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Short Communication

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Strengthening Community Based Health Care Provision Capacity is Critical for Emergency Preparedness – Lessons from Iraq and Uganda

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INTRODUCTION

Women, children and the poor constitute the most vulnerable groups in emergencies. Continuity of delivery of services at the community level is critical in preventing morbidity and mortality. Insecurity and other disasters reduce access to public health services. Conventional emergency preparedness emphasizes community capacity development after a disaster to build resilience and thereby mitigate against effects of a similar occurrence in the future. Lessons from Iraq and Uganda seem to indicate that this should be addressed as part of preparedness. Our review of the context in two completely different settings supports this view. We present here, work undertaken in Iraq to strengthen community level Maternal Newborn and Child Health (MNCH) provision before the insecurity following the invasion by Islamic State of Iraq and Syria (ISIS) and experiences from Northern Uganda during the insecurity caused by the Lord's Resistance Army and Ebola Disease outbreaks.

IRAQ - ACCESS TO MATERNAL NEW-BORN AND CHILD HEALTH LIMITED FOR THE MOST VULNERABLE

In 2013 the Ministry of Iraq decided to use Traditional Birth Attendants (TBAs) as a strategy to reach the unreached mothers. TBAs are usually mature women in society who attend to deliveries but are often consulted for other health matters. TBAs are considered a vital link with the formal health services. Available evidence shows that TBAs can prevent some perinatal deaths if well prepared.[1] There is also emerging evidence that deployment of adequate numbers of well trained and supported cadres at the community level can improve Maternal and Child health practices especially those related to postnatal care and early initiation of breastfeeding.[2] Experiences in Malawi with Health Surveillance Assistants and use of community volunteers in Zimbabwe during the cholera outbreaks show they can also have significant impact in controlling communicable diseases outbreaks.

In Iraq and most of the Middle East, the Traditional Birth Attendant (TBA) is an integral part of family organization. She is referred to as *Djiddah*, *Jidda* or *Jiddha* which literally means grandmother. She is consulted on a number of health decisions including provision of delivery, child care services and female circumcision.[3] About 13% of Iraq women seek the services of TBAs and in Al Anbar, Kirkuk, Ninewa and Salahadin, the number varies from 13 - 16%. A Ministry of Health survey in 2011 found 2,210 TBAs linked to both rural (79%) and urban (21%) health centers. Although TBAs are predominantly rural based, they have a significant urban presence in Bagdad, Kirkuk, Babil, Salahdin and Karbala. Most of the TBAs (56%) are middle aged (between 40 and 60 years) and 3% were below 30 years indicating a growing interest in the art among the young. 38% of TBAs are literate. The Ministry of Health

and USAID developed a program to train TBAs and established a system of support supervision and equipping them from October 2013. This is outlined in a Ministry of Health TBA Strategy endorsed in February 2014.[4]

In June 2014 the security situation in Al Anbar, Kirkuk, Ninewa and Salahadin deteriorated significantly with the Islamic State of Iraq and Syria (ISIS) taking up most of the Northern provinces. This led to significant restriction of access and utilization of public health services. For many rural, poor communities, these TBAs remain an important source of service, thanks to the work undertaken to train and equip these cadres. As insecurity increased, most rural poor mothers depended largely on these women for care.

INSECURITY IN UGANDA AND ACCESS TO SERVICES

In a totally different context, northern Uganda experienced insecurity resulting from the insurgency by the Lord's Resistance Army (LRA) for decades. By 2006 the war had displaced almost 1.5 million people into internal displacement camps.[5] A major constraint in the provision of health services was the low levels of staffing which was below 50% of the establishment in 2008.[6] Health services were often offered by Community Health Workers, Traditional Birth Attendants and other traditional healers. The role of these providers became even more significant in the control of communicable diseases including Ebola.[7] Based on these lessons, deliberate efforts were made to create linkages between the health services and these informal providers. Various strategies including recognition of their presence and roles, rewarding them for making referrals, and sensitizing them against harmful practice were utilized while providing them with appropriate skills. This view is widely supported by other observations and studies.[8,9] In the Ebola outbreak August 2000 to January 2001; these community based providers became critical in community education against harmful burial practices, disease surveillance and contact tracing.[10] In surveillance, a category referred to as '*alert'* was introduced in the reporting for community level workers to report anybody in the community who died suddenly and had fever or haemorrhage. This became a critical input in the control of Ebola in Northern Uganda.

CONCLUSIONS

From these two totally different contexts we conclude that the health community has to rethink the role of communities in situations of severely restricted access to care. The delivery of Maternal Newborn and Child Health (MNCH) services in situations of restricted access as in emergencies needs to use the community available resources to continue care. In the case of communicable diseases, the case is even stronger in Africa. After infecting over 25,000 people and causing over 9000 deaths in Sierra Leone, Liberia and Guinea, the Ebola Virus Disease outbreak was showing signs of decline until the second week of February 2015 when an upward trend was seen following an unsafe burial in Guinea. This resulted in 11 new cases from this burial alone.[11] This resurgence was due to communities refusing the safe burial practice instructions by health staff. It is commendable to note that the global strategy has now resorted to a locally driven public health approach of contact tracing, community mobilization and treatment based in the affected localities.[12] Building capacities of local communities in delivery of services has greater potential than has been appreciated in public health.

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