How To Guide

REPRODUCTIVE HEALTH IN REFUGEE SITUATIONS

Strengthening Safe Motherhood Services

Report on a participatory approach to strengthening Safe Motherhood Services

Kigoma and Ngara, Tanzania
November, 1998
UNHCR

This is the fifth in a planned series of HOW TO GUIDES that document how Reproductive Health (RH) activities were implemented in the field. The Guide was compiled by Judith O'Heir, UNHCR RH Consultant who provided technical assistance, from September-November 1998, to review safe motherhood services in the refugee camps in Kigoma and Ngara, Tanzania. The review process was action-oriented and participatory involving the RH Co-ordinators for each of the agencies working in the situation. This document describes the review approach and gives practical tools for managers and providers of safe motherhood services. Service delivery protocols, based on WHO technical materials, were prepared for use for strengthening safe motherhood services.

Each HOW TO GUIDE documents one field experience and illustrates an innovative approach to a particular area of RH. The Guide is not meant to present a definitive solution to a problem. Rather, its recommendations should be used and adapted to suit particular needs and conditions of each refugee setting.

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I. INTRODUCTION

WHAT IS THE PURPOSE OF THIS HOW TO GUIDE?

This How to Guide describes the process used to review and strengthen safe motherhood services in the refugee camps in Kigoma and Ngara, Tanzania. Information is provided about safe motherhood in refugee settings, the activities undertaken during the review process and the key people involved in the activities. The main findings of the review process are also presented, together with the conclusions and recommendations for strengthening safe motherhood services in the refugee camps in Kigoma and Ngara.

WHO IS THIS GUIDE FOR?

This guide is intended for supervisors or co-ordinators of reproductive health care services in refugee settings. The content of the guide focuses on the safe motherhood component of reproductive health and provides an action-oriented, participatory approach for supervisors or co-ordinators to review safe motherhood services and determine immediate and future needs/interventions for strengthening services.

WHAT IS UNHCR'S POLICY ON SAFE MOTHERHOOD?

UNHCR supports the organization of comprehensive services for antenatal, delivery and postnatal care, consistent with WHO policies and the Inter-agency Field Manual on Reproductive Health in Refugee Situations.[1] The organization of such services should take into account existing facilities for the local population; the needs of both refugee and local populations should be considered. The services provided should be responsive to obstetric emergencies, although, where appropriate, host country services should be used in preference to establishing new, refugee-specific facilities which will not be maintained in the long term.

In order to ensure that the services provided are appropriate, accessible, and of the highest quality, it is essential to:

- identify skilled care providers involved in childbirth (physicians, midwives, experienced nurses, trained Traditional Birth Attendants (TBAs);
- provide refresher training and supportive supervision, as needed;
- ensure the availability of the basic supplies, equipment and drugs; and
- be aware of and discuss community beliefs and practices, and health seeking behaviour relating to delivery – e.g. position for delivery, presence of relatives for support and traditional practices both positive (breast-feeding) and harmful (female genital mutilation).

Antenatal and postnatal services should be offered in an appropriate environment, in the same location as family planning, STD services, the "baby clinic" and other related primary health care services.

[1] The Inter-agency Field Manual is currently being revised, based on the results of several years of field testing, and should be available in early 1999.

The emphasis for delivery care must be on provision of skilled assistance. In the absence of midwives or nurses, TBAs should be trained in clean and safe delivery practices, early detection of problems, and immediate and safe referral to a health care facility.

The essential interventions for safe motherhood, to which UNHCR agrees, can be summed up as follows[2]:

Before and During Pregnancy

- information and services for family planning
- STD/HIV prevention and management
- tetanus toxoid immunization
- antenatal registration and care
- treatment of existing conditions (for example, malaria and hookworm), according to country policy
- advice regarding nutrition and diet
- iron/folate supplementation
- prevention, early detection and management of complications (e.g. haemorrhage, pre-eclampsia/eclampsia, anaemia, abortion)

During Delivery

- clean and safe (atraumatic) delivery
- prevention, early detection and management of complications (e.g. haemorrhage, prolonged/obstructed labour, eclampsia)

After Delivery: Mother

- management of complications (e.g. haemorrhage, sepsis, eclampsia)
- postpartum care
- information and services for family planning
- STD/HIV prevention and management
- tetanus toxoid immunization

After Delivery: Baby

- resuscitation
- prevention and management of hypothermia
- early and exclusive breast-feeding
- prevention, early detection and management of infections, including ophthalmia neonatorum and cord infections
- birth weight and referral for immunization and growth monitoring

[2] World Health Organization. *Mother-Baby Package: Implementing Safe Motherhood in Countries.* WHO/FHE/MSM/94.11. Geneva, World Health Organization 1994.

II. BACKGROUND

WHAT IS THE REFUGEE SETTING?

Ethnic conflict in Burundi in 1993 and in Rwanda in 1994 forced thousands of people to flee their homelands. Some 495,000 refugees from these countries were accommodated in seven temporary camps in the Ngara District of Tanzania, a remote, poor area of the country with a native population of some 180,000. It was estimated that approximately 200,000 of the refugees were females between the ages of 10 and 50 years and 120,000 were children aged 7-14 years. The vast majority of refugees – more than 400,000 – were from Rwanda. They were given temporary asylum by the Tanzanian Government and were not permitted to farm or trade outside the camps. In late 1996 it became possible for the Rwandan refugees to return home, and all were repatriated in December, leaving only about 80,000 Burundians in the camps. At present there are two established camps in Ngara District – Lukole A and Lukole B – housing Burundian refugees.

In addition to providing a safe haven for Rwandans and Burundians, north-western Tanzania has provided refuge for citizens from the Democratic Republic of the Congo who began crossing Lake Tanganyika in October 1996 to flee civil war. Refugees from the Congo and Burundi continue to arrive daily in the Kigoma Region.

As of this writing, there are nine established camps in the Kigoma Region. Four camps in the northern Kibondo District (Nduta, Mtendeli, Mkugwa, and Kenambwa) house Burundian refugees. An additional three camps in the central Kasulu District (Mtabila I, Mtabila II, and Muyovosi) house Burundian refugees. Two camps, one in Kasulu District (Nyarugusu) and one in the southern Kigoma District (Lugufu) house Congolese refugees. The estimated population for the camps ranges from 3,000 (Mkugwa in Kibondo District) to 77,000 (Lukole A in Ngara District). As of October 1998, the total population in the established camps was estimated at 320,000 (XXX add Lugufu XXX).

UNHCR is responsible for co-ordinating the establishment and maintenance of the camps, while the implementing agencies, which include both national and international NGOs, are responsible for activities at the camp level. There is a UNHCR Sub-Office in Kigoma and Ngara towns, and Field Offices in Kasulu and Kibondo.

HOW ARE THE HEALTH SERVICES ADMINISTERED?

Each camp has a compound at which health services are delivered. Most compounds include facilities for both outpatient and inpatient services, including maternity inpatient services. Patients requiring services not available at the camp health compound (e.g. surgical interventions and complex medical treatment) are referred to a district, regional or tertiary hospital operated by the Ministry of Health (MoH).

The administration of health services is the responsibility of the designated implementing agency for a particular camp. The agency is responsible for hiring and supervising staff, providing and maintaining infrastructure, ensuring the availability of the necessary supplies, equipment and drugs, and implementing and monitoring the delivery of a range of preventive and curative health services. IFRC/TRCS is responsible for health services at Mtabila I, Mtabila II, and Muyovosi camps; Christian Outreach at Nyarugusu camp; IRC at Nduta and Mtendeli camps; UMATI at Mkugwa and Kenambwa camps; and NPA at Lukole A and Lukole B camps.

Health care providers include expatriate and Tanzanian staff, as well as refugee workers who are qualified health professionals or who have been trained by the implementing agency to perform particular tasks related to the delivery of health care services.

WHAT ARE THE SAFE MOTHERHOOD NEEDS OF REFUGEE WOMEN?

Women living in refugee settings require the same services as pregnant women elsewhere. These services include comprehensive antenatal care, including careful assessment, health promotion, screening and treatment for diseases such as syphilis, iron/folate supplementation, malaria prophylaxis/treatment, and tetanus toxoid immunization; clean and safe delivery care, including the prevention, early detection and management of obstetric emergencies; essential newborn care, including thermal protection, basic newborn resuscitation, and early and exclusive breast feeding; and postnatal care, including comprehensive family planning information and methods. The services for pregnant women must be linked by a functioning referral system which has the capacity to respond to obstetric emergencies, if and when they arise.

In an emergency phase, pregnant refugee women may need additional psychological support and more intensive monitoring of the pregnancy to ensure a safe outcome.

HOW ARE SAFE MOTHERHOOD NEEDS OF REFUGEE WOMEN MET?

At the camps in Kigoma and Ngara, antenatal care is provided, usually daily. The care includes most of the main elements recommended by WHO. Not all of the camps have a maternity ward; however, women requiring hospital delivery are referred to the maternity ward at a neighbouring camp. The requirements for clean and safe delivery practices are in place at all camps, for both hospital and home deliveries. At most camps, the capacity exists to respond to almost all of the major obstetric emergencies. The main exception is caesarean section, although one camp in Ngara is able to provide this service. A functioning referral system is in place to transfer women needing emergency obstetric care, from the camp health facility to a MoH referral facility. Postnatal care and family planning information and services are provided at all camps.

The main service providers are midwives, who are supported with emergency backup by camp doctors or clinical officers. Traditional Birth Attendants (TBAs) also play an important role in providing culturally appropriate care for women in the community and forming an important link between the woman and the formal health care system.

WHAT ARE SOME OF THE BARRIERS TO SAFE MOTHERHOOD IN REFUGEE SETTINGS

Possibly the most common barrier to safe motherhood is the inaccessibility of good quality, basic maternal and newborn health services. However, at the refugee camps in Kigoma and Ngara these services are readily accessible and are generally of good quality; in other words, the services are within easy reach of the women in the camps and the quality of the services encourages women to use them. The health services in the camps are free of charge, which eliminates an additional common barrier to safe motherhood.

Another common barrier to safe motherhood is the lack of understanding, at individual and community levels, of the health needs of pregnant women and newborn babies. Health promotion activities aimed at educating women, their partners, families, and the community, should help to overcome this barrier. In the camps, both group and individual health promotion is provided.

Gaps in the availability of basic supplies, equipment and drugs may also create barriers to safe motherhood, although at most camps these gaps are small and do not present major barriers. The aim, of course, is for the implementing agencies to prevent these gaps from occurring.

III. REVIEWING AND STRENGTHENING SAFE MOTHERHOOD SERVICES IN REFUGEE SETTINGS

WHAT COMPONENTS OF SAFE MOTHERHOOD SHOULD BE REVIEWED?

The review of safe motherhood services in the refugee camps in Kigoma and Ngara included the following terms of reference:

Review all aspects of the safe motherhood services, identify strengths and weaknesses of the programme, develop standardized tools, protocols and reporting forms, provide on-the-job training to health workers to strengthen their work. Specifically:

Review antenatal care (ANC) services, standardize procedures and protocols for management of effective antenatal care, including:

- identification and special care for “at risk” pregnancies
- standardization of procedures for routine nutrition supplementation
- review and standardization of management of anaemia in pregnancy, including community-based procedures for distribution of iron/folate supplementation
- recording of appropriate information on maternal health cards
- registration and reporting in ANC registries
- identification and streamlining of ANC visit procedures to reduce waiting time
- review and provision of guidance on health education at ANC clinics
- initiation of discussions and procedures for community-based birth planning
- review and strengthening of the testing, treatment and follow-up of partners for syphilis screening in pregnancy (RPR)

Review clinic-based obstetric care, standardize procedures and protocols for effective management of emergency obstetric care, including:

- review of maternity wards and identification of areas for improvement
- identification of standard lists of equipment for maternity units and current gaps
- standardization of emergency referral systems, including transport procedures
- review and standardization of protocols for neonatal care and emergency obstetric care
- review of the use of partograms and train staff in their appropriate use
- review of the management of the complications of unsafe and spontaneous abortions
- review and standardization of recording and reporting procedures
- introduction of a system for investigating each maternal death

Review referral-level hospitals in each district, working with MoH and others and recommend improvements in the management of emergency obstetric care.

Review the TBA programme in each health agency, including the training, equipping, incentive packages, supervision and monitoring of TBAs, provide on-the-spot direction for strengthening the work of TBAs, including:

- community birth planning
- the role of TBAs in identifying and referring obstetric emergencies
- reporting procedures, including pregnancy outcomes and birth weights

In addition to reviewing the components of safe motherhood services outlined above, a job description was developed for RH Co-ordinators.

HOW SHOULD THE REVIEW BE CONDUCTED AND WHO SHOULD BE INVOLVED?

The health facilities at ten camps were visited, as follows: Mtabila I, Mtabila II, Muyovosi (IFRC/TRCS), and Nyarugusu (AEF) in Kasulu District; Nduta, Mtendeli (IRC), Mkugwa, and Kanembwa (UMATI) in Kibondo District; Lukole A and Lukole B (NPA) in Ngara District. In addition, the following referral facilities were visited: Kabanga Mission Hospital, Kasulu District Hospital and Kibondo District Hospital.

With respect to the review of safe motherhood services in the camps and referral facilities, a common approach was used to collect the required information and determine immediate and future needs/interventions. The WHO Safe Motherhood Needs Assessment[3] was used as a basis for developing various forms to facilitate the collection of information. Specifically, the forms developed and used included those for: (a) interviewing staff about clinical care (antenatal care, delivery and newborn care, including management and referral of obstetric emergencies, and postnatal care); (b) conducting exit interviews with antenatal and postnatal clients; (c) reviewing antenatal, delivery, and postnatal records and registers; (d) holding individual discussions with RH Co-ordinators/focal points, and group discussions with TBAs and women representatives; and (e) assessing the availability of staff, services, clinical protocols/guidelines, drugs, supplies, and equipment (see Appendices 1 through 5).

Postnatal care and family planning services were not included in the terms of reference for the consultancy; however, it seemed appropriate to include postnatal care in the review process because it is provided by the same staff who provide antenatal care. Family planning services, on the other hand, are provided by staff specifically trained for this purpose.

The number of interviews with staff, antenatal and postnatal clients, record reviews and group discussions with TBAs and women representatives, are included in Appendix 6.

The proposed approach for reviewing and strengthening safe motherhood services was discussed with the Health Co-ordinator and the RH Co-ordinator for the implementing NGO before proceeding to the camps for which they are responsible. Modifications in the approach outlined above were made at the suggestion of the RH Co-ordinators although, in general, there was very little need for change.

At the camp level, the RH Co-ordinator or the RH focal point was made available to work with the consultant throughout the review process. In some camps a second staff member was made available to translate during exit interviews with clients and group discussions with TBAs and women representatives. Translation was also provided when interviewing professional staff who found it easier to use their first language.

As the review process progressed, the findings and potential approaches for strengthening services were discussed with the relevant service providers (i.e. midwives) and/or co-ordinators/supervisors (e.g. RH co-ordinators/focal points). In addition, appropriate opportunities throughout the review process were used for informal on-the-job teaching-learning related to various aspects of maternal and newborn care (e.g. the content, organization and delivery of antenatal and postnatal care; management of obstetric emergencies; and newborn care, including basic newborn resuscitation). The discussions and on-the-job teaching-learning were important activities in terms of making the review process action-oriented and participatory in nature.

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[3] World Health Organization. *Safe Motherhood Needs Assessment*. WHO/RHT/MSM/96.18. Geneva, World Health Organization 1996.

Approximately half way through the review process a meeting was arranged with the RH Co-ordinators from the five implementing NGOs to develop a job description for them. Only three RH Co-ordinators were able to attend the meeting, which was held in Kibondo. The participants described their responsibilities as RH Co-ordinators and these were organized under the following headings: programme planning; programme implementation and monitoring; co-ordination; supervision and support; education and training; and other related activities. A copy of the job description was provided to the two RH Co-ordinators who were unable to attend the meeting, for review.

Following completion of the review process, a meeting was held with the Health Co-ordinator, the RH Co-ordinator and other staff members involved in maternal and newborn care for the particular implementing NGO. The purpose of the meeting was to discuss the findings and recommendations, and to review the draft guidelines for antenatal care, delivery and newborn care, and postnatal care, which were developed as the review process progressed. At these meetings the RH Reporting System/Indicators provided by PTSS, UNHCR/HQ was discussed and a copy of the workbook which outlines the system was provided to the RH Co-ordinator. Follow-up on implementation of the system will be provided by the UNHCR Senior Health Co-ordinator, Kigoma (see Appendix 7 for the list of RH indicators).

A final debriefing took place in Kigoma, following completion of the review process, and was attended by the Health Co-ordinator and/or the RH Co-ordinator for each implementing NGO, as well as representatives from UNICEF, IRC, IFRC/TRCS, MSF, AMREF/UMATI, and the Ministry of Health. At this meeting, the main findings of the review process were presented and discussed, the recommendations for strengthening safe motherhood services were reviewed, revised, where necessary, and endorsed, as were the draft guidelines. In addition, plans for implementing the recommendations were discussed and agreed, and the job description for RH Co-ordinators (see Appendix 8) was endorsed.

WHAT WERE THE FINDINGS OF THE REVIEW?

The main findings of the review process are presented under the following headings: antenatal care; labour and delivery care; postnatal care; and traditional birth attendants. Under each of these headings, the findings from all camps are presented together in summary form, while in some instances specific findings are related to a particular camp. Relevant general information about the camps, the health facilities, and the staff involved in the delivery of safe motherhood services is included in Appendix 9.

The first important overall finding is that the staff involved in the delivery of safe motherhood services at the camps visited were, without exception, interested in and supportive of the process. This applies in particular to the RH Co-ordinators and midwives, who were consistently eager to learn as much as possible during the review process, especially with respect to new and/or better ways of providing services. As the review process progressed, it became increasingly clear that, although the circumstances in which midwives and other staff work may be less than ideal, their primary aim is to provide the best possible care to refugee women and their babies.

A second important overall finding is that the women representatives who attended the group discussions conducted during the review process have a positive view of the health services provided for pregnant women. Specifically, they indicated that the services help to: (a) prevent problems during pregnancy through the provision of antenatal care (including malaria prophylaxis, iron/folate supplementation, tetanus toxoid immunization, syphilis screening, and health education); (b) avoid maternal malnutrition through the provision of food supplementation; and (c) respond to the needs of women during labour by providing 24 hour/day service. The main suggestions for improving services included the introduction of surgical obstetric care (i.e. caesarean section) at the camps, and the reintroduction of disposable delivery kits.