UNHCR
The UN Refugee Agency

Improving newborn and neonatal care

In line with UNHCR's global Strategy for Public Health (2014 – 2018)[1], with the support of the Gates Foundation, UNHCR started a special project to improve neonatal care focusing on low cost interventions in Jordan, Kenya and South Sudan.

A baseline assessment of newborn health care was undertaken in refugee camps in South Sudan, Jordan and Kenya. This consisted of assessments of all health facilities in the camps, and in-depth interviews with medical coordinators and healthcare providers to gather information about the newborn care services. Focus group discussions with community members, including groups of mothers, fathers, grandmothers, traditional birth attendants and community health workers provided valuable insight into community perceptions of health care as well as traditional practices around pregnancy, childbirth and newborn care.

Essential care for every newborn

One of the key factors in newborn survival is use of a skilled birth attendant during childbirth. The coverage of skilled birth attendance is close to 100% in Syrian refugee camps in Jordan, 80% in Kenya and 77% in South Sudan[2]. Furthermore, there is a good coverage of resuscitation services as well as emergency obstetric care services in the three countries. However, simple actions at and around the time of birth, such as delayed cord clamping, thermal care, neonatal resuscitation, provision of eye prophylaxis and Vitamin K, and the promotion of early and exclusive breastfeeding, have the potential to prevent illness and save newborn lives are not consistently practiced in all sites.


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Preventing deaths from intrapartum complications

Neonatal deaths account for 40% of deaths under the age of 5 years worldwide. Neonatal death audits conducted in all refugee camps in Dadaab, found that around 75% of deaths occurred within the first week of life, while between 25% to 45% occurred within the first 24 hours. The audit established that the main causes of neonatal mortality were: asphyxia and prematurity.

Three specific types of delays can play a role in maternal and neonatal death: delay in seeking care (cultural /religious reasons, lack of knowledge of available services), delay in reaching care (transport difficulties/long distance), and delay in receiving care (due to lack of supplies, trained providers or poor referral system). A fourth delay is included in Kenya, referring to the delay to consent for care once at the health facility. The assessment found that transportation from home to the hospital when in labour continues to be difficult for many women. Although community-based ambulance services are in place, women in focus group discussions reported this to be an on-going barrier to facility delivery in all locations, and this important component of care needs to be strengthened. The partograph is a key tool to monitor labour progress and document both maternal and fetal wellbeing during labour and childbirth. In Jordan two out of three delivery facilities in the camps (67%) and one of the two referral hospitals assessed did not use partographs.

1 http://www.unhcr.org/530f12d26.pdf

2 http://twine.unhcr.org/app/

Strengthening care for preterm babies

Complications of preterm delivery is another leading cause of neonatal mortality. Analysis of neonatal death audits carried out in 2014 in Zaatri refugee camp in Jordan, found that 60% of neonatal deaths were associated with preterm birth and its related complication of respiratory distress syndrome. In Doro camp, South Sudan, premature babies born in the MSF primary health care centre receive kangaroo mother care (KMC). Although KMC was very unfamiliar to community members at first, word-of-mouth and observation of the practice in the postnatal wards soon made it a known and acceptable practice among mothers.

If the baby is born in the 7th month, put it between your breasts to keep it warm. MSF will give you blankets to cover you.
– Mother Doro camp

KMC involves keeping the baby skin-to-skin on the chest of the mother for extended periods of time, which facilitates thermoregulation and breastfeeding, among other benefits. The facility supports the practice through simple methods such as designating beds especially for KMC, not using incubators in their facilities, and providing staff with clinical guidelines to support the practice. While thermal management is vital for preterm babies, incubator use in low-resource settings can be problematic. Incubators can be difficult to keep clean, shortages may mean that more than one baby is placed inside, creating infection risks; and lack of reliable electricity, frequent breakdowns and problems with maintenance add to the potential difficulties. This, along with the growing body of evidence[3,4] that outcomes for premature babies are better for those cared for with KMC than with standard incubator care, means a shift away from incubator care is warranted.

Despite its benefits and suitability, the assessment found low adoption of kangaroo mother care in all three countries (Jordan 0%, South Sudan 50% and Kenya 0%). It was found that nurses and midwives, even when familiar with the method, did not promote it routinely because of barriers such as perceived resistance from mothers, lack of training, and lack of supportive policies and guidelines.

In line with UNHCR Operational Guidelines on Improving Newborn Health in Refugee Operations[5], the promotion of Kangaroo Mother Care will be critical element of the project.

Strengthening community-based care to prevent sepsis and promote breastfeeding

The first week of life is a critical period, as it is when the majority of newborn deaths occur and danger signs such as problems with breastfeeding or breathing, or signs of infection or jaundice may appear. The assessment found that in Jordan, routine postnatal visits were paid to the mother only, and the newborns are not being assessed in the critical first week following discharge from hospital. HIS indicators are recording post-natal care for mother-only. A network of community health workers (CHWs) who are refugees themselves, are in place in all camps. An opportunity exists to build on their existing skills in the follow up of the newborn and health education, and to maximize the home visits through checking thermal care, breastfeeding and identifying danger signs. In some settings this will include taking the respiratory rate and temperature of the newborn.

CHWs can also help prevent newborn sepsis from infection of the baby's umbilical cord. The assessment found that traditional umbilical cord care practices continue to be extremely common among mothers in all three countries. In South Sudan, charcoal from the Lalobe seed, mixed with sesame oil is placed on the umbilicus; in Kenya, charcoal or the leaves from the Malmal tree are used; and in Jordan, cigarette ashes are commonly applied. In addition to on-going health education, distribution of chlorhexidine, an effective and safe cord antiseptic, by CHWs, to be used in the case of home delivery, may help reduce the use of foreign substances on the umbilicus, and thereby the incidence of sepsis from umbilical cord infection.

3 Conde-Agudelo A, Diaz-Rossello JL. Kangaroo mother care to reduce morbidity and mortality in low birthweight infants. Cochrane Database Syst Rev. 2014;4:CD002771.

4 Conde-Agudelo A, Belizan JM, Diaz-Rossello J. Kangaroo mother care to reduce morbidity and mortality in low birthweight infants. Cochrane Database Syst Rev. 2011;3:CD002771.

5 http://www.unhcr.org/protection/health/54bd0dc49/operational-guidelines-improving-newborn-health-refugee-operations.html

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I delivered my first baby outside the camp. The staff gave him a bottle instead of my breast. The second one I delivered here, and I knew from Save the Children to give my breast right away – Mother, Zaatari camp, Jordan

The baseline assessment found that in all three locations, exclusive breastfeeding rates are lower than the target, e.g. 77.5% in Maban refugee camps, 23.5% in Dadaab and according to a survey conducted in 2014, 46% in Jordan refugee camps. The use of sugar water, powdered milk, animal milk or commercial infant formula frequently supplements breastfeeding, and results in additional risks to the newborn, particularly through the use of unclean water or bottles. Many improvements have already been seen in breastfeeding practices in all three countries, through health education efforts and engaging community members. In Dadaab, Kenya, maternal, infant and young child feeding program workers from the Kenyan Red Cross run breastfeeding support groups in Ifo 2 camp, and have recently begun a kitchen gardening activities in the group, both to provide nutritious food as well as an incentive to participation. In Azraq and Zaatari camps in Jordan, community-based breastfeeding support sessions have become very popular with women, and are an important venue for socializing, health education and peer support.

Next steps

The implementation of the programme will focus on capacity building through training of health workers and the community based health workforce with a strong focus on low cost, high impact new-born care practices, as well as procurement of medicines and medical supplies. UNHCR will use this to draw lessons learned and improve newborn and neonatal care in other refugee operations.