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Sexual and reproductive health in humanitarian settings: value of MDSR data and systems in crises settings

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human reproduction programme hrp

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Why settings matter

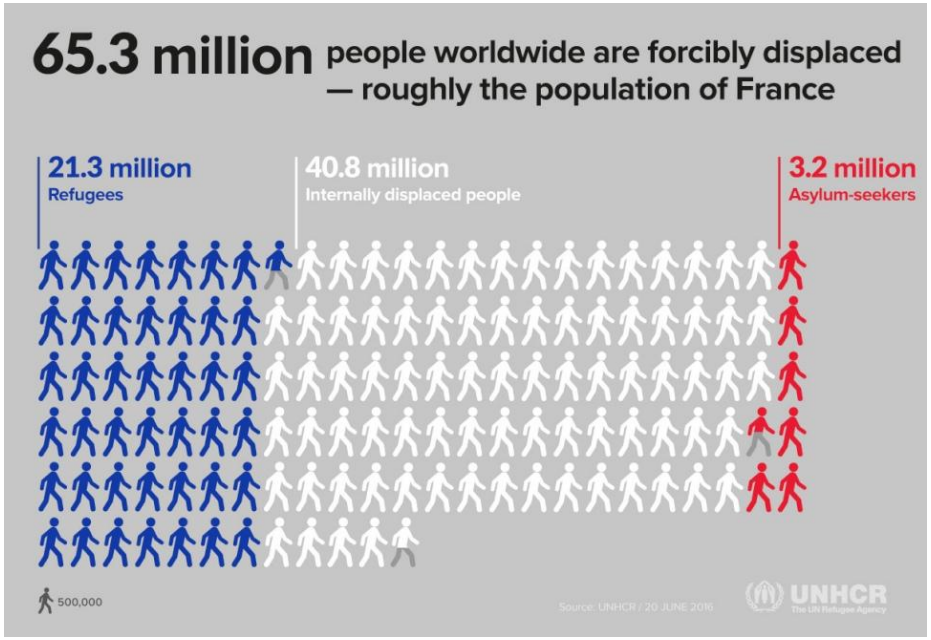
- More displaced people now than at any point since WWII
- The average time spent in displacement has now reached 20 years

- According to UNHCR, in 2015 there were 65.4 million internally-displaced people and international migrants, half of whom come from Afghanistan, Somalia and the Syrian Arab Republic
- The proportion of women among refugees ranged between 47 and 49 per cent from 2003 to 2015, while that of children has ranged more widely, from 41 per cent in 2009 to 51 per cent in 2015
- 26 million women and girls with reproductive health needs

Crises and health

- Crises leads to disruptions people's lives, families and communities, and their access to basic services such as healthcare and education

- Crises expose extant weaknesses in health systems, impacting sub-populations, especially women, children and adolescents, differently



- Low resilience in health systems and an absence of quality data in emergencies hinders design and implementation of sustainable interventions.

The SRHR context

- An estimated 26 million women and girls of reproductive age live in emergency situations

ALL of whom need SRH services

- Three-quarters of the countries with maternal mortality ratios above 300 per 100 000 live births are designated as ‘fragile states’ by the OECD

What the Evidence Currently Shows

- Pregnant women may have increased medical risks such as gestational hypertension and anemia, along with adverse pregnancy outcomes including low birth weight or preterm birth.

- Crises further increase the risk of pregnancy-related death due to pre-existing nutritional deficiencies, susceptibility to infectious diseases, lack of access to ANC, assisted deliveries and emergency obstetric care

Fundamental gaps continue

- Some progress has been made;
- Significant gaps remain in a full range of SRHR services remains precarious in most settings.

Key causes:

- Lack of equitable and adequate funding dedicated to
  - SRHR services,
  - Commodity management and security and
  - Critical services such as contraception (particularly LARCS), safe abortion, EMOC, and post-rape care;
- Compounded by a very weak evidence base, few high quality evaluation studies and limited health systems and service delivery data for monitoring, programming and budgeting.

Increasing Recognition of central role of SRHR in Crises

- Lessons from recent crises:
  - Syria,
  - Ebola, Zika,
  - Haiti, Nepal, Philippines

The changing global context

- The global refugee and migrant crises exposed the weaknesses of systems to respond to SRHR issues.
- Rethinking resilience and recognising the need for rights-based reorientation of health systems to respond to crises and specific needs of populations
- Increased recognition by UN agencies and partners of the imperative to address SRHR issues in crises

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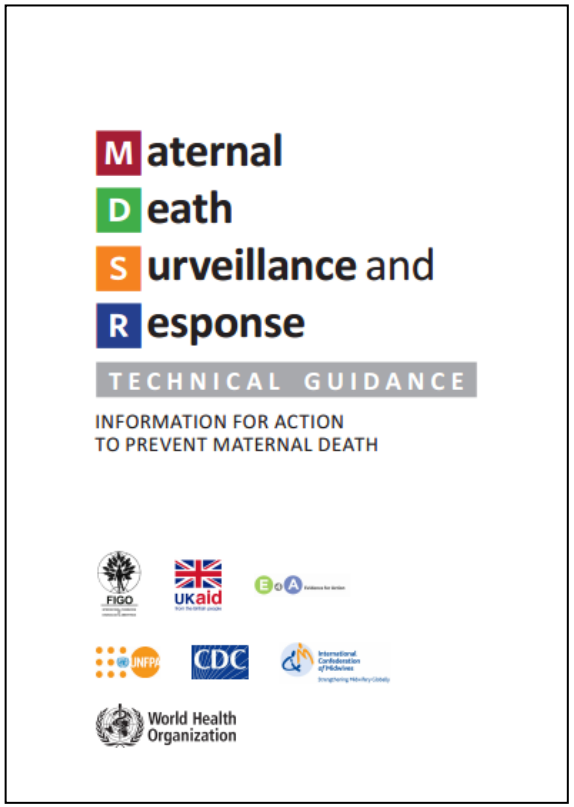
Monitoring and data in humanitarian crises

- Measuring maternal mortality remains a challenge
  - MM is relatively a rare event with unstable and imprecise data and sample size constraints.
  - Functioning VR systems undercount and misclassify maternal deaths, in addition, both the data sources and data qualities change over time.
  - The data used for estimating maternal mortality come from different sources:
    - Vital registration (VR)
    - Population-based surveys
    - Confidential Inquires, Surveillance systems, and censuses.
  - Each data source comes with its limitations and quality issues

In conflict and humanitarian settings where maternal mortality is at its highest, there is often **NO** VR/HIS to start monitoring of MM

Maternal death surveillance and response (MDSR)

- Accurate information on how many women died, where they died & why they died is essential, yet currently inadequate
- MDSR, a relatively new concept, builds on the principles of public health surveillance
- MDSR promotes routine identification and timely notification of maternal deaths and is a form of continuous surveillance linking HIS and quality improvement from local to national level.
- Adds to quantification & determination of causes and avoidability of maternal deaths.
- Each untimely fatalities provides valuable information, which if acted on, can prevent future deaths



In a crises setting, is it feasible, can it work, if so how?

Next steps: Strengthening data and monitoring

- Strengthen capacity for implementing agencies to undertake rapid assessments to determine the magnitude, risk factors, needs and appropriate response for SRH issues within specific humanitarian contexts;
- Develop tools and methodologies to strengthen routine data collection, processing, analysis and use by implementing agencies operating in humanitarian settings;
- Strengthen the capacity of humanitarian programmes to use appropriate and valid metrics for improving policy and investment decision-making and accountability:
- Identify and implement methodologies to analyse and estimate global levels of maternal mortality in humanitarian settings

THANK YOU!