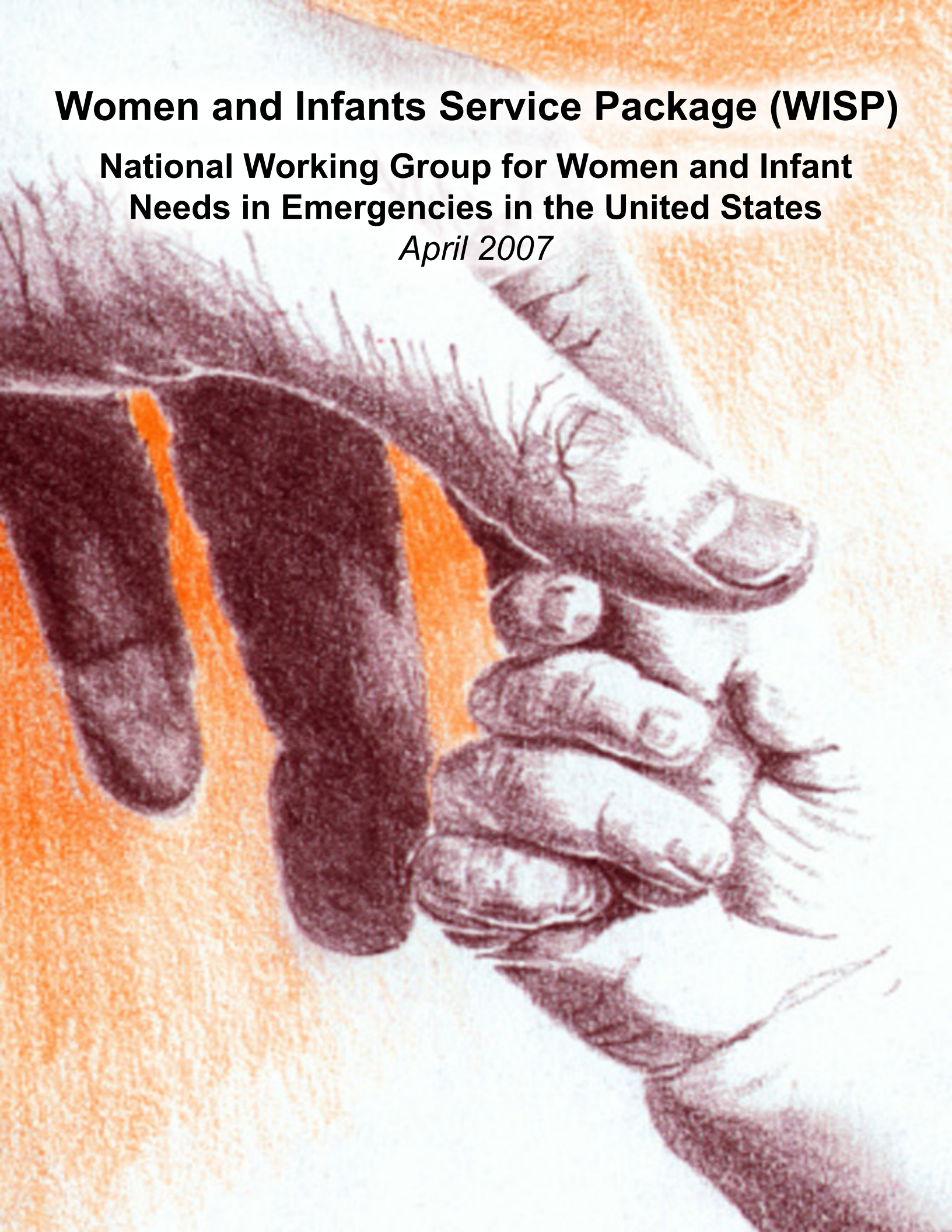
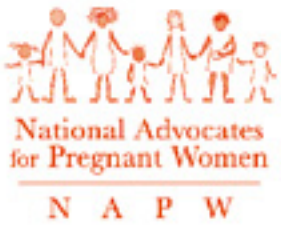
Women and Infants Service Package (WISP)

National Working Group for Women and Infant Needs in Emergencies in the United States

April 2007



Supporting Organizations



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EXECUTIVE SUMMARY

What is WISP?

The mass chaos that followed Hurricane Katrina was a wake-up call for U.S. emergency and disaster preparedness program developers and for maternal and child health providers as it became increasingly apparent that many city and state emergency disaster plans do not take into account the special needs of two of the most vulnerable populations in such events: pregnant women and newborns. In the wake of Katrina, members of the White Ribbon Alliance for Safe Motherhood formed a working group to devise a package of guidelines for state and local government and nongovernmental organizations (NGOs), private groups, and individuals on how to plan for meeting the needs of these vulnerable groups during the acute phase of an emergency. These guidelines, known as the Women and Infants Services Package (WISP), present a framework for the minimum and initial actions needed to respond to the essential health care needs of pregnant women, new mothers, fragile newborns, and infants in a crisis or emergency, such as a natural disaster, an epidemic, or a terrorist event. WISP includes general information, rationale, activities and actions, recommended equipment and supplies, and a monitoring and surveillance component.

The group completed an extensive review of existing state and federal emergency plans in 2006 and found little or no specific attention to this sub-population. The efforts of this group, and others, have been a catalyst for increased attention to this issue and efforts are underway at the federal, state, and organizational level to address these preparedness planning gaps. This is a working document and will be adapted as further evidence, resources, and tools become available.

Goal and Objectives

The goal of WISP is to ensure that the health care needs of pregnant women, new mothers, fragile newborns, and infants are adequately met during and after a disaster. The guidelines are intended to aid emergency planners and managers, maternal and child health organizations, professional associations, and federal, state and local government agencies. WISP guidelines address three major objectives:

1. Identify national, state and local organizations and individuals who will be responsible for coordinating and implementing WISP and advocate for the unique needs of women and newborns.

2. Prevent excess neonatal and maternal morbidity and mortality by:
    - meeting the special needs of pregnant women and infants during, and in the aftermath of a disaster.
    - preventing and managing the consequences of sexual and gender-based violence.
    - preventing unplanned pregnancies.

- reducing HIV and STI transmission.

3. Collect, analyze, and use information to better manage maternal and infant health care programs in emergencies through monitoring and surveillance.

Each topic area includes an explanation of why these measures need to be addressed and lists key activities to consider during the planning and implementation phases.

Why is WISP necessary?

Pregnant women, newborns, and infants have special needs, particularly in times of disaster. Women, for example, experience greater rates of health complications associated with pregnancy, including premature births, low-birth weight infants, and infant deaths. Additionally, there is increased sexual violence, exposure to HIV and other STIs, and lack of access to family planning and other services. Furthermore, in all disaster-affected communities, displaced women and infants living in shelters and evacuee camps often experience little social support, poor security, and limited access to assistance, transportation, health care, and other services. While current U.S. research is limited on the effects of disasters on this population in the United States, anecdotal evidence and reports from government agencies and health care providers has confirmed the reality. In additional to providing guidelines for emergency response, this document calls for further research and evidence gathering in future disasters related to maternal and child health. In addition, WISP seeks to provide guidance on types of emergencies, such as pandemic flu and bioterrorist attacks, in which the public health community does not yet know the full effects, but for which planning is paramount.

In the case of pandemic flu planning, preparations for childbirth are particularly important. Childbirth is the second most common reason for a hospital visit (4.0 million per year with an average length of stay of 2.6 days.). While predictions of the impact of an influenza pandemic in the United States vary, it is generally expected that hospital capacity will be overwhelmed and women in labor will face the possibility of delivering outside of the usual health care system. For this reason, attention needs to be directed toward developing realistic plans to address the needs of childbearing women and their infants in the event of a flu pandemic.

Federal, state and local emergency planners and managers have recognized gaps in emergency plans and intensive efforts are being coordinated to improve these plans. As emergency/disaster preparedness plans are developed for all public health concerns, it is imperative that the special needs of these vulnerable populations are taken into consideration.

INTRODUCTION

What is WISP?

The Women and Infants Service Package (WISP) guidelines present a framework for the minimum and initial actions needed to respond to the essential health care needs of pregnant women, new mothers, fragile newborns, and infants in a crisis or emergency in the United States, such as a natural disaster, an epidemic, or a terrorist event. The purpose of this document is to provide guidance to state and local government and nongovernmental organizations (NGOs), private groups, and individuals on how to plan for meeting the needs of these vulnerable groups during the acute phase of an emergency. WISP includes general information, rationale, activities and actions, recommended equipment and supplies, and a monitoring and surveillance component. The package has been adapted by a committee of professional maternal, neonatal, and public health experts from a variety of international[1,2] national, and professional standards.

Goal

The goal of WISP is to ensure that the health care needs of pregnant women, new mothers, fragile newborns, and infants are adequately met during and after a disaster. WISP guidelines will assist policymakers, planners, and responders to achieve the objectives described below. While neither exhaustive nor prescriptive, WISP guidelines identify key needs and other issues for consideration for a wide-range of disaster scenarios. Emergency planners and maternal and child health providers will adapt the guidelines to their needs.

Objectives

1. **IDENTIFY** national, state and local organizations and individuals who will be responsible for coordinating and implementing WISP and advocate for the unique needs of women and newborns.

2. **PREVENT** excess neonatal and maternal morbidity and mortality:
    - 2.1 **MEET** the special needs of pregnant women and infants before, during, and in the aftermath of a disaster.
    - 2.2 **PREVENT** and **MANAGE** the consequences of sexual and gender-based violence.
    - 2.3 **PREVENT** unplanned pregnancies.
    - 2.4 **REDUCE** HIV and STI transmission.

[1] Inter-agency Working Group on Reproductive Health in Refugee Situations, *Reproductive Health for Refugees: an Inter-agency Field Manual,* 1999.
[2] Women's Commission for Refugee Women and Children, *Minimum Initial Service Package for Reproductive Health in Crisis Situations: A Distance Learning Module,* September 2006.

3. **COLLECT**, **ANALYZE,** and **USE** information to better manage maternal and infant health care programs in emergencies through monitoring and surveillance.

Why is WISP necessary?

Pregnant women, newborns, and infants have special needs, particularly in times of disaster. Women, for example, experience greater rates of health complications associated with pregnancy, including premature births, low-birth weight infants, and infant deaths. Additionally, there is increased sexual violence, exposure to HIV and other STIs, and lack of access to family planning and other services. Furthermore, in all disaster-affected communities, displaced women and infants living in shelters and evacuee camps often experience little social support, poor security, and limited access to humanitarian assistance, transportation, health care, and other services. As emergency/disaster preparedness plans are developed for all public health concerns, it is imperative that the special needs of these vulnerable populations are taken into consideration. The purpose of WISP is to provide planning guidance in these areas.

Who is responsible for incorporating WISP into preparedness programs and response?

Emergency and disaster preparedness program developers and maternal and child health providers are responsible for incorporating the activities and information outlined in WISP. In addition, other nongovernmental organizations are responsible for including these precautions in their activities, and individual constituents are likewise responsible for ensuring these precautions are implemented.

Why was WISP developed?

As illustrated in the aftermath of Hurricane Katrina, mass chaos—including lack of medical care, destruction of health care facilities, food and water shortages, and separation of families—can have a devastating effect on communities affected by disaster, with pregnant women and newborns being particularly vulnerable.

In the days after Hurricane Katrina struck Louisiana, 125 critically ill newborn babies and 154 pregnant women were evacuated to Woman's Hospital in Baton Rouge. Some of the fragile newborns arrived without their mothers, and some women delivered on their way to the facility[3]. Of the pregnant women who managed to reach a health clinic, many arrived without records, medications, and prenatal vitamins, putting them at risk for further complications. Many facilities also lacked basic provisions such as diapers, formula, baby bottles, and clean clothes.

Two other problems that often occur after an emergency, interrupted access to contraceptives for couples and the increased incidence of sexual violence, can increase the number of unplanned pregnancies. The birth rate in New Orleans increased by 39% from May 2005 to May 2006, and rates for June and July are expected to have increased even more substantially[4]. The large increase in births in affected areas can put a serious strain on existing facilities and services. While these issues

[3]Rama Lakshmi, "Group Urges Disaster Planning for Pregnant Women, Babies," *Washington Post,* 17 Aug. 2006.
[4] Szabo, "New Orleans Birthrate Increases," *USA Today,* 29 Aug. 2006

also have roots in pre-existing social conditions, they are exacerbated in emergencies and the eminent need to address these is recognized.

Hurricane Katrina served as a wake-up call for all health professionals, emergency planners, and citizens alike. A review city and state emergency disaster plans revealed that many do not take into account the special needs of pregnant women, newborns, infants, and mothers of newborns and infants. Imminent disasters such as pandemic flu, terrorist attacks, and natural disasters represent an ever-present threat that needs to be acknowledged. While the response will differ in each of these circumstances, the need to address the special needs of women, newborns, and infants in all of these events is critical. When the members of the White Ribbon Alliance for Safe Motherhood, an active leader in maternal and neonatal health in the international arena, recognized that a gap in preparedness planning existing in the United States, they formed a working group to devise a package of guidelines that has become WISP.

Who developed WISP?

The National Working Group is composed of representatives from the following groups:

- American Association of Birth Centers (AABC)
- American College of Nurse-Midwives (ACNM)
- American College of Obstetricians and Gynecologists (ACOG)
- Association of Maternal & Child Health Programs (AMCHP)
- Centers for Disease Control and Prevention (CDC)
- DC Rape Crisis Center
- George Washington University Dept. of Health Sciences & Global Health
- March of Dimes
- Midwives Alliance of North America (MANA)
- National Association of Certified Professional Midwives (NACPM)
- National Association of County & City Health Officials (NACCHO)
- Perinatal Programs at MIEMSS (Maryland Institute for Emergency Medicine Services/Systems)
- Sacopee Rescue Inc.
- SaferMaternity.org
- Save the Children
- University of Maryland, School of Nursing
- White Ribbon Alliance for Safe Motherhood (WRA)
- Women's Commission for Refugee Women and Children

How can organizations obtain funding to implement activities outlined in WISP?

Organizations responding to women and infants during an emergency should include funding for WISP activities in proposals to donors, such as the Health Resources and Services Administration Maternal and Child Health Bureau, the Centers for Disease Control Division of Reproductive Health, the Department of Defense, the Department of Homeland Security, or private donors who may support emergency response activities. For more information on how to structure and implement maternal- and infant health-based emergency response programs, interested parties should contact organizations such as the Association of Maternal and Child Health Programs (AMCHP), the National Association of County and City Health Officials (NACCHO), and the Federal Emergency Management Agency (FEMA).

I. COMPONENTS OF WISP

The components of WISP guidelines are presented below in three sections, one each for the three objectives. Each component includes a rationale for and key activities to consider when planning and implementing the maternal and infant health response during an emergency or disaster. Supporting resources that can be used for reference during planning and implementation can be found in Chapter II: Resources and additional resources are listed in detail in Appendix B.

1. IDENTIFY organizations and individuals who will be responsible for coordinating and implementing WISP and advocate for the unique needs of women and newborns

State and local governments, nongovernmental, voluntary, faith-based, and professional organizations, employers, and health care providers are all challenged to meet the increasing demands for general public health disaster preparedness. Those involved in policy as well as implementation, monitoring and surveillance will benefit from a coordinated effort to identify the resources necessary to respond adequately to the emergency needs of special populations, such as pregnant women, their infants, and their families. WISP is not intended as a parallel emergency system; rather, the guidelines should be incorporated into existing emergency plans and added to existing information, education, and communication materials already distributed to communities and households.

Community participation is important at all stages of any emergency to ensure the acceptability, appropriateness, and sustainability of maternal and infant services. Through community participation, essential information on the cultural, economic, ethical, legal, linguistic and religious backgrounds of the populations can be gathered to inform emergency response plans for key services and programs. It is especially important to empower women as part of this process to ensure that services are provided to them.

Information received from the community should be used to identify:

- The best means of access to providers by the community
- Appropriate sites for providing services
- Training needs of care providers and responders
- Available resources
- Proper means of disseminating information to the community
- Options for women if they are not able to reach a birthing facility (e.g., a birth preparedness/complication readiness plan)

The ability of communities to prevent adverse outcomes for pregnant women, fragile newborns, and infants during disasters will be directly proportional to emergency planning efforts and coordination among the many groups responsible for public health in disaster situations.

Key activities to consider during planning and implementation:

1. Review regional, state, and local planning documents for appropriate and consistent content.
2. Reach out to engage governmental and nongovernmental organizations, hospitals, midwives, and other health care providers and women's groups.
3. Build consensus for planning and adopting an emergency plan.
4. Identify responsible entities and a 'chain-of-command' for disaster planning at the regional, state, and local level.
5. Assess needs and determine how to use and share available resources of stakeholders.
6. Provide information to stakeholder organizations and individuals in the community about the emergency plan.
7. Engage women through multiple venues, including churches and religious groups, during health care visits, and creative media, to communicate the plan.

2. PREVENT excess neonatal and maternal morbidity and mortality

2.1 MEET the special needs of pregnant women and infants before, during, and in the aftermath of a disaster.

Why is meeting the special needs of pregnant women and infants before, during, and in the aftermath of a disaster important?

The stressful conditions that often prevail during an emergency or disaster situation can increase the risk of complications among pregnant women. Any population affected by an emergency or crisis will include women who are in the later stages of pregnancy and who may deliver within the initial phase of a disaster. In the United States, approximately 99% of all births occur in a hospital or clinical setting[5]. During an emergency, however, this setting is not always immediately accessible. In the early phase of an emergency, for example, births might take place outside the health facility without the assistance of trained health personnel. Without access to emergency obstetric services, many women and infants could die or suffer long-term health consequences that are preventable. In addition, in an emergency many women who had not planned to breastfeed will be breastfeeding out of necessity, so more information on how to successfully establish lactation will be needed by health professionals and consumers. Another concern is that since immediate physical needs tend to be the health priority during an emergency, the critical mental health needs of those involved often is not addressed. In fact, depression during and after pregnancy is the most common maternal health complication, affecting 1 out of 8 women.

[5] American College of Nurse Midwives (ACNM).

Key activities to consider during planning and implementation:

1. Become familiar with basic local and regional health and vital statistics. Planning for emergencies should take into account the expected numbers of births per unit time, population demographics, and information about where births currently take place.
2. Engage local and regional potential providers—obstetric/gynecologists (OB-GYNs), certified nurse midwives (CNMs), certified midwives (CMs), certified professional midwives (CPMs), labor and delivery (L&D) nurses, emergency medical technicians (EMTs), family practice physicians, nurse practitioner (NPs), physician assistants (PAs), emergency and first responders, and doulas[6] to:
    - Educate and train home-based delivery skills, services, and equipment to institution-based birth providers.
    - Acknowledge that they (the providers named above) may not have experience providing delivery skills with few resources or medications, or working with women who have expectations of a medicated delivery.
3. Engage local maternal and child health experts, including the March of Dimes chapters and MCH/Title V Directors, in developing specific plans to meet the needs of pregnant women and infants.
4. Prepare or organize maternal and infant health care information, education, and communication (IEC) outreach among communities using IEC tools, including interpersonal and mass media communications. Materials can include:
    - Information on how to prepare for an emergency home birth (all three stages of birth).
    - Contents of an emergency home birth kit to be prepared for disaster situations.
    - Information on optimal breastfeeding practices, relactation, and steps to prepare sterilized formula using powdered formula if breastfeeding is not an option. (More information can be found in Appendix II: Resources, II. Breastfeeding, A. CDC.)
    - Disaster preparedness information specifically developed for families with infants or anyone caring for a newborn.
    - Disaster preparedness information specifically developed for pregnant women.
    - Contact numbers or locations to try to reach for emergency assistance or to learn methods of evacuation specifically catering to maternal and infant health care.
    - Websites and toll-free numbers for maternal health resources and reporting.

[6] Doula: A person who accompanies a woman in pregnancy and labor, taking care of her emotional needs throughout childbirth. A doula also provides support and suggestions for partners that can enhance their experiences of birth. (DONA International)

5. Support, facilitate, and integrate into the primary health care system ways to address the following needs during the acute phase of an emergency:
    - prenatal care
    - postpartum care
    - breastfeeding and re-lactation
    - newborn care
6. Initiate or reinforce a referral system to transport and manage obstetric emergencies.
7. Determine how pregnant, laboring, and postpartum women will be triaged and cared for.
8. Identify the safest place for pregnant and laboring women, newborns, and their families. If appropriate, identify and provide separate shelters for pregnant women and families with newborns and infants.
9. Collaborate with emergency mass housing/emergency shelter planners at the state and local levels to assist in developing temporary shelters, transitional housing, mobile units, or other locations for evacuees.
    - Determine who is involved with emergency housing and transitional housing camps.
        - Agencies/organizations may include the local American Red Cross, local faith-based organizations, local emergency managers, and state emergency housing planners
    - Develop local plans that determine how emergency shelter planners can improve the quality of life for the women and infants who will be living in the shelters and camps.
    - Draft and sign memoranda of understanding (MOUs) between responsible organizations that define the roles and responsibilities for caring for women and infants living in shelters and camps.
10. Identify, compile, and provide equipment, supplies, and practice guidelines for basic birth kits and normal deliveries for use by mothers, midwives, or health professionals to promote safe deliveries outside of traditional healthcare institutions. (More information on birth kits can be found in Chapter II: Resources and Appendix B.)
11. Identify, compile, and provide equipment, supplies, and practice guidelines for high-risk and difficult deliveries to ensure safe deliveries in alternative sites.
12. Plan for providing safe and accessible prenatal care and well-baby services for the affected population.
13. Determine how mothers can stay with their newborns if they are evacuated and how to reconnect families with infants if they become separated.
14. Collaborate with mental health response teams to address the needs of perinatal depression. (More information on perinatal depression can be found in Chapter II: Resources.)

To be considered

Note on Liability raised by professional associations:

The current professional liability crisis is having a significant impact on the delivery of MCH services in the United States. Obstetrician-gynecologists and nurse midwives are typically covered by professional liability policies that limit the settings in which they can practice. The decision about the safest place to give birth in an emergency should be made based on clinical factors. Insurance carriers should offer protection from liability to OB providers who attend births outside the usual settings. Emergency planners and responders need to be aware of the liability laws and issues in their areas.

2.2 PREVENT and MANAGE the consequences of sexual violence

Why take the possibility of sexual violence into account?

Sexual violence has been strongly associated with emergency situations[7]. In such circumstances, women and children are at increased risk and can be forced into having sex to gain access to basic needs such as water, food, or even security. In this context, it is vital that all stakeholders in emergency response be made aware of this issue and put in place preventive measures; in addition, measures for assisting disaster survivors and evacuees who have been victims of sexual violence, including rape, which should be established in the early phase of an emergency.

Key activities to consider during planning and implementation:

1. Preventing and managing sexual violence:
    - Design and locate evacuee centers or shelters, in consultation with evacuees when possible, to enhance physical security.
    - Ensure evacuees and disaster survivors are informed of the availability of services for survivors of sexual violence.
    - Identify individuals or groups who may be particularly at risk of sexual violence (single female heads-of-households, unaccompanied minors, etc.) and address their needs for protection and assistance.
2. Health care responses to sexual violence:
    - Provide a medical and forensic response to survivors of sexual violence, as medically appropriate.
    - Ensure access to emergency contraception and pregnancy tests.
    - Make Sexual Assault Forensic Examiner (SAFE) and Sexual Assault Nurse Examiner (SANE) kits available.
3. Security and legal issues:
    - Ensure the presence of female protection, health staff, and interpreters.
    - Assure medical evidence documentation for legal proceedings, as requested and required.

[7] Inter-Agency Standing Committee, *Guidelines for Gender-Based Violence Interventions in Humanitarian Settings.*

4. Assessment/incidence data collection:
    - Identify and provide outreach to sexual violence survivors.
    - Use emergency workers that have knowledge of forensic exams and evidence chain of custody to protect a woman's ability to pursue legal channels after the disaster.

2.3 PREVENT unplanned pregnancies

Why address unplanned pregnancy?

Approximately six million pregnancies occur every year in the United States, three million of which are unplanned[8]. The interruption of access to contraceptives for couples, as well as the increased incidence of sexual violence that often occur during the aftermath of an emergency, increase the number of unplanned pregnancies. Unplanned pregnancies have been associated with maternal depression, maternal and fetal malnutrition, low birth weight infants and premature labor, putting both the infant and mother at risk during pregnancy, birth, and the postpartum period. Preventing unplanned pregnancies, accordingly, is a crucial component of responding to the needs of women and infants in emergencies.

Key activities to consider during planning and implementation:

1. Ensure immediate availability of condoms.
2. Ensure access to contraceptive methods currently in use and make provisions for women to access providers.
3. Ensure providers have up-to-date knowledge of family planning methods, including the Lactational Amenorrhea Method (LAM) based on specific patterns of breastfeeding, to suppress ovulation, and natural family planning methods.
4. Ensure access to emergency contraception.

2.4 REDUCE HIV and STI transmission.

Why is reducing HIV and STI transmission necessary?

At the end of 2005, there were approximately 1.2 million adults and children living with HIV in the United States. The current rate of HIV diagnoses in the United States per year is 40,000 people[9]. Circumstances that can lead to the increase of HIV and STI rates can include:

- Risky sexual behavior such as rape and sexual exploitation resulting from vulnerability or as a means of survival.
- Normally available HIV counseling and other programs being suspended during a crisis.
- Limited access to condoms.
- Temporarily unavailable treatment for those infected.

[8] Guttmacher Institute, *In the Know: Questions About Pregnancy, Contraception and Abortion,* May 2006.
[9] Global Health Council.

With the proper methods and successful emergency planning, the rate of infection can be controlled in circumstances that would otherwise be favorable to increased HIV and STI transmission.

Key activities to consider during planning and implementation:

1. Assess the need for treatment for HIV+ women and providing links to providers.
2. Ensure adequate supply of HIV treatment drugs.
3. Provide prevention of mother-to-child transmission (PMTCT) education and treatment to health personnel and the community. Materials may include:
    - Safer delivery practices
    - Counseling and support for infant feeding
    - Access to PMTCT antiretroviral drugs
4. Educate providers to ensure that universal precautions that reduce the risk of transmission of blood-borne pathogens through exposure to blood or body fluids among patients and health care workers are implemented. Ensure providers have an adequate supply of latex (or latex alternative) gloves. In cases of exposure, establish a referral system for laboratory screens and testing, if available.
5. Guarantee the availability of free condoms, making sure the public is aware that condoms are available and where they can be obtained. Ensure confidentiality and privacy at condom distribution points.

3. COLLECT, ANALYZE, and USE information to better manage maternal and infant health care programs in emergencies through monitoring and surveillance.

In order to better manage maternal and infant health care programs in emergencies, a system of monitoring and surveillance of deliveries and births, complications, staffing, equipment, supplies and drugs needs to be implemented and adhered to by all contributing parties. To ensure that the situation is adequately assessed, such monitoring needs to begin at the onset of the emergency/disaster and continue until the situation is completely resolved. To ensure that the needs of women and infants are adequately met in a time of crisis, each community needs to apply a unique system of implementation by assessing its own interests and capacities.

During the early phase of an emergency, a limited amount of data should be collected to assess the implementation of WISP, and modifications should be made as needed. Information on mortality and morbidity by age and sex should be routinely collected during the early phase of an emergency, and for longer periods in the case of displaced populations living in transitional housing sites.

The planning process should consider how important monitoring and surveillance data and indicators will be reported. Efforts should be made to keep the collection and reporting simple, to determine who would benefit from such data, and to share the information. Some indicators to take into account are listed below; this is a suggested rather than a comprehensive list, and should be adapted as appropriate.

WISP Indicators Checklist

1. Collect or estimate basic demographic information, including:

- ☐ Total population
- ☐ Number of women of reproductive age
- ☐ Number of men of reproductive age
- ☐ Crude birth rate
- ☐ Maternal mortality rate
- ☐ Infant mortality rate
- ☐ Age-specific mortality rate
- ☐ Sex-specific mortality rate
- ☐ Number of pregnant women
- ☐ Number of lactating women

2. Identify organizations or individuals who will be responsible for coordinating and implementing WISP and advocate for the unique needs of women and newborns.

- ☐ Organizations or individuals identified to spearhead development and implementation of emergency plans, such as governmental and nongovernmental organizations, hospitals, midwives and other health care providers, and women's groups.
- ☐ Comprehensive plan developed and communicated to the community and stakeholders.
- ☐ Materials for the implementation of WISP available and used.

3. Prevent excess neonatal and maternal morbidity and mortality.

- ☐ Birth kits for providers and families available and distributed.
- ☐ All potential emergency care providers trained and up to date on out-of-facility birthing skills.
- ☐ IEC campaign implemented. NOTE: Further evaluation can be conducted by assessing the effectiveness of the campaign in successfully communicating key messages to target audience(s). This type of evaluation should be conducted during planning and evaluation stages.
- ☐ Shelter beds available to pregnant women in designated shelters.
- ☐ Shelter beds available to families with infants in designated shelters.
- ☐ Emergency hotline or website available for maternal health resources.
- ☐ Referral system for obstetric emergencies functioning.
- ☐ Support systems identified for:
    - prenatal care
    - postpartum care
    - breastfeeding and re-lactation
    - newborn care

4. Prevent and manage the consequences of sexual and gender-based violence.

- ☐ Systems to prevent sexual violence are in place.
- ☐ Health service able to manage cases of sexual violence.
- ☐ Staff trained (retrained) in prevention and response systems for cases of sexual violence.

5. Prevent unplanned pregnancies.

- ☐ Condoms and emergency contraceptives readily available.
- ☐ Sites identified for future delivery of comprehensive family planning services.
- ☐ Plan in place for delivery of all commonly used family planning methods.

6. Prevent HIV and STI transmission.

- ☐ Materials in place for adequate practice of universal precautions.
- ☐ Health workers trained/retrained in practice of universal precautions.
- ☐ Condoms procured and distributed in a free and confidential manner.
- ☐ PMTCT supplies and delivery systems in place.
- ☐ Sites and resources identified for confidential testing and treatment of HIV and other STIs.

Further, once the emergency or crisis has been resolved or is in a recovery phase, the individual(s) and organizations responsible for planning and implementing WISP will need to revisit their strategy and evaluate whether the goals and objectives were successfully and efficiently met. Success stories and specific challenges must be incorporated into a lessons learned section of the plan. WISP is a dynamic guideline to be updated and adapted for each scenario.

For more guidance on monitoring and surveillance techniques, please contact emergency planning and prevention specialists as listed in Chapter II: Resources. Participating agencies and organizations can be found under "1. National, State, and Local Information and Outreach" and "7. Disaster Preparedness for Pregnant Women and Families with Infants."

II. RESOURCES

In planning and implementing the suggested guidelines and activities within WISP, readers will find the following materials and resources helpful.

1. National, State, and Local Information and Outreach

Department of Homeland Security – Planning and Prevention
http://www.dhs.gov/dhspublic/display?theme=14

National Disaster Medical System
http://www.ndms.fema.gov/

State-specific links
http://www.pandemicflu.gov/plan/tab2.html#stateinfo

2. Disaster Preparedness for Pregnant Women and Families with Infants

American Academy of Pediatrics
www.aap.org

a.) Family Readiness Kit: Preparing to Handle Disasters
www.aap.org/family/frk/frkit.htm

American College of Nurse Midwives
http://www.midwife.org/education.cfm?id=984

March of Dimes
www.marchofdimes.com

a.) *Disaster Planning – Meeting the Special Needs of Pregnant Women and Infants – 6 Key Elements for Every Disaster Plan* (attached as Appendix C)
b.) Disaster Preparedness Information
- Prepare for Disasters: Special Information for Families with Infants or Anyone Caring for a Newborn
- Prepare for Disasters: Special Information for Pregnant Women

3. Funding

Association of Maternal and Child Health Programs
www.amchp.org

National Association of County and City Health Officials
http://www.naccho.org

4. Births in Out-of-Hospital Settings

Giving Birth in Place: A Guide to Emergency Preparedness for Childbirth, American College of Nurse-Midwives, 2003, available at: http://www.midwife.org/about.cfm?id=288

5. Birth Kits

Resources are included here and examples of birth kit materials and supplies can be found in Appendix A.

Birth House Supply
http://home.comcast.net/~l.amondson-muller/birthhousesupply.html

Cascade Healthcare Products, Inc.
http://www.1cascade.com/category.aspx?categoryID=1034

Everything Birth
http://midwifesupplies.com/

Homebirth Equipment List
http://www.homebirth.org.uk/list.htm

Homebirth Sample Kit
http://pregnancy.about.com/library/blbirthkit.htm

Natural Birth Supplies
http://www.naturalbirthsupplies.com/page2.html

Supporting Women in their Childbirth Choices: Supported Births of Arizona
http://www.supportedbirthaz.com/ShopOurStore_files/childbirthkitsnsupplies.htm

6. Breastfeeding

Baby Transport in an Emergency: Babywearing
http://www.mamatoto.org/

International Lactation Consultant Association: Position on Breastfeeding in Emergencies
http://www.ilca.org/pubs/InfantFeeding-EmergPP.pdf

La Leche League: Emergency Breastfeeding Resources
http://www.lalecheleague.org/emergency.html

U.S. Breastfeeding Committee: Infant and Young Child Feeding in Emergencies
http://www.usbreastfeeding.org/Issue-Papers/Emergency.pdf

(Complete document: *Infant and Young Child Feeding in Emergencies: Operational Guidance for Emergency Relief Staff and Programme Managers*, Version 2. IFE Core Group, May 2006.)

WHO guidelines on Relactation
http://www.who.int/child-adolescent-health/New_Publications/NUTRITION/WHO_CHS_CAH_98_14.pdf

World Alliance for Breastfeeding Action: Fact Sheet on Feeding Babies in Emergencies
http://www.waba.org.my/pdf/Factsheet.pdf

7. Perinatal Depression

American Psychological Association
http://www.apa.org
1-800-374-2721

Hotlines for Women and Families:

a.) 1-800-PPD-MOMS/1-800-773-6667 (Trained counselor on call 24 hours)
b.) 1-877-773-4773 PPD Hope (Peer referral within 48 hours)

National Institute of Mental Health, NIH, HHS
http://www.nimh.nih.gov
301-496-9576

National Mental Health Association
http://www.nmha.org
1-800-969-NMHA

National Mental Health Information Center, SAMHSA, HHS
http://www.mentalhealth.org
1-800-789-2647

National Women's Health Information Center, HHS
www.4women.gov/faq/postpartum.htm
1-800-994-9662 (English and Spanish)

Postpartum Support International
http://www.postpartum.net
1-805-967-7636 (Leave message for a local peer referral)

8. HIV/AIDS and STI

Interagency Standing Committee Guidelines for HIV/AIDS Interventions in Emergency Settings
http://www.unfpa.org/upload/lib_pub_file/249_filename_guidelines-hiv-emer.pdf

9. Family Planning

Emergency Contraception:

a.) http://www.plannedparenthood.org/pp2/portal/files/portal/medicalinfo/ec/fact-emergency-contraception.xml

b.) http://www.emergencycontraception.org/asec/resources.html

Essentials of Contraceptive Technology:
http://www.infoforhealth.org/pubs/ect/wallchart/index.shtml

APPENDIX A: Birth Kits

Content Examples

I. Emergency Birth Kit for Professionals

1. Pair of sterile exam gloves
2. Sterile disposable scalpel
3. Plastic-lined underpad
4. Disposable towels
5. Receiving blanket
6. Sterile gauze pads
7. Sterile plastic umbilical clamps
8. Disposable plastic apron
9. Plastic bag for placenta
10. Twist ties
11. OB towellettes
12. Lubrication jelly
13. Infant hat
14. Scrub brush, hibiclens, sterile
15. Suturing materials and local anesthetics
16. IV set and LR fluids
17. Satellite phone
18. Job aid – laminated card

Medical Equipment

1. Sphygnomanometer and stethoscope
2. Fetoscope or Doppler
3. Cylinder of oxygen, a bag and mask for mother and baby
4. Baby resuscitation equipment
5. Oxytocin and methergine from federal stock
6. Vitamin K

II. Birth Kit for Families

1. 10 blue bed pads 23" by 24"
2. 1 plastic "peri-bottle"
3. 1 newborn hat
4. 6 packs of sterile lubricant
5. 2 plastic newborn cord clamps
6. 12 alcohol prep pads, individually wrapped
7. 1 dozen hospital-grade sanitary pads
8. 12 sterile gauze pads
9. 1 bulb syringe
10. 1 bottle of peroxide solution (for cleaning blood stains from carpet)
11. A thermometer
12. Crank radio to tune in for emergency news and to charge a cell phone

APPENDIX B: Additional Resources

I. HIV/AIDS

A. Preventing Mother-to-Child Transmission

1. ***Prevention of Mother-to-Child Transmission of HIV/AIDS: Resources for Programs Volume I.*** **The White Ribbon Alliance for Safe Motherhood, April 2006.**

   This is a collection of resources related to PMTCT, including the best articles, reports, and other helpful documents. The following sections are included:

   - General HIV/AIDS information
   - General information on prevention of mother-to-child transmission
   - Integrating PMTCT with maternal and reproductive health and family planning
   - Gender and HIV/AIDS
   - Community involvement and mobilization
   - Voluntary counseling and testing
   - PMTCT-Plus
   - Breastfeeding in the context of HIV/AIDS

   Please visit the WRA website at www.whiteribbonalliance.org to request a copy.

2. ***Testing and Counseling for Prevention of Mother-to-Child Transmission of HIV (TC for PMTCT) Support Tools.*** **World Health Organization, December 2005.**

   The TC for PMTCT Support Tools facilitates the integration and delivery of essential PMTCT messages in antenatal care, labor and delivery, and post-delivery facilities in resource-constrained settings. The flipcharts, client brochures, wall charts, and reference guide can be adapted to include national policies and protocols referral services. The tools were developed by the CDC, World Health Organization (WHO), UNICEF, USAID, and their PMTCT implementing partners.

   To order printed copies send an e-mail to info@cdcnpin.org (include TC for PMTCT as the subject line and attach the form to your e-mail). The order form is available at http://www.womenchildrenhiv.org/doc/p05-vc/vc-10-order.doc

   To order by phone, call 1-919-361-4892 or fax the order form to 1-888-282-7681.

B. Universal Precautions

1. ***Universal Precautions, Including Injection Safety HIV/AIDS.*** **World Health Organization available at http://www.who.int/hiv/topics/precautions/universal/en/#cost**

   This site comprehensively provides the rationale and procedures for providing universal precaution education. The site focuses primarily on injection safety but the proper ways of dealing with soiled linens and exposure to bodily fluids are also explained in detail. Information here can be used as a basis for enforcing universal precautions. Resources that will supply further information are mentioned below.

II. BREASTFEEDING

Disasters: where does breastfeeding fit in?

Disasters disproportionately impact pregnant and nursing women and young children. A family disrupted by an emergency is twice-victimized if breastfeeding is abandoned. Women play a critical environmental role by their ability to provide a safe and secure food supply for their young children. Promoting breastfeeding prior to environmental disasters and protecting breastfeeding during and after disasters, especially floods and earthquakes, is a fundamental part of disaster mitigation and management.

Humanitarian relief that offers infant formula in an emergency may spring from good intentions, but these efforts undermine a woman's confidence in her power to provide food and protection for her child. It is especially difficult to use formula safely in disaster conditions, and formula feeding also risks the considerable increase in child morbidity and mortality that comes when children lose the unique anti-infective properties of breastmilk. It is the infants in communities where no one remembers how to breastfeed who are most at risk during disasters[10].

A. CDC: Breastfed Babies Should Continue Breastfeeding after a Natural Disaster or Power Outage

http://www.bt.cdc.gov/disasters/foodwater.asp

"Breastfed infants should continue breastfeeding. For formula-fed infants, use ready-to-feed formula if possible. If using ready-to-feed formula is not possible, it is best to use bottled water to prepare powdered or concentrated formula. If bottled water is not available, use boiled water. Use treated water to prepare formula only if you do not have bottled or boiled water.

- If you prepare formula with boiled water, let the formula cool sufficiently before giving it to an infant.
- Clean feeding bottles and nipples with bottled, boiled, or treated water before each use.
- Wash your hands before preparing formula and before feeding an infant. You can use alcohol-based hand sanitizers for washing your hands if the water supply is limited."

B. Basic Aid for Breastfeeding

Infant Feeding in Emergencies: Core Manual for Training, Practice, and Reference. Module 2, Version 1.0. **ENN, IBFAN, Terre des hommes, UNICEF, UNHCR, WHO, WPF, December 2004.**

Step 1: **Ensure effective suckling:**

- Observe a breastfeed for the four points of good attachment (areola, mouth, lip, chin) and effective suckling.
- If attachment is not good or suckling not effective, improve position (straight, facing, close, supported) and help attach the baby. If necessary, also improve the position by:
    - Reducing baby's wrappings so s/he can reach breast.

[10] Commission on the Status of Women, Theme: environmental management and mitigation of environmental disasters: a gender perspective, 2002.

    - Showing the mother how to hold her breast well behind the nipple, without pinching.
    - Encouraging her to lie down, hold the baby under arm or across the body.
- Avoid distractions and let baby suckle at own speed.
- Avoid feeding bottles and pacifiers.

Step 2: <u>Build the mother's confidence and help milk flow:</u>

- Help mother and infant until suckling is effective.
- Encourage her to enjoy skin-to-skin contact and to play with her baby face-to-face.
- Build her confidence:
    - Recognize and praise what she is doing right, including signs of milk flow.
    - Give relevant information in an encouraging way and correct misconceptions.
- Help her to breastfeed near trusted companions, which helps relaxation.

Step 3: <u>Increase milk production:</u>

- Encourage more frequent breastfeeds:
    - Ask mother to breastfeed very often, 12 times or more in 24 hours if the baby is willing.
    - Tell her the value of keeping the baby with her day and night and breastfeeding at night.
    - Encourage her to give the breast for comfort at any time.
    - If baby is ill or unusually sleepy, encourage her to wake baby up and offer her breast often.
- Encourage longer breastfeeds:
    - Suggest that the mother continues each feed until baby stops him/herself and does not want more. It is best if she does not detach the baby or put her breast away quickly.
    - Encourage her to offer the other breast and let the baby decide if s/he wants more or not.
- Ensure mother gets enough to drink (Supportive care has assured enough food).
    - Help her to keep drinking water available for herself.
- Remove interferences
    - Help the mother to reduce any milk supplements by 50 ml/day, monitoring weight weekly to reassure her that infant is still gaining 125 g/week.
    - Ask her to avoid separation from the baby, scheduled feeding, care of the baby by others, delaying feeds and, as above, giving bottles and pacifiers.
    - Help her to prevent a new pregnancy with non-oestrogen family planning methods.

Step 4: <u>Encourage age-appropriate feeding:</u>

- Help the mother to establish or re-establish exclusive breastfeeding until the baby is six months old.
- If supplements are needed, teach her to give them by cup, not bottle.
- Show her how to prepare and give adequate complementary foods from six months of age, as well as frequent breastfeeds.

C. Relactation

La Leche League International, "When an Emergency Strikes Breastfeeding Can Save Lives, Part 2," media release, September 1, 2005. Accessed October 3, 2006 from **http://www.lalecheleague.org/Release/emergency2.html**

September 1, 2005 (Schaumburg, IL) When an emergency occurs, such as the recent Hurricane Katrina in the Gulf Coast, breastfeeding saves lives. Breastfeeding protects babies from the risks of a contaminated water supply. It provides protection against respiratory illnesses and diarrhea--diseases that can be fatal in populations displaced by disaster. The basics of breastfeeding during an emergency are much the same as they are in normal times. Continuing to breastfeed whenever the baby seems hungry maintains a mother's milk supply and provides familiar comfort. The release of hormones while a mother is breastfeeding relieves stress and anxiety and is calming to both mother and baby.

If a Mother Has Just Given Birth
If it is within even five days of the birth a mother can have a full milk supply quickly by putting the baby to the breast immediately and breastfeeding the baby, every two to three hours or more frequently. Breast milk is 87% water, so the mother should drink to thirst plus a little bit more. Drinking too much water is not recommended as the mother will be uncomfortable and no additional milk will be produced.

Relactation Information
If a mother has not just recently given birth, but it is up to six months after birth she can relactate by putting baby to the breast, or express the breast, every two hours. Initially she may be producing only drops per day. Some mothers find that their supply increases by about one ounce every 24 hours. Mother then decreases the amount of formula, or donated human milk from another mother, by about one ounce a day. The younger the baby the sooner it will be to establish a full milk supply.

For more information on breastfeeding during an emergency, check out this page on the La Leche League Web site at www.lalecheleague.org/emergency.html.

APPENDIX C

DISASTER PLANNING

MEETING THE SPECIAL NEEDS OF PREGNANT WOMEN & INFANTS

6 KEY ELEMENTS FOR EVERY DISASTER PLAN

1	**DESIGNATED SHELTERS** FOR PREGNANT WOMEN & FAMILIES WITH INFANTS	• Medical services for pregnant women and infants provided at the shelter • Furniture and equipment – cots and chairs for pregnant women, cribs • Health and hygiene needs for mothers and infants and pregnant women • Area for bottle washing or method for bottle exchange • Identification of women and children via ID bracelets • Location near a hospital • Educational materials for pregnant women and families with infants
2	**BASIC SUPPLIES & EQUIPMENT** FOR PREGNANT WOMEN & INFANTS	• Medical supplies - disposable medical supplies • Health and hygiene needs for mothers and infants – ready to feed formula, diapers including preemie diapers, infant and preemie pacifiers, infant clothes, breast pumps, breast pads, feminine hygiene products • Health and hygiene needs for pregnant women – maternity clothes, bras, underwear, over the counter prenatal vitamins, feminine hygiene products • Furniture and equipment – cribs, car seats, strollers
3	A PLAN TO PROVIDE **PRENATAL CARE & WELL BABY SERVICES** IN THE AFTERMATH OF A DISASTER	• Plan to advise public on where to get prenatal care and well baby services • Information on availability of Disaster Medicaid and information on various health insurance plans and what coverage is provided • Prenatal care and well baby services for women living in shelters and temporary housing • Transportation to get women and infants to prenatal care and well baby services
4	A PLAN TO ENSURE THAT ALL WOMEN HAVE **ACCESS TO SAFE ENVIRONMENTS TO DELIVER BABIES**	• Plan to provide alternative locations for safe deliveries in the event that existing facilities are not available • Plan to provide medical personnel for deliveries in the alternative locations • Plan to advise the public on accessing alternative locations • Information on availability of Disaster Medicaid and information on various health insurance plans and what coverage is provided • Method to provide women with their own digital prenatal health records
5	A PLAN TO **KEEP FAMILIES & INFANTS TOGETHER** & RECONNECT FAMILIES WITH INFANTS	• Hospitals should have a plan in place outlining where infants will be evacuated to in an emergency • Method to keep digital health records with patients during a disaster when possible • Duplicate methods to get in touch with family members including out-of-state contacts provided for all infants and kept with the infants' records • Method to connect parents and infants such as a website (specific to moms and babies), hotline, and direct contact information for the hospital
6	**EDUCATIONAL MATERIALS** FOR PREGNANT WOMEN & FAMILIES WITH INFANTS	• Educational materials on disaster preparedness and recovery • Educational materials on all maternal and child health issues • Public information about how to access prenatal and well baby services • A way to reach women in rural and hard to reach areas • A way to reach women when traditional methods are not available