

SURVIVING DAY ONE:

Caring for Mothers and Newborns in Humanitarian Emergencies on the Day of Childbirth



IAWG

INTER-AGENCY WORKING GROUP
ON REPRODUCTIVE HEALTH IN CRISES



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Summary

The United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) estimates that nearly 132 million people living in 42 countries will need humanitarian assistance in 2019.¹ Even more alarming, women and children suffer disproportionately in humanitarian emergencies.² Though investment in reproductive health in humanitarian emergencies has increased in recent years, focus on care for the mother-baby dyad during childbirth remains inadequate. Globally, of the ten countries with the worst neonatal mortality rate, five are in humanitarian emergencies: Afghanistan, Somalia, South Sudan, Central African Republic, and Chad. Moreover, all have a neonatal mortality rate above 30 deaths per 1000 live births⁷. Reducing maternal and newborn mortality requires the improvement of access to and quality of comprehensive sexual, reproductive services, skilled care during labor and childbirth, and access to quality emergency obstetric and newborn care. While progress has been made in financing and delivering reproductive health in crisis settings, significant gaps remain in the provision of essential and emergency obstetric and newborn care.³ As humanitarian contexts continue to become more complex, with an increased number of displaced persons and protracted settings as reported by UNHCR, more strategic action is needed to reduce preventable maternal and newborn deaths and stillbirths.

Reaching women and newborns with safe, quality, respectful care on the day of childbirth and during the first week of life is the most effective way to reduce both maternal and neonatal deaths. The recently updated Minimum Initial Service Package for Reproductive Health (MISP), the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings and the Newborn Health in Humanitarian Settings: Field Guide emphasize the importance of quality care on the day of childbirth for mothers and newborns including essential newborn care, and care for small and sick newborns. The World Health Organization's Every Newborn Action

Plan and Strategies Toward Ending Preventable Maternal Mortality documents clearly outline how to reduce preventable deaths and improve maternal and newborn health globally. However, various barriers prevent us from meeting this need, especially in humanitarian emergencies, which have become increasingly complex. These challenges include siloed approaches to maternal and newborn health, limited availability of skilled birth attendants, lack of essential commodities, low uptake of services by women and delayed access to comprehensive emergency obstetric and neonatal care.

Ensuring women and newborns are provided quality, respectful, timely and effective care, particularly in the hardest to reach places, requires collective action. To achieve this vision, we call on countries, donors, implementing organizations and global policymakers to mobilize around three key actions:

1. Intensify preparedness and resilience-building efforts focused on maternal and newborn health
2. Prioritize integrated maternal and newborn life-saving interventions in crisis settings
3. Amplify the role of communities in the delivery of maternal and newborn health interventions, recognizing they are both the immediate and long-term responders

The priorities and recommendations highlighted in this paper are the product of consultations with members of the IAWG Maternal and Newborn Health Sub-Working Group, participants at the 2019 Newborn Strategy Experts Meeting held in Geneva, and inputs from international NGO field staff, local NGO staff in Bangladesh, UN representatives and donors.

Burden of maternal and newborn deaths in humanitarian emergencies



Background

Many countries experiencing humanitarian crises, including civil conflict, recurring natural disasters, or both, also have severe newborn and maternal mortality.^{4,5} For countries already burdened with poor maternal and newborn health outcomes, emergencies exacerbate existing challenges. Population movements, insecurity, increased burden on health systems, poor or damaged infrastructure and limited availability of qualified health workers can restrict access to quality care.⁶ Recent analyses have indicated that roughly 60% of maternal deaths and 45% of newborn deaths occur in countries affected by a humanitarian crisis or fragile conditions.^{7,8} The highest rates of stillbirth occur in conflict and emergency

settings.⁹ Further studies and efforts to improve measurements are encouraged in order to better track progress and increase accountability.

A global burden analysis of maternal and newborn mortality and stillbirths in humanitarian settings was undertaken by the IAWG Sub-working Group on Maternal and Newborn Health, Save the Children and the Humanitarian Emergencies Research Team at the Rollins School of Public Health at Emory University. The purpose of the study was to generate improved estimates of levels and trends in maternal and newborn mortality and stillbirths in these settings to inform future investments and efforts by policymakers, countries, donors, and implementing partners.



Search strategy and selection criteria

Countries that experienced a complex humanitarian emergency, a public health emergency of international concern, or had a Level 3 emergency response declared by the Inter-Agency Standing Committee between the years of 2014 and 2019 were included in the analysis. The United Nations Office for the Coordination of Humanitarian Affairs, ACAPS, Reliefweb situation reports, Office of U.S. Foreign Disaster Assistance, and the World Health Organization Bulletin Reports were used as sources. The type of emergency was further categorized as either acute or protracted, according to predetermined definitions. Countries that experienced an acute emergency within a protracted crisis were classified as protracted crises. Exclusion criteria included fragile states not experiencing a humanitarian emergency, countries hosting refugees but not

experiencing an emergency, active emergencies not yet declared, emergencies with no coordinated international response, emergencies that were not complex, outbreaks that were self-contained, and the Zika virus.

Maternal, newborn, and stillbirth data were collected from all eligible countries using publicly available sources. Data sources included modeled estimates and national-level survey data from the UN Inter-agency Group for Child Mortality Estimation, WHO Global Health Observatory, World Bank, UNICEF, UNFPA, UN Population Division, and the Healthy Newborn Network. Data from the most recent year was analyzed for protracted emergencies. Where available, sub-national data were included in the review.

There are various limitations to the study. There is a dearth of sub-national data available, therefore, the main data sources were from national-level surveys or were based on modeled estimates from these surveys (primarily Demographic Health Surveys and Multiple Indicator Cluster Surveys). Further, the maternal mortality ratio surveys were

not conducted frequently enough to capture effects attributable to acute emergencies, so only protracted emergencies in 2015 were analyzed with this data. Likewise, the only available stillbirth rates for the study period were from 2015. The analysis of acute emergencies was limited by the lack of data available since the emergency.



Key Findings

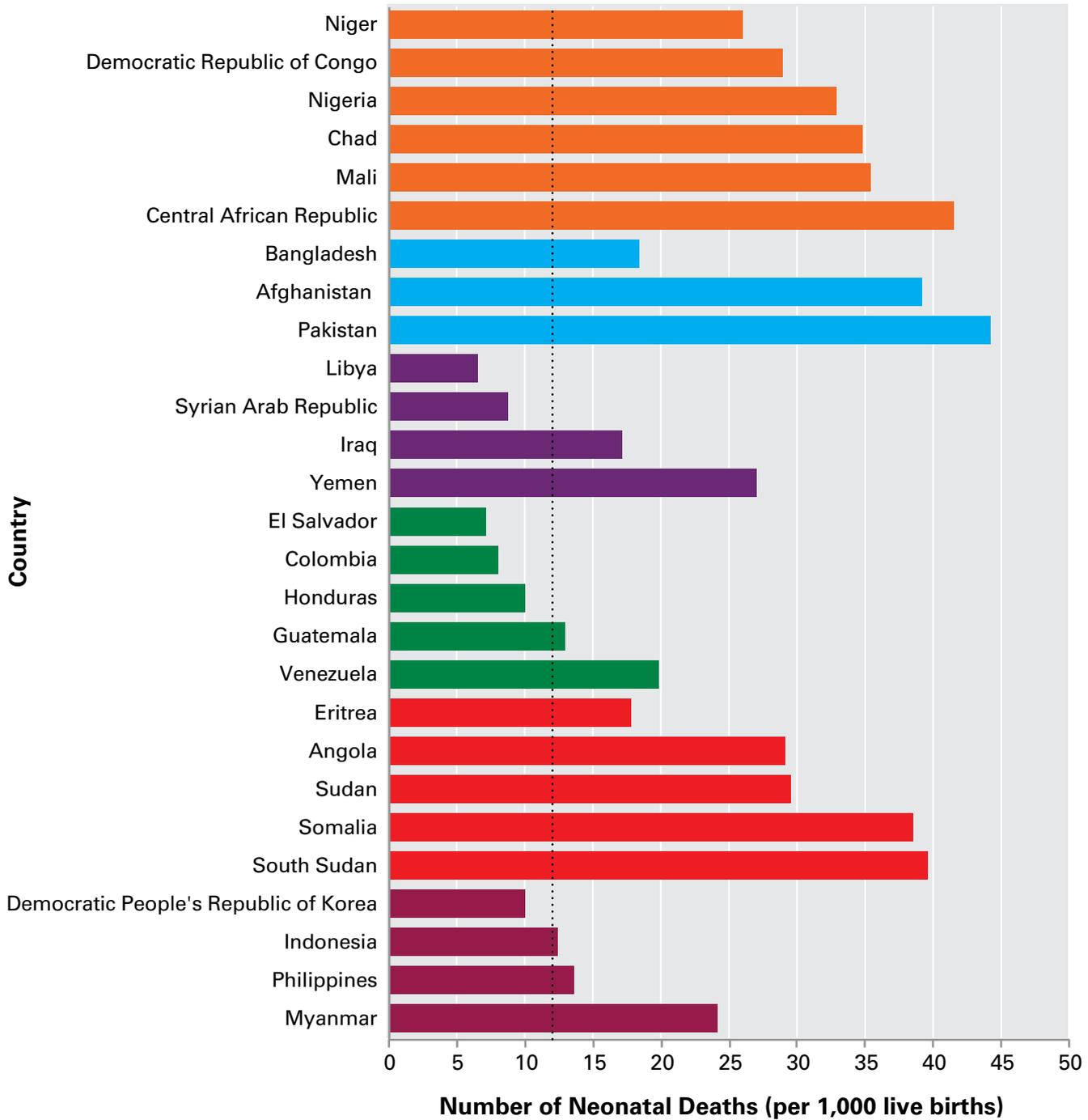
A total of 49 countries were included in the analysis; 22 were classified as experiencing an acute humanitarian emergency and 27 as experiencing a protracted humanitarian crisis. Overall, 81% (22 out of 27) of countries that experienced protracted emergencies in 2015 fall short of the SDG maternal mortality ratio goal. Additionally, 75% (37 out of 49) of countries experiencing humanitarian emergencies fall short of the SDG target for neonatal mortality.

The five countries experiencing complex emergencies with the highest burden of:

- Maternal deaths in 2015 were Sierra Leone, Central African Republic, Chad, South Sudan, and Nigeria.
- Newborn deaths between 2014-2017 were Pakistan, Central African Republic, Afghanistan, Somalia, and South Sudan.
- Stillbirths in 2015 were Pakistan, Nigeria, Chad, Niger, and Somalia.

FIGURE 1.

Neonatal mortality rate across 27 countries with protracted emergencies, 2017



1 Neonatal Mortality Rate data was taken from the UN Inter-agency Group for Child Mortality Estimation, which is led by UNICEF and includes the World Health Organization, the World Bank Group, and the United Nations Population Division of the Department of Economic and Social Affairs. The data are based on modeled estimates from the most recently available data for each country and assessed for data quality.

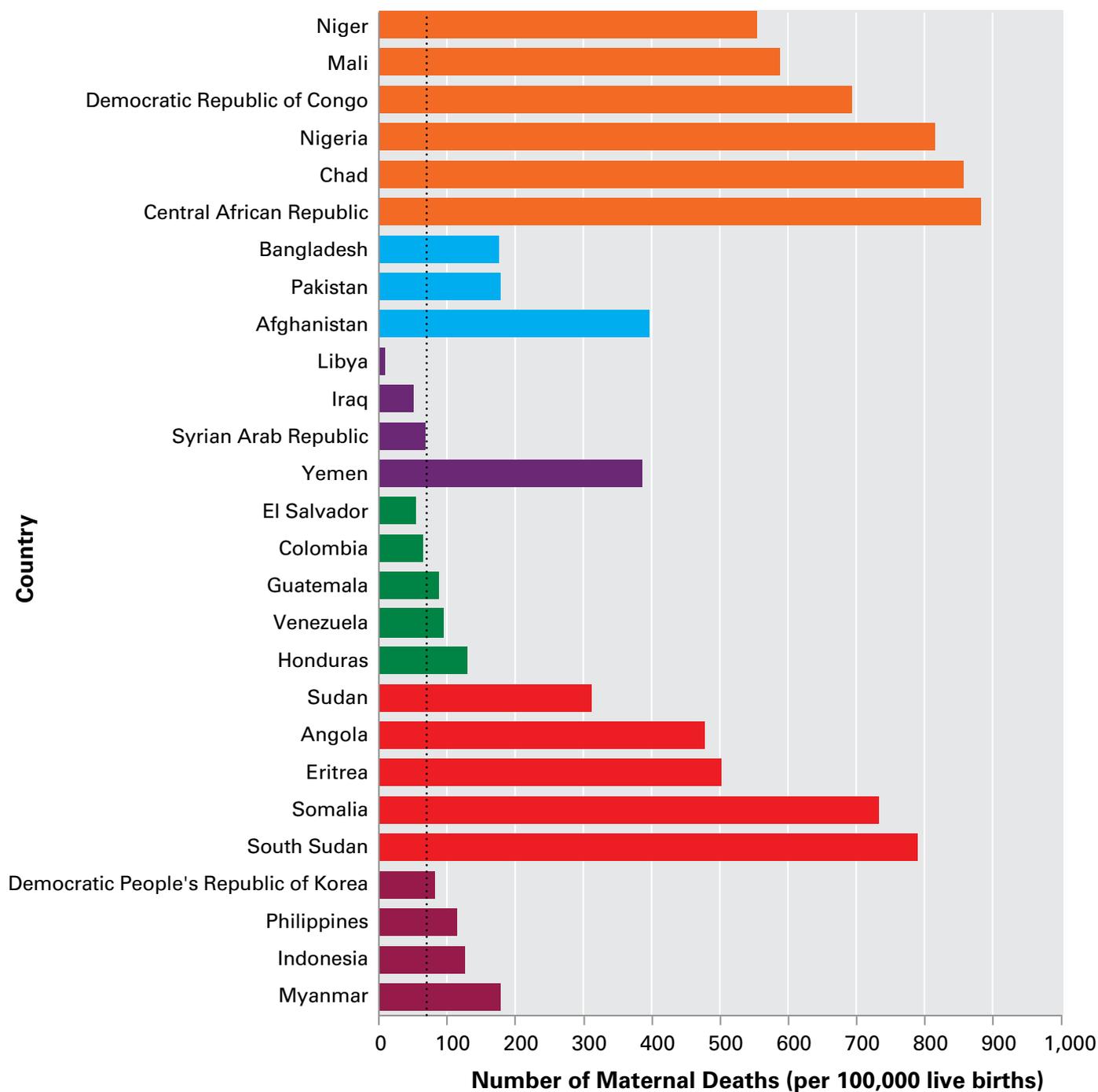
2 Countries were classified as acute versus protracted based on predetermined definitions and categorized based on triangulation of information taken from the United Nations Office for the Coordination of Humanitarian Affairs, ACAPS, Reliefweb situation reports, Office of U.S. Foreign Disaster Assistance and the World Health Organization Bulletin Reports.

Key

- West and Central Africa
- South Asia
- Middle East and North Africa
- Latin America and Caribbean
- Eastern and Southern Africa
- East Asia and Pacific
- SDG Target, 12 or under

FIGURE 2.

Maternal mortality ratio across 27 countries with protracted emergencies, 2015



¹ Maternal Mortality Ratio data are modeled estimates taken from the publication, Trends in Maternal Mortality: 1990 to 2015, led by the Maternal Mortality Estimation Inter-Agency Group and comprised of the World Health Organization, UNICEF, UNFPA, World Bank Group, and the United Nations Population Division.

² Countries were classified as acute versus protracted based on predetermined definitions and categorized based on triangulation of information taken from the United Nations Office for the Coordination of Humanitarian Affairs, ACAPS, Reliefweb situation reports, Office of U.S. Foreign Disaster Assistance and the World Health Organization Bulletin Reports.

Key

- West and Central Africa
- South Asia
- Middle East and North Africa
- Latin America and Caribbean
- Eastern and Southern Africa
- East Asia and Pacific
- SDG Target, 12 or under

FIGURE 3.**Most recent maternal, stillborn and newborn mortality data for countries affected by humanitarian emergencies, 2019¹⁰**

1 VENEZUELA More than 3 million refugees and migrants have left the country due to political instability and insecurity.

MMR: 95 per 100,000 live births

NMR: 19.8 per 1000 live births

SBR: 7.1 per 1000 total births

2 NIGERIA 7.1 million conflict affected people need humanitarian assistance in the north-east; 80% are women and children.

MMR: 814 per 100,000 live births

NMR: 32.9 per 1000 live births

SBR: 42.9 per 1000 total births

3 NIGER 2.3 million people in need of assistance due to climatic instability, malnutrition, conflict and disease outbreaks.

MMR: 553 per 100,000 live births

NMR: 26 per 1000 live births

SBR: 36.7 per 1000 total births

4 CAMEROON Political tension and violence affect 4.3 million people, resulting in food insecurity and requiring protection assistance.

MMR: 596 per 100,000 live births

NMR: 25.5 per 1000 live births

SBR: 19.6 per 1000 total births

5 CENTRAL AFRICAN REPUBLIC

2.9 million people require lifesaving assistance due to intense conflict. Approximately 1 in 5 Central Africans have been forcibly displaced.

MMR: 882 per 100,000 live births

NMR: 41.5 per 1000 live births

SBR: 34.4 per 1000 total births

6 DEMOCRATIC REPUBLIC OF THE CONGO

12.8 million people face food insecurity, ongoing conflict and are at risk of epidemics.

MMR: 693 per 100,000 live births

NMR: 28.9 per 1000 live births

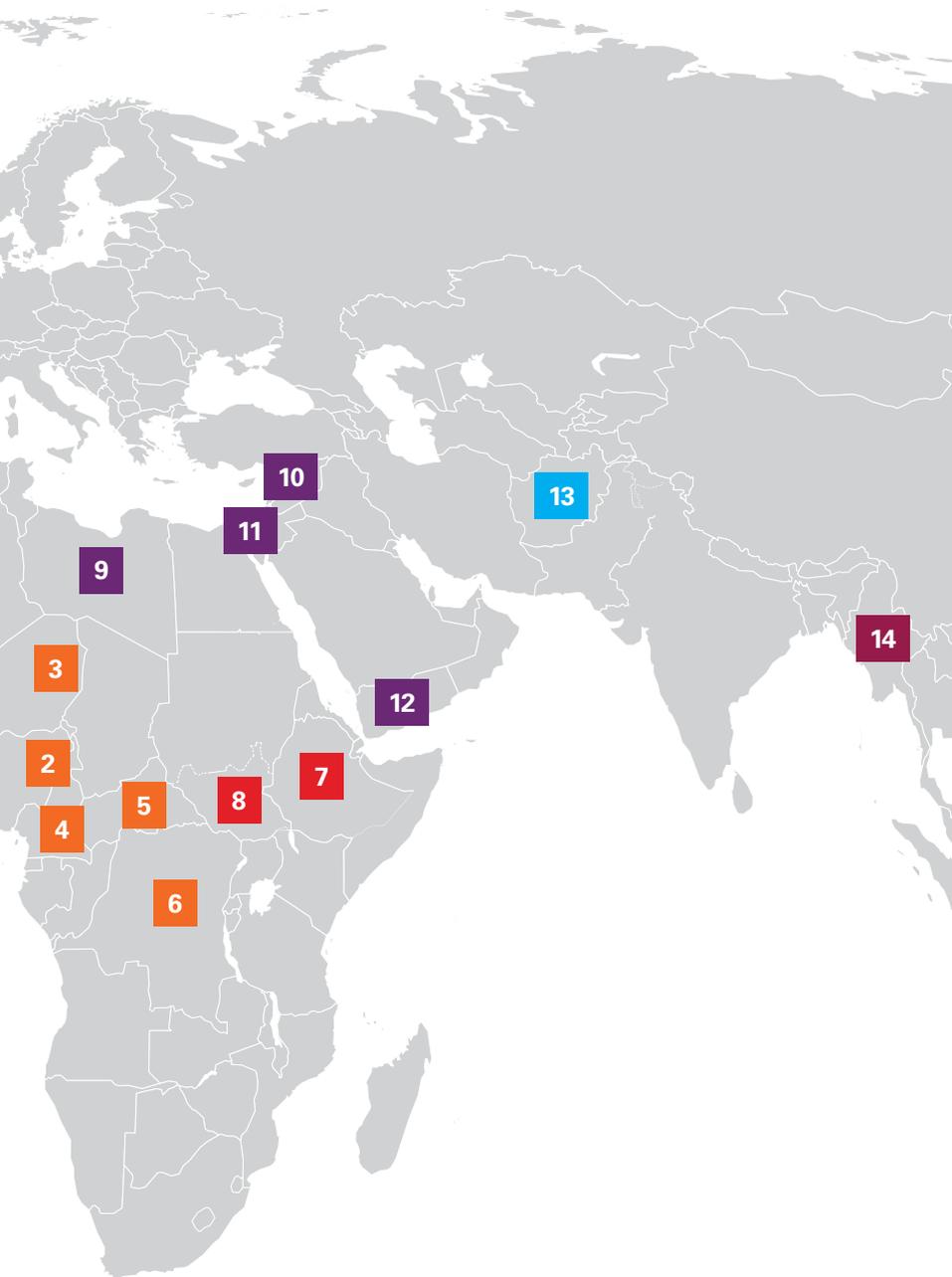
SBR: 27.3 per 1000 total births

7 ETHIOPIA 8 million people affected by drought require food assistance.

MMR: 353 per 100,000 live births

NMR: 28.9 per 1000 live births

SBR: 29.7 per 1000 total births



14 MYANMAR Over 900,000 Rohingya in need of protection, essential health care services and livelihood support currently living in Bangladesh.

MMR: 282 per 100,000 live births
NMR: 24 per 1000 live births
SBR: 20 per 1000 total births

13 AFGHANISTAN 6.3 million people require assistance due to drought, political tensions and refugee returns.

MMR: 396 per 100,000 live births
NMR: 39.2 per 1000 live births
SBR: 26.7 per 1000 total births

12 YEMEN Considered the worst humanitarian crisis in the world with more than 24 million people affected by food insecurity and conflict.

MMR: 385 per 100,000 live births
NMR: 27 per 1000 live births
SBR: 29 per 1000 total births

11 STATE OF PALESTINE 2.5 million people in need related to food insecurity, conflict, forced displacement and restrictions on livelihoods.

MMR: 45 per 100,000 live births
NMR: 11.3 per 1000 live births

10 SYRIAN ARAB REPUBLIC Ongoing Political instability and insecurity necessitates life-saving aid, early recovery and protection for 13 million people.

MMR: 68 per 100,000 live births
NMR: 8.7 per 1000 live births
SBR: 11.1 per 1000 total births

8 SOUTH SUDAN Nearly two-thirds of the population (7.1 million people) is impacted by conflict, displacement and livelihood destruction.

MMR: 789 per 100,000 live births
NMR: 39.6 per 1000 live births
SBR: 30.1 per 1000 total births

9 LIBYA 823,000 people are in need of assistance due to continued political instability and violence

MMR: 9 per 100,000 live births
NMR: 6.5 per 1000 live births
SBR: 8.8 per 1000 total births

Collective action is needed to achieve results for women and newborns in humanitarian emergencies

Globally, 46% of all maternal deaths and 40% of all newborn deaths and stillbirths occur during labor and on the day of birth, making it the most vulnerable time for women and neonates.¹¹ The WHO and UNICEF estimate that more than 3 million women and babies could be saved each year by investing in quality care around the time of birth, with special care for maternal complications and care for small and sick newborns.¹² However, caring for women and newborns at this crucial

time remains a challenge. These challenges are further exacerbated in humanitarian contexts. Collective action by stakeholders across the humanitarian-development nexus is necessary to improve coverage and quality of care for women and newborns in emergency settings, ensuring their equal rights to health and dignified care. This document proposes three key actions to catalyze improvement in maternal and newborn health outcomes in humanitarian emergencies.

Intensify preparedness and resilience-building efforts focused on maternal and newborn health

Humanitarian emergencies are becoming more complex and protracted, resulting in people requiring assistance for longer periods of times. The average humanitarian crisis currently lasts more than nine years according to UNOCHA.¹³ Preparedness and resilience-building efforts at the national, regional, and local levels can mitigate the impact emergencies have on women and newborns by ensuring laws, policies, protocols, communication channels, pre-positioned stock, and coordination mechanisms support the implementation of the MISIP, including priority maternal and newborn health interventions.¹⁴ Response efforts are more effective when bolstered by long-term development initiatives that focus on strengthening health systems to provide quality preventive and supportive care to women and newborns along the continuum of care, engaging women and communities through participatory approaches and accountability mechanisms, and building capacity of health workers. An estimated 61% of all maternal, fetal, and neonatal deaths could be prevented if there was universal coverage of midwifery interventions for maternal and newborn

health in countries with the lowest human development index.¹⁵ Task-sharing approaches that engage mid-level health providers, auxiliary nurses and midwives and lay health workers (e.g., community health workers) can support better reach of maternal and newborn health services.¹⁶ Furthermore, efforts to support and scale community health worker activities and mothers' groups can improve health-seeking behaviors and outcomes as these are critical channels to promote maternal and newborn survival, care, and development. Community health worker initiatives are most effective when they are well managed, benefit from adequate training, funding, supervision, motivation, and support from communities, health providers and leaders.¹⁷ Developing policies that outline the priority roles of community health workers and required resources during humanitarian emergencies can help to ease the disruption to health systems, avoid over-burdening of health staff, and lessen the impact on maternal and newborn health.

Prioritize integrated maternal and newborn life-saving interventions in crisis settings

The Minimum Initial Service Package (MISP), the standard for the provision of reproductive health services in humanitarian emergencies, identifies preventing excess maternal and newborn morbidity and mortality as one of six priority objectives. The recently updated Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (November 2018) and the Newborn Health in Humanitarian Settings: Field Guide provides additional guidance on implementing key life-saving and high-impact interventions to reduce maternal and newborn deaths. Despite overall progress of MISP implementation in humanitarian settings in recent years, evaluations show critical gaps remain in the availability of emergency obstetric and newborn care.¹⁸ To address these gaps, needs assessments and response activities must prioritize maternal and newborn health from the onset of the crisis, ensuring integrated approaches, mother-

baby dyad care, and focusing on the delivery of quality, respectful care for women and newborns on the day of birth and the first week of life. In turn, funding requests should reflect these priorities. Essential actions include hiring and building the capacity of a sufficient number of skilled birth attendants, ensuring an adequate supply of essential commodities and equipment, establishing timely access to emergency referral services, engaging communities to facilitate uptake of services, promote facility birth and postnatal care, and providing comprehensive sexual and reproductive health services as soon as possible. The latter includes establishing accountability mechanisms and meaningful participation of women and communities in efforts to promote healthy pregnancy and birth practices and ensure context-appropriate strategies for health service delivery, information provision, and demand generation.

Amplify the role of communities in the delivery of maternal and newborn health interventions, recognizing they are both the immediate and long-term responders

As people require humanitarian assistance for longer periods of time, the role of communities in responding to the health needs and reducing vulnerabilities of women and newborns is vital. Engagement of communities through respectful partnerships has shown to be effective at increasing uptake of maternal and newborn health services, establishing and maintaining trust between communities and health facilities, and identifying context-specific solutions. Home-visits and community-based education campaigns were shown to increase facility-based births among internally-displaced women in Darfur.¹⁹ A study from eastern Nepal showed community health workers supported the uptake of essential newborn practices, antenatal care and post-natal care through educational activities.²⁰ Case studies from Bangladesh and Rwanda described in this paper also illustrate the role of communities in increasing facility births and promoting healthy infant feeding practices. Evidence from low and middle-income settings suggests dialogue and engagement of community health workers and men in promoting maternal and newborn health can improve care-

seeking behavior and home behaviors.^{21,22,23}

The need for further research on the application and effectiveness of community-based approaches for maternal and newborn health outcomes in humanitarian settings is essential. Several research questions, including the effectiveness of home-based postnatal care, have been identified by IAWG members as high priority to support the improved health of women and newborns.²⁴

Two case studies were conducted by IAWG in collaboration with public health students at Stanford University. The selected sites, both refugee camps, serve to illustrate the gaps and opportunities in addressing maternal and newborn health in emergency settings. While only a small portion of populations in need of humanitarian assistance live in camps, the challenges and lessons learned described in these case studies reflect those encountered in other emergency settings that similarly grapple with a low-resource setting, dearth of qualified health providers, lack of funding and socio-political barriers to care.

CASE STUDY I

Increasing facility births through community engagement and tiered health approaches

Rohingya Refugee Camps, Bangladesh



Purpose

To increase understanding of the challenges and opportunities for maternal and newborn health service delivery in the Rohingya refugee camps in Bangladesh.

Methodology

A total of 17 in-depth interviews were conducted between November and December 2018 with program managers from UN agencies and implementing organizations, midwives, community health workers and community leaders. An online survey was shared with 32 partner agencies in Bangladesh, and completed by seven respondents.

Background

Violence against the Rohingya community in Myanmar in August 2017 resulted in the flight of more than 700,000 Rohingya refugees to Bangladesh.²⁵ In 2019, nearly 900,000 Rohingya refugees will require humanitarian assistance.²⁶ While in Myanmar, Rohingyas experienced longstanding restricted access to education, reproductive health information, livelihoods, and freedoms, and gender-based violence.²⁷ Maternal and newborn health remains an urgent and considerable need among Rohingya refugees. Community support and engagement in Rohingya refugee camps have been critical to the success of reaching women and newborns with skilled care at the most critical time—on the day of birth—as well as inform them of their rights to access contraception. Community health workers have strengthened trust with community leaders, which has facilitated uptake of services by women. Despite operating within a predominantly home-birth culture, targeted initiatives have successfully increased the percentage of women delivering in health facilities from 22% to 40% during 2018.²⁸

Key Interventions

Establishing a close collaboration between community health workers, traditional birth attendants, and midwives has supported health coverage from homes to the facility. The capacity of community health workers is reinforced through regular trainings and supervision by midwives. Roles, responsibilities, and communication channels are well established between the two cadres. Community health workers carry out home visits before and after birth to conduct basic mother/baby check-ups, share information on danger signs and counsel women to seek care at health facilities for antenatal, safe delivery, post-natal, and family planning services. During these visits, women are provided a contact number where they can speak with a midwife 24 hours a day. When needed, community health workers are deployed to escort women to camp-based health facilities. Health facilities are staffed by Bangladeshi midwives, many of whom have been deployed from other parts of the country to support the crisis response. Camp facilities provide maternal and newborn services, including 24/7 safe delivery care, with referrals for complications to government hospitals.

Key Challenges

- Despite the improvement in uptake of services, many Rohingya continue to distrust public health services and service utilization remains a challenge. Home births with traditional birth attendants continue to be common. Likewise, post-natal care is challenging as cultural norms encourage women to stay indoors for 40 days after birth, making it difficult to access health facilities.
- Reaching women with critical information and care is reliant on effective community-based programming. However, community health workers are insufficient in numbers, lack knowledge and skills (especially in essential newborn care), are not well distributed geographically, and lack adequate incentives.
- The midwife cadre is relatively new in Bangladesh, as the first class graduated only two years prior to the Rohingya crisis. As a result, many deployed midwives lack work experience and selected key competencies. In particular, clinical skills to manage newborn resuscitation and essential newborn care greatly need strengthening.

Lessons Learned

- Community engagement through interpersonal communication and mass awareness activities supported by community health workers and local leaders on the importance of maternal and newborn health has been an essential driver in building trust and increasing service utilization.
- Household decision-makers and influencers including men, traditional birth attendants, and other gatekeepers should be targeted for key messages and encouraged to be promoters of maternal and newborn health.
- Tiered-health interventions can expand the reach of maternal and newborn health messages and services by facilitating a continuum of care from the facility to the home. Successful interventions rely on an adequate number of community health workers combined with capacity building activities, proper incentives, supervision, and geographic distribution.
- Capacity building of health providers including clinical training on maternal and essential newborn care for midwives and community health workers is critical for ensuring good quality of care.

CASE STUDY II

Improving maternal and newborn outcomes through capacity-building of midwives and focused infant feeding interventions along the continuum of care

Burundian Refugees, Mahama Camp, Rwanda



Purpose

To understand the opportunities and constraints for maternal and newborn health service delivery in a Burundian refugee camp in Rwanda.

Methodology

A total of four in-depth interviews were conducted in November 2018 involving two program managers (Save the Children and Partners in Health), a midwife (Save the Children) and public health officer (UNHCR).

Background

Since April 2015, more than 390,000 Burundians have sought refuge in neighboring countries including Tanzania, Rwanda, Democratic Republic of Congo, and Uganda due to political violence.²⁹ Continued political tensions, compounded by natural disasters, has resulted in the continued need for life-saving emergency assistance such as food assistance, shelter, access to essential health, education, sanitation, and hygiene services. In 2019, an estimated 1.77 million vulnerable Burundians will require humanitarian assistance.³⁰ Mahama Camp in Rwanda currently hosts approximately 58,000 Burundian refugees.³¹ Initiatives to prevent and address undernutrition in women and babies combined with efforts to build the capacity of health providers at the primary and referral care levels have been critical to improving the health of mothers and newborns.

Key Interventions

Emergency referral systems for women and newborns with complications can be challenging to establish and maintain in humanitarian settings yet are essential to reducing preventable deaths. Primary health care facilities in Mahama Camp are able to provide a wide range of maternal and newborn health services, but women with complicated pregnancies or childbirth and unwell newborns must be transferred to the district hospital. The coordination among the health facilities in Mahama Camp and the Kirehe District Hospital involves a 24/7 ambulance service, joint-capacity building efforts of health staff, and coordinators dedicated to facilitating patient transfers and follow-up. Joint capacity building efforts have included trainings for health staff on essential newborn care, Kangaroo mother care, Helping Babies Breathe and emergency obstetric care. Midwives and nurses from the hospital and primary health care facilities in the camp participate in trainings, supporting the quality of care improvement along the continuum. One-to-one mentoring for midwives at Kirehe District Hospital, which is part of a national initiative, has also enhanced the quality of care for women and newborns.

Recognizing widespread food insecurity, lack of knowledge on exclusive breastfeeding, and malnutrition in Mahama camp, specific



interventions support improved nutrition among women and infants. Initiatives to prevent and address malnutrition among women and newborns are implemented at the district hospital, health facility, and community levels. The neonatal unit at the district hospital promotes early initiation of breastfeeding through trained “Expert Moms” who provide counseling to mothers with infants who have trouble breastfeeding. This not only reduces the burden on nurses and midwives on the unit but also ensures comprehensive counseling for mothers. Equipment including refrigerators to store breastmilk and chairs and pillows to facilitate breastfeeding positions are also available. Once discharged, an outpatient pediatric clinic at the district hospital provides ongoing feeding support for infants who are preterm, low birth weight, or have physical disabilities. Health staff at the hospital and camp facilities have benefited from training on breastfeeding counseling. Home visits by community health workers reinforce messages on exclusive breastfeeding and nutrition among women and children and involve screening. In the communities, mother-to-mother support groups provide opportunities to promote infant and young child feeding and



improved nutrition through key messages and cooking demonstrations. Implementing partners also interface regularly with community health committees—composed of community and religious leaders—in which health priorities including maternal and newborn health interventions are discussed.

Key Challenges

- High staff turnover undermines mentoring and training efforts to build the capacity of health care providers in emergency obstetric and essential newborn care.
- The utilization of health services, particularly for newborns, is challenged by social and cultural explanations and traditional medical practices, which can cause delays in seeking medical treatment and in some cases exacerbate the condition.
- The district hospital staff and resources are burdened by the additional needs of the refugee population.
- Emergency referrals from the camp have been challenging at times, involving delays, lack of patient follow-up and administrative tasks related to health insurance.

Lessons Learned

- Country leadership to facilitate coordination among partners, linkages across tiers of the health system, the realization of opportunities for cross-learning and trainings, and retention of health care staff are critical to the success of maternal and newborn health service delivery.
- Community outreach and mobilization initiatives that leverage community health workers, mother support groups, and community health committees can be effective ways to change knowledge and behavior including enhancing health-seeking behavior for maternal and newborn services, exclusive breastfeeding and improved nutrition.
- Task-sharing breastfeeding counseling from nurses and midwives to “Expert Moms” has improved efficiency and quality of counseling for mothers in the neonatal unit.

Achieving the vision of safe, timely and respectful care for all mothers and newborns in humanitarian settings on the day of childbirth

Recommendations for countries affected by humanitarian emergencies

- **Strengthen resilience at national and sub-national levels by integrating priority maternal and newborn health interventions into preparedness and response plans using global guidance and evidence to inform policies.**
Response plans and guidelines, including the Newborn Health in Humanitarian Setting Field Guide, can be promoted through forums that bring together national, local, and international humanitarian and development actors.
- **Support improved measurement and accountability for women and newborns by strengthening maternal and perinatal death surveillance and response.** Adopt global indicators for maternal and newborn deaths proposed in the *2015 Every Newborn Action Plan*. Strengthen death surveillance and response through the development of national guidelines and multi-stakeholder engagement inclusive of communities. Adopt and rollout tools that support actors in conducting mortality audits and near-miss reviews of stillbirths and maternal and neonatal deaths, as part of quality care improvement efforts.
- **Invest in a skilled health workforce and introduce task-sharing approaches to expand the provision of key maternal and newborn health interventions.**
Before emergencies occur, establish deployment mechanisms for midwives and others with midwifery skills to work in affected areas. Review scopes of work for health cadres and identify opportunities for task-sharing key maternal and newborn interventions to mid-level health providers and community health workers.
- **Integrate community engagement in national strategies and action plans, and invest in scaling up mother's support groups and community-based health worker activities.** Promote activities and retention of community health workers through ensuring sufficient numbers are trained, geographically distributed, adequately supervised, supported, and motivated. Invest and scale mother's support groups that increase access to key maternal and newborn health information and promote uptake of antenatal care, facility deliveries, post-natal care, essential newborn care, infant feeding practices, and family planning. Engage with other community networks (e.g., youth, religious leaders, health committees) to promote maternal and newborn health and reinforce linkages with health facilities along the referral continuum.
- **Develop policies and procedures to facilitate the rapid establishment of efficient and functional emergency referral systems for emergency obstetric and neonatal care during crises.** Creating protocols for first aid and stabilization at the primary level prior to referral, determining transport options, and instituting communication channels that link communities, health facilities, and referral centers will expedite women and newborns needing referrals from the onset of a disaster. Policies should include awareness-raising activities on the existence and access to referral services for communities and health providers, and the conditions for which referrals should be sought.



Recommendations for global policymakers

- **Integrate maternal and newborn health indicators into cross-sectoral coordinated needs assessments and monitoring frameworks.** Include maternal and newborn health indicators into local, national, regional, and global monitoring frameworks for the Sustainable Development Goals. Ensure maternal and newborn health is reflected in all humanitarian multi-sectoral assessment frameworks that look at population risks, vulnerabilities, capacities, and root causes.
- **Strengthen policy guidance on integrating respectful maternal and newborn health into national and regional emergency preparedness plans.** Integrate respectful maternal and newborn health into the 2019 revision of the IASC Operational Guidance on Coordinated Assessments in Humanitarian Crises and support missions.
- **Hold global platforms accountable for ensuring the right to health and access to sexual and reproductive health care in humanitarian settings.** Support greater tracking and accountability to ensure global platforms and institutions meet these obligations. Take action when states fail to provide access to maternal and newborn health, including emergency obstetric care and skilled delivery services, to populations living in humanitarian contexts.

Recommendations for donors

- **Encourage and fund partnerships that aim to support and enhance (rather than replace) local capacities in the provision of maternal and newborn health in emergencies.** Support programs that include resilience building activities for communities including training, equipping, and supporting local midwives, community health workers, mother support groups, and local organizations.
- **Support research activities that build the evidence base of effective maternal and newborn health interventions in humanitarian settings.** Priority research questions on maternal and newborn health identified by the IAWG in October 2018 include respectful care during childbirth, the effectiveness of home-based postpartum maternal and neonatal care and integration of basic emergency obstetric care into primary care facilities. Promote the integration of maternal and newborn health into related health research projects to avoid siloed approaches.
- **Expand multi-year, flexible funding to support critical impact areas for maternal and newborn health across the humanitarian-development nexus.** Fund initiatives that support the integration of MISP standards and maternal and newborn guidelines into the country and regional preparedness and response strategies and trainings on guidelines for international, national, and local actors. Invest in health systems' strengthening efforts aimed to deliver maternal and newborn health care, including emergency obstetric and neonatal care, such as midwifery training and capacity building.



- **Include beneficiary feedback ratings as a critical element of grant review criteria.** Prioritize emergency-affected populations' experience of care by standardizing beneficiary feedback ratings in grant review criteria. These scores should be given sufficient weight in scoring and awarding grants and will help ensure that respectful, dignified care is being provided on a routine basis.
- **Contribute to rapid funding mechanisms for humanitarian emergencies.** Prioritize maternal and newborn health thematic areas and indicators, including rapid transition to comprehensive sexual and reproductive health services.

Recommendations for implementing organizations

- **Implement priority maternal and health interventions at the onset of humanitarian emergencies consistent with global guidance.** Align organizational health response guidelines, protocols, and policies and train first-responders and support staff on guidelines. Focus on the provision of quality and respectful care for women and newborns on the day of birth and the first week of life by a skilled health attendant operating in an enabling environment, with timely access to referral level services. Transition to delivery of comprehensive sexual and reproductive health services as quickly as possible.
- **Build capacity of midwives and other health care providers through training, mentoring, or similar performance improvement approaches to ensure they have competencies in all seven signal functions of basic emergency obstetric, essential newborn care, and care for small and sick newborns underpinned by respectful maternity care.** Identify opportunities for task-sharing to enhance the efficiency of mid-level providers like nurses and midwives and expand the reach of key interventions to women and newborns. Ensure enabling work environments to improve health worker motivation.
- **Engage in respectful partnerships with communities to promote maternal and newborn health services and behaviors.** Consult with local organizations, women’s groups, youth, community leaders, and community health workers to identify perceived needs, barriers to care, context-specific solutions, capacities, roles, and accountabilities. Identify opportunities for building the capacity of community health workers and other community networks, including linking to health facilities, task-sharing, and support with information, training, and commodities.
- **Establish systematic feedback mechanisms for mothers and communities to provide feedback on their experience of care and recommendations for improvement.** Include routine patient feedback mechanisms in the design and implementation of maternal-newborn health services. These should go beyond cross-sectional “patient exit surveys” and instead be a dynamic, responsive system that implementing agencies continually review and respond to ensure the highest quality, dignified, respectful care.
- **Conduct high-quality research to build evidence of effective community-based approaches to maternal and newborn health in humanitarian settings.** Refer to priority research questions on maternal and newborn health identified at the IAWG Workshop on Sexual and Reproductive Health Research Priorities in Humanitarian Settings held in 2018, and seek funding opportunities to carry out operational research.
- **Pre-position supplies to ensure life-saving commodities are available at the onset of a disaster.** Support organizational and country-level preparedness planning in forecasting, identifying supply chain options (both emergency and sustainable), and bolstering supply chain management to ensure timely implementation of maternal and newborn services.

2025 TARGETS

- *Proportion of Humanitarian Response Plans (HRPs) that specifically mention integrated maternal and newborn health interventions as a priority*
 - *Baseline: 48% of HRPs (11 out of 23) ; Goal: 75%³²*
- *Number of research studies conducted (or in progress) on maternal, stillborn or newborn care in humanitarian settings from 2019-2025*
 - *Goal: 15*
- *Number of countries that have adopted global core indicators for maternal and perinatal death (per Every Newborn Action Plan 2015)*
 - *Baseline: 38 countries with perinatal death review system in place³³; Goal: 55 countries*



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