



# Expansion of the Saving Maternal and Newborn Lives in Refugee Settings Project (Cameroon, Niger, Chad): Summary of Baseline Assessment



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Access to quality health services is essential for women and newborns in refugee contexts. In times of conflict, displacement, or humanitarian emergency, neonatal and maternal health is often compromised and the availability of maternal, newborn, and family planning services becomes even more important.

In line with UNHCR's mandate and with support from the Bill and Melinda Gates Foundation (BMGF), UNHCR has extended the "Saving Maternal and Newborn Lives in Refugee Settings" project to three further refugee situations in Cameroon, Niger and Chad. With the aim to improve newborn and maternal health, the two-year project is focusing on low cost, high impact maternal and newborn interventions, ensuring that every refugee mother and newborn has the chance to live a healthy life.

## Context

Following successful interventions to strengthen maternal and newborn health services in Jordan, South Sudan and Kenya, UNHCR has launched “Expansion of the Saving Maternal and Newborn Lives in Refugee Contexts” in selected refugee operations in Niger, Cameroon and Chad. The project aims to scale up and to consolidate life-saving newborn, maternal, and family planning interventions. This also includes quality family planning services, recognizing the important role of family planning in reducing maternal and neonatal morbidity and mortality, preventing unwanted pregnancies, reducing rates of abortion (including unsafe abortion), and reducing the risks of adolescent pregnancy.

A baseline assessment was conducted in the targeted refugee sites, including health facility assessments; interviews of program managers and front-line health providers to gather in-depth information about their practices, needs, and perceived gaps in care; and focus group discussions with community members which provided valuable insight into community perceptions of health services as well as traditional beliefs and practices.

Chad, Cameroon and Niger were chosen for this project due to their poor reproductive health indicators as well as high burden of refugee populations in the countries. Each of the three countries are facing similar challenges, including poorly funded health systems and under resourced and under staffed health facilities, particularly at the district hospital level. Remote locations, poor roads, and regular influxes of new refugees further complicate operations. Insecurity and violent attacks limit access and care provision, particularly in the Malian camps of Niger and Sudanese camps of Eastern Chad, some of which are only accessible with a military escort.

## Key Findings

### Routine Childbirth and Emergency Obstetric and Neonatal Care

Skilled birth attendance rates vary widely from site to site, with an average of 94% of births in Cameroon sites attended by skilled personnel; 62% in Niger; and 90% in Chad.

It is estimated that between 5-15% of all childbirths face complications, therefore camp primary health facilities must be prepared to provide basic emergency obstetric and neonatal care (BEmONC)

for every birth. The main barriers to providing all seven BEmONC signal functions included lack of newborn resuscitation equipment; lack of knowledge in newborn resuscitation; and lack of assisted delivery with vacuum due to lack of equipment, lack of knowledge, or both. In other cases, lack of indication (i.e. no presenting patient) meant the service was not provided. The baseline assessment found that the majority of childbirth providers have not had recent training in routine or emergency obstetric and neonatal care, and gaps in skills and knowledge were numerous.

## Plans

Recognizing the numerous training needs of front-line health providers, as well as the reality of care provision in remote areas, such as lack of funds for off-site training courses, high turn-over of staff, and the need to involve all health workers who provide delivery care, UNHCR has designed a facility-based, low-dose high-frequency (LDHF) training package and has trained “Master Trainers” in each health facility to train their peers. This innovative training approach has been chosen due to its proven efficacy in similar settings and its practical, hands-on approach.



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## Care for the Sick or Small Newborn

Care for the sick or small newborn is challenging in many low resource settings, including refugee situations. Challenges include lack of equipment, electricity, and trained staff. Key advanced services for the sick or preterm newborn may include kangaroo mother care, parenteral antibiotics, oxygen therapy, intubation, continuous positive pressure ventilation (CPAP), and phototherapy. The baseline assessment found that on average, district hospitals (the main point of reference) in Cameroon offered 36% of these services, Niger regional maternal/newborn hospitals offered 64%, and district hospitals in Chad only 14%. Oxygen was available the day of assessment in only 25% of hospitals in Cameroon, 50% in Niger, 0% in Chad.



The ability to resuscitate a newborn who does not breathe at birth is an important component of emergency obstetric and newborn care and must be available at every birth. Only 50% of facilities in Cameroon and 35% in Chad had a functioning bag and mask for newborn resuscitation. However, in Niger, 100% of facilities had these components. In addition, only around half of health workers could demonstrate the basic steps newborn resuscitation, indicating a great need for further training.

Despite its benefits and suitability to a low-resource setting, the baseline assessment found kangaroo mother care (KMC) (continuous skin-to-skin care for low birth weight babies) was under-used in all three countries. Although many health workers have heard of KMC, it is not a routine practice. In Cameroon, 60% of health facilities stated that they used this method, 43% in Niger, and 41% in Chad. At the reference hospital level, where the majority of care for premature newborns takes place, 25% of hospitals in Cameroon, 100% in Niger, and 20% in Chad stated that they use kangaroo method. However, 0% had kangaroo fabric wraps and none had protocols, structured programs or designated beds, suggesting that in practice its use is even more limited. Barriers to use of KMC include lack of training, lack of related guidelines or policies, lack of familiarity with the method, and lack of fabric wraps. Health facilities instead used alternatives, including hot water bottles (Cameroon) or emergency foil blankets (Chad) due to lack of electricity for other methods.

### Plans

In order to address the identified gaps, the project will ensure that every health facility is complete with functioning neonatal resuscitation equipment and will ensure that all staff are trained in neonatal resuscitation. To support health facilities to implement KMC method, UNHCR will ensure all health workers are receive training in care of low birth weight newborns, manufacture kangaroo wraps locally to ensure availability in all facilities, and will endeavour to link national experts with local hospitals to strengthen their care protocols.

### Community Matters

Focus group discussions and results from nutritional surveys highlighted that early and exclusive breastfeeding needs further promotion, with many mothers giving water, sugar water or animal milk to the newborn in addition to breastmilk. Some mothers continue to practice the tradition of discarding the colostrum during the first three days. Care for the newborn's umbilicus at home, a potential site of serious infection, revealed the routine use of many potentially

harmful foreign substances (carbon, match ends, toothpaste, hot sand), with little health advice given on this subject.

Women in many locations described the difficulty they faced in reaching the health facility when in labour. Most camps assessed either do not provide transportation service during labour; it is not available at night; or the transport options are insufficient or not well organized, creating barriers for women. Women also described lack of available midwives; poor past experiences of health facility care; and certain cultural barriers, such as modesty (particularly among the Peulh groups); fear of male staff; and preferences for certain skills and practices of the traditional birth attendant as reasons why they may choose to deliver at home.

### Plans

Building on previous learnings and successes, we plan to improve community-level services, including training lay community workers ('relais communautaires' and matrons) to conduct home visits during pregnancy and in the postnatal period, to identify danger signs and promote healthy behaviours.

In response to women's concerns about reaching health facilities, we plan to improve transport options between home and health facilities for women in labour through the provision of moto-tricycle ambulances or horse/donkey chariot ambulances in desert areas. To ensure health services are culturally acceptable, UNHCR will include a 'respectful care' component in health worker training modules to set the standard for women-centred, respectful maternity services.

### Neonatal Mortality and Stillbirth Rates

Documenting the occurrence of stillbirths and newborn deaths is a first step to understand and address the direct and indirect causes. Review of UNHCR's health information system's (HIS) for 2017 found neonatal mortality rates to be low in almost all project locations. These rates are unlikely to be accurate reflections of the state of neonatal health but rather of incomplete data collection as a result of issues with data collection; fear to report deaths due to professional repercussions; and fear of reporting deaths due to concerns that the family will lose the additional food ration. There is a need to implement neonatal death audits adopting an open and non-punitive approach to encourage reporting, as well as to actively search for deaths occurring in the community to better address underlying contributors.

## Family Planning

The baseline assessment highlighted a gap in the availability of contraceptives in health facilities, with none of those assessed having a full complement of contraceptive options available and stock ruptures very common. Only 45% of health facilities in Cameroon; 14% of facilities in Niger; and 34% of facilities in Chad had family planning related clinical guidelines available. Moreover, the majority of health staff in all three countries had never received training in family planning.

Fertility rates in the three target countries are among the highest in the world, and the refugee populations largely consist of traditional societies who prefer large families and are only gradually accepting modern contraceptives.

In our focus group discussions with community members, men were generally more likely to oppose the use of modern contraceptives and natural methods of birth spacing were preferred by both men and women, such as counting the fertile days per month. A belief that contraceptives were only for prostitutes, and that they allowed wives to be unfaithful without consequence was also raised. Beliefs that the use of contraceptives was against Islam was also a concern among some Muslim groups in Chad.



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Fear of side effects was one of the main barriers to use of modern contraceptives for women across all locations, particularly fear of menstrual abnormalities, fear of permanent infertility, or believing the condom could become lost in the uterus or abdomen. This highlights the need for more thorough counselling on an individual and community level.

Despite all groups of young men and women in the three countries stating that they frequently - yet secretly - have sex before marriage, they reported having limited access to contraceptives due to hesitance to visit health centres out of shame and embarrassment; not being prioritized for consultations; and difficulty finding condoms at the community level.

## Plans

In order to improve the provision of free, full, and informed contraceptive choice, the project plans to provide supplementary supplies of contraceptive items to prevent stock ruptures in commodities and advocate to UNFPA for a reliable ongoing supply. We will provide training to all health workers on provision of contraceptives, ensuring all are up to date in clinical skills, knowledge and counselling skills to provide quality family planning services. Likewise, we will include male health consultants in the training plan and ensure family planning services are available in every consultation room to increase access to men, unmarried persons, adolescents, and others hesitant to access services normally offered only through the maternity department. Community outreach will be strengthened or initiated through increased sensitization efforts by community health workers (relais communautaires). In Minawao camp, Cameroon, we will expand the "stratége avancé" where midwives and community health workers provide family planning services in locations around the camp. Finally, in response to the feedback from refugee youth, we plan to routinely increase access to condoms in community locations.

## Improving Medical Supplies and Health Facility Infrastructure

The project will aim to ensure that essential drugs and equipment are in place for maternal and newborn care through project order and improvements in pharmacy management. It will ensure that all ambulances are equipped with emergency medical supplies, and ensure routine and emergency medications and equipment are in place in all delivery rooms.

Electricity is an essential service when providing care to women and newborns, but was absent or unreliable in the majority of health facilities assessed. Lack of electricity results in the inability to provide oxygen, lack of blood banking, and the inability to use other essential equipment such as phototherapy for jaundice. The project aims to provide solar panels for the maternity units in order to provide sustainable and reliable electricity.

UNHCR is committed to supporting the health and well-being of refugee populations. Through our project activities we will continue our efforts to ensure that every refugee mother and newborn has the chance to live a healthy life.