Community-Based Maternal and Newborn Health Care

Bringing care closer to home in humanitarian and fragile settings

The burden of maternal and newborn death is disproportionately high in countries affected by humanitarian crises – 64% of global maternal deaths, 50% of newborn deaths, and 51% of stillbirths occur in the 29 countries with UN Humanitarian Appeals in 2023. Most of these deaths are preventable with access to simple, low-cost, low-tech interventions that rarely reach the people who need them.

Lifesaving MNH care too often fails to reach the most vulnerable

The global community agrees facility-based care is among the most effective ways to reduce maternal and newborn deaths, yet this is not an option for millions of women living in fragile and conflict-affected communities where health facilities are damaged or distant; where they may face danger when traveling for care; and where trained health workers are in short supply, putting them at significant risk of complications and death. This contributes to fragile settings often having among the world's highest maternal and newborn mortality rates.

Community-based MNH care is an evidenced-based solution to reduce the risk of death

While some interventions should always be delivered at a higher level of the health system, evidence from more stable settings like Nepal and Malawi demonstrate that MNH services delivered at the community level can reduce maternal deaths by 20% and newborn deaths by 25%. It is not about discouraging facility-based care but about reducing the risk for women and babies who cannot or do not reach a facility. Tragically, the benefits of community-based MNH care have yet to reach millions of women and newborns living in fragile and conflict-affected settings where mortality rates are high and access to facility-based care is low.

Approximately 60% of women in Sub-Saharan Africa give birth at home without a skilled professional. The number is higher where IRC works, with approximately 80% of women in Somalia and South Sudan giving birth outside of a facility, frequently without a provider.

International Rescue Committee's ambitions for community-based MNH care

The International Rescue Committee (IRC) is leveraging our research and innovation expertise to design and test context-appropriate, client-demanded, evidence-based MNH services, that can be safely delivered at the community level to reach mothers and newborns with limited access to health facilities. We are working in places with the highest mortality rates and the greatest potential for breakthrough impact, including in Somalia and South Sudan.

All data sources in this document can be found at www.rescue.org/mnh

We are tapping into

Behavioral insights

Combining economics, psychology, anthropology, and cognitive science to better understand human decision-making, biases, and actions.

User-centered design

Using qualitative research to uncover client's needs, values, and existing behaviors, and then building and testing solutions leveraging these insights.

Constrained optimization

Leveraging a mathematical modeling approach to design strategies that maximize a selected output within real-life constraints, such as budget and human resources.

Economic evaluation

Tracking the cost-efficiency of interventions and adapting project design or delivery to maximize the outputs and outcomes achieved per dollar spent.

Research and evaluation

Generating evidence to inform decision-making and to influence the sector.

Innovation

Conceptualizing and testing new solutions (or improving existing ones) though ideation, design, prototyping, piloting, and rigorous evaluation.

Program design and delivery

Developing and implementing health programs including the training needs, delivery mechanisms, and monitoring efforts.

Advocacy and influence

Utilizing strategic advocacy to increase political will and ensure evidence generated can help to inform policy, practice, and learning.

Case Study

Community-based MNH care in Somalia

Somalia has among the world's highest rates of maternal and newborn mortality with 621 maternal deaths per 100,000 live births, 36 newborn deaths per 1,000 live births, and 28 stillbirths per 1,000 births. Access to and use of MNH services play a significant role in these poor outcomes with only 32% of deliveries in Somalia occurring with skilled health personnel. The IRC is collaborating with the Federal Government of Somalia and partners for a multi-year initiative to design, test, and evaluate a context-appropriate, client-demanded, community-based MNH care package.

Behavioral insights (BI) and user-centered design: Conducted an exercise with mothers and healthcare practitioners to understand a woman's pregnancy and postpartum journey, with the purpose of identifying potential solutions for altering life-saving behaviors or improving service uptake. The focus was on exploring behaviors around breastfeeding, thermal care, and umbilical cord care. Moving forward, user-centered design will be leveraged to design and protype different solutions to the barriers identified.

Constrained optimization: Partnered with the University of Chicago, Booth School of Business to develop a constrained optimization model to help national stakeholders prioritize interventions by taking into account local constraints including the cost of commodities and services, time and capacity of CHWs, bandwidth for training, existing policies, and more.

Program design and delivery: Worked closely with national stakeholders to take the findings/recommendations from the BI, user-centered design, and constrained optimization activities to design a comprehensive community-based MNH care program to be implemented in Dhusamareb district, Galgaduud region. Program implementation will span 2023-2025.

Research and evaluation: The EQUAL research consortium – led in Somalia by the IRC and the Somali Research and Development Institute (SORDI) – will conduct implementation research to evaluate the IRC's community-based MNH care program in Dhusamareb. This will increase understanding of the factors – including those unique to humanitarian contexts – that affect the process and results of a community-based MNH care program delivering evidence-based, life-saving services in areas with limited access to health facilities.

Advocacy and influence: Coupling the program and research with ongoing advocacy and communications. This includes consulting national stakeholders at every step of the research process, engaging in/establishing platforms to elevate this topic as a priority for concerted effort and investment, and establishing a high-level strategic advisory group.

Next steps: Learnings in Somalia will be used to further iterate on and refine the community-based MNH care program and to design/execute similar initiatives in other IRC countries, including South Sudan (beginning in 2023), Nigeria, CAR, Chad, and DRC.

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