of water and shelter.³ Of the displaced, 69,300 pregnant women were at special risk because of lack of access to obstetric care, prenatal care and assisted delivery.³ An estimated 6000

women were going to deliver within the next month and 900 women needed surgical interventions.³

Reproductive healthcare during humanitarian relief operations for displaced population has been recognised as a neglected area. The health risks of these people are at higher stake as they are forced to flee natural disasters and live in restricted living conditions in refugee camps with lack of or complete absence of reproductive healthcare. For a displaced woman, reproductive health is at great risk as she loses her home, protection, support of her community and access to medical care. Complications arising due to unsafe abortions, sexually transmitted diseases (STDs), maternal mortality rate (MMR) and requirements and implementation of family planning (FP) are particularly higher in displaced women.⁴

Worldwide it is estimated that there are about 18 million refugees and 24 million internally displaced people (IDPs); 80% of them being women and children.⁵ According to UNFPA, 20% of all refugee women will be pregnant at some point, and 15% of all pregnant refugee women will suffer complications during pregnancy and delivery.²

Minimum Initial Service Package (MISP) for reproductive health in emergency situations was established in 1995. The emergency healthcare needs of men and women in

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natural and man-made disaster situations are addressed by designing MISP and Emergency reproductive health kits in such a way that it focuses on the management and prevention of gender-based, sexual violence and STDs, provision of delivery kits for safe and clean deliveries.² MISP does not represent kits and equipments or supplies only; it implies to the implementation of a set of services by appropriately trained staff in a coordinated manner.⁶ MISP is a set of services designed to respond to the reproductive health needs of the affected population in the early phase of a disaster. Minimum standards and key indicators were developed. These standards are qualitative in nature and based on Sphere standards and indicators given in the Sphere handbook.

It has to be ensured by the health facilities that midwives, traditional birth attendants (TBAs) and visibly pregnant women receive supplies of clean delivery kits and inform the community about the referral system in place for women with complications of pregnancy or delivery.⁷ Literature review on skilled birth attendants showed that only 65.7% of all pregnant women were attended by skilled birth attendants in 2008.⁸

In February 2005, when humanitarian workers in tsunami-affected areas of Indonesia were asked about MISP, only 52% of the workers had heard of MISP, and only 1 in 25 accurately described it properly.⁷ Assessment of displaced people in Columbia revealed that there were no reproductive health focal points and no implementation of MISP despite the fact that women and girls were representing 55% of the two million people.²

The current study was planned to determine the availability and distribution of 'Clean Delivery Kits' to health facilities and skilled birth attendants for ensuring clean and safe deliveries, and to determine the presence of standard referral system and suitable transportation for obstetric emergency patients.

Subjects and Methods

The descriptive cross-sectional study was conducted in the sprawling Jalojai camp (District Nowshera), about 30 kilometers east of Peshawar, Pakistan. The camp is divided in 17 phases, with each phase further divided in 8-12 sectors. Each sector is further subdivided in 4-13 blocks. The research was conducted from January to July 2010. At the time of the survey, the population of Jalojai was 110,000 individuals (20,000 families).

A two-pronged approach was used: a pre-tested semi-structured questionnaire was administered to the four health facilities in the camp. Besides, the research team conducted structured interviews and meetings with 23

households. Using purposive sampling technique, the households were randomly selected in a single phase. The inclusion criteria at health facility were women who had their deliveries in camp within the preceding three months.

Permission for conducting the study was obtained after explaining from the camp management the purpose and objectives of the study. Informed consent was taken from all the respondents, who were assured of confidentiality. Cultural norms and traditions were kept in consideration during the interview. Descriptive statistics for various variables were analysed and presented in the form of frequencies and percentages, using SPSS 17.0.

Results

None of the 4 health facilities working in the camp had knowledge about MISP. Of the 23 women, 20 (87%) had knowledge about the availability of delivery service at the

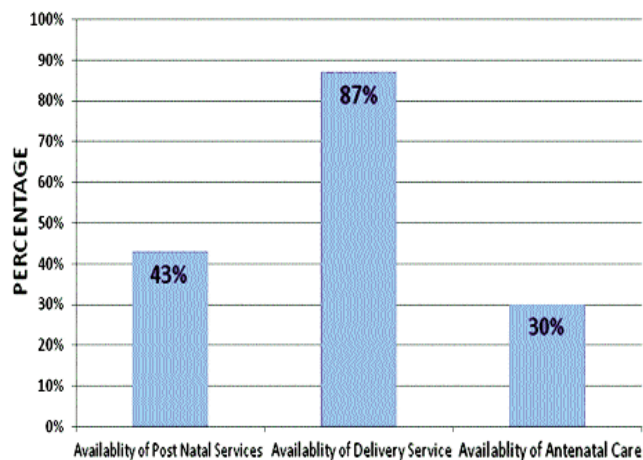


Figure-1: Reproductive Health Services.

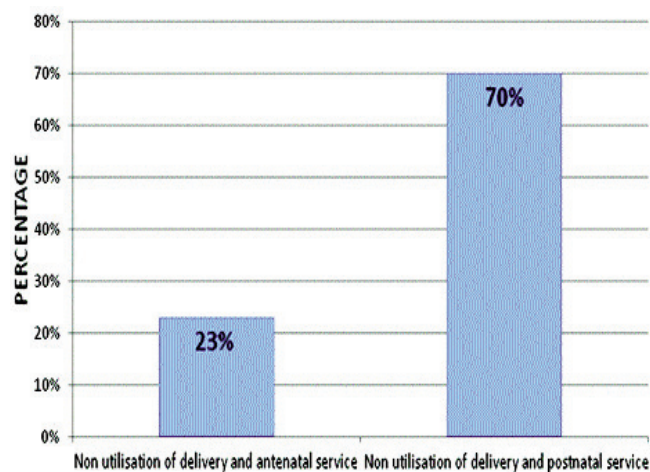


Figure-2: Non-utilisation of Reproductive Health Services.

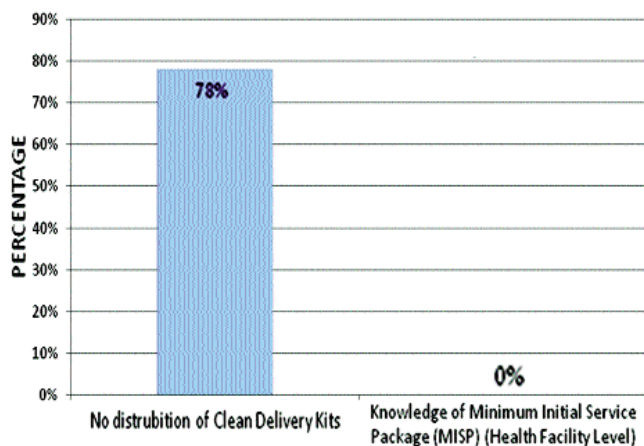


Figure-3: MISP and Clean Delivery Kits.

health facilities (Figure-1), but 14 (70%) of them reported that no antenatal care was being provided at the health facilities. Five (23%) women had problems using the delivery and antenatal service at the health facility due to reasons like timings and cultural norms (Figure-2).

All the four health facilities reported that services provided there were free of cost, but only 19 (86%) women agreed. Besides, 18 (78%) of the respondents had not been given 'Clean Delivery Kits' during their pregnancy and none of the 5 (23%) respondents whose delivery had taken place in tents were provided with the kits (Figure-3). Three (75%) of the four health facilities were not providing 'Clean Delivery Kits' to pregnant women and were not familiar with 'New Emergency Health Kits' (NEHK-2).

In terms of postnatal services 10 (43%) women were aware of their provision, but 7 (70%) of them were not using the services due to unexplained reasons. Also 20 (87%) respondents said that no health facility staff had visited the tents for follow-up treatment of mothers after delivery or checkups of pregnant ladies.

None of the pregnant women were provided with transport for referral centre. Three (75%) out of the four health facilities had the facility to properly sterilise the equipment.

Discussion

The MISP is described briefly as an international standard in Sphere Standards and Indicators. It is a set of reproductive health services to meet the needs of people in crisis situations and should be implemented as soon as possible. One of the major aims of MISP is prevention of neonatal and maternal morbidity and mortality by ensuring the availability of skilled staff and required equipments to facilitate clean and safe deliveries, and to

manage newborn and obstetric emergencies. Also provision of 'Clean Delivery Kits' to visibly pregnant women and TBAs has been made compulsory by health agencies according to MISP.⁹

A study carried out in Mwanza, Tanzania, showed that newborns of mothers who had used the 'Clean Delivery Kits' had 13.1 times less chance of developing cord infections compared to those infants whose mothers did not use a 'Clean Delivery Kit'.¹⁰ Similarly, chances of puerperal sepsis were 3.2 times less in mothers who used the kits.¹⁰ Another study found that the kit is associated with reduction in umbilical cord and puerperal infections.¹¹ Our survey team found that 78% of the women were not provided with such kits, and no health facility staff had visited them for follow-up treatment. This can lead to increased risk of infection in these women and neonates.

During a detailed interview with households, we found that five women had given birth in tents and most of the women whose delivery had taken place at the health facility did not go for postnatal check up. This can be attributed to the fact that family traditions, like not going to a health facility for checkup during pregnancy, play a negative role regarding reproductive health of women. A qualitative study on delivery care services in Indonesia suggested that health education strategies were required to increase the awareness of general public about the importance of health services along with existing financing mechanism for poor people.¹²

Also, MISP aims at the establishment of a referral system comprising free transport to and from the referral centre in case of obstetric emergencies. According to a study carried out in the UK regarding maternity referral systems in developing countries, transport arrangements and formalised communication is very important for a successful referral system.¹³ However, we found that due to lack of electricity and communication means, timely communication of patients with the health facilities was difficult. Also, free-of-cost transport was not provided to those women who were referred to a referral centre.

Although international organisations are specially focusing on reproductive health services, including the prevention of STDs and FP, but none of the women we questioned had been provided with such services at the health facility. A study suggested that FP is the best strategy in controlling maternal mortality rate as it reduces the number of abortions which are estimated to kill 200,000 women per year in developing countries.¹⁴

Conclusion

Health facilities need to create awareness among women regarding the availability of reproductive health services. However, despite the fact that Jalozai camp is home to 110,000 IDPs, the health providers of all the health facilities providing services there were not at all aware of MISP or its components or the importance of its implementation. Steps should be taken to educate health providers about the requirements and standards set by Sphere and its implementation in disaster-hit communities.

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