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Short Commentary

How to Help Women When Providing Outreach Visits to Rural and Remote Areas of a Low Income Country (LIC)

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In Papua New Guinea (PNG), as in many LICs, there are areas of the country where people do not have access to health services - either because there are no health services or because their village does not have a road link to the nearest (or not so near) health facility. In PNG it is estimated that 20% of people live more than 4 hours walk (travel) from the nearest health facility. In addition, over the past 30 years more than 50% of rural health posts have closed because of health funding, lack of supervisory support, lack of community support and tribal conflict issues. This means that there are large swathes of PNG where nowadays women have no access to health care for their pregnancies.

The maternal mortality ratio (MMR) for women having a supervised birth in a provincial hospital is 50–100 (per 100,000 live births); in a rural health facility the figure is about 200. But if a woman delivers at home and there is little possibility of transfer to a health facility if some serious complication develops (as it does in about 2% of births), then the woman is in great danger of dying; for these reasons the MMR risk of home birth in PNG is about 800/100,000 live births. (In high income countries MMRs are typically less than 10). Therefore, one of the most cost effective ways of helping women not die from pregnancy complications is to help them not get pregnant when they are not wanting to do so; ie. provide them with effective contraception.

In PNG the total fertility rate is 4.4, and Demographic Health Surveys [1] consistently show that women (and men) generally have a desired family size of one child less than the total fertility rate; this indicates a huge unmet need for family planning services. This unmet need for family planning is also an issues in urban areas and rural areas with access to health services, but in remote rural areas where there are no health services women have virtually no choice at all with regards fertility regulation. Research shows that 40% of pregnancies in PNG are unplanned and 20% are unwanted as well [2]; this means that out of the 250,000 births each year in PNG 50,000 - 100,000 are unplanned/unwanted, and probably result in 200–400 additional maternal deaths pa [3].

To be effective strategies to assist women and families obtain and use family planning need to be tailored for individuals, communities and socio-demographic circumstances. Recently a number of hospitals in PNG started offering contraceptive Implants to women as a family planning option for insertion immediately postpartum. Women are counselled in antenatal clinics and indicate to the maternity carers before their due date if they would like to take up this option. Last year about 7000 women received Implants the day after their supervised birth in a health facility, and this provided about 25,000 couple years of protection (CYPs) [4]. However, only 40% of women in PNG currently access a supervised birth: this being the case then how can we assist women and families who live in remote rural areas where there is no opportunity or reasonable access for supervised birth or contraceptive services.

In colonial days (ie prior to independence in 1975) rural health workers would regularly walk to remote areas from their rural health facilities to provide outreach services like immunization and family planning. Very little outreach of this kind continues today. The Missionary Aviation Fellowship is proposing that outreach to remote areas with no health services could be conducted using their small planes by flying a health outreach team into a remote rural airstrip. The outreach team conducts health and medical work over 2–3 days and then is picked up again by another flight. The question is how can we provide something useful for women on these proposal 'fly in- fly out' health outreach trips?

When health outreach patrols take place sick people come, women bring their newborns for vaccination services and their babies for 'a health check', and pregnant women also come for a 'check up'. In remote areas fertility control is not something that people are aware of or consider as a life option. Therefore, couples do not present for 'family planning' assistance. Women who bring small babies for checks and vaccination can be offered Implants and there may be good uptake for these women because few women are contemplating another pregnancy in the near future when they have a small breast feeding baby. However, who can the outreach team assist the pregnant women who attend the outreach mobile clinic?

One antenatal check (with no possibility of a supervised birth) does not actually provide much benefit for the woman, her pregnancy nor improve the chance that she will survive when it comes to lab or and delivery time. However, effective contraception for several years after the birth will at least ensure that, if she survives this birth, she does not die from another (probably unplanned pregnancy) in the near future. Fly in fly out outreach health patrols of this kind are not provided on a

regular basis, and even if there will be another such patrol in the same area when the currently pregnant women have delivered there is no guarantee that they will present or have access to the clinic at that time. For this reason we are considering offering pregnant women a 5 year contraceptive Implant (Jadelle) insertion while they are in the current pregnancy in these exceptional circumstances where supervised birth is not possible and post partum contraception not available either. The World Health Organization (WHO) has declared that inadvertent insertion of progestergen based Implants have no negative impact on a pregnancy [5]. It is reasonable therefore to suggest that 'advertent' insertion of the Implant in pregnancy will likewise have no negative impact, and in these circumstances offer the very great benefit to the woman of about 4 years of postpartum contraception.

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