Saving Newborn Lives in Refugee Settings: Evaluation Summary

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More than half of all neonatal deaths occur in countries with a neonatal mortality rate of 30 or more deaths per 1,000 live births. Many of these countries have experienced recent conflict or humanitarian emergencies and are hosting refugees.

With the aim to improve newborn care in refugee situations, UNHCR implemented a two-year project "Saving Newborn Lives in Refugee Situations (2016-2018)" with the support of the Bill and Melinda Gates Foundation. The project was implemented in three countries: South Sudan, Kenya and Jordan, focusing on low cost, high impact newborn interventions.

Across all countries, there were noticeable improvements in maternal and child care. The partnership enabled women to seek advice on appropriate treatment of sick and small newborns, access improved infrastructure and services, and adapt their behaviours to ensure healthy pregnancies.

Implementation

A baseline assessment was initially conducted, followed by a literature review to identify context-specific needs and key priorities. Action plans were then developed and clinical training packages were distributed to improve health worker knowledge and skills, including essential newborn care, care for the small and sick newborn, emergency neonatal and obstetrical care and maternal health care.

Low-cost, high impact actions that target the leading causes of neonatal mortality guided the choice of activities. The project focused on strengthening the home visit program by training community health workers on home care during pregnancy and the throughout the first week following the birth. It included procurement of essential newborn medications and supplies, the development of missing clinical files, job aids, and checklists to support and improve quality of care, and the implementation of monitoring tools to measure progress in the improvement of the services availability and quality.

Impact

General improvements in the skills and knowledge of health workers allowed for improved delivery of neonatal care services. Staff improved and sustained their skills in newborn resuscitation, prevention and management of postpartum haemorrhage, and knowledge of essential newborn care after the two-year period.

The project allowed for an increase in the availability and use of the partograph, and implementation of checklists for breastfeeding and counselling on newborn danger signs. There was an update on protocols for eye and cord care and antenatal corticosteroids, an increase in the documentation of neonatal admissions, referrals, and availability of protocols, job aids and health education posters.

Next steps

Building on the successes and recommendations outlined in “Saving Newborn Lives in Refugee Situations: Project Evaluation Final Report” the project is being extended to three further countries (Chad, Cameroon, Niger). It will continue to focus on low cost, high impact maternal and newborn care practices, and improving family planning services.

Strengthening Community-based Interventions

In every location, a network of community health workers were trained to provide health promotion advice and raise awareness of the key services, particularly among new arrivals. Staff were trained how to use radios to call for an ambulance in situations where skilled health staff are evacuated, and how to uphold minimum services when professional health services are disrupted by conflict and violence.

A number of potentially dangerous home-based practices were identified, including the application of foreign substances to the newborn’s umbilicus and mixed feeding methods.

In South Sudan, refugees commonly used charcoal and sesame oil on the umbilical stump of newborns, while in Jordan, Syrian refugee women reported using cigarette ash on the baby’s cord.

To address these practices, the project focused on increased intervention at the home and community level by training community health workers to identify and target these practices. Training focused on promoting hygienic umbilical cord care and increasing acceptance of early and exclusive breastfeeding.

One-day old baby Omar, receives assistance at the field hospital in Azraq refugee camp, Jordan.

Improving Care of Low Birth Weight Newborns through Kangaroo Mother Care

Maintaining warmth for low birth weight babies is a key aspect of care and is crucial for survival. Kangaroo Mother Care (KMC) is a life-saving, low-technology method of caring for low birth weight babies, which is particularly useful in low resource refugee settings.

Through a strategic approach, the project

promoted the method through the training of health workers, the provision of cloth wraps to hold the baby skin-to-skin with the mother, and the introduction of support tools such as KMC registers to support implementation.

Across all countries, health partners reported an increase in the uptake of Kangaroo Mother Care for low birth weight babies. Uptake was particularly successful in Kenya and South Sudan.

"Previously you realised that no one is even remembering the kangaroo, even if the electricity is off and the baby might be exposed to hypothermia. But, now kangaroo is often practiced and part of the normal activities that we are conducting." - Midwife, Dadaab, Kenya

Improving Essential Infrastructure for Care of Sick or Small Newborns

Across all countries, the project improved essential infrastructure for care of sick or small newborns.

One of the greatest outcomes of the project was the construction of a newborn care unit in Maban County Hospital in South Sudan. Prior to the project, the hospital was the only facility functioning in the state and had a very small maternity department. The hospital received all complicated obstetrical and neonatal cases from the surrounding refugee camps and from the host population, serving a population of over 200,000.

Recognising the importance of the facility, the project funded the construction of a newborn care unit, increasing the capacity to provide neonatal care including KMC, nasogastric tube feeding, intravenous fluids and antibiotics. During the first ten-months of the unit's operation, 106 referrals were made for vulnerable newborns.

Gisma, a Sudanese refugee, sits with her newborn baby in the Maban Hospital Maternity Ward.

Relevance

To ensure the project was relevant, activities were locally developed and tailored to each unique context and health system. Where possible, local or regional consultants were hired to design and implement trainings and training materials were translated into local languages.

Efficiency

Considering the efficiency of the project, countries were able to implement nearly all project activities in the two-year period. However, to see significant changes in health outcomes, the timeframe to rollout new interventions required extension.

Sustainability

Health staff improved and sustained their skills in newborn resuscitation, prevention and management of postpartum haemorrhage, and knowledge of essential newborn care after the two-year period. UNHCR training materials intend to be handed over to implementing partners for ongoing use, and the inclusion of future donors have been encouraged.

Barriers to further success

Despite the availability of newborn units in South Sudan and Kenya, low numbers of staff available for continuous monitoring and outreach support mothers and their newborns continued to be a barrier to quality care. Community health workers were often overwhelmed with competing priorities and sometimes had to shift activities. As one community health worker expressed:

"*If cholera comes in today, you find that our attention tends to be changed a bit because now cholera becomes an emergency*" - Health worker, Dadaab, Kenya.

Issues related to policy and procedure also impacted implementation. In some cases, national policies for newborn care conflicted with global best-practice guidelines making local uptake difficult. In Jordan, camp referral policies continued to support referral of low birth weight babies to out of camp hospitals, resulting in the separation of mother and newborn and restricting the ability to breastfeed.

Ten Recommendations for Improving Newborn Health Programming in Refugee Settings

Recommendation 1: Use evidence from baseline assessments to inform country-specific action plans, and prioritize activities that address contextual factors that impede gains in newborn health.

Recommendation 2: Provide sufficient time to develop a health provider training strategy that addresses the sustainability of knowledge and skills in contexts with high staff turnover, with buy-in from senior health management.

Recommendation 3: Ensure educational materials are available in local languages that can be accessible for training community health workers and other non-English speaking staff.

Recommendation 4: Authorize task-shifting where appropriate and invest in designing training curricula appropriate for facility-based lay health workers, particularly in countries facing ongoing insecurity.

Recommendation 5: Initiate a newborn technical working group at the camp level to support the implementation of local policy changes, coordination, and improved standardization.

Recommendation 6: Strengthen the use of kangaroo mother care method and ensure proper management of small and sick newborns. Identify critical health facilities, and invest in adequate space and staffing.

Recommendation 7: Investigate the cost-effectiveness of referring stable, small and sick newborns versus care closer-to-home in camp primary care facilities, and improve the follow up of referred newborns.

Recommendation 8: Prioritize the implementation of community-based newborn care in future operations by reinforcing CHW responsibilities and training especially in insecure settings, with standardized home visits and checklists.

Recommendation 9: Ensure key newborn indictors are included in Health Information Systems (HIS) that monitor trends in health status and evaluate the effectiveness of interventions and service coverage.

Recommendation 10: In order to better understand causes and contributing factors to newborn deaths, integrate perinatal death audits into the maternal death audit process, with UNHCR leadership, to consist of a sample of stillbirths and neonatal deaths that should have survived.

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