



MIDWIVES ON THE FRONT LINE: DELIVERING MIDWIFERY SERVICES IN DIFFICULT TIMES

**A snapshot from selected Arab Countries
2016**



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ABBREVIATIONS AND ACRONYMS

AAAQ	availability, accessibility, acceptability and quality
AIDS	acquired immune deficiency syndrome
BEmONC	basic emergency obstetric and neonatal care
CEmONC	comprehensive emergency obstetric and neonatal care
CMR	clinical management of rape
CSO	civil society organisation
EmONC	emergency obstetric and neonatal care
FGM	female genital mutilation
GBV	gender-based violence
GP	general physician
HIV	human immunodeficiency virus
HRH	human resources for health
IDP	internally displaced person
ISIL	Islamic State in Iraq and the Levant
LARC	long-acting reversible contraceptive
MDSR	maternal death surveillance and response
MISP	Minimum Initial Service Package
MoH	ministry of health
NGO	non-governmental organisation
Ob/GYN	obstetrician/gynaecologist
PMTCT	prevention of mother to child transmission (of HIV)
RH	reproductive health
SDG	sustainable development goal
SRMNAH	sexual, reproductive, maternal, newborn and adolescent health
STI	sexually transmitted infection
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations Refugee Agency
UNICEF	United Nations Children’s Emergency Fund
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
UNRWA	United Nations Relief and Works Agency
WHO	World Health Organization



EXECUTIVE SUMMARY

Humanitarian crises, and the associated population displacement, are a large and growing problem across the globe. Countries in the Arab States region feature prominently in global statistics for fragility and humanitarian crises: according to the United Nations Refugee Agency (UNHCR), in 2015 40% of the world's refugees, internally displaced persons and asylum seekers originated from this region, and countries in this region host 34% of the world's forcibly displaced population. These statistics underline the urgent need for action, both in reaction to current crises and in terms of building resilience to possible future crises.

One of the impacts of humanitarian crises is a reduction in the availability and accessibility of health services, which results in increased rates of mortality and morbidity and is a major barrier to recovery from the crisis and progression towards the sustainable development goals. An effective response to this requires an understanding of how fragility and crises affect different population groups: a 'one size fits all' approach is likely to decrease equity and thus decrease resilience. The impact of crises on women

and children is well documented, with high rates of maternal, neonatal and child mortality and morbidity due to poor access to sexual, reproductive, maternal, newborn and adolescent health (SRMNAH) services. UNFPA's vision places SRMNAH at the core of humanitarian action, because it views good SRMNAH as a basic human right which enables and empowers women and girls to contribute towards resilience to and recovery from humanitarian crises. SRMNAH services should therefore be considered essential right from the onset of a crisis, rather than as something that is of secondary importance after other health services such as care for severe physical injuries.

Good SRMNAH workforce planning and management is essential to tackle these issues, and in the Arab States region there have been calls for information and guidance for countries looking to strengthen their SRMNAH workforce, whether in response to a current crisis or with a view to improving preparedness for crises that may occur in the future. The evidence shows that midwives who are properly educated, supported and enabled can meet the vast majority of the

need for SRMNAH care. Specific and focused investment in midwifery and midwives is therefore an effective strategy for countries either in crisis or aiming to improve their preparedness for crises and their overall resilience.

This report is the output from a data collection exercise in six Arab states currently affected by humanitarian crises: Iraq, Libya, Somalia, Sudan, Syria and Yemen. UNFPA country offices coordinated the data collection, in consultation with relevant national stakeholders such as government, private sector providers, NGOs and professional organisations. Each country was sent a self-completion questionnaire, which requested data on how the crises had affected the need for SRMNAH services and the availability, accessibility, acceptability and quality of midwives and other SRMNAH workers.

Crises and emergencies take different forms, including violence and conflict, political instability, natural disasters, environmental decline and cyclical climatic problems, all of which are features of the crises affecting one or more of the countries featured in this report. Crises can be short-term or last for many years: some of the countries in this report have been in crisis for a short time, some for much longer. The nature and duration of the crisis, along with the level of development of the country before the crisis began, will dictate its effects and what constitutes an appropriate response to these effects. The variety of responses to this data collection exercise reflects the diversity of experiences across the six countries.

Humanitarian crises tend to increase unmet **need** for SRMNAH services, and thus to increase the consequences of unmet need. For example, reduced access to reproductive health (RH) commodities can result in increased rates of unwanted pregnancies and sexually transmitted infections (STIs), and reduced availability of skilled SRMNAH workers which lead to increased rates of

maternal, newborn and child mortality and morbidity. The most commonly reported impact, however, was an increased incidence of gender-based violence (GBV) including rape, and the need to provide adequate response such as clinical management of rape (CMR).

A strong, well-managed and well-supported SRMNAH workforce is essential to mitigate against these effects, yet humanitarian crises tend to result in massive losses from the health workforce and therefore lower **availability** of SRMNAH workers. Only two of the participating countries (Libya and Yemen) were able to provide estimates of the size of these losses, and both indicated that more than half of their SRMNAH workers had been lost from the workforce. The losses affected all SRMNAH cadres, but were particularly large among physician and nursing cadres and relatively small among midwifery cadres. (Even countries unable to provide exact data indicated that midwives were more likely than other SRMNAH cadres to continue to provide services during a crisis.) Crises can also affect the number of new SRMNAH workers joining the workforce, due to losses from the teaching workforce and destruction of education institutions.

Crises affect the **accessibility** of SRMNAH workers, due to: widespread destruction of health facilities, inability to pay for services, travel restrictions and security concerns. Three countries (Libya, Syria and Yemen) were able to provide data on the number of health facilities closed or destroyed because of the crisis. In Libya, most hospitals and primary healthcare facilities in conflict-affected areas providing SRMNAH services had ceased to operate. Countries without a policy of free access to essential SRMNAH care reported that accessibility had been adversely affected because of rising poverty levels as a result of the crises. Restrictions on travel also affected accessibility in all participating countries.

Public perceptions of SRMNAH workers were reported to have worsened in many crisis-affected countries, thus affecting the **acceptability** of SRMNAH services. This was attributed to women and their families being less able to consult a known and trusted provider.

There were also indications of the impact of the crisis on **quality** of care provided by SRMNAH workers. One of the main effects was that SRMNAH workers did not have reliable supplies of the drugs, supplies and equipment needed to provide the full range of services, because distribution systems had been disrupted. Some countries reported that the loss of teaching staff had affected education quality, and in one country there had been a decision to review the duration of training for community midwives. All six countries reported a shortage of SRMNAH workers with the skills to provide care for survivors of GBV, women with obstetric emergencies and those with Human Immunodeficiency Virus (HIV) or other STIs. This was partly due to low availability of SRMNAH workers, but in some countries it was also due to these skills not being routinely included in pre-service training curricula.

The impact of crises as described above have changed the environment in which midwives operate. Midwives have become more autonomous and independent as a result of the crises, and in many countries they do more community outreach work as part of mobile teams sent to areas where health facilities have been destroyed. The (proportionally) large losses of other SRMNAH cadres mean that midwives in most of the countries featured in this report are expected to provide a wider range of services than normal, but the quality of care that they are able to provide is compromised by: inadequate supplies of essential drugs/equipment, insufficient time to spend with those needing care, inadequate motivation

and retention schemes for midwives in hard to reach areas and lack of supportive supervision mechanisms.

The legal frameworks in place can also represent either an enabling or disabling factor in the range of services that midwives are able to provide. For example, very few countries in the Arab States region authorise midwives to provide all seven basic emergency obstetric and neonatal care (BEmONC) signal functions, and many restrict the types of family planning methods that midwives can provide. Similarly, some Arab States still do not officially recognise midwifery as an autonomous profession, and several have no recognised definition of a professional midwife. These restrictions and limitations prevent midwives from obtaining the required skills and providing the care that women, adolescents and newborns need, either because they are not authorised to do so, or because the public does not perceive them as being sufficiently competent to do so. Given that midwives have a greater tendency than other SRMNAH workers to remain in post during a crisis, enabling them to work to their full scope of practice is a highly effective strategy to improve resilience to humanitarian crises.

As noted earlier, humanitarian crises occur for a number of reasons, and can take a number of forms, which means that their impact can vary, and responses to them must be context-specific. This said, a number of common themes emerge from this study which allow us to draw conclusions about the implications for countries either experiencing crises or wishing to make their SRMNAH systems more resilient to possible future crises:

1. Responding effectively and sustainably to humanitarian crises and improving resilience to possible future crises requires a health system approach, with a particular

focus on human resources, RH commodities and financing so as to maximise availability, accessibility (including affordability), acceptability and quality of care. A health system approach requires integrated and strong partnership working between all stakeholders, including the private sector and external funders where appropriate. Health system strengthening is acknowledged to be difficult during phases of acute humanitarian response in particular, but also in fragile contexts/protracted emergencies where there are often weaknesses in capacity and limited resources. However, it is important to plan and implement system strengthening measures as early as possible, to minimise the impact of crises on the provision of essential services.

By the same logic, health system strengthening in countries not currently affected by humanitarian crises will improve resilience in the event of a future crisis. Resilience can be defined as the capacity of a health system to prepare for and withstand shocks and crises. It can only be achieved if there is: (a) clarity about the roles and responsibilities of different local, national, regional and global actors, (b) a sound legal and policy foundation, and (c) a strong and committed health workforce which is sufficiently large and sufficiently motivated to meet the needs of the population even in difficult and dangerous environments (see point 2 below). Data on the size of the SRMNAH workforce in the Arab States region have shown that only a few countries have enough workers to meet all of the need.

2. Retention and motivation of midwives and other SRMNAH workers is vital. In the short term, this means ensuring that those who have stayed in post (most commonly midwives) are adequately equipped, supported and motivated to do their jobs. In some countries, it may also involve innovative solutions such as recruiting SRMNAH workers

from displaced populations, task shifting or supporting students to study abroad if the national education system is not functioning adequately. The status of midwifery during a crisis will depend to some extent on the status of midwifery in that country before the crisis, so some countries will need to consider ways of improving the status of the profession, e.g. expanding the scope of practice of midwives and/or investment in supportive supervision mechanisms.

3. The quest for increased workforce availability should not be pursued at the expense of quality. Competency-based education is as important in crisis situations as it is in other settings, and there are strong arguments for adjusting pre-service education curricula so that all SRMNAH workers are equipped with the skills that they are likely to need should they find themselves working in a crisis setting. Task shifting has been shown to be an effective strategy to expand capacity in crisis settings, but this can work only if those taking on new tasks have the competencies to perform them to a high standard.

4. Mechanisms to improve affordability are vital both in crisis-affected countries and those aiming to increase their resilience to possible future crises. Mechanisms such as minimum benefit packages and social protection schemes can reduce or remove barriers to access.

5. Data and evidence are needed as much in crisis situations as in other settings, in order to plan and manage the SRMNAH workforce effectively. Some of the countries featured in this report were able to provide the requested data about SRMNAH worker numbers, health facility closures and health worker graduate numbers, which shows that it is possible to maintain information systems even during a crisis.

Key messages and recommendations

- **All countries, whether in crisis or not, should consider actions to strengthen the health system, make it more resilient to shocks and crises, and more ready to respond to emergencies, by:**
 - providing clarity about the roles and responsibilities of all local, national, regional and global actors,
 - ensuring there is a sound legal and policy foundation to the health system, including the elimination of user fees for essential health services,
 - investing in the health workforce to ensure there are enough competent health workers, and that they are sufficiently loyal and motivated to remain in post even in challenging situations,
 - investing in data and information systems so that policy and planning can be evidence-informed, and
 - ensuring that different levels and sections of the health system are properly integrated (including those provided by external agencies as part of disaster relief efforts), and that the health sector works in partnership with related sectors such as education and transport.

- **A focus on SRMNAH services should be at the heart of the humanitarian response and resilience agendas and prioritised from the outset, as this will hardwire equity into the system and thus facilitate recovery from fragility or crisis.**
- **Properly educated and enabled midwives are vitally important and effective providers of SRMNAH services, so efforts to make the SRMNAH system more resilient to crises will be more successful if they involve a strong focus on midwives. In many countries, this will require: action to recognise midwifery as an autonomous profession, review of legislation to ensure that midwives can operate to their full scope of practice, and/or review of education and training curricula to ensure that midwives are competent to provide the kind of SRMNAH services that are needed during a crisis, e.g. how to care for survivors of GBV, all seven BEmONC signal functions, long-acting contraceptive methods.**
- **During a crisis, midwives are more likely than physicians and nurses to continue working, but need to be enabled to do so via systems to ensure reliable supplies of essential drugs, commodities and equipment, and the provision of transport and security support to help them provide outreach services in regions without functioning health facilities.**
- **Countries currently in crisis may also benefit from innovative solutions such as task shifting, recruiting SRMNAH workers from displaced populations or sponsoring student physicians and midwives to study abroad to maintain the pipeline of new graduates joining the workforce.**





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1 BACKGROUND AND OBJECTIVES

Humanitarian crises currently affect large parts of the world, and result in massive population displacement which in turn presents significant challenges for the provision of essential services such as health care, education and housing. According to the United Nations Refugee Agency (UNHCR), at the end of 2015, globally 65.3 million people had been forcibly displaced and were living as asylum seekers, refugees or internally displaced persons (IDPs).¹ In other words, 1 in every 113 people in the world was affected by forced displacement, representing a continuation of the rising trend observed since the mid-1990s and the highest number ever recorded. Not only is the scale of the problem growing, but the protracted nature of many current and recent crises means that people are being displaced for longer periods of time.² The implications of this include the need for effective systems to meet the long-term health and social needs of displaced persons in addition to short-term emergency relief efforts.

In this context, there is an unprecedented level of attention at the global level on countries experiencing humanitarian crises. In May 2016 the first World Humanitarian Summit was convened in Istanbul,³ bringing together representatives of national governments, civil society organisations (CSOs), non-governmental organisations (NGOs) and United Nations (UN) agencies, to discuss the

challenges presented by humanitarian crises and possible solutions to these challenges.⁴ The focus of global architecture such as the Sustainable Development Goals (SDGs)⁵ and the *Every Woman, Every Child* movement⁶ is on the eradication (as opposed to reduction) of problems such as hunger, poverty and disease epidemics, which by definition means that special attention must be paid to populations - such as forcibly displaced persons - who are particularly affected by these problems. At the highest levels, there have been calls to develop health systems and a health workforce that are more resilient to the effects of conflicts and crises.⁷

Countries in the Arab States region feature prominently in the 2015 global statistics for humanitarian crises: Syria and Somalia were among the top three countries of origin of the world's refugees, Syria and Iraq were among the top three countries in the world in terms of IDPs, Yemen was the country with the highest number of new IDPs, and Lebanon and Jordan were among the top six host countries in the world for displaced persons.¹ Two-fifths of the world's refugees, IDPs, asylum seekers and other people of concern to UNHCR originated in the United Nations Population Fund (UNFPA) Arab States region, and the region hosts 34% of the world's forcibly displaced population.¹ These statistics are summarised in Figures 1 and 2.

Figure 1: Number of persons of concern in Arab States countries, 2015



Notes: Data for Somalia are for the whole country, but the three administrative zones are shown separately because they participated separately in this piece of research (see Section 2). This map is designed for ease of data presentation and therefore makes no reference to areas/borders under dispute.

Source: Map produced by ICS Integreare based on data from United Nations Refugee Agency¹.

Figure 2: Number of refugees per 1,000 population in Arab States countries, 2015



Notes: Data for Somalia are for the whole country, but the three administrative zones are shown separately because they participated separately in this piece of research (see Section 2). This map is designed for ease of data presentation and therefore makes no reference to areas/borders under dispute.

Source: Map produced by ICS Integreare based on data from United Nations Refugee Agency¹.

In addition to countries in crisis, many countries can be described as ‘fragile states’ due to high levels of violence, lack of access to justice, ineffective national institutions, poor economic foundations and/or low levels of resilience to shocks and disasters.⁸ According to the OECD, 8 of the 50 most fragile states in the world in 2015 were in the Arab States region.⁸ Similarly, the Global Peace Index places 8 Arab States among the 20 least peaceful countries in the world,⁹ and the Index for Risk Management places 5 Arab States among the 12 countries at highest risk of crises and disasters that could overwhelm the country’s capacity to respond.¹⁰ Action to improve resilience in fragile states and neighbouring countries is necessary to mitigate against the risk of future humanitarian crises affecting them.

Humanitarian crises have been shown to affect sexual, reproductive, maternal, newborn and adolescent health (SRMNAH) in various ways, including a reduction in the availability and accessibility of basic services such as family planning and antenatal care as well as emergency obstetric care.¹¹ As a result, rates of maternal, neonatal and child mortality tend to be high in settings of conflict and displacement (about 60% of the world’s preventable maternal deaths occur in humanitarian and fragile settings¹²), and there are also higher rates of morbidity for childbearing women.¹³ The targets set under the SDGs include significant reductions in maternal mortality, the eradication of preventable child deaths and universal access to sexual and RH care services, including family planning. The Global Strategy for Women’s Children’s and Adolescents’ Health focuses strongly on equitable access to SRMNAH services and highlights “humanitarian and fragile settings” as a priority area for action.¹⁴

The number of the humanitarian crises and fragile contexts in the Arab States region is a significant challenge to the achievement of these ambitious global development goals in the region. When responding to a

humanitarian crisis or considering how to improve resilience to crises, it is important to address the different ways that crises affect different population groups. This will avoid the perpetuation of existing inequalities and improve preparedness and the ability to recover from the crisis.¹² Women and girls can be disproportionately affected by fragility and crises because they tend to have fewer assets, are often less well-educated than men and boys and do not always have equal protection of their rights, which reduces their resilience and their ability to survive and recover from crises.¹² UNFPA’s vision for humanitarian action places SRMNAH at the core of the various elements of action (prevention and preparedness; effective response; equitable, inclusive development; resilience; recovery).¹² This is because good SRMNAH is a basic human right which helps to break down inequalities and thus enables and empowers women and girls to contribute towards resilience to and recovery from humanitarian crises.

Recent years have seen the production of a convincing body of evidence regarding the effectiveness of midwifery for addressing poor SRMNAH outcomes, which shows that midwives who are properly educated, supported and enabled can meet the vast majority of the need for SRMNAH care.¹⁵⁻¹⁷ Investment in and support of midwifery as a profession would therefore be a highly effective strategy both in terms of improving resilience to crises and in terms of supporting countries in crisis to give SRMNAH an appropriately high priority when reacting to crises. The importance of midwifery and the potential contribution it can make to improving SRMNAH outcomes is starting to be recognised in the Arab States region: there have been midwifery conferences, symposia and workshops,^{18,19} and in November 2015 a report entitled *Analysis of the midwifery workforce in selected Arab countries*²⁰ was launched at a regional midwifery workshop in Cairo, Egypt.²¹ During this workshop,

there were calls for, *inter alia*, recognition of the crucial and unique role played by midwives in improving SRMNAH outcomes, including during conflicts and humanitarian crises. Participants expressed the need for more support, tools and guidance designed specifically for countries facing such crises, so that they can provide midwifery services to those in need of them. WHO guidance exists on health workforce development in *post*-conflict environments,^{22,23} and a Cochrane review is currently being undertaken, which aims to evaluate the effectiveness of interventions aimed at improving maternal, newborn and women’s RH in crisis settings,¹¹ but there is less information and guidance on human resources for health (HRH) for countries *currently* in crisis situations, or those who wish to take steps to improve health workforce resilience to possible future humanitarian crises.

The Arab States regional midwifery report provided some qualitative case studies showcasing initiatives to provide midwifery care in crisis situations, but there was no systematic data collection or focus on

countries in crisis, and two key countries (Libya and Syria) were not among the countries included in the report. Therefore, in response to the call for a focus on countries in crisis, the UNFPA Arab States Regional Office commissioned ICS Integrare to conduct some additional data collection and analysis in six countries: Iraq, Libya, Somalia, Sudan, Syria and Yemen. Palestine was also invited to participate, but was not able to provide the requested data at this time. This additional data collection forms the basis of this report, which aims to:

1. Deepen understanding of the impact of crisis situations on the availability, accessibility, acceptability and quality of human resources for SRMNAH, and particularly midwives, in the Arab States region
2. Consider the implications of the above on SRMNAH policy and planning in countries at risk of or experiencing humanitarian crises

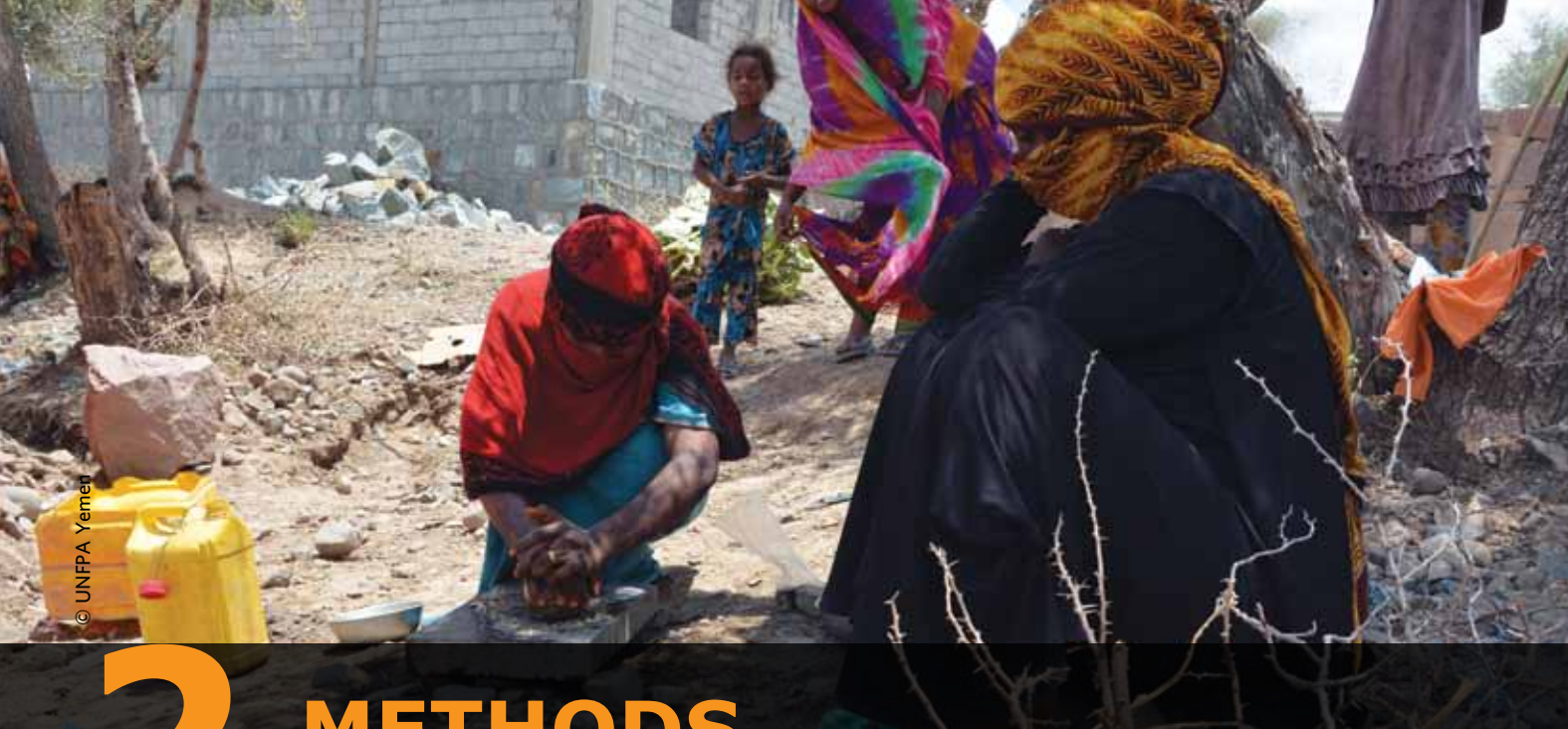
The characteristics and humanitarian impacts of the crises affected the six countries are summarised in Table 1.





Table 1: Characteristics and reported impacts of humanitarian crises affecting the selected countries

Country	Nature and impact of crisis	Duration of crisis	Source
Iraq	<p><u>Violence and conflict</u> linked to the takeover of Iraqi territory by the Islamic State in Iraq and the Levant (ISIL) and the counter-insurgency operation launched by the government and its allied forces.</p> <p>People have been subjected to mass executions, systematic rape and acts of violence, including torture. Civilians who have remained in or returned to ISIL areas have been targeted, at risk of reprisal as territory is retaken from ISIL. They face discrimination, arbitrary detention, destruction of property or are denied access to their homes.</p>	2014 until present day	UNOCHA, 2015 ²⁴
Libya	<p><u>Armed conflict</u> and <u>political instability</u>.</p> <p>Widespread violations of international humanitarian and human rights law are being perpetrated by different parties to the conflict. People have been exposed to violence, rights violations, explosive remnants of war, forced recruitment and other forms of abuse.</p>	2011 until present day	UNOCHA, 2015 ²⁵
Somalia	<p><u>Cyclical climatic impacts, armed conflict, clan violence, political instability</u>, exacerbated by low level of development. Southern and central Somalia is the most affected by armed conflict. Somaliland and Puntland are relatively stable, although there have been recent reports of increased armed clashes in Puntland.</p> <p>There are high rates of malnutrition, food insecurity, poor health infrastructure, recurrent disease outbreaks, lack of clean and safe water, poor education services and pervasive protection violations. Grave human rights violations (arbitrary arrests, violations of child rights and gender-based violence)</p>	Nearly three decades from late 80s/early 90s	UNOCHA, 2015 ²⁶
Sudan	<p><u>Armed conflict</u> between government forces and armed movements, exacerbated by fragility in neighbouring countries, <u>environmental factors</u> and <u>economic challenges</u>.</p> <p>Armed conflict has driven people from their homes and led to an increase in criminality and food insecurity.</p>	2003 until present day	UNOCHA, 2015 ²⁷
Syria	<p><u>Armed conflict</u>, leading to a deep economic recession.</p> <p>There are indiscriminate attacks on densely populated areas and severe restrictions on civilian movement. There have been large-scale acts of murder, torture, rape and kidnapping. People are experiencing food insecurity, lack of clean and safe water and power supplies, and reduced access to health and other services. Civilian infrastructure has been destroyed.</p>	2011 until present day	UNOCHA, 2015 ²⁸
Yemen	<p>Recent escalations in <u>armed conflict</u> have exacerbated the prior humanitarian emergency caused by <u>political instability</u>, intermittent conflict, <u>under-development</u> and <u>environmental decline</u>.</p> <p>There are indiscriminate air strikes and shelling, and confrontations between opposing movements. People are experiencing food insecurity, lack of clean and safe water, and reduced access to health and other services.</p>	2011 until present day	UNOCHA, 2015 ²⁹



2 METHODS

Countries were invited to participate on the basis of the severity of the humanitarian crises affecting them. In 2015, the six participating countries hosted 19.7 million out of the region's 21.9 million refugees, IDPs, asylum-seekers and other people of concern to the UNHCR.¹ (These figures include only those people under the mandate of the UNHCR; in addition, over 5 million registered refugees were under the mandate of the United Nations Relief and Works Agency (UNRWA) in Jordan, Lebanon, Palestine and Syria.³⁰)

The UNFPA country office in each country was sent a self-completion questionnaire (see Annex), which requested a mixture of quantitative and qualitative information about: the current SRMNAH workforce, the challenges of HRH management in crisis situations, and the impact of the crisis on the availability, accessibility, acceptability and quality (AAAQ) of midwives and other SRMNAH workers. AAAQ are widely acknowledged as the four dimensions that determine whether a health system and its health workforce are providing effective coverage, i.e. whether service users are obtaining the care they want and need.^{17,31}

UNFPA country office focal points were asked to co-ordinate questionnaire completion, and encouraged to convene a meeting with relevant stakeholders, e.g. government, private sector, NGOs, professional associations and civil society organisations as appropriate, so that consensus could be reached when answering the questions.

The questionnaires were issued at the beginning of May 2016, and all completed questionnaires were received by mid-June 2016. Quality assurance checks were made, and countries were asked to provide clarity in the case of ambiguous responses, which resulted in additional detail being provided. The data were entered into a spreadsheet, then a second researcher compared the spreadsheet against the completed questionnaires to ensure accurate data entry. Descriptive analyses were carried out using this dataset.

Somalia chose to complete a separate questionnaire for each of the three zones in the country: Puntland, Somaliland and the southern states of the Federal Government of Somalia. Where appropriate, results for Somalia have been reported for the country as a whole (e.g. for many multiple choice questions, a positive response given by at least one of the three zones is translated into a positive response for the country as a whole), but for some questions this was either not feasible or not appropriate, in which case the results for each zone have been reported separately. The approach used is made clear in each section. The Somaliland respondents noted that they do not consider Somaliland to be experiencing a humanitarian crisis (although it has recently experienced severe drought), so many of the questions relating to the impact of the crisis were left unanswered for Somaliland.

3 STUDY LIMITATIONS

The main limitation of this study is a lack of empirical data on key questions such as SRMNAH worker numbers, student numbers and the number of health facilities affected by the crises. A few countries were able to provide accurate data on some of these things, but others provided only estimates and some provided no data at all. Those involved in providing the information were well-informed experts, but still some of the data are based on subjective opinion rather than objective data. Further, it is likely that much of the data and information provided relates solely to the public sector SRMNAH system rather than to the whole system. Results should be interpreted with these limitations in mind.



4 RESULTS

The nature and duration of the crisis, along with the level of development of the country before the crisis began, will dictate its effects and what constitutes an appropriate response to these effects. Furthermore, the status of midwifery during a crisis will depend to some extent on the status of midwifery in that country before the crisis. The variety of responses to this data collection exercise reflects the diversity of experiences across the six countries (see Table 1).

Many of the questions in the questionnaire asked for information about a range of cadres of SRMNAH worker, in recognition of the fact that an SRMNAH system can only meet the need if it consists of a range of health workers with complementary skills and competencies. Some questions, however, focus specifically on midwives because, as can be seen in Section 4.2.1, midwives are more likely than other cadres to remain in post during a humanitarian crisis and they can meet nearly all of the need for essential SRMNAH services if appropriately educated and supported.^{17,20} Although the term 'midwife' is used throughout this section, it should be noted that some participating countries have

nurse-midwives as well as midwives, and the results reported here relate to both. It should also be noted that two of the six featured countries have more than one cadre with the title 'midwife':

- Sudan has both midwives and community midwives. Community midwives were classed as auxiliary midwives in this analysis because they have a narrower scope of practice and take a shorter time to qualify than midwives.
- Yemen has both technical midwives and community midwives. As with Sudan, community midwives were classed as auxiliary midwives due to their narrower scope of practice and shorter training duration in comparison to technical midwives.

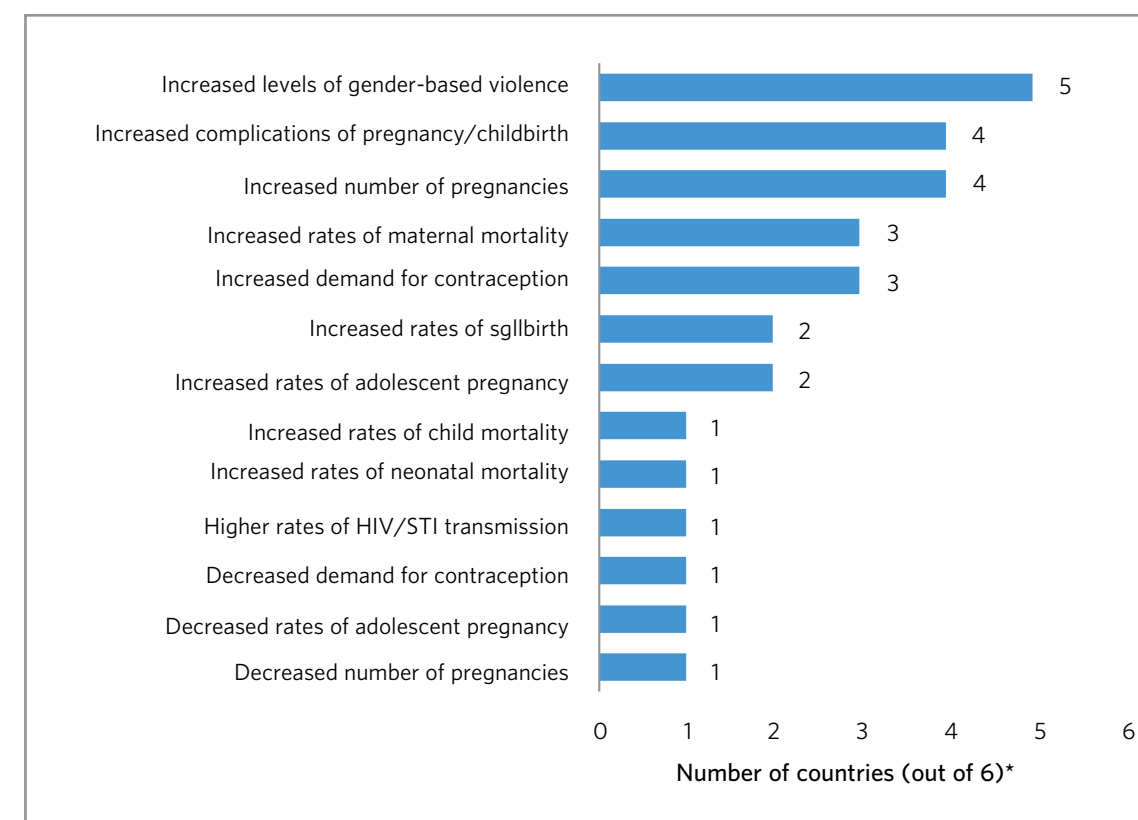
4.1 Need for SRMNAH services

An understanding of the level and type of need for SRMNAH services is essential in any assessment of the effectiveness of the SRMNAH system in meeting the needs of the population it serves.¹⁷ Correspondingly,

an understanding of the impact of humanitarian crises on the need for midwifery services is essential in improving SRMNAH systems' resilience to such crises.

All participating countries except Libya (which had no relevant data sources) reported at least one way in which the need for SRMNAH services had changed since 2010. Figure 3 shows that the main change - reported by 5 of the 6 participating countries and all of those providing a response - was an increase in GBV, including domestic violence, early marriage, sexual assault or rape. Four countries (Iraq, Somalia, Syria and Yemen) reported both larger numbers of pregnancies^a and higher rates of pregnancy/childbirth complications. The reasons for this could include reduced service availability, reduced accessibility including due to security, and reduced uptake of all ANC visits. Increased rates of maternal mortality were reported in Somalia (southern states zone only), Syria and Yemen.^b Increased demand for contraception was reported in Somalia, Sudan and Yemen.

Figure 3: Changes in need for SRMNAH services since 2010



* Somalia was counted if at least one of the three zones selected the response.

Note: some countries/zones (Iraq, Somaliland, Sudan) used official data sources to answer this question, others (Puntland, southern states of the Federal Government of Somalia, Syria, Yemen) relied on expert estimates.

a Official UN estimates³² confirm a rise in the number of births in Iraq, Somalia and Yemen between 2010 and 2015, but indicate a decrease in the number of births in Syria, contrary to the response from this country. Pregnancies and births are, of course, different, but correlated.

b Official WHO estimates⁴⁸ confirm that the maternal mortality ratio for Syria was higher in 2015 than in 2010, but the WHO estimates for Somalia and Yemen indicate a reduction in the MMR between 2010 and 2015, contrary to the responses from these two countries.

Only Libya and Yemen reported that a SRMNAH needs assessment covering the whole country had been conducted since 2010. Assessments covering parts of the country had been carried out in Somalia and Sudan, and no assessment at all in Iraq and Syria.

4.2 Availability of midwives and other SRMNAH workers

Availability depends firstly on the number of health workers in the current workforce, and secondly on the rate at which those health workers leave the workforce (outflows) and the rate at which new health workers join the workforce (inflows). In a crisis situation, high outflows can be a significant problem, and it can be difficult to maintain inflows if education institutions are affected by the crisis.

4.2.1 Outflows from the workforce

Two countries - Libya and Yemen - were able to estimate the impact of the crisis on the size of their SRMNAH workforce. The remaining

countries were unable to provide data on the current number of health workers and/or the number lost from the workforce as a direct result of the crisis.

Libya was only able to provide estimates for midwives and obstetrician/gynaecologists (ob/gyns), which indicated that about 60% of the country's midwives and 85% of the country's ob/gyns had been lost from the workforce as a result of the crisis, leaving just 400 midwives and 53 ob/gyns serving a population of 1.7 million women of reproductive age in 2015 and over 120 000 births per year.³² Internal displacement is also a key factor in affecting national SRMNAH workforce availability.

The data from Yemen (Table 2) indicated that 15% of the country's technical midwives, 25% of its community midwives, and 50% of its ob/gyns had been lost due to the crisis, as had 40% of its generalist physicians (GPs). Losses from the nursing cadres were estimated to be even higher (85% of nurse-midwives and 70% of nurses). This has left just 9000 midwives/nurse-midwives and 200 ob/gyns serving a population of 6.6 million women of reproductive age in 2015 and almost 900 000 births per year.³²

Table 2: Estimated impact of the crisis on the SRMNAH workforce in Yemen

Cadre	% time spent on SRMNAH	% lost	Number remaining (approx.)
Technical midwives	100	15	1500
Community (auxiliary) midwives	100	25	7000
Nurse-midwives	90	85	500
Obstetricians/gynaecologists	100	50	200
Generalist physicians	50	40	1500
Nurses	20	70	1000

Respondents from Syria and the two crisis-affected zones of Somalia said that the crises had resulted in SRMNAH workers spending a smaller percentage of their working time on SRMNAH in 2015 when compared to 2010, e.g. due to being diverted to other activities such as vaccination, general surgery or general nursing. Conversely, in Libya, Sudan and Yemen, it was reported that the crisis had resulted in SRMNAH workers spending *more* of their time on SRMNAH care. In Sudan this is because SRMNAH workers were not thought to

have the required competencies to perform non-SRMNAH tasks due to low capacity in the country to provide the necessary in-service training. In Yemen it was due to the widespread destruction of health facilities resulting in midwives having to work in the community and therefore being able to focus exclusively on SRMNAH.

Even though only two countries were able to provide data on SRMNAH worker numbers, five of the six participating countries said that midwives represented a larger percentage of SRMNAH workforce in 2015 than they did in 2010, due to relatively large losses from physician and nursing cadres.

Only Syria and Yemen were able to provide estimates of the impact of the crisis on the availability of other relevant human resources for health: Syria estimated that about half of its health service managers and a quarter of its health service support staff (e.g. administrators, cleaners, ambulance drivers) had been lost from the workforce due to the crisis. Yemen estimated that 2% of health service managers and 10% of support staff had been lost.

4.2.2 Inflows to the workforce

Four of the six participating countries provided information about who has come to replace 'lost' SRMNAH workers, but Libya and Sudan were not able to provide data on this. New graduates educated in country were replacing lost workers in most countries. In addition, Yemen reported that in-migrants from other countries had joined its SRMNAH workforce. Somalia and Yemen also reported that temporary relief workers (from the UN, charities and the diaspora) were providing SRMNAH care.

Although new graduates continued to be produced in most of the participating countries, Syria and Yemen reported that the crisis had reduced the number of SMRNAH

worker education institutions in the country. Syria reported that there were 54 such schools in 2010, of which 14 (26% or one in four) had ceased to operate as a direct result of the crisis. Schools teaching midwives and ob/gyns were hit hardest, with 31% of midwifery schools and 28% of ob/gyn schools having closed or been destroyed, compared with 21% of nursing schools and 17% of schools producing GPs. In Yemen, school closures almost exclusively affected community (as opposed to technical) midwives and nurses: 17 of the 42 schools (40%) had been closed or destroyed as a direct result of the crisis, along with one of the seven medical schools.

Despite the smaller number of schools, the response from Syria indicated that there were roughly the same number of graduate midwives and nurses in 2015 as there were in 2010, but there were no comparable data on GPs and ob/gyns. (It is possible that the school closures may have more of an impact in the coming years.) In Yemen, there were no nursing or midwifery graduates at all in 2015, whereas production of newly-qualified GPs and ob/gyns continued at roughly the same rate as in 2010.

In Iraq, Sudan and Somalia, there were no reports of school closures; indeed the number of midwifery, nursing and medical schools in Somaliland and Sudan was reported to have *increased* since 2010. Correspondingly, the reported numbers of graduates appeared to have been unaffected by the crises in these countries (although data on graduate numbers for Somalia were scarce). Libya provided no data on the impact of the crisis on the number of schools or number of graduates. In interpreting these findings, it should be noted that the crisis in Somalia began nearly three decades ago, making it much more prolonged than the crises affecting the other countries featured in this report. There is evidence to show that school closures strongly affected the health system prior to 2010, but since that date the situation has been relatively stable.

Most countries were unable to provide detailed data about the impact of the crises on the percentage of new graduates being absorbed into the SRMNAH workforce. Iraq and Syria reported that there had been no impact on the absorption rate of newly-qualified midwives. Similarly, Iraq, Syria and Yemen said that there had been no impact on the absorption rate of ob/gyns. Iraq said the same for GPs, but Yemen said that the absorption rate for newly-qualified GPs had decreased from 30% in 2010 to 2% in 2015.

4.3 Accessibility of midwives and other SRMNAH workers

Even if SRMNAH workers are available, they can only meet the need if service users can access them. There are several aspects of accessibility, including: geographical (i.e. can women and their families physically get to a health facility to consult a SRMNAH worker) and financial (i.e. can service users afford to pay any fees charged for SRMNAH services).

4.3.1 Geographical accessibility

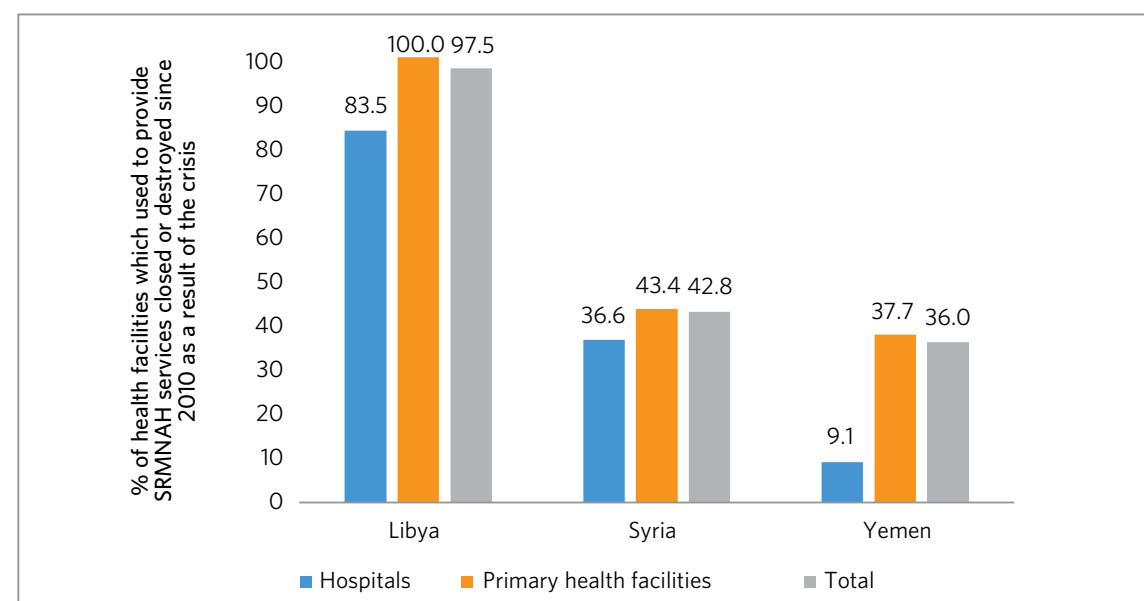
Because most SRMNAH workers operate in health facilities, a key indicator of accessibility

is the number and geographical distribution of health facilities providing SRMNAH services.

Three countries were able to provide complete data on how the numbers of health facilities providing SRMNAH services had changed since 2010: Libya, Syria and Yemen. Figure 4 shows that all three countries reported significant numbers of health facilities having ceased to provide SRMNAH services as a direct result of the crisis (e.g. destroyed, permanently closed). Both hospitals and primary health facilities were affected, but primary health facilities were hit hardest, especially in Libya, where none of the 572 primary health centres which had provided SRMNAH services in 2010 continued to offer these services. This left just 17 hospitals in Libya still offering these services. The Libyan respondents noted that, as a result, some parts of the country (e.g. El Ghat, Awbari, Kufrah) had reported a skilled birth attendance rate of zero.

In Syria, there were 164 hospitals and 1632 primary health facilities offering SRMNAH services in 2010, of which 60 hospitals and 709 primary facilities had been closed or destroyed due to the crisis. District hospitals were more affected than referral hospitals in both Syria and Yemen.

Figure 4: Percentage of health facilities which provided SRMNAH services that were closed or destroyed since 2010 as a result of the crises in Libya, Syria and Yemen



Data from Sudan indicated that 22 hospitals and 1177 primary health facilities that had previously provided SRMNAH services had closed or been destroyed since 2010, but there were no data on the number that had existed in 2010 so it was not possible to calculate what proportion of facilities had closed. Iraq indicated that the country had 10 fewer hospitals and 186 fewer primary health facilities offering SRMNAH services in 2015 than in 2010.

From Somalia, data from the zones of Puntland and Somaliland indicated no health facility closures since 2010, but no data were available for the southern states of the Federal Government of Somalia, so no conclusions can be drawn about the impact on health facilities for Somalia as a whole. Again, it should be noted that the crisis in Somalia is much more protracted than the crises affecting the other countries featured here, so these results should be seen as a reflection of the relative stability since 2010 and not as an indication that the crisis did not affect health infrastructure.

All six participating countries indicated that certain parts of the country had suffered more than others in terms of health facility losses, and all named specific areas as shown in Table 3:

Table 3: Areas most severely affected by closure or destruction of health facilities providing SRMNAH services

Country	Worst affected areas
Iraq	Provinces under ISIL control (Salah Al-din, Mosul, Anbar) & areas near to military action
Libya	Benghazi Sirt, Al-Ghat, Aubari, Murzuq and others
Somalia	Southern areas with an Al-Shabab presence
Sudan	Rural areas, especially fragile ones
Syria	Hasakeh, Der Azzor, Raqqa, Dara'a Idelb and rural Damascus
Yemen	Taizz, Sada'a, Hodiedah, Hajjah, Amran, Albaidah and others

In all six countries, attempts were being made to fill the gaps left by health facility closures: all reported the presence of mobile clinics, and four (Iraq, Somalia, Syria and Yemen) said that temporary clinics were in place. In Iraq and Syria, the role of H6 agencies^c in providing family planning, emergency obstetric and neonatal care (EmONC) and child health clinics was acknowledged. Likewise, in Somalia and Sudan, external donors were funding maternity homes, basic EmONC (BEmONC) centres and community outreach services.

Health facility closures were a significant barrier to accessibility of SRMNAH services. Respondents from all six participating countries also pointed out that the remaining health facilities face shortages of staff (see Section 4.2) and essential equipment (see Section 4.5.3), which compounded the problems of accessibility. For example, the respondents from Syria noted that the smaller numbers of ob/gyns and other health professionals meant that people living in hard-to-reach areas could not access SRMNAH care, and that the remaining SRMNAH workers were overloaded, which restricted accessibility even in areas with some availability.

Community outreach work is one way to improve accessibility when there is a lack of health facilities, and can be particularly suited to the low-intervention ethos of midwifery. In Iraq, Somalia (southern states), Sudan and Yemen, midwives were reported to do more community outreach work as a result of the crises. In the southern states of the Federal Government of Somalia, it was noted that this was due to donor funding of these services. In Yemen, the increase in outreach work was achieved through midwives being deployed as part of mobile teams; it was not considered safe for them to do community work on their own. In Sudan, the increase in outreach work was a result of travel restrictions: it was

^c The H6 partnership (formerly known as H4+) aims to pool the capacities of six UN agencies, related organisations and programmes to reduce mortality and morbidity among women and children. The six agencies are: UNAIDS, UNFPA, UNICEF, WHO, UN Women and the World Bank. H6 serves as the technical arm of the UN Global Strategy for Women's, Children's and Adolescents' Health.

considered to be more difficult for service users to travel to health facilities than for midwives to travel to service users.

By contrast, in Syria and the Puntland and Somaliland zones of Somalia, midwives did less community outreach work as a result of the crises. In Puntland and Somaliland, midwife shortages and improved health infrastructure had led to most midwives being deployed in health facilities rather than in community settings. In Syria, safety and security concerns were given as the main reason for the decrease in outreach work. Similarly, respondents from Syria, Yemen and the Puntland zone of Somalia reported that midwives were doing fewer home visits as a result of the crises. In Syria and Yemen this was due to safety concerns, and in Puntland it was due to a midwife shortage.

4.3.2 Affordability

Syria and Yemen reported that the official policy is for essential SRMNAH care to be provided free to all, including internally displaced people (IDPs), and registered and non-registered refugees. This was also the case for two of the three zones of Somalia (Puntland and Somaliland). Libya reported that the policy was for SRMNAH care to be provided free of charge for nationals only (i.e. excluding all refugees). The same was true of Sudan, but only for a very restricted set of services: care for under-5s, folic acid and sulphate supplements and prevention of mother-to-child transmission (PMTCT) of HIV (the last of which was donor funded). Iraq and the southern states of the Federal Government of Somalia reported that there was no policy of free access to SRMNAH care for anyone, but a new policy was expected imminently in Iraq, to remove user fees for maternal and child health services.

All participating countries reported that the crises had resulted in higher levels of poverty, with the result that fewer people could afford to pay SRMNAH services. In Iraq, this was attributed partly to the conflict with ISIL and partly to the collapse in oil prices. In Syria,

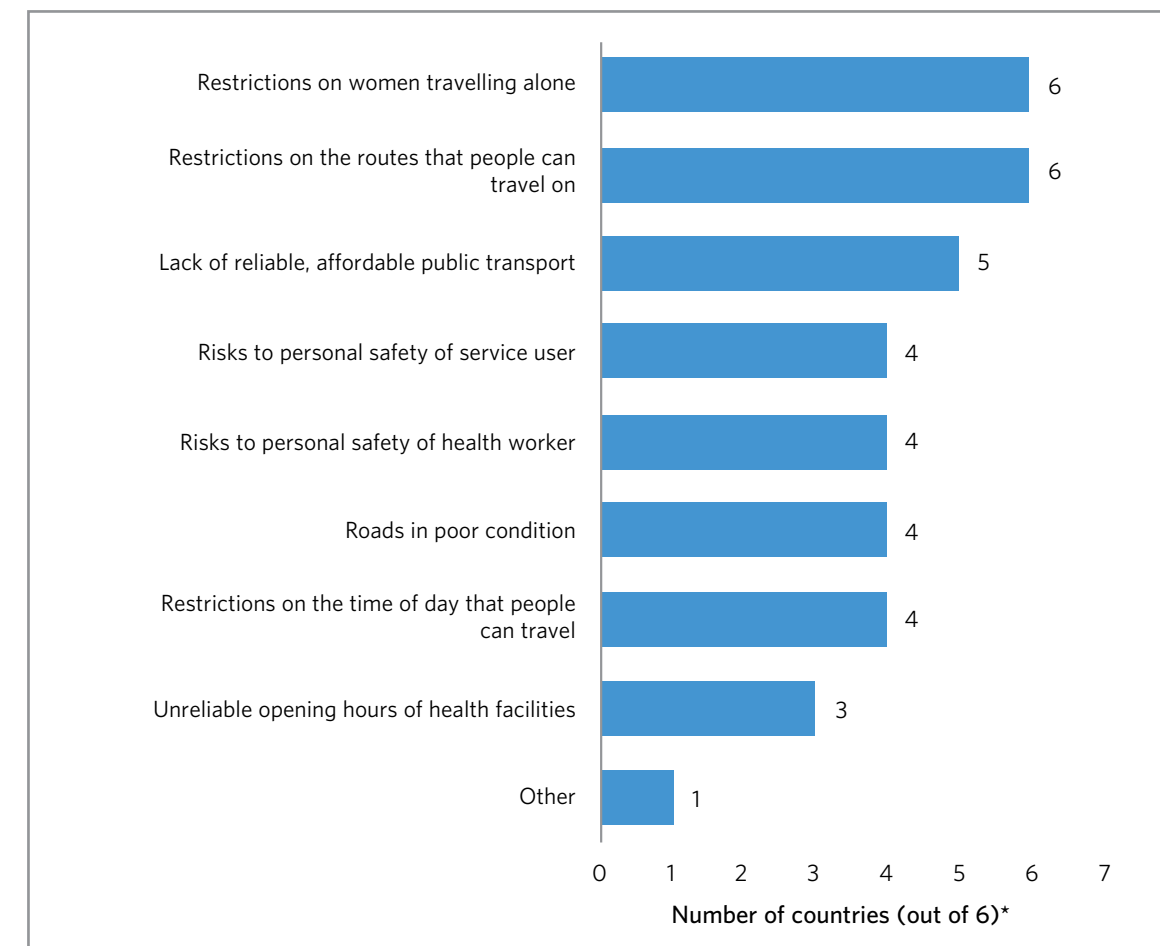
it was noted that this had affected only the private sector, since public sector services were free of charge, but because the private sector provided a large proportion of the country's RH services, this resulted in an accessibility problem. In Yemen and the southern states of the Federal Government of Somalia it was reported that user fees had been introduced or increased for all SRMNAH service users as a result of the crises. In two of the three zones of Somalia (Puntland and southern states), respondents reported that the crisis had led to more demand from health workers for informal payments.

4.3.3 Other aspects of accessibility

In addition to health facility closures and affordability, respondents identified a number of other factors that can affect service accessibility (see Figure 5), many of which were caused or exacerbated by the crises. All six countries noted that travel restrictions can prevent women and their families from accessing SRMNAH services, whether these were restrictions on route choices (e.g. in Iraq there were widespread road closures) or restrictions on women travelling alone. Four countries also noted that there were restrictions in terms of the times of day that people could travel.

A lack of reliable, affordable public transport was a problem in five of the six countries, and the condition of the roads was a problem in four countries, which added to the time required for already lengthy journeys for women living in rural areas. Risks to the personal safety of service users and providers were highlighted as a barrier to access in four countries (Iraq, Somalia, Syria and Yemen). Iraq, Somalia (all three zones) and Yemen also noted that the unreliable opening hours of health facilities were a barrier to accessibility. The respondents from Somaliland blamed this on inefficient salary and supply distribution systems, which led to health workers not being motivated to keep health facilities open throughout the day, especially in rural areas.

Figure 5: Barriers to accessing SRMNAH care



* Somalia was counted if at least one of the three zones selected the response.

The respondents from Yemen detailed some of the consequences of poor accessibility of SRMNAH services, namely: increased mortality and morbidity due to women presenting late and/or arriving at facilities with insufficient capacity to care for them, an increased rate of home births, increased number of cases of fistula and ruptured uterus, increased rate of preterm births and abortions being performed at community level.

4.4 Acceptability of midwives and other SRMNAH workers

Even if care is available and accessible, effective coverage will be reduced if either the care or the workforce is unacceptable to women, their families and communities. It is therefore important to understand public perceptions of the SRMNAH workforce and how these can change during a crisis.

All six participating countries reported changes in public perceptions of the SRMNAH workforce as a result of the crisis. Mostly these were changes for the worse: in Iraq and Yemen it was reported that the crisis had discouraged or prevented people from using SRMNAH services

and that relationships between SRMNAH workers and the public had deteriorated. In Syria it was noted that there was less trust in SRMNAH workers because many respected ob/gyns (particularly from the private sector) had left the country, leaving women to seek out less trusted alternative providers.

The response from the southern states of the Federal Government of Somalia, on the other hand, noted some positive changes in public perceptions: increased trust in SRMNAH workers, greater usages of SRMNAH services and better relations between SRMNAH workers and service users. This was attributed to increased investment in health workers generally (and midwives specifically) and rising awareness of their value, which had led to them being more respected and in demand.

Looking specifically at midwives rather than the whole SRMNAH workforce, in all six participating countries it was noted that midwives had become more independent and autonomous as a result of the crises. This may in some cases have been due to losses of other SRMNAH cadres from the workforce, but in Sudan it was noted that midwives had been officially empowered to work more independently. The increase in autonomy in Syria was attributed to midwives starting to practise privately rather than through the public health system.

4.5 Quality of care provided by midwives and other SRMNAH workers

The fourth and final dimension of effective coverage is quality: even if the workforce is available, accessible and acceptable, poor-quality care will dramatically reduce its effectiveness. There are many aspects to quality of care, including health worker education, the resources available to health workers and their work environment. The impact of the crises on some of these aspects are discussed in this section.

4.5.1 Quality of education

In most of the participating countries, the crises had no effect on minimum entry requirements to train as an SRMNAH worker, nor to the duration of education and training courses. However, some changes were reported in Iraq, Somalia and Sudan. As a result of the crisis in Iraq, the minimum age for embarking on a midwifery course was raised from 15 to 18, and the minimum age for embarking on a nursing course was lowered from 18 to 15. The response from the southern states of the Federal Government of Somalia indicated that the duration of midwifery training had been shortened from three years to two. This is contrary to international recommendations for a minimum 3-year course for professional midwives,³³ but steps were taken to maintain quality, including: ensuring that the curriculum is competency-based, compulsory clinical placements, long working weeks and short vacations, so there is no evidence to suggest that the quality of education in Somalia is inferior to that in other countries. The crisis in Sudan resulted in a new requirement for those beginning a community midwifery course to have completed secondary schooling to ensure that they were competent to deal with tasks being shifted from midwives to community midwives. Sudan also reported that, in some fragile states, SRMNAH worker shortages had led to the duration of community midwives' education being reduced from 18 months to 12 months between 2004 and 2010, then increased to 15 months.

Most of the participating countries had a standard curriculum for midwifery education both in 2010 and 2015, so there is no evidence that the crises affected the existence of standard curricula. Indeed, since 2010 both Iraq and the southern states of the Federal Government of Somalia had introduced a standard midwifery curriculum despite the crisis (the other two zones of Somalia already had one), although not all schools followed it. The standard curricula in Iraq and all three zones in Somalia had been updated since

2012, but the curricula for Syria and Yemen had not been updated since 2005 and 2007 respectively.

Similarly, most countries had a standard curriculum for GP education in both 2010 and 2015, and Iraq introduced one during this period. Information about when the GP curriculum was last updated was provided only for Syria and Yemen (2015 and 1999 respectively).

The situation is less clear for other SRMNAH cadres, because not all countries were able to provide information. Iraq and the southern states of the Federal Government of Somalia made progress on this issue during the period 2010-2015. In contrast to midwifery, the standard nursing curriculum in Syria was updated in 2015, but in Yemen it had not been updated since 2007. Like the GP curriculum, the ob/gyn curriculum in Yemen was last updated in 1999.

Iraq and Yemen reported that student to teacher ratios in SRMNAH worker education institutions had been unaffected by the crises. The other countries were unable to provide data on this question.

In all six participating countries, the government ran at least some of the SRMNAH worker schools. In addition, there were private sector schools in Somalia, Syria and Yemen, and NGOs ran some schools in Iraq and Sudan. Support to the Iraqi and Sudanese governments was provided by UNFPA, WHO and NGOs, e.g. curriculum development and the provision of in-service training. The response from the southern states of the Federal Government of Somalia noted that private sector schools were unregulated and that there were concerns about the quality of education provided by them.

Iraq, Somalia and Sudan reported that the quality of SRMNAH worker education had improved between 2010 and 2015. In Iraq and Somalia this was attributed to the updated curricula and an increase in the number and/or competencies of teaching staff. The Somaliland respondents also noted that an education regulatory body had been

established. In Sudan the improvement was attributed to high levels of political will to expand the role of the community midwife cadre, with a view to helping to fill the gaps left by the high turnover of doctors and nurses.

In contrast, the view from Syria was that the quality of SRMNAH worker education had deteriorated due to the crisis, and the Libyan respondents said that the situation varied by school location. The Syrian respondents attributed the deterioration in quality to qualified teaching staff being lost from the workforce due to the crisis, and to the poor condition of the remaining education institutions.

To improve quality of care, all countries except Somalia mentioned the need for more in-service training (particularly in relation to obstetric emergencies) and/or continuing professional development. The need for improvements to pre-service training was also mentioned by respondents from Sudan and two of the three zones of Somalia (Puntland and the southern states), including a suggestion from Sudan that the curriculum should include a course about how to work in a humanitarian crisis.

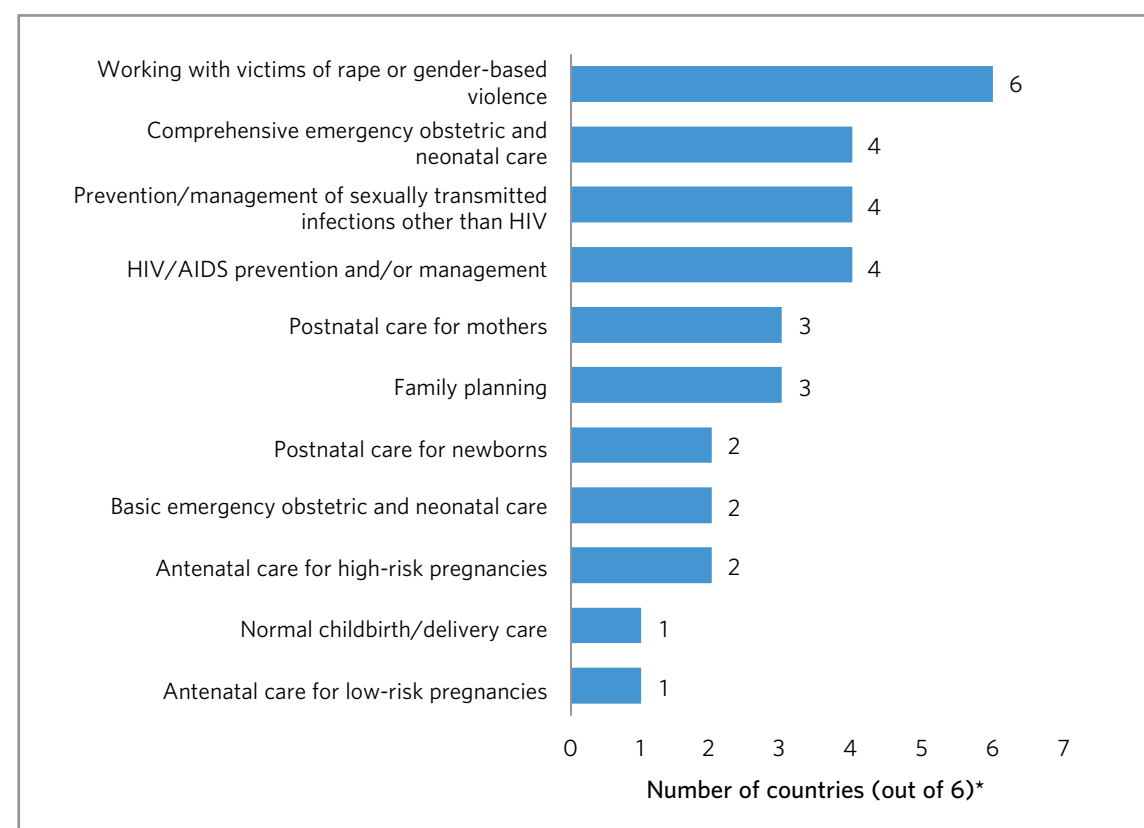
4.5.2 Skills and competencies in the SRMNAH workforce

All countries reported at least one essential SRMNAH skill that needed further development in the SRMNAH workforce. Figure 6 shows that all six were lacking in the skills to work effectively with survivors of rape or GBV, which is of particular concern given that all countries had experienced increases in incidence of these behaviours (see Section 3.1). Iraq reported that health worker education institutions in the country had no plan or strategy to include GBV in general, or clinical management of rape (CMR) specifically, but that the MoH had recently made efforts to validate its own CMR protocol and to train health workers on its implementation. In Syria, legal problems

made it difficult for working with rape survivors to be included in education and training curricula, but efforts were being made to address this. In the meantime, NGO workers with these skills were being deployed.

Other skills which were reported as lacking included comprehensive EmONC (CEmONC) skills and prevention/management of HIV/AIDS and other sexually transmitted infections (STIs). Steps were being taken in Syria to address the lack of CEmONC skills through in-service training for midwives and ob/gyns. The lack of these skills in Sudan and in two zones of Somalia (Puntland and Somaliland) was attributed to insufficient numbers of SRMNAH workers (especially in remote areas), but it was also noted in Somaliland that lack of trust in SRMNAH workers can be a barrier to women accessing services such as postnatal care.

Figure 6: SRMNAH skills in short supply or missing from the workforce



* Somalia was counted if at least one of the three zones selected the response.

Respondents were asked to state in their own words how, if at all, the quality of the care provided by midwives had been affected by the crises. Iraq, Syria, Yemen and the Somaliland zone of Somalia reported a deterioration in quality of care. The main reasons given for this were: (1) lack of equipment/drugs/supplies/utilities (Iraq, Somaliland, Yemen), (2) insufficient time to spend with those needing care due to midwife shortages (Iraq, Somaliland, Syria), and (3) lack of supportive supervision for midwives (Iraq, Syria).

On the other hand, in Sudan, Puntland and the southern states of the Federal Government of Somalia, respondents reported an *improvement* in quality of care due to investment in midwifery training in Somalia and improved supervision systems in Sudan. This is probably related to the lengthy duration of the crises in Somalia and Sudan (see Table 1) which has given them time to invest more in midwifery. Further evidence of this can be seen in Sections 4.2 (more midwifery schools) and 4.4 (improved public perceptions of midwives and midwifery).

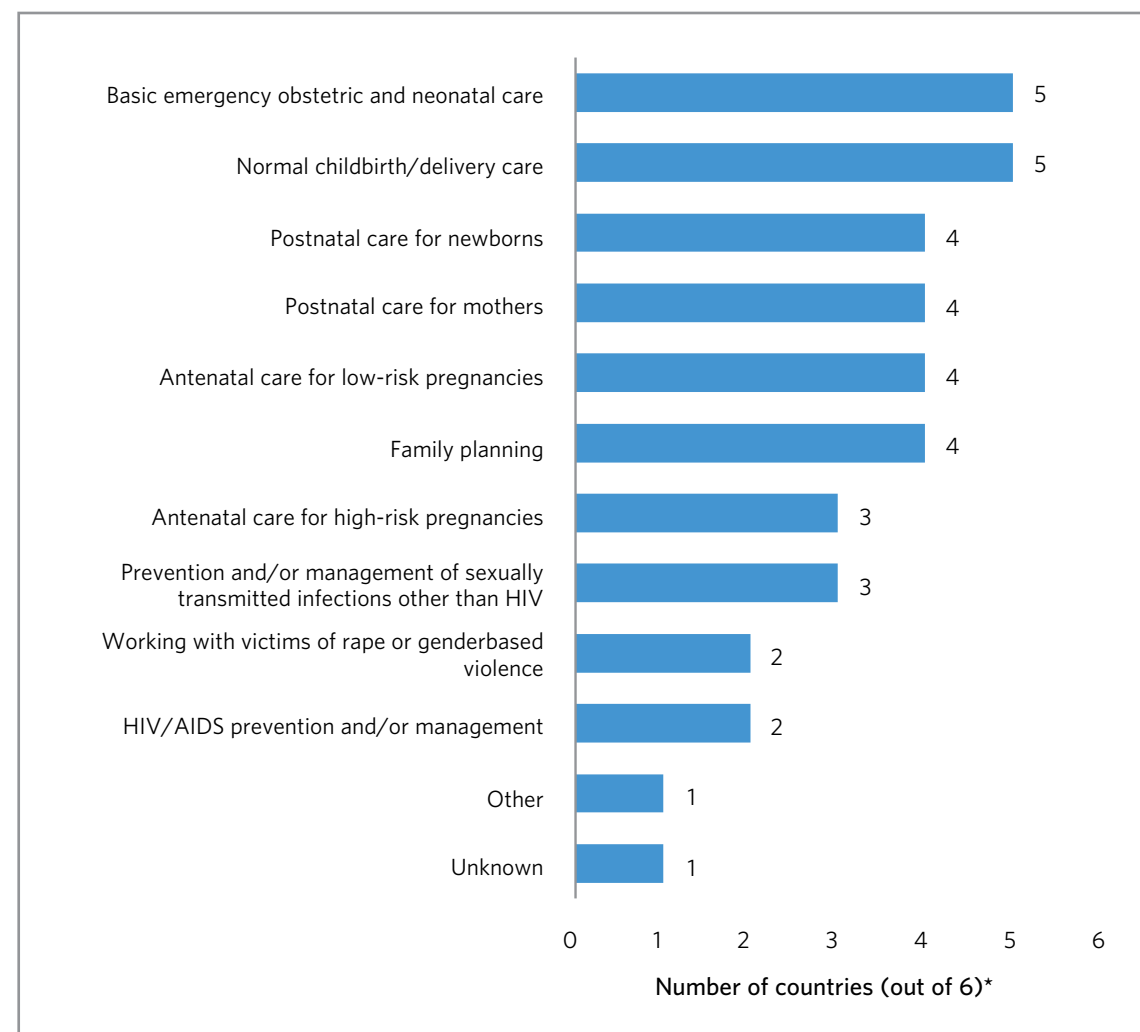
In five of the six participating countries (the exception being Libya), respondents reported that midwives provided a wider range of services than they used to in the parts of the country affected by the crises. Family planning, BEmONC, PMTCT, health education, caring for complicated/high-risk pregnancies, maternal death surveillance and response (MDSR) and care for survivors of female genital mutilation (FGM) were among the additional services listed by respondents from Somalia, Sudan and Syria. In Iraq it was noted that midwives were trusted members of the community which made it acceptable

to service users for midwives to provide a wider range of services.

Respondents were asked which SRMNAH services midwives/nurse-midwives continued to provide in the parts of the country affected by the crisis, and the results are shown in Figure 7. Iraq was not able to give a response, as the ministry of health (MoH) did not know what services, if any, were provided in the governorates controlled by ISIL. In all of the other countries, midwives continued to provide BEmONC services and normal childbirth/delivery care. As noted above, it was less common for midwives to provide care for high-risk pregnancies, work with survivors of GBV and provide services to prevent and/or manage HIV/AIDS and other STIs. Somalia made the point that midwives can only provide services if they have the necessary equipment and supplies. The Syrian respondents noted that midwives provided SRMNAH services privately if the public health facility was not able to provide them. The Yemeni respondents stated that midwives operating in crisis-affected areas did so through mobile teams and outreach initiatives.



Figure 7: SRMNAH services that midwives continue to provide in crisis-affected parts of the country



* Somalia was counted if at least one of the three zones selected the response.

One of the main reasons given for midwives not being able to provide the full range of services was that crises had led to restrictions on movement and/or poor road infrastructure (this was mentioned by respondents from Iraq, Somalia and Sudan). The same three countries reported insufficient supplies of essential RH commodities such as family planning supplies. The Sudanese respondents also pointed out that working with HIV/AIDS and GBV were new tasks for midwives, which meant that not all were in a position to provide these services. Similarly, not all Yemeni midwives had received training in these areas. In Iraq, it was also noted that there were legislative restrictions on midwives' scope of practice which prevented them from providing the full range of midwifery services.

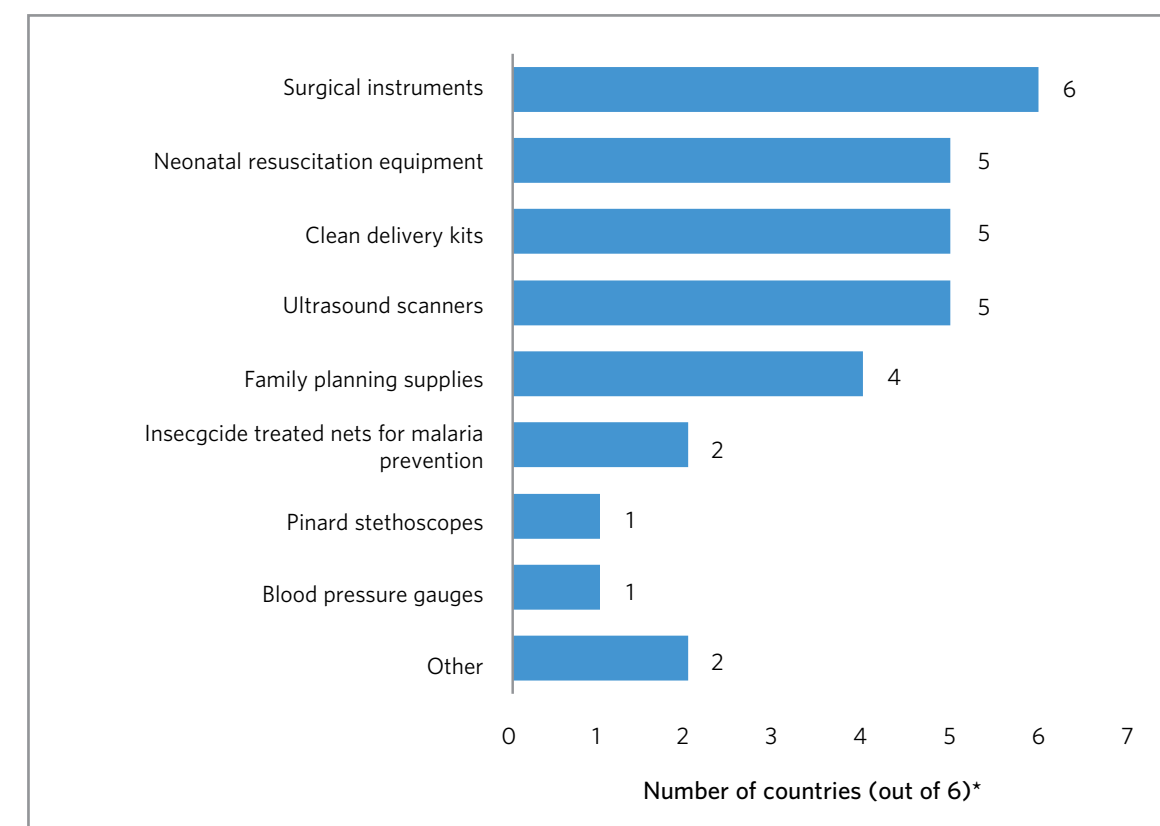
Respondents were asked to state what additional equipment, supplies or support would enable midwives to provide a wider range of SRMNAH services during the crises. All countries except Sudan made at least one suggestion. The most common suggestion was to improve the supply chain to ensure that health facilities were adequately equipped (mentioned by respondents from Iraq, Somalia and Yemen). Respondents from Iraq and the southern states of the Federal Government of Somalia suggested that midwives would be able to offer a wider range of

services if it was made easier for them (and service users) to travel. Two countries - Iraq and Syria - pointed out that a change in legislation and/or job description would be required for midwives to broaden their practice. In other words, the main barrier in these countries to extending the range of services provided by midwives was not the crisis itself, but official restrictions on their practice.

4.5.3 Availability of essential SRMNAH drugs, equipment and supplies

Midwives and other SRMNAH workers can only provide high-quality care if they can access essential SRMNAH drugs, equipment and supplies. Four countries (Iraq, Libya, Somalia and Yemen) suggested that the quality of midwifery care would improve if midwives could access sufficient equipment/supplies/utilities, particularly emergency RH kits and solutions to the problem of interrupted power supplies. All six countries reported that at least some essential SRMNAH equipment and supplies were in short supply due to the crises. The main gaps were: surgical instruments, neonatal resuscitation equipment, clean delivery kits and ultrasound scanners (Figure 8). Family planning supplies were also in short supply in Iraq, Somalia, Sudan and Yemen.

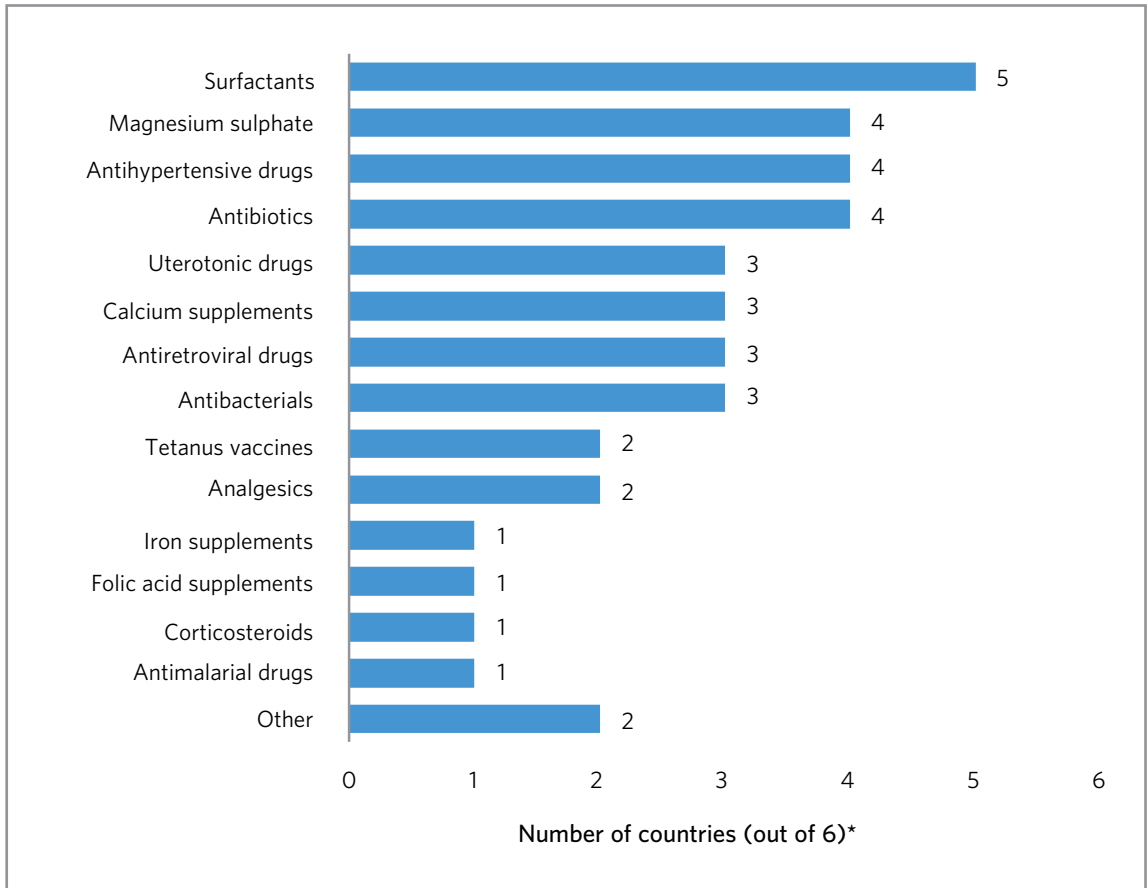
Figure 8: Essential SRMNAH equipment and supplies in short supply due to the crises



* Somalia was counted if at least one of the three zones selected the response.

Likewise, all six countries reported that at least some essential SRMNAH drugs were in short supply due to the crises. The main shortages were of: surfactants, magnesium sulphate, antihypertensive drugs and antibiotics (Figure 9). In Syria, only surfactants were specifically mentioned as being in short supply generally, but the point was made that almost all drugs were in short supply in the non-accessible parts of the country as highlighted in Table 3 (Section 3.3.1).

Figure 9: Essential SRMNAH drugs in short supply due to the crises



* Somalia was counted if at least one of the three zones selected the response.

Various reasons were given for these shortages of drugs, equipment and supplies. All six countries reported inadequate distribution systems, exacerbated in the case of Iraq by significant growth in demand for SRMNAH services (presumably driven by refugee inflows) and the cases of Somalia (southern areas), Syria and Yemen by the security situation. Libya and Somalia mentioned insufficient stocks as well as poor distribution systems. Iraq cited a decrease in fiscal space due to a collapse in oil prices, and the fact that family planning drugs and supplies were not designated as lifesaving commodities, which led to delays in procurement. Sudan had a policy of free drugs for treatment of children aged under 5 years, and it was suggested that this led to insufficient availability of drugs for other population groups such as women of reproductive age.

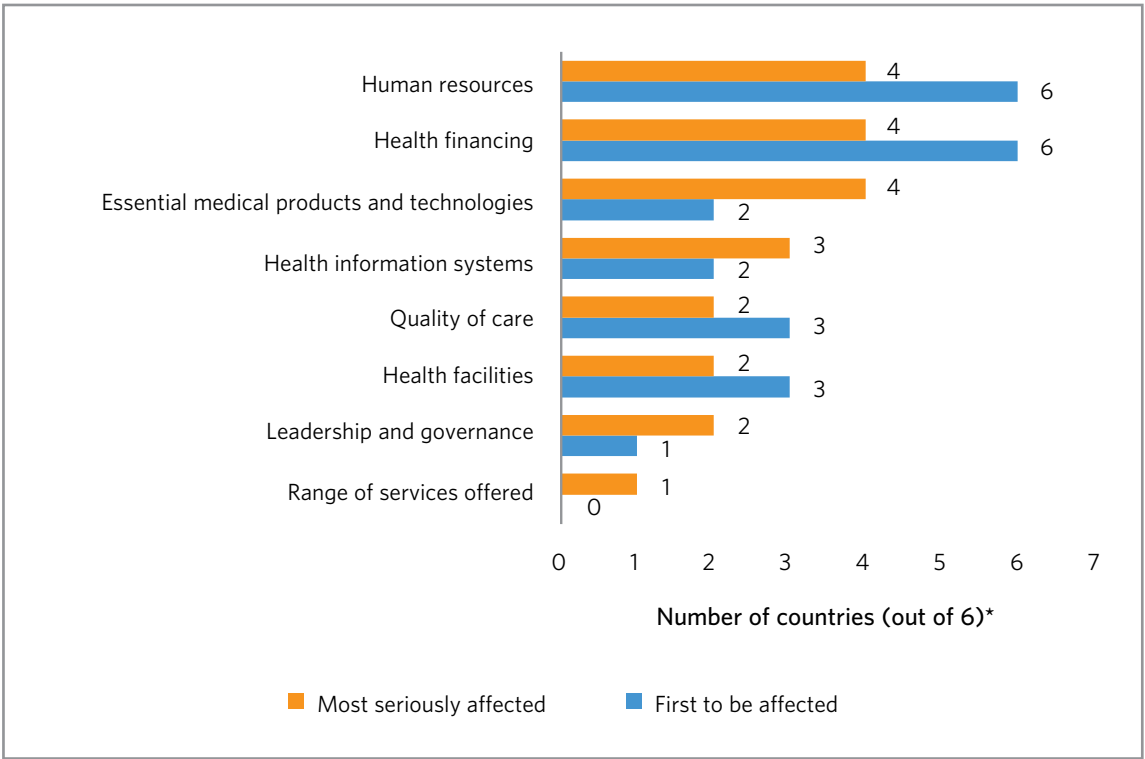
4.6 Impact on the health system and building resilience to humanitarian crises

4.6.1 How health systems are affected by humanitarian crises

WHO has published a list of six key components of a well-functioning health system: (1) leadership and governance, (2) health information systems, (3) health financing, (4) human resources, (5) essential medical products and technologies, and (6) service delivery.³⁴ This list was adapted for use in this questionnaire by splitting 'service delivery' into three sub-components: (1) health facilities, (2) range of services offered, and (3) quality of care. From the resultant list of eight components, respondents were asked to select the three that were the first to be affected by the crisis, then the three that had been most seriously affected. Some countries chose more than three options.

Figure 10 shows that all six countries found that HRH and health financing were among the health system components to be immediately affected by the crises, followed by quality of care (selected by Libya, Sudan and Syria) and health facilities (selected by Libya, Sudan and Yemen). In terms of the components *most seriously* affected, again HRH and health financing topped the list, along with essential medical products and technologies. HRH was selected by Somalia, Sudan, Syria and Yemen; health financing was selected by Libya, Somalia, Sudan and Yemen; and medical products/technologies by Iraq, Libya, Sudan and Yemen.

Figure 10: Components of the health system first affected, and most seriously affected, by the crises in Arab States countries



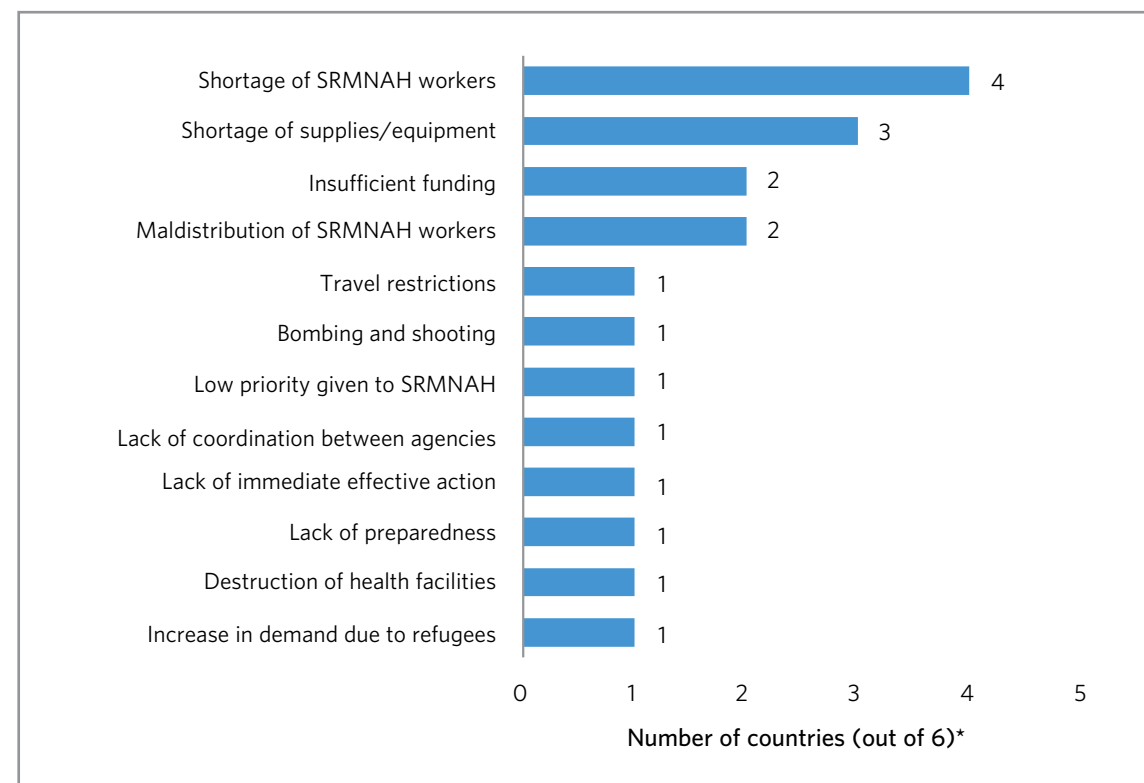
* An answer was attributed to Somalia if it was selected by at least two of the three zones

4.6.2 Identifying and responding to SRMNAH challenges and bottlenecks

The most important challenges/bottlenecks

Respondents were asked to record - in their own words - up to three of the most important challenges or bottlenecks to the provision of SRMNAH services during the crisis. Figure 11 shows that the most common response was a lack of SRMNAH workers, which was mentioned four times across the six countries. Echoing the results reported in Section 4.2.1, two countries (Sudan and Yemen) specified that the shortages particularly affected the more senior and/or specialized cadres. Shortages of supplies and equipment were cited by three countries as among the most important challenges and bottlenecks. Insufficient funding and maldistribution of SRMNAH workers were each mentioned twice.

Figure 11: Most important challenges or bottlenecks to the provision of SRMNAH services



* The first answer given was used for each of the three zones of Somalia so that the total number of responses from Somalia was three, in line with the other countries. One of the answers given by Sudan covered two topics, so was counted twice, which is why the total number of responses is 19 rather than 18.

Organisations and individuals responding to the challenges and bottlenecks

Respondents then listed the individuals and organisations that were responding to the identified challenges and bottlenecks. Four countries (Somalia, Sudan, Syria and Yemen) mentioned UN agencies, and four (Iraq, Somalia, Syria and Yemen) mentioned NGOs. Three countries (Iraq, Libya and Somalia) said that their own MoHs were responding, and three countries (Iraq, Libya and Sudan) mentioned other government departments, ministries or agencies. Respondents

from Somalia and Yemen said that the private sector was contributing. Other groups and organisations were mentioned by individual countries, including: donors (Somalia), the diaspora (Somalia), professional associations (Somalia) and community volunteers (Syria).

Those responding to the challenges and bottlenecks were reported to be providing a range of different types of support, including:

- mobile health services/outreach (Iraq, Somalia, Yemen)
- situation assessments / action plans / work plans (Libya, Syria)
- funding (Libya, Somalia)
- provision/distribution of essential supplies (Somalia, Yemen)
- education of SRMNAH workers (Somalia)
- voluntary blood collections (Iraq)

It was noted by respondents from Sudan and Yemen that the response had been in some ways disappointing, in that expectations had not been met (Sudan) and coordination between external agencies and the national government had been poor (Yemen).

What should be done differently to address challenges and bottlenecks?

When respondents were asked what should be done differently to respond to the identified challenges and bottlenecks, the most common responses related to the need to address maldistribution of SRMNAH workers and supplies. Four countries (Libya, Somaliland, Sudan and Yemen) suggested maldistribution of workers needed to be more effectively addressed, e.g. using retention and motivation strategies, and three countries (Libya, Somalia and Yemen) mentioned the need for improvements to the supply chain.

The need for better coordination of efforts was also raised again. Three countries (Iraq, Syria and Yemen) felt that different actors such as MoH, health facilities and NGOs, needed to work together more effectively. Iraq and Libya suggested that there should be better strategic planning, both in terms of being prepared for crises, and supporting countries to maintain service provision during crises. Somalia and Sudan mentioned the need for advocacy with national governments to accord a higher priority to SRMNAH. Linked to this was the suggestion from Somalia that the country should be reducing its dependency on donors and seeking sustainable funding solutions from the domestic health budget.

4.6.3 Making health systems more resilient to humanitarian crises

At the end of the questionnaire, respondents were asked to provide recommendations for other countries which would make their health systems more resilient to humanitarian crises. Five of the six countries recommended that countries should have clear strategic, action and/or contingency plans in place. Four countries (Somalia, Sudan, Syria and Yemen) suggested that countries should have 'preparedness training'/drills so that the health system can continue to operate in a crisis. Iraq and Syria pointed out the importance of strengthening coordination between different actors with a role in SRMNAH, e.g. between government and NGOs/UN agencies, and between the health sector and other sectors within the country.

Two of the three zones in Somalia made the point that rebuilding a health workforce takes a long time and some funders are reluctant to contribute to recurrent HRH costs (e.g. salaries), so countries should consider ways to maintain the existing workforce, e.g. by ensuring that professional development activities can continue even through a crisis.

5 DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

The results reported here give an indication of the impact of humanitarian crises on the need for SRMNAH services and the SRMNAH workforce. Humanitarian crises can occur for a wide range of reasons, and take a number of different forms. Therefore, while a number of common themes emerge from this study, there is also evidence of differing experiences depending on factors such as: the country's stage of socioeconomic development before the crisis, the nature of the crisis, the duration of the crisis and the amount of population displacement that has resulted from it. It is therefore crucial to take the country context into account when considering short- and long-term solutions to crisis situations, or when putting contingency plans in place to make a health system more resilient to possible future crises.

It is acknowledged that humanitarian crises negatively affect SRMNAH by weakening the health system,³⁵ so a health system approach is necessary to build resilience to crises and shocks. The resilience of health systems can be defined as "the capacity of health actors, institutions and populations to prepare for and effectively respond to crises; maintain

core functions when a crisis hits; and, informed by lessons learned during the crisis, reorganise if conditions require it".³⁶ Thus, a resilient health system functions adequately whether or not the country is in crisis, and requires the following preconditions:³⁶

- Clarity about the roles of local, national, regional and global actors. When a crisis strikes, there should be no delay or confusion regarding the roles and responsibilities of these different actors. Although a crisis may occur within the borders of an individual country and therefore be seen as the responsibility of that country's government, the repercussions may reach well beyond those borders, e.g. if the country does not have sufficient domestic resources to provide a response or if large numbers of people are displaced.
- A sound legal and policy foundation to guide the response and establish accountability, including the implementation of WHO's International Health Regulations,³⁷ and legislation and policies which make clear the roles and responsibilities of different actors.

- A strong and committed health workforce that will report for duty even in difficult and dangerous situations. This can be achieved partly by ensuring sufficient availability of health workers (a situation which currently applies in only a few countries in the region²⁰), and partly by supporting and investing in those workers so that they feel a sense of loyalty and responsibility to their employer and to the communities they serve.

Additionally, resilient health systems demonstrate the following characteristics:³⁶

- Awareness, due to effective information systems that provide strategic intelligence about issues such as the demography and epidemiology of the country.
- Diversity in terms of being able to meet a wide range of health needs rather than focusing on a few key problem areas.
- Self-regulation and stability so that services can be delivered even when there is disruption.
- Integration of different parts of the health system, and of the health system with other relevant sectors such as education and transport.
- Adaptiveness to changing needs and conditions.

It is notable that several of the above preconditions and characteristics were mentioned by respondents to this survey when they were asked what would improve the resilience of health systems (see Section 4.6.3). Countries whose health systems lack these preconditions and characteristics, or which have not achieved universal coverage of health care, cannot be considered resilient to future crises that may affect them. In the event that a crisis does strike, non-resilient health systems can be severely affected, sometimes to the point of collapse,³⁸ and in

turn can put massive pressure on the health systems of neighbouring countries who take in large numbers of refugees.³⁹

In the early stages of a crisis, the focus is often exclusively on the provision of food, shelter and care for severe physical injuries. If this type of thinking extends much beyond the first few days, the response will not acknowledge the reality that women and girls need - and have a right to - specific SRMNAH services and protection from GBV:¹² services which are most effectively provided by midwives.¹⁵ Under the Minimum Initial Service Package (MISP) for RH, seven priority SRMNAH services that should be considered essential from the onset of a crisis: EmONC, a referral system for obstetric emergencies, supplies for clean and safe deliveries, contraception, condoms, antiretrovirals and clinical care for survivors of rape.¹² As noted above, building resilience and responding effectively and sustainably to humanitarian crises requires a health system approach rather than a series of vertical approaches. In considering the health system, a helpful framework for structuring activities is WHO's six health system components: (1) leadership and governance, (2) health information systems, (3) health financing, (4) human resources, (5) essential medical products and technologies, and (6) service delivery.³⁴

Participants in this survey all agreed that human resources and financing were among the first components of the health system to be affected by the crisis, and most agreed that these two, plus essential medical products/technologies were among the most seriously affected. Whilst, therefore, attention should be paid to all six components in order to make a SRMNAH system strong and resilient to humanitarian crises, these three deserve particular attention. This requires an integrated health system with strong partnerships and coordination between (a) the health sector, other government sectors and community-based organisations, (b)

different parts of the health system, and in many cases (c) UN agencies, NGOs and other stakeholders in the aid and development community. Countries with pre-existing crisis management systems and action plans have a much better chance of continuing to provide essential health services during a crisis.¹¹

Some of the countries which participated in this study provided estimates of the impact of the crises on the availability of SRMNAH workers, and their responses indicate huge losses, particularly from physician and nursing cadres. Significant losses were also reported from midwifery cadres, but the data suggest that midwives are more likely than other SRMNAH workers to continue to provide services during a crisis, even if they turn to private practice rather than continuing to work in the public sector. Their ability to provide quality care, however, is limited by: lack of essential drugs/supplies/equipment, travel restrictions, and in some countries the widespread destruction of health facilities.

These results indicate a need to ensure that the SRMNAH workers who remain in post during a crisis are equipped with essential SRMNAH drugs and supplies so that they can provide services to as many women and newborns as possible. Given that midwives are the SRMNAH cadre most likely to remain in post, in many countries are a trusted cadre of health worker, and can meet the vast majority of the need for essential SRMNAH services,^{17,20} a particular focus on adequately equipping and supporting midwives would be a cost-effective way of maintaining essential SRMNAH services through a crisis and building resilience into the SRMNAH system. In countries currently affected by crises, however, this would still leave a shortage of SRMNAH workers, including midwives but most notably in the more specialised physician cadres. Furthermore, evidence from previous crises indicates that physicians who have left the country due a crisis tend not to return once the crisis has ended.⁴⁰ In addressing workforce shortages, it is

important for external agencies and NGOs to avoid weakening the SRMNAH workforces of crisis-affected countries by recruiting large numbers of SRMNAH workers from the national health workforce or by setting up parallel systems rather than integrating services with the existing health system.¹¹

Reduced health worker education capacity in some crisis-affected countries, combined with significant losses from the workforce, means that heavy investment in the production of new graduates will be necessary in crisis-affected countries, in order to increase the availability of SRMNAH workers to meet future needs. In the shorter term, other solutions may be considered, such as: incentive strategies to limit further losses from the workforce and address maldistribution of HRH, recruiting qualified SRMNAH workers from refugee and IDP populations^{41,42} and sponsoring nationals to study abroad. (In the latter two scenarios, it would be beneficial to build in mechanisms that would motivate health workers to return to their native countries to provide SRMNAH care when conditions permit this.) It is vital that attempts to maximise the availability of SRMNAH workers do not result in lower levels of quality.

Midwives' greater propensity to remain in post and their increased independence and autonomy during a crisis mean that they often provide a wider range of services during a crisis than would normally be the case. The majority of the additional services provided (including family planning, EmONC, MDSR) are things that any midwife educated according to global standards and working within an enabling environment can deliver. This indicates that things like education curricula, legislation or lack of professional recognition were preventing them from doing so before the crises. Indeed, the 2015 Arab States midwifery report²⁰ provided evidence that many Arab States place regulatory or legislative restrictions on midwifery practice. For example, only 3 of the 13 participating countries allowed midwives to practise all

7 BEmONC signal functions⁴³ and only 7 permitted midwives to fit intrauterine devices. Four countries had no legislation recognising midwifery as an autonomous profession and six had no recognised definition of a professional midwife. This implies an urgent need in many Arab States to take steps to extend midwives' scope of practice as an effective way to increase the resilience of the SMRNAH system to humanitarian crises.

Task shifting from physician cadres to midwifery and nursing cadres and/or from midwifery and nursing cadres to auxiliary cadres or community health workers is likely to occur in humanitarian settings, either as an official policy or because there is no other option. Task shifting has been identified as a strategy that can be successful in expanding capacity in crisis settings, by strengthening the existing health workforce and/or increasing the availability of health workers.³⁸

The widespread destruction of health facilities in some crisis-affected countries brings about a need for temporary and mobile clinics to provide SRMNAH services in the short term, especially in rural and remote areas, and in many cases these are provided by UN agencies or NGOs. However, poor road infrastructure, travel restrictions and security concerns limit the extent to which mobile clinics can respond to the need. Furthermore, previous studies have found that external agencies and NGOs who provide these services often recruit health workers from the country's public health system, thus weakening it further.³⁸ Initiatives to improve transport options and/or increase the safety and security of SRMNAH workers during outreach work would have a positive impact on accessibility during a crisis. Similarly, interrupted power supplies can be another barrier to the provision of quality care, even if SRMNAH workers are available. Investment in alternative power and water solutions in health facilities (e.g. solar power) would be an option for building up resilience to crises.

Increased poverty levels during crises mean that women in countries with a large private health sector and countries in which health workers charge user fees for essential services will experience greater barriers to accessibility of SRMNAH services during a crisis, as was reported by some of the countries featured in this report. The impact of crises on countries' economies mean that initiatives to improve affordability of SRMNAH care in crisis-affected countries are important, e.g. voucher schemes. In the longer term, resilience to the effect of crises on accessibility could be increased by the removal of user fees for essential care in all countries. Many countries already have a minimum benefits package which includes essential SRMNAH care as defined by international norms,⁴⁴ and social protection mechanisms for ensuring that affordability is no barrier to access.⁴⁵ Investment in these initiatives in other countries (with financial support where needed from development partners) would increase the resilience of health systems to humanitarian crises. Data from the 2015 Arab States midwifery report²⁰ show that even countries in the region with policies of free access to essential SRMNAH services do not include all of the services recommended by global standards, implying the need for revision of these packages.



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These results also show the impact that crises can have on quality of SRMNAH care, whether this is due to the available health workers not having enough time to spend with service users, problems in health worker education (e.g. the destabilisation of the education system), problems with the supply chain (e.g. disrupted supplies of essential drugs, commodities and equipment), or problems with health worker motivation (e.g. due to lack of remuneration or fears for personal safety). In particular, increased levels of GBV were reported in five of the six participating countries, and yet all countries reported that there was a shortage of SRMNAH workers with the skills to work with survivors of GBV (including rape). There is an evident need for an SRMNAH workforce with the skills and competencies to work with these survivors, yet many first responders to crises do not have this expertise.¹² The most sustainable way to rectify this would be to ensure that pre-service education equips midwives and other SRMNAH workers to provide the essential services that may be required of them in a crisis situation^{38,42} - including, but not limited to, working with survivors of GBV. Regular 'skills and drills' training would assist any health workforce to be more resilient to future humanitarian crises.

Despite the obvious difficulty of collecting reliable data during a crisis, the fact that

some countries were able to provide empirical data in response to this study indicates that it is possible to do so, especially if partners (government, NGOs, UN agencies, community organisations etc) can coordinate their efforts. Evidence-based planning is important in all settings, but arguably it is even more important in a crisis situation, so investment in data collection and management systems should not be overlooked when planning for and managing health systems during humanitarian crises. For example, surveys can be used to assess needs, incidence of complications/diseases and service coverage; surveillance systems can be used to map incidence of issues such as GBV; focus groups can be used to help understand barriers to uptake of services; routine health management information systems can be used to monitor the supply chain (using innovative solutions where infrastructure is poor⁴⁶).

Although the main focus of this report is countries currently in crisis, it contains strong messages for other countries categorised as fragile or at risk of crisis. Guidance exists for risk reduction activities,⁴⁷ and it is important to include SRMNAH within resilience plans. Not only is meeting the SRMNAH needs of a population a matter of basic human rights, it also contributes to recovery from and resilience to current and potential future crises because good SRMNAH helps to tackle inequalities, thus increasing the number of people who can contribute to recovery and rebuilding efforts. It is likely that crises will continue to occur in the foreseeable future, so it is important to place as much emphasis on improving resilience as on reacting to crises as they occur.¹² This report provides some advice about preparedness and resilience from countries currently in crisis, and it is hoped that this report will help to ensure that their experience is shared for the benefit of others and their voices are heard for the benefit of the communities that they serve.

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ANNEX: QUESTIONNAIRE

Impact of humanitarian crises on the sexual, reproductive, maternal, newborn and adolescent health (SRMNAH) workforce

UNFPA Arab States Regional Office (ASRO) has asked ICS Integrare (a UNFPA Implementing Partner) to conduct research among countries currently experiencing humanitarian crises. The research aims to deepen understanding of:

- the impact of such crises on human resources for sexual, reproductive, maternal, newborn and adolescent health (SRMNAH) in your country
- how health systems can be strengthened to be more resilient to emerging humanitarian crises in the future
- what technical, operational and programmatic support is needed to maintain SRMNAH services in countries experiencing humanitarian crises

Seven countries have been invited to complete this questionnaire. All responses will be analysed by ICS Integrare, who will prepare a paper to share the results and make recommendations. You will be invited to review and comment on the paper before it is submitted for publication.

Instructions:

Please complete the questionnaire by clicking on the boxes provided and / or entering text responses in the middle column entitled 'response'. For questions requesting facts and figures, we request you that you gather **the most recent available data**. If no data exist, please provide an expert estimate and indicate that it is an estimate.

The right-hand column should also be used to provide information about data sources, and any additional detail and explanation that you feel would be helpful to aid understanding of your responses. If a question cannot be answered, please state the reason in this column.

Please submit your completed questionnaire to Andrea Nove of ICS Integrare (andrea.nove@icsintegrare.org) and Mohamed Afifi of UNFPA (afifi@unfpa.org). If you have any questions, please contact Andrea or Mohamed by email in the first instance.

Please submit your responses as soon as possible, and no later than 31 May 2016.

Thank you very much for completing this questionnaire. Your time and engagement is very much appreciated.

Module 1: Need for SRMNAH services

No.	Question	Response	Further explanation and data sources
101	Name of country PLEASE ENTER COUNTRY NAME		NA
102	In what way(s) has the need for SRMNAH services in your country changed since 2010? PLEASE SELECT ALL THAT APPLY	<input type="checkbox"/> Increased number of pregnancies <input type="checkbox"/> Decreased number of pregnancies <input type="checkbox"/> Increased rates of adolescent pregnancy <input type="checkbox"/> Decreased rates of adolescent pregnancy <input type="checkbox"/> Increased rates of pregnancy and childbirth complications (e.g. preterm birth, sepsis) <input type="checkbox"/> Increased demand for contraception <input type="checkbox"/> Decreased demand for contraception <input type="checkbox"/> Higher rates of transmission of HIV and/or other sexually transmitted infections <input type="checkbox"/> Increased levels of gender-based violence (including domestic violence, early marriage, sexual assault or rape) <input type="checkbox"/> Increased rates of maternal mortality <input type="checkbox"/> Increased rates of stillbirth <input type="checkbox"/> Increased rates of neonatal mortality <input type="checkbox"/> Increase rates of child mortality <input type="checkbox"/> Other	What is the source of this answer? Is it from a verifiable source or is it an estimate made specifically for this study?
103	Has a SRMNAH needs assessment been carried out in your country since 2010? PLEASE SELECT ONE ONLY	<input type="checkbox"/> Yes, covering the whole country <input type="checkbox"/> Yes, covering part(s) of the country <input type="checkbox"/> No	If yes, please provide a reference/ weblink here, or attach a soft copy of the report when you submit your completed questionnaire.

Module 2: Current SRMNAH workforce

No.	Question	Response	Further explanation and data sources
201	Which of the following health worker cadres are engaged in the provision of SRMNAH care in your country? PLEASE SELECT ALL THAT APPLY	<input type="checkbox"/> Midwives or nurse-midwives <input type="checkbox"/> Auxiliary midwives or nurse-midwives <input type="checkbox"/> Nurses <input type="checkbox"/> Auxiliary nurses <input type="checkbox"/> Generalist physicians <input type="checkbox"/> Obstetricians/gynaecologists (ob/gyns) <input type="checkbox"/> Other	If you selected 'other', please list the other cadres here.

Please answer the following questions for each SRMNAH worker cadre that exists in your country (one column for each cadre). Include both public and private sector workers as far as possible. Please leave the column blank if that cadre does not exist in your country, or if it exists but is not engaged in the provision of SRMNAH care.

Please indicate the source(s) and year(s) of the data in the left-hand column.		Source of data & year	Midwives/ nurse-midwives	Auxiliary midwives/ nurse-midwives	Nurses	Auxiliary nurses	Generalist physicians	Ob/ gyns	Other SRMNAH workers
202	Name of this cadre (if different from the name in the column heading). PLEASE ENTER CADRE NAME								
203	Overall, what percentage of its available working hours does this cadre spend on providing SRMNAH care? PLEASE ENTER A PERCENTAGE								

Please answer the following questions for each SRMNAH worker cadre that exists in your country (one column for each cadre). Include both public and private sector workers as far as possible. Please leave the column blank if that cadre does not exist in your country, or if it exists but is not engaged in the provision of SRMNAH care.

Please indicate the source(s) and year(s) of the data in the left-hand column.

	Source of data & year	Midwives/ nurse-midwives	Auxiliary midwives/ nurse-midwives	Nurses	Auxiliary nurses	Generalist physicians	Ob/ gyns	Other SRMNAH workers
204	How many workers in this cadre are currently engaged in providing SRMNAH care in your country? PLEASE ENTER A NUMBER							
205	Since 2010, how many workers from this cadre have been lost from the workforce as a direct result of the crisis (e.g. killed, displaced, voluntarily left the country)? PLEASE ENTER A NUMBER							
	Question	Response				Further explanation and data sources		
206	Since 2010, what percentage of health service managers have been lost from the workforce as a result of the crisis? PLEASE ENTER A %					Please cite data sources if available, or indicate that your answer is an estimate. Please also describe the impact this has had on the health system in your country.		
207	Since 2010, what percentage of health service support staff (e.g. administrators, cleaners, ambulance drivers) have been lost from the workforce as a result of the crisis? PLEASE ENTER A PERCENTAGE					Please cite data sources if available, or indicate that your answer is an estimate. Please also describe the impact this has had on the health system in your country.		

IF WORKERS HAVE BEEN LOST FROM THE SRMNAH WORKFORCE DUE TO THE CRISIS SINCE 2010, PLEASE ANSWER QUESTIONS 208 TO 212. OTHERWISE, PLEASE GO TO QUESTION 213.

208	Are those who have been lost from the SRMNAH workforce from all age groups, or are they mainly younger or older workers? PLEASE SELECT ONE	<input type="checkbox"/> All age groups <input type="checkbox"/> Mostly younger (under 50 years old) <input type="checkbox"/> Mostly older (50+ years old)	If you selected 'mainly younger' or 'mainly older', please say why this group has been disproportionately affected.
209	Are those who have been lost from the SRMNAH workforce from both sexes, or are they mainly men or mainly women? PLEASE SELECT ONE	<input type="checkbox"/> Both sexes <input type="checkbox"/> Mainly men <input type="checkbox"/> Mainly women	If you selected 'mainly men' or 'mainly women', please say why they have been disproportionately affected.
	Question	Response	Further explanation and data sources
210	If the age, gender and/or ethnic profile of the SRMNAH workforce has changed as a result of the crisis, what effect has this had on public perceptions of the workforce? PLEASE SELECT ALL THAT APPLY	<input type="checkbox"/> It has made some people trust SRMNAH workers <u>more</u> than they did before <input type="checkbox"/> It has made some people trust SRMNAH workers <u>less</u> than they did before <input type="checkbox"/> It has <u>encouraged</u> some people to use SRMNAH services <input type="checkbox"/> It has <u>discouraged</u> or <u>prevented</u> some people from using SRMNAH services <input type="checkbox"/> It has <u>improved</u> relationships between SRMNAH workers and service users <input type="checkbox"/> It has <u>worsened</u> relationships between SRMNAH workers and service users <input type="checkbox"/> Other <input type="checkbox"/> No effect on public perceptions <input type="checkbox"/> Not applicable - profile has not changed	Please explain your answer: who has been affected, how and why.

Please answer the following questions for each SRMNAH worker cadre that exists in your country (one column for each cadre). Include both public and private sector workers as far as possible. Please leave the column blank if that cadre does not exist in your country, or if it exists but is not engaged in the provision of SRMNAH care.		
Please indicate the source(s) and year(s) of the data in the left-hand column.		
211	Who, if anyone, has come to replace the SRMNAH workers who have been lost from the workforce due to the crisis? PLEASE SELECT ALL THAT APPLY	<input type="checkbox"/> New graduates from within this country <input type="checkbox"/> SRMNAH workers from other countries (in-migrants) <input type="checkbox"/> Temporary relief workers, e.g. UN or charity employees <input type="checkbox"/> Other <input type="checkbox"/> No-one has replaced the lost SRMNAH workers
212	What effect has the crisis had on the skill mix of the SRMNAH workforce? PLEASE SELECT ALL THAT APPLY	<input type="checkbox"/> Midwives represent a larger percentage of the workforce than they did in 2010 <input type="checkbox"/> Nurses represent a larger percentage of the workforce than they did in 2010 <input type="checkbox"/> Auxiliaries represent a larger percentage of the workforce than they did in 2010 <input type="checkbox"/> Generalist doctors represent a larger percentage of the workforce than they did in 2010 <input type="checkbox"/> Ob/gyns represent a larger percentage of the workforce than they did in 2010 <input type="checkbox"/> No effect on skill mix

If you selected 'other', please describe here.

EVERYONE PLEASE ANSWER

213	Which of the following statements is the most applicable to your country? PLEASE SELECT ONE	<input type="checkbox"/> As a result of the crisis, SRMNAH workers spend a smaller percentage of their working time on SRMNAH care than they did in 2010 (e.g. due to being diverted to other activities such as vaccination, general surgery or general nursing) <input type="checkbox"/> As a result of the crisis, SRMNAH workers spend a greater percentage of their working time on SRMNAH care than they did in 2010 <input type="checkbox"/> The crisis has had no effect on the percentage of working time spent on SRMNAH
214	Which SRMNAH skills are in short supply or missing from the workforce? PLEASE SELECT ALL THAT APPLY	<input type="checkbox"/> Family planning <input type="checkbox"/> HIV/AIDS prevention and/or management <input type="checkbox"/> Prevention and/or management of other sexually transmitted infections <input type="checkbox"/> Working with victims of rape or gender-based violence <input type="checkbox"/> Antenatal care for low-risk pregnancies <input type="checkbox"/> Antenatal care for high-risk pregnancies <input type="checkbox"/> Normal childbirth/delivery care <input type="checkbox"/> Basic emergency obstetric and neonatal care <input type="checkbox"/> Comprehensive emergency obstetric and neonatal care <input type="checkbox"/> Postnatal care for mothers <input type="checkbox"/> Postnatal care for newborns <input type="checkbox"/> Other <input type="checkbox"/> None

Module 3: Education of SRMNAH workers

Please answer the following questions for each SRMNAH worker cadre that exists in your country (one column for each cadre). Please leave the column blank if that cadre does not exist in your country, or if it exists but is not engaged in the provision of SRMNAH care. Please indicate the source(s) and year(s) of the data in the left-hand column.

	Question	Source of data & year	Midwives/ nurse-midwives	Auxiliary midwives/ nurse-midwives	Nurses	Auxiliary nurses	Generalist physicians	Ob/ gyns	Other SRMNAH workers
301	In 2010, how many training schools in your country produced SRMNAH workers? Please include both public and private sector schools. PLEASE ENTER A NUMBER								
302	How many training schools <u>currently</u> produce SRMNAH workers? Please include both public and private sector schools. PLEASE ENTER A NUMBER								
303	Since 2010, how many schools have ceased to operate as a direct result of the crisis? (e.g. destroyed, closed) PLEASE ENTER A NUMBER								
304	What was the average student to teacher ratio in... PLEASE ENTER A RATIO FOR BOTH PARTS A AND B	a) ...2010?							
		b) ...2015 (or latest available year)?							

	Question	Source of data & year	Midwives/ nurse-midwives	Auxiliary midwives/ nurse-midwives	Nurses	Auxiliary nurses	Generalist physicians	Ob/ gyns	Other SRMNAH workers
305	Across all schools, how many students graduated in ... PLEASE ENTER A NUMBER	a) ...2010? b) ...2015 (or latest available year)?							
306	How many students are <u>expected to graduate</u> in...? PLEASE ENTER A NUMBER	a) ... 2016? a) ... 2017? a) ... 2018?							
IF NO TRAINING SCHOOLS ARE CURRENTLY PRODUCING SRMNAH WORKERS IN YOUR COUNTRY, PLEASE GO TO MODULE 4. OTHERWISE PLEASE ANSWER QUESTIONS 307 TO 314.									
307	What percentage of graduates were employed in the provision of SRMNAH care within one year of graduation in... PLEASE ENTER A NUMBER	a) ...2010? b) ...2015 (or latest available year)?							
308	As a result of the crisis, what changes (if any) have been made to the minimum entry requirements to train as this cadre, e.g. age, high-school qualifications? PLEASE DESCRIBE THE CHANGES OR ENTER 'NO CHANGES'								

	Question	Source of data & year	Midwives/ nurse-midwives	Auxiliary midwives/ nurse-midwives	Nurses	Auxiliary nurses	Generalist physicians	Ob/gyns	Other SRMNAH workers
309	As a result of the crisis, what changes (if any) have been made to the number of years it takes to train as this cadre? PLEASE DESCRIBE THE CHANGES OR ENTER 'NO CHANGES'								
310	In 2010, was there a standard curriculum for this cadre? PLEASE SELECT ONE		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
311	Is there <u>currently</u> a standard curriculum for this cadre? PLEASE SELECT ONE		<input type="checkbox"/> Yes, and all schools follow it <input type="checkbox"/> Yes, but not all schools follow it <input type="checkbox"/> No	<input type="checkbox"/> Yes, and all schools follow it <input type="checkbox"/> Yes, but not all schools follow it <input type="checkbox"/> No	<input type="checkbox"/> Yes, and all schools follow it <input type="checkbox"/> Yes, but not all schools follow it <input type="checkbox"/> No	<input type="checkbox"/> Yes, and all schools follow it <input type="checkbox"/> Yes, but not all schools follow it <input type="checkbox"/> No	<input type="checkbox"/> Yes, and all schools follow it <input type="checkbox"/> Yes, but not all schools follow it <input type="checkbox"/> No	<input type="checkbox"/> Yes, and all schools follow it <input type="checkbox"/> Yes, but not all schools follow it <input type="checkbox"/> No	<input type="checkbox"/> Yes, and all schools follow it <input type="checkbox"/> Yes, but not all schools follow it <input type="checkbox"/> No
312	In which year was the standard curriculum last updated? PLEASE ENTER THE YEAR OR 'NOT APPLICABLE'								

	Question	Response	Further explanation and data sources
313	Which organisation(s) run the SRMNAH training schools that currently operate in your country? PLEASE SELECT ALL THAT APPLY	<input type="checkbox"/> Government department or agency <input type="checkbox"/> NGOs <input type="checkbox"/> Relief agencies <input type="checkbox"/> Religious organisations <input type="checkbox"/> Other private sector <input type="checkbox"/> Other	
314	Would you say that the overall quality of education of SRMNAH workers in your country is better than it was in 2010, worse, or about the same? PLEASE SELECT ONE	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> The same <input type="checkbox"/> It varies	Please explain your answer, e.g. it what way(s) is it better or worse and why?

Module 4: Infrastructure and accessibility of SRMNAH workers

Please now think about all the health facilities in your country that are designated to provide any aspects of SRMNAH care, both public and private sector.

Please indicate the source(s) and year(s) of the data in the left-hand column.

No.	Question	Source of data & year	Health facility type 1	Health facility type 2	Health facility type 3	Health facility type 4	Health facility type 5	Health facility type 6
401	Please list all types of health facility that provided any aspects of SRMNAH care in your country in <u>2010</u>, from the highest level of care to the lowest (e.g. referral/ specialist hospital, provincial hospital, district hospital, primary health centre). Use a separate column for each type of facility ENTER HEALTH FACILITY TYPE							
402	How many of this type of health facility were providing SRMNAH services in <u>2010</u>? PLEASE ENTER A NUMBER							
403	And how many are <u>currently</u> providing SRMNAH services? PLEASE ENTER A NUMBER							
404	Since 2010, how many health facilities have ceased to provide SRMNAH services as a direct result of the crisis? (e.g. destroyed, closed down) PLEASE ENTER A NUMBER							

IF NO HEALTH FACILITIES HAVE CEASED TO PROVIDE SRMNAH SERVICES AS A RESULT OF THE CRISIS, PLEASE GO TO QUESTION 407. OTHERWISE PLEASE ANSWER QUESTIONS 405 AND 406.

	Question	Response	Further explanation and data sources
405	Have particular parts of the country been more affected by the closure or destruction of health facilities, or has the whole country been equally affected? PLEASE SELECT ONE	<input type="checkbox"/> Certain parts of the country have been more affected <input type="checkbox"/> The whole country has been equally affected	If certain parts of the country have been more affected, please specify which (e.g. urban areas, border areas, specific regions), and state why they have been more affected.
406	What, if anything, has been done since 2010 to replace the health facilities that have ceased to operate due to the crisis? PLEASE SELECT ALL THAT APPLY	<input type="checkbox"/> New building programme <input type="checkbox"/> Temporary clinics <input type="checkbox"/> Mobile clinics <input type="checkbox"/> Other <input type="checkbox"/> Nothing has been done to replace them	Please give more detail about actions taken to replace health facilities, e.g. which organisations are managing the process, which services are provided, which services are <i>not</i> provided.
EVERYONE PLEASE ANSWER			
407	As a result of the crisis, which essential SRMNAH equipment and supplies are in short supply in some or all parts of this country? PLEASE SELECT ALL THAT APPLY	<input type="checkbox"/> Family planning supplies (e.g. condoms, IUDs) <input type="checkbox"/> Blood pressure gauges <input type="checkbox"/> Pinard stethoscopes <input type="checkbox"/> Ultrasound scanners <input type="checkbox"/> Clean delivery kits <input type="checkbox"/> Surgical instruments <input type="checkbox"/> Insecticide treated nets (ITNs) for malaria prevention <input type="checkbox"/> Neonatal resuscitation equipment (e.g. bag and mask) <input type="checkbox"/> Other <input type="checkbox"/> None	Please give more detail: what specifically is in short supply and why? (e.g. insufficient stocks, poor distribution systems)

	Question	Response	Further explanation and data sources
408	<p>As a result of the crisis, which essential SRMNAH drugs and medicines are in short supply in some or all parts of this country?</p> <p>PLEASE SELECT ALL THAT APPLY</p>	<input type="checkbox"/> Analgesics <input type="checkbox"/> Antibacterials <input type="checkbox"/> Antibiotics <input type="checkbox"/> Antihypertensive drugs <input type="checkbox"/> Antimalarial drugs <input type="checkbox"/> Antiretroviral drugs <input type="checkbox"/> Calcium supplements <input type="checkbox"/> Corticosteroids <input type="checkbox"/> Folic acid supplements <input type="checkbox"/> Iron supplements <input type="checkbox"/> Magnesium sulphate <input type="checkbox"/> Surfactants <input type="checkbox"/> Tetanus vaccines <input type="checkbox"/> Uterotonic drugs <input type="checkbox"/> Other <input type="checkbox"/> None	<p>Please give more detail: what specifically is in short supply and why? (e.g. insufficient stocks, poor distribution systems)</p>
409	<p>Which, if any, of these things can prevent women and their families from accessing SRMNAH care when they need to?</p> <p>PLEASE SELECT ALL THAT APPLY</p>	<input type="checkbox"/> Restrictions on the time of day that people can travel <input type="checkbox"/> Restrictions on the routes that people can travel on <input type="checkbox"/> Lack of reliable, affordable public transport <input type="checkbox"/> Roads in poor condition <input type="checkbox"/> Risks to personal safety of health worker <input type="checkbox"/> Risks to personal safety of service user <input type="checkbox"/> Restrictions on women travelling alone <input type="checkbox"/> Too few health facilities <input type="checkbox"/> Health facilities are not adequately staffed <input type="checkbox"/> Health facilities are not adequately equipped <input type="checkbox"/> Unreliable opening hours of health facilities <input type="checkbox"/> Inability to pay for services <input type="checkbox"/> Lack of trust between service providers and service users <input type="checkbox"/> Other	<p>Please give examples</p>

410	<p>Which of these statements best describes your country's official policy about who, if anyone, should have to pay to access essential SRMNAH services?</p> <p>PLEASE SELECT ONE</p>	<input type="checkbox"/> It is our policy that essential SRMNAH care should be free for any resident of this country, including registered and non-registered refugees <input type="checkbox"/> It is our policy that essential SRMNAH care should be free for nationals and registered refugees only (i.e. excluding non-registered refugees) <input type="checkbox"/> It is our policy that essential SRMNAH care should be free only for nationals (i.e. excluding all refugees) <input type="checkbox"/> There is no policy of free access to essential SRMNAH care for anyone <input type="checkbox"/> Other	<p>Please provide additional details to explain the policy</p>
411	<p>In what way(s), if at all, has the crisis affected the affordability of SRMNAH services?</p> <p>PLEASE SELECT ALL THAT APPLY</p>	<input type="checkbox"/> No effect on affordability <input type="checkbox"/> User fees have been introduced or increased for some groups (e.g. refugees) <input type="checkbox"/> User fees have been introduced or increased for all users of SRMNAH services <input type="checkbox"/> User fees have decreased or been abolished for some groups (e.g. refugees) <input type="checkbox"/> User fees have decreased or been abolished for all users of SRMNAH services <input type="checkbox"/> There is more demand for informal payments to health workers <input type="checkbox"/> There is less demand for informal payments to health workers <input type="checkbox"/> Poverty levels have risen so fewer people can afford to pay for services <input type="checkbox"/> Other	

Module 5: The rôle of midwives during humanitarian crises

PLEASE ANSWER THE QUESTIONS IN MODULE 5 IF YOUR COUNTRY HAS MIDWIVES OR NURSE-MIDWIVES. OTHERWISE, LEAVE THESE QUESTIONS BLANK AND GO TO MODULE 6.

	Question	Response	Further explanation and data sources
501	In the parts of the country affected by the crisis, do midwives (or nurse-midwives) provide... PLEASE SELECT ONE	<input type="checkbox"/> ... a wider range of services than they used to, <input type="checkbox"/> ... a narrower range of services than they used to, or <input type="checkbox"/> ... the same range of services as they used to?	Please explain your answer: which specific services do midwives (or nurse-midwives) provide that they didn't used to provide? Which services do they no longer provide? Why?
502	In the parts of the country affected by the crisis, which SRMNAH services are midwives (or nurse-midwives) continuing to provide? PLEASE SELECT ALL THAT APPLY	<input type="checkbox"/> Family planning <input type="checkbox"/> HIV/AIDS prevention and/or management <input type="checkbox"/> Prevention and/or management of other sexually transmitted infections <input type="checkbox"/> Working with victims of rape or gender-based violence <input type="checkbox"/> Antenatal care for low-risk pregnancies <input type="checkbox"/> Antenatal care for high-risk pregnancies <input type="checkbox"/> Normal childbirth/delivery care <input type="checkbox"/> Basic emergency obstetric and neonatal care <input type="checkbox"/> Postnatal care for mothers <input type="checkbox"/> Postnatal care for newborns <input type="checkbox"/> Other <input type="checkbox"/> None	Please explain your answer. Which specific aspects of care are midwives (or nurse-midwives) able to provide even during crisis situations?

503	In the parts of the country affected by the crisis, what has been the effect of the crisis on the way in which midwives deliver care? PLEASE SELECT ALL THAT APPLY	<input type="checkbox"/> Midwives (or nurse-midwives) do <u>more</u> home visits than they used to <input type="checkbox"/> Midwives (or nurse-midwives) do <u>fewer</u> home visits than they used to <input type="checkbox"/> Midwives (or nurse-midwives) do <u>more</u> community outreach work than they used to <input type="checkbox"/> Midwives (or nurse-midwives) do <u>less</u> community outreach work than they used to <input type="checkbox"/> Midwives (or nurse-midwives) are <u>more</u> independent and autonomous than they used to be <input type="checkbox"/> Midwives (or nurse-midwives) are <u>less</u> independent and autonomous than they used to be <input type="checkbox"/> Other <input type="checkbox"/> No effect on the way they deliver care	Please explain: what has caused these changes in the way that midwives (or nurse-midwives) work?
504	In what way, if at all, is the quality of the care provided by midwives (or nurse-midwives) affected by the crisis? PLEASE RESPOND IN YOUR OWN WORDS		Please give full details: in what way(s) is the quality better or worse, and why? If quality is improved or not affected, how do midwives (or nurse-midwives) in your country manage to maintain quality despite the crisis?
505	What additional equipment, supplies or support would enable midwives (or nurse-midwives) to provide better quality of SRMNAH care during the crisis? PLEASE RESPOND IN YOUR OWN WORDS		Please be as specific as possible to describe how midwives (or nurse-midwives) could be enabled to provide better quality of care during the crisis.

	Question	Response	Further explanation and data sources
506	In the parts of the country affected by the crisis, which services are midwives (or nurse-midwives) <u>not</u> able to provide, e.g. due to lack of supplies or travel restrictions? Please consider services that midwives (or nurse-midwives) would normally be competent and authorised to provide. PLEASE SELECT ALL THAT APPLY	<input type="checkbox"/> Family planning <input type="checkbox"/> HIV/AIDS prevention and/or management <input type="checkbox"/> Prevention and/or management of other sexually transmitted infections <input type="checkbox"/> Working with victims of rape or gender-based violence <input type="checkbox"/> Antenatal care for low-risk pregnancies <input type="checkbox"/> Antenatal care for high-risk pregnancies <input type="checkbox"/> Normal childbirth/delivery care <input type="checkbox"/> Basic emergency obstetric and neonatal care <input type="checkbox"/> Postnatal care for mothers <input type="checkbox"/> Postnatal care for newborns <input type="checkbox"/> Other <input type="checkbox"/> None	Please explain your answer: which specific aspects of care are midwives (or nurse-midwives) not able to provide, and what prevents them from providing these aspects of care?
507	What additional equipment, supplies or support would enable midwives (or nurse-midwives) to provide a wider range of SRMNAH services during the crisis? PLEASE RESPOND IN YOUR OWN WORDS		Please be as specific as possible to describe how midwives (or nurse-midwives) could be enabled to provide a wider range of services during the crisis.

Module 6: Building health system resilience to humanitarian crises

	Question	Response	Further explanation and data sources
601	Which components of the health system were the <u>first</u> to be affected by the crisis? PLEASE SELECT UP TO THREE	<input type="checkbox"/> Leadership and governance <input type="checkbox"/> Health information systems <input type="checkbox"/> Health financing <input type="checkbox"/> Human resources <input type="checkbox"/> Essential medical products and technologies <input type="checkbox"/> Health facilities <input type="checkbox"/> Range of services offered <input type="checkbox"/> Quality of care <input type="checkbox"/> Other	Please explain your answer
602	Which components of the health system have been the <u>most seriously</u> affected by the crisis? PLEASE SELECT DFUP TO THREE	<input type="checkbox"/> Leadership and governance <input type="checkbox"/> Health information systems <input type="checkbox"/> Health financing <input type="checkbox"/> Human resources <input type="checkbox"/> Essential medical products and technologies <input type="checkbox"/> Health facilities <input type="checkbox"/> Range of services offered <input type="checkbox"/> Quality of care <input type="checkbox"/> Other	Please explain your answer

	Question	Response	Further explanation and data sources
603	In your view, what are the three most important challenges or bottlenecks to the provision of SRMNAH services in your country during the current crisis? You may refer to issues already covered in this questionnaire, or different issues. PLEASE ENTER UP TO THREE RESPONSES	1) 2) 3)	
604	Which individuals and organisations are responding to these challenges and bottlenecks? PLEASE RESPOND IN YOUR OWN WORDS		
605	In what way(s) are they responding? What are they doing and how well is this working? PLEASE RESPOND IN YOUR OWN WORDS		
606	What should be done differently to respond better to these challenges and bottlenecks? PLEASE RESPOND IN YOUR OWN WORDS		

607	What additional technical, operational and/or programmatic support does your country need to address these challenges and bottlenecks? PLEASE RESPOND IN YOUR OWN WORDS		
608	What would be your recommendations for countries not in crisis, to make their health systems more resilient to future humanitarian crises that may affect them? PLEASE RESPOND IN YOUR OWN WORDS		



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UNFPA

Arab States Regional Office

70 A al nahda street

intersection with street # 22
New Maadi, Cairo, Egypt

Phone: +20225223900

Web: arabstates.unfpa.org