INTERNATIONAL RESCUE COMMITTEE

Maternal and Newborn Health in Humanitarian Settings

Pregnancy and childbirth don't stop in times of crisis… neither should access to high-quality, life-saving care.

Overview

Conflict and crises weaken health systems, deplete essential health resources, and consequently lead to staggeringly high rates of maternal and newborn mortality. Pregnancy and childbirth do not stop in times of crisis, and neither should access to high-quality, life-saving care. Many of these deaths can be prevented with accessible and cost-effective interventions, yet these often remain under resourced and underdelivered in humanitarian settings, where heath systems are disrupted, and human resources are insufficient.

The International Rescue Committee (IRC) is committed to ensuring safe pregnancy and childbirth from the earliest stages of crisis through recovery and development by delivering essential maternal and newborn healthcare (MNH) in 25 countries across Africa, Asia, Latin America, and the Middle East. We call on governments, donors and implementing partners across the humanitarian-development nexus to take action to advance three key strategies that will help overcome disparities in maternal and newborn mortality in humanitarian settings.

Cover photo: Will Swanson, Yemen

We cannot reduce maternal and newborn mortality without EmONC, but more targeted investment is needed to achieve access in humanitarian settings.

1

Invest in EmONC in the Greatest Time of Need

Emergency obstetric and newborn care (EmONC) is globally recognized as an essential health package for reducing maternal and neonatal mortality. Despite this, EmONC is extremely challenging to deliver in humanitarian responses due to it being costly, highly technical to deliver, and resource intensive, both in terms of equipment and human resources.

The 2012-2014 Inter-agency Working Group on Reproductive Health in Crises (IAWG) global evaluation of reproductive health services in responses found limited availability of EmONC services across humanitarian settings, and particularly within acute emergencies (IAWG, 2016). This prompted global health actors to commit to prioritizing increased investment and capacity building in MNH, particularly EmONC. However, the 2019 WHO Global Health Cluster Partner Capacity Survey showed little progress, with only 30% of local partners, 40% of international partners, and 50% of national partners reporting capacity to deliver BEmONC (Health Cluster, 2019).

The lack of progress and capacity for EmONC in humanitarian settings cannot be ignored as new emergencies occur every year and protracted crises endure in many countries. In the month following the February 2023 earthquakes in Türkiye and Syria, almost 400,000 women were expected to give birth amidst devastated health systems (UNFPA, 2023). In the Democratic Republic of the Congo, four women die during labor or due to pregnancy-related complications every hour (UNOCHA, 2023). The Mortality in Humanitarian Settings Dashboard reveals that the 29 countries with global humanitarian response plans in 2023 account for 64% of global maternal deaths, 50% of newborn deaths and 51% of stillbirths (AlignMNH, 2023).

In recognition of this need, MNH is a core part of the IRC's emergency health package. Within days of an emergency, we design responses that deliver the Minimum Initial Service Package in Crisis Situations (MISP), which prioritizes life-saving services with an emphasis on EmONC to ultimately prevent maternal and newborn morbidity and mortality. From 2013-2021, the IRC implemented the MISP in 19 acute emergencies across 15 countries in Africa, Asia, Europe, Latin America, and the Middle East. In 2022, ~11,000 women were treated for obstetric complications and over 215,000 deliveries were supported by skilled providers across all IRC programs.

When a crisis occurs, the needs are overwhelming. Yet, despite its importance, the global community is not doing enough to elevate EmONC - pregnant women and their newborns continue to die. Therefore, the IRC works with partners and global networks to deliver essential care and advocate for greater attention and resources for EmONC in the immediate aftermath of a shock.

Photo: Julian Ruiz, Colombia

Women and newborns in crises deserve respectful, dignified care, but are the least likely to receive it – with deadly consequences.

2

Implement Rights-Based, Women-Centered Approaches to Ensure Respectful Care, Everywhere

Global progress towards reducing the number of maternal deaths has stalled (WHO, 2023) with more than half of maternal deaths occurring in countries facing severe humanitarian crises. Meeting the Sustainable Development Goals (SDGs), and the Ending Preventable Maternal Mortality (EPMM), and Every Newborn Action Plan (ENAP) targets is only possible if we address these settings with the highest burden.), and Every Newborn Action Plan (ENAP) targets is only possible if we address these settings with the highest burden.

For mothers and their newborns to survive and thrive, they must have access to high-quality care. The IRC aims to improve quality of care through pregnancy, childbirth, and postpartum periods at all levels of the health system, from community to facility and through referral pathways. This is done through context-appropriate service delivery, data use for action, quality assurance, capacity building, and supportive supervision. Globally, we know that women want respectful, dignified care, but high rates of mistreatment during childbirth of both women and newborns prevail. The IRC recognizes the legal and human rights women and newborns are entitled to and aims to uphold principles of respectful maternity care (RMC) throughout our service delivery.

Furthermore, through close collaboration with IRC's Women's Protection and Empowerment (WPE) team, we aim to design and deliver comprehensive care with a focus on the needs of women and girls by establishing safe spaces, engaging women-led organizations, and creating and supporting women-guided social accountability mechanisms. Recognizing the importance of delivering holistic care in crisis, we continue to expand access to care by exploring new IPC and WASH practices for MNH, delivering integrated services for MNH and nutrition, and designing responses that support maternal mental health.

Photo: Harrison Thane, Somalia

Data and evidence are required to document the burden and identify the best approaches for ensuring accessible and responsive care in humanitarian and fragile settings.

Conduct Maternal Mortality Studies in Humanitarian Settings Using Crisis-Adapted Methodologies

To truly understand the mortality and morbidity burden in countries with humanitarian settings, data systems must better capture the realities of sub-national crises and areas of fragility. Relying on global mortality estimates is not enough, due to uncertainty surrounding estimates in crisis-affected countries and difficulty in tracking progress when health systems are weak or disrupted. Capturing data, conducting surveys, and monitoring progress are challenging due to insecurity, frequent population movement, and lack of resources. Many humanitarian-affected countries have not collected mortality surveys in over 5 or 10 years, and oftentimes, the most recent mortality data pre-dates the conflict or disaster (AlignMNH, 2022).

An essential piece of improving maternal and newborn data in humanitarian and fragile settings is accurate and timely maternal and perinatal death surveillance and response (MPDSR). The IRC is committed to improving mortality surveillance, including through the use of MPDSR, enhanced reporting mechanisms, staff training at each stage of MPDSR, and in-depth data analysis. The IRC also participates in WHO's MPDSR in humanitarian settings sub-working group, through which we commissioned a study examining the effectiveness and feasibility of MPDSR in humanitarian-affected settings. The learnings from this study informed WHO's latest report on MPDSR and will feed into future tools and guidelines to improve the adoption and use of mortality surveillance where its most needed.

Advocating for the inclusion of humanitarian settings within research studies is another way to improve the availability of data in these settings. Through a global research priority on MNH, we invest in innovations and conduct rigorous research to design, test, and scale client-centered solutions for delivering care in the last mile. The EQUAL research consortium, the IRC's flagship MNH research project, is now generating evidence on facility-based quality of care, community-delivered MNH care, maternal and perinatal death surveillance, and response at the community level, midwifery education and workforce development, and the politics and financing of MNH in conflict-affected contexts. In two of EQUAL's focus countries, Somalia and South Sudan, the project has begun a multi-step approach to design, implement, and evaluate the delivery of community-based maternal and newborn care interventions.

IRC believes everyone deserves access to comprehensive MNH services, regardless of where they live. Data and evidence are required to not only accurately reflect the burden and need, but also to identify the best approaches for ensuring high-quality health services are accessible and responsive to the unique challenges of delivering health care in humanitarian and fragile settings.

Photo: KC Nwakalor, Nigeria

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