USING A SYSTEMS APPROACH

to improve newborn care at the community and facility level among displaced populations in South Sudan

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REFERENCES

1. http://www.who.int/reproductivehealth/topics/family_planning/contraceptive-access-women-and-girls/en/
2. http://iawg.net/wp-content/uploads/2016/08/IAWG-Global-Evaluation-2012-2014-1.pdf
3. UN Interagency Group for Child Mortality Estimation (IGME) in 2016 http://www.childmortality.org

BACKGROUND

- Despite improvements globally in newborn health, relatively poor outcomes persist in areas plagued by conflict or political instability. 75% of the 15 countries with the highest neonatal mortality rate have experienced a recent conflict or recurring natural disaster.
- In 2015, it was estimated that there were over 26 million women and girls of reproductive age living in humanitarian settings, all of whom require health care services.[1]
- The 2012 – 2014 IAWG Global Review on Reproductive Health in Humanitarian Settings highlighted that EmOC and ENC are among the most poorly funded and poorly provided components of humanitarian responses.[2]
- There is a lack of assessment of the functionality of routine health systems and context-specific evidence-based guidance through all phases of an emergency.

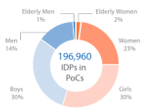
SOUTH SUDAN

- National NMR of 39 with almost 17,000 newborn deaths per year.[3]
- In August 2016, at the time of the study, there were 259,800 refugees in South Sudan and 1.6 million internally displaced South Sudanese.
- The routine health system is strained by a limited health workforce and training institutions, and poor medical supply chains and infrastructure.
- In 2016, 43% of health facilities were deemed functional, and at least 24 humanitarian aid workers were killed.
- While intended for a protracted or post-conflict setting, increased instability led to a loss of trained staff and severely affected facilities: a health facility in Malakal was burned down in February just before this study began, and a maternity ward in Juba was shelled during an outbreak of violence in July.

KEY FIGURES

1.6 million
Internally displaced people

196,960
IDPs in Protection of Civilians sites



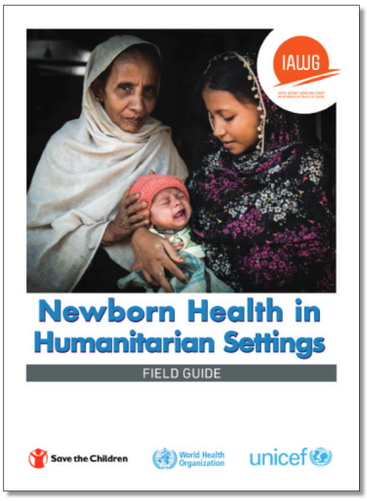
(UNMISS Aug 2016)

259,800
Refugees in South Sudan

882,200
South Sudanese refugees in neighbouring countries post Dec 2013

NEWBORN HEALTH IN HUMANITARIAN SETTINGS

FIELD GUIDE



- The *Field Guide* was developed through an inter-agency collaboration to address the gap in newborn health programming in humanitarian settings.
- A companion to the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (IAFM) and Minimum Initial Service Package (MISP).
- Prioritizes the most critical health services and supplies to prevent and manage the three main causes of newborn death at each level of care.

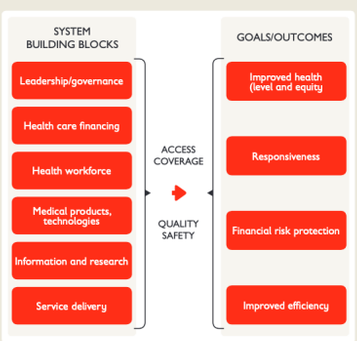
THE STUDY

- The *Field Guide* was piloted **in four displaced person camps in South Sudan** from June – November 2016 **with Ministry of Health engagement.**
  - Used a mixed method case study design:
  - We conducted focus group discussions among community and facility-based health workers, in-depth interviews among program managers, and observations of health facility readiness.
- Secondary data were gathered from documents that were associated with the implementation of the intervention during our study period.
- We aimed to describe the key health system bottlenecks and facilitators that influence newborn health program implementation using a health systems framework.
- Constructs from the Consolidated Framework for Implementation Research (CFIR) and WHO Health Systems Framework were used to understand factors that moderate implementation.

RESULTS

- Key bottlenecks and facilitators are organized by the health systems building blocks: leadership and governance, health financing, health workforce, essential commodities, health service delivery, and health information systems.
- Findings include:
  - Newborn health is seen as a 'new' activity in humanitarian response and is therefore excluded from most emergency response proposals;
  - Lack of policy support inhibited ability to scale implementation to other sites or plan for long-term activities;
  - Severe shortage of skilled care at birth was the main bottleneck for implementing quality newborn care;
  - Reproductive health kits procured during crisis do not include all recommended newborn supplies; and
  - Ongoing supportive supervision, educational materials, and community acceptance of practices enabled community-based newborn interventions.

Charles Lomodong/Save the Children



LEARNINGS/RECOMMENDATIONS

Improving integration of newborn interventions into national policies, training institutions, health referral systems, and supply chains can expand emergency care provided to women and their newborns in these contexts.

- Advocacy and Policy: greater advocacy for comprehensive packages in response plans/policies could prevent choosing between life-saving services; review and improve existing policies, and sensitize health officials and donors on newborn care; increase awareness and engagement of community leaders; advocate for inclusion of newborn care among humanitarian donors.
- Human resources: increase hiring of locally trained staff; authorize task-shifting where appropriate and invest in training institutions; increase number of CHWs to meet Sphere standards or dedicate cadre for MNH by transitioning TBAs to CHWs. There were many important learnings based on professional and more-experienced staff being evacuated during the periods of crisis.
- Training: integrate comprehensive curricula on newborn care into national training institutions; train program and clinical leads from INGOs on newborn care.
- Service delivery: improve tracking of supplies and improve forecast of newborn supply needs to buffer for times of acute crisis; increase knowledge among program managers on newborn programming; strengthen newborn care at primary care level; adopt simpler protocols for mid-level cadre to take on additional responsibilities.