Case Studies on Newborn Health Policy, Strategy and Action Plan Implementation in Humanitarian and Fragile Settings

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Case Studies on Newborn Health Policy, Strategy and Action Plan Implementation in Humanitarian and Fragile Settings

UNICEF in partnership with Save the Children
Implementing agencies: Johns Hopkins and Stanford Universities

UNICEF
Programme Division – Health Section,
Health in Emergencies and Humanitarian Settings (HiEHS) Unit
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Contents

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This document was developed as part of the work of Every Newborn Action Plan, Emergency Group (ENAP-E), led by UNICEF and Save the Children.

UNICEF commissioned the case studies from Afghanistan, Iraq, Somalia, South Sudan, and Yemen and Save the Children the case studies from Colombia and the DRC. Johns Hopkins and Stanford Universities were the implementing agencies, respectively.

The leads of the four organizations during the development of the analysis were Fouzia Shafique from UNICEF; Meghan Gallagher from Save the Children; Hannah Tappis from the Johns Hopkins Center for Humanitarian Health; and Clea Sarnquist from Stanford University.

This report is also the result of the collaboration of several participants and organizations from the countries involved in the analysis, including ministries of health, various non-governmental organizations, United Nations agencies, and healthcare staff, in addition to academia and civil society organizations.

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Executive summary

In 2021, out of the 5 million global deaths in children under 5 years of age, 46 percent were newborn deaths, making it the first cause of child mortality, above pneumonia, diarrhea and malaria. Also, out of the 2.3 million global newborn deaths during the same year, nearly 50 percent took place in a humanitarian setting. Hence, if the world is to achieve the goals proposed under Sustainable Development Goal (SDG) Target 3.2, it is a priority to improve the access and quality of maternal and newborn services in humanitarian contexts.

The objective of this report is to describe the situation, bottlenecks and opportunities on newborn health in varied humanitarian settings and foster north- and south-to-south collaboration to advance this agenda. The participating countries were Afghanistan, Colombia, Democratic Republic of the Congo (DRC), Iraq, Somalia, South Sudan, and Yemen.

Although there were particular challenges and recommendations for each country depending on their unique context, the following are the key recommendations that are common across the majority of the analyzed settings for actualizing the implementation of the Every Newborn Action Plan (ENAP) and reducing preventable newborn mortality and morbidity in humanitarian settings:

- Establish a common understanding of country-level ENAP objectives, and critically review targets and costed implementation plan to ensure contents are fit for purpose and context.

- Integrate considerations for crisis-affected areas and populations. This may include differentiating targets for stable and crisis-affected areas of the country, articulating distinct approaches and activities for crisis-affected populations, or identifying conditions under which activities can and cannot be implemented. This recommendation is of particular importance for countries with sub-national humanitarian crises.

- Consider additional engagement and investments in health system strengthening that may be required to ensure government ownership and accountability for ENAP implementation in crisis-affected countries, since many of the identified barriers to ENAP implementation were embodiments of broader challenges of weak or disrupted health systems.

- Engage representatives of crisis-affected populations, as well as humanitarian actors, in ENAP development, implementation and progress monitoring.

- Ensure ENAP development and implementation efforts are aligned and integrated with broader health initiatives, such as primary healthcare (PHC) strategies, and promote a continuum of care for the mother/newborn dyad.

List of acronyms

BEmONC	basic emergency obstetric and newborn care
CEmONC	comprehensive emergency obstetric and newborn care
CHW	community healthcare worker(s)
DRC	Democratic Republic of the Congo
EmONC	emergency obstetric and neonatal care
ENAP	Every Newborn Action Plan
ENAP-E	Every Newborn Action Plan, Emergency Group
EPHS	essential public health services
EPMM	ending preventable maternal mortality
EWEC	Every Woman Every Child
IAWG	inter-agency working group on reproductive health in crises
IDPs	internally displaced persons
IMNCI	integrated management of newborn and childhood illness
ISIL	Islamic State of Iraq and the Levant
JHU	Johns Hopkins University
KMC	kangaroo mother care
LMICs	low- and middle-income countries
LB	live births
MISP	minimum initial service package (for sexual and reproductive health in crisis situations)
MMR	maternal mortality rate
MNH	maternal and newborn health
MoH	Ministry of Health
MoPHP	Ministry of Public Health and Population (Yemen)
M&E	monitoring and evaluation
NGO	non-governmental organization
NICU	newborn intensive care unit
NMR	newborn mortality rate
PHC	primary healthcare
PNC	prenatal care
PoC	protection of civilians
QI	quality improvement
RH	reproductive health
RMNCH	reproductive, maternal, newborn, and child health
SBR	stillbirth rate
SDG	Sustainable Development Goal
TWG	technical working group
U5MR	under-5 mortality rate
WHO	World Health Organization

Background and objectives

Background

According to the United Nations Interagency Group for Child Mortality Estimation (UN-IGME) report for 2021, out of the 5 million deaths in children under 5 years of age, 2.3 million, or 46 percent, were newborns, making overall neonatal-related conditions such as pre-term birth, intrapartum-related complications, and sepsis the first cause of child mortality above pneumonia, diarrhea or malaria. In terms of mortality trends, the global newborn mortality rate (NMR) for the same year was 18 deaths per 1,000 live births (LB), a decrease in 13 points from the year 2000. Although more modest, a decreasing trend has also been observed for stillbirths, with a decline of 7 points, from 21 to 14 stillbirths per 1,000 births for the same period. Similarly, the global maternal mortality rate (MMR) has decreased 35 percent from 2000 to 2020, from 342 to 223 deaths per 100,000 LB.[1]

Despite this improvement, there are still 62 countries that in 2020 were off-track for meeting the NMR goal for that year, i.e., 15 newborn deaths per 1,000 L.B.[2] Moreover, the rates previously mentioned still represent an unsettling situation since only in 2020 there were 287,000 maternal deaths, and in 2021 2.3 million newborn deaths and 1.9 million stillbirths, many of them preventable. In addition, the reduction in mortality is uneven between and within countries, where most of the burden is concentrated in low- and middle-income countries (LMICs), particularly in Sub-Saharan Africa and South Asia, as well as in rural and distant communities, the poor, and importantly, in humanitarian settings.[3, 4]

Notably, out of the 2.3 million neonatal deaths in 2021, 1.6 million,[5] or nearly 50 percent, took place in a country facing a humanitarian crisis, as per OCHA's classification.[6] Thus, humanitarian contexts represent a priority in the global efforts to reduce maternal, newborn and child mortality, where the SDG targets of reducing maternal mortality to 70 per 100,000 LB (SDG 3.1) and newborn mortality to 12 per 1,000 (SDG 3.2) will not be achieved unless stakeholders focus their efforts to expand access and improve health services for mothers, newborns, and children living in these settings.

Providing health services in emergency and humanitarian contexts, however, presents several challenges due to the destruction or damage of infrastructure; frequent movement of populations; disruption of supply chains, health and other social services; limited healthcare staff capacity; as well as hazards for healthcare providers and patients. These multiple challenges, often associated to the prioritization of other health needs, hinder access to and decrease the quality of maternal and newborn services such as antenatal care, skilled birth attendance, and postnatal care, including regular and specialized care for small and sick newborns.

As a response to the important burden of newborn deaths, in 2014 the international community agreed on a roadmap to implement key actions to reduce newborn deaths and stillbirths, as well as to contribute to a reduction in maternal mortality via the Every Newborn Action Plan (ENAP), led by the World Health Organization (WHO) and UNICEF.[7] This initiative is complementary to the Every Woman Every Child (EWEC) global strategy to advance the health status of women, children and adolescents,[8] and the Ending Preventable Maternal Mortality (EPMM) strategy.[9]

Given the particular challenges of working in humanitarian settings, ENAP established a working subgroup that focuses on emergencies, ENAP-E, co-led by UNICEF and Save the Children. This group works closely with the Inter-Agency Working Group on Reproductive Health in Crises (IAWG) and other humanitarian actors to ensure a response that is sensitive to the health needs of women, mothers, and newborns in these contexts. The current report is the product of a collaboration of ENAP-E and partners.

Objectives

Deepen understanding of the content and status of national/ sub-national newborn health policies and action plans

Examine how contextual considerations influence newborn health priority setting, policy and action plan formulation, implementation, monitoring and adaptation of newborn health policies and action plans in humanitarian and fragile settings.

Assess barriers, support needs and opportunities to advance newborn health investment/ action in humanitarian and fragile settings.

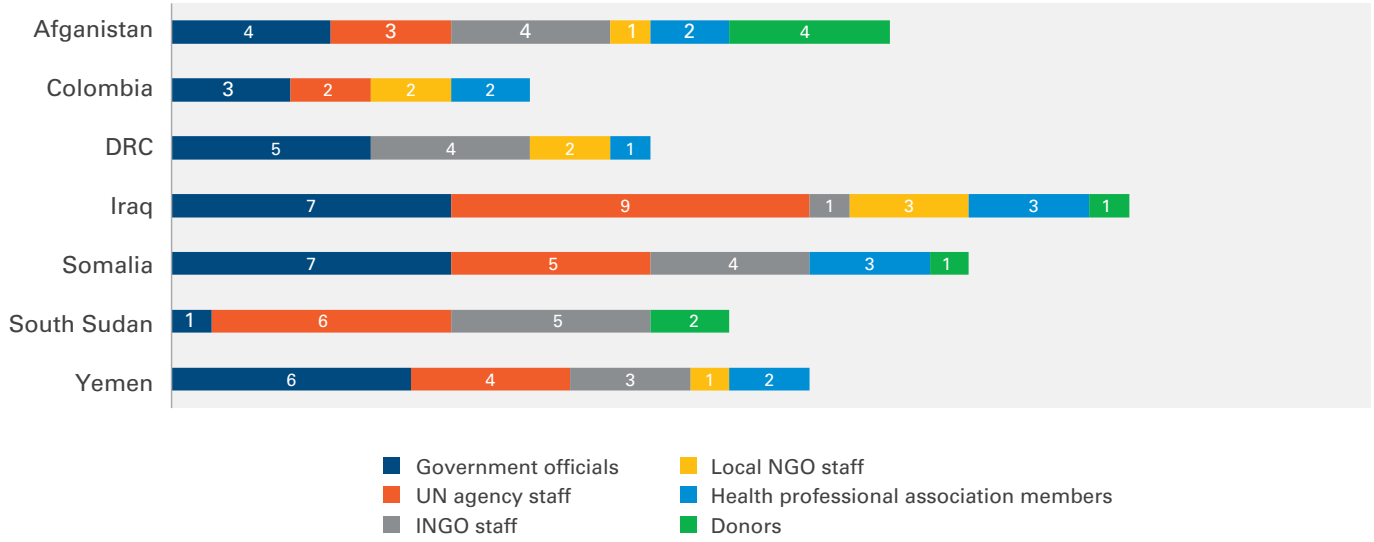
Methodology

Methods

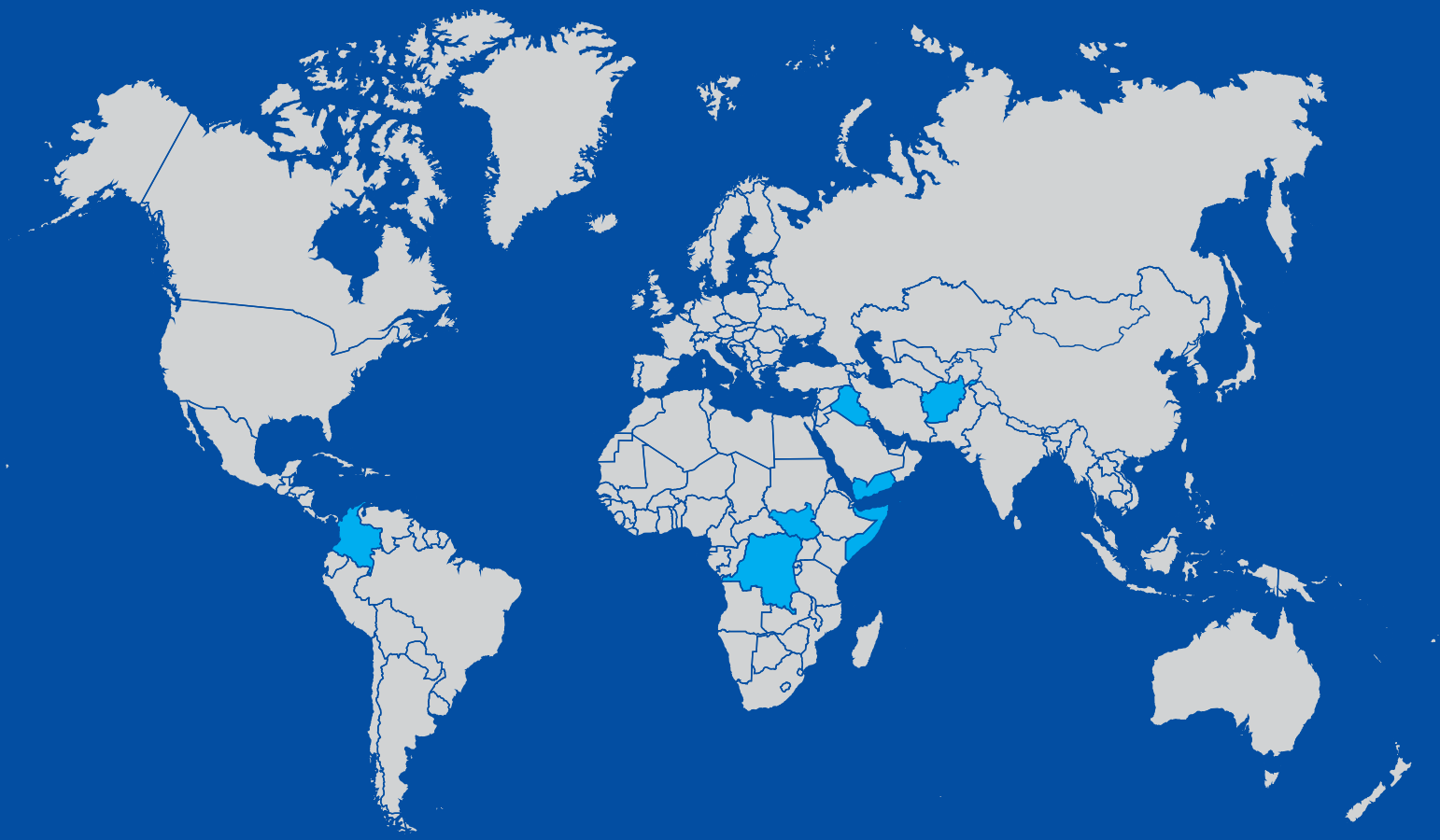
- Desk review– journal articles, policy/program documents
- Identification of key informants in consultation with UNICEF and Save the Children country offices and Ministry of Health focal points
- Individual and group key informant interviews conducted remotely (via Zoom, WhatsApp or telephone), using semi-structured interview guides tailored to case-specific context and individual participants
- Thematic coding of documents and interview notes in Dedoose (JHU) or QDA Miner Lite (Stanford) software
- Synthesis guided by case study framework in common protocol
- Review of preliminary findings and finalization of country-specific recommendations in consultation with UNICEF and Save the Children country offices and Ministry of Health focal points
- Collaborative cross-country synthesis
- The research was conducted during 2021, and the analysis and compilation of results during 2022

Data collection

- **7 countries**
- **82 hours of interviews**
- **114 participants**
  - 33 government officials (national and state/governorate level)
  - 29 UN agency staff
  - 21 international NGO staff
  - 9 local NGO staff
  - 13 health professional association members or technical experts
  - 7 donor agency representatives



Country-specific findings and recommendations



The country profiles that follow include highlights from each of the seven country case studies.

Additional information on data collection methods, findings and recommendations emerging from each case study are available per request (see contacts in the Acknowledgments section).

Case Studies

1. Afghanistan
2. Colombia
3. Democratic Republic of the Congo (DRC)
4. Iraq
5. Somalia
6. South Sudan
7. Yemen

Case Study 1: Afghanistan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Afghanistan

- Low income
- High intensity conflict
- Health Cluster est. 2008
- Grade 2 Health Emergency
- ENAP launched in 2016
- NMR 37
- SBR 26

Humanitarian needs in 2020

Approx. 14 million in need of humanitarian assistance

- 500,000 internally displaced persons (IDPs)
- 570,000 cross-border returnees
- 104,600 affected by natural disasters (flooding, landslides, avalanches, earthquakes)

- Afghanistan is one of the most protracted humanitarian emergencies in the world, characterized by ongoing and wide-scale conflict and displacement, as well as natural disasters, and great uncertainty about future stability.
- Public health service delivery is contracted out to NGOs in 31 of 34 provinces. MoPH and donors rely heavily on third party monitoring for verification of service statistics and assessment of health system performance.
- Afghanistan was **among the first countries to conduct an ENAP bottleneck analysis,** which led to development of a costed Comprehensive Newborn Care Program (2016-2020) integrated in the RMNCAH Strategy (2017-2021).
- There was no mention of the ongoing conflict, access constraints or attacks on health in ENAP documents.
- Stakeholders generally felt that the Comprehensive Newborn Care Program, like many policy and strategy documents in Afghanistan, was too aspirational and not fit-for context.
- Key achievements included establishment of newborn corners and stabilization units, capacity building of healthcare providers and expansion of community-based newborn care efforts – including distribution of chlorhexidine for newborn cord care, in select areas.
- ENAP components not yet addressed include scale-up of high impact interventions across communities and facilities, and strengthening services for small and pre-term babies.

Promising initiatives need sustained support for scale-up and institutionalization

- Pilot projects and site-specific initiatives demonstrate feasibility and potential impact of investment in MNH - from clinical mentoring to household birth preparedness and complication readiness counseling with related commodity distribution to introduction of kangaroo mother care (KMC).
- Heavy reliance on NGOs and development donor support.

Strategies and guidelines reflect an ideal scenario as opposed to the realities of increasing insecurity and access constraints

- Strategies assume access to facilities, functional referral networks, and data-driven decision making.
- Contracting out of health services has facilitated notable improvements in population health but presents challenges in accountability for ENAP implementation.
- Insecurity is not static. Most districts report interruption of health services at some point; though duration and severity varies. Care seeking for MNH is not seen as a priority in areas with severe and persistent insecurity.

Recommendations for Health Sector Planning

1. Explicitly acknowledge and address impacts of insecurity and humanitarian needs in RMNCAH Strategy and sector-wide planning
2. Identify entry points and priorities for development partner financing and support to advance progress towards ENAP objectives – including activities that can be funded through on-budget support
3. Continue to invest in fostering a culture of quality improvement and accountability across public and private sector

Recommendations for Humanitarian Policy and Programming

1. Include clear expectations for maternal and newborn health in humanitarian response and contingency plans - consider defining a two-tiered strategy with provisions for accessible and “hard-to-reach” areas
2. Strengthen humanitarian partner capacity to improve coverage and quality of newborn health care at facility and community levels, including raising awareness of danger signs of newborn complications, ensuring provision of essential services at health facilities, and establishing mechanisms to support female health workers amidst insecurity

Case Study 2: Colombia

Colombia

- Upper Middle Income
- Refugee hosting (Venezuela)
- Health Cluster est. 2010 (emergency not graded)
- No ENAP
- NMR 8
- SBR 8

Humanitarian needs in 2020

Approx. 5.1 million in need of humanitarian assistance

- 1.8 million Venezuelan refugees
  (~ 75% of Venezuelans in Colombia)

- Colombia is an upper-middle income country in its 7th consecutive year of humanitarian appeals to address needs resulting from refugees and migrants fleeing political and economic crises in Venezuela.
- Demographics of immigrants from Venezuela to Colombia have altered, with more women and children crossing the border than men or youth. A significant number of pregnant women have migrated to deliver their babies in Colombia.
- In Colombia, large disparities in the NMR exist between those of Colombian nationality and Venezuelan refugees.
- Colombia does not currently have an ENAP. However, it has similar countrywide newborn health policies and strategies, as well as reporting on key MNH indicators that align with ENAP.
- Stakeholders applauded a clear national commitment to provide care and support to Venezuelan refugees and migrants in Colombia, particularly through a strong policy framework.
- The Colombian Ministry of Health (MOH) has responded to the influx of refugees and migrants by extending access to care to Venezuelans in Colombia, especially pregnant women and newborns.
- Key challenges include lack of prenatal care, poor health and lack of follow-up care of Venezuelan migrants and refugees due to migration, and financial barriers.

National policies extend care and rights to refugees/ immigrants

- Strong national commitment to healthcare for Venezuelan refugees and migrants (for example, Law 1997, extending citizenship to babies born in Colombia to Venezuelan parents)
- Coordination and decentralization of healthcare
- Collaboration with multinational organizations and NGOs
- Integrated health care model
- Implementation of KMC

Challenges of refugee hosting

- Pregnant women arrive ill and malnourished
- High health care needs
- Adds strain to entire healthcare system
- Sheer numbers and migratory nature of group makes follow-up care a challenge
- Despite Colombia's low NMR, many sick newborns are not able to receive needed care
- No long-term sustainability

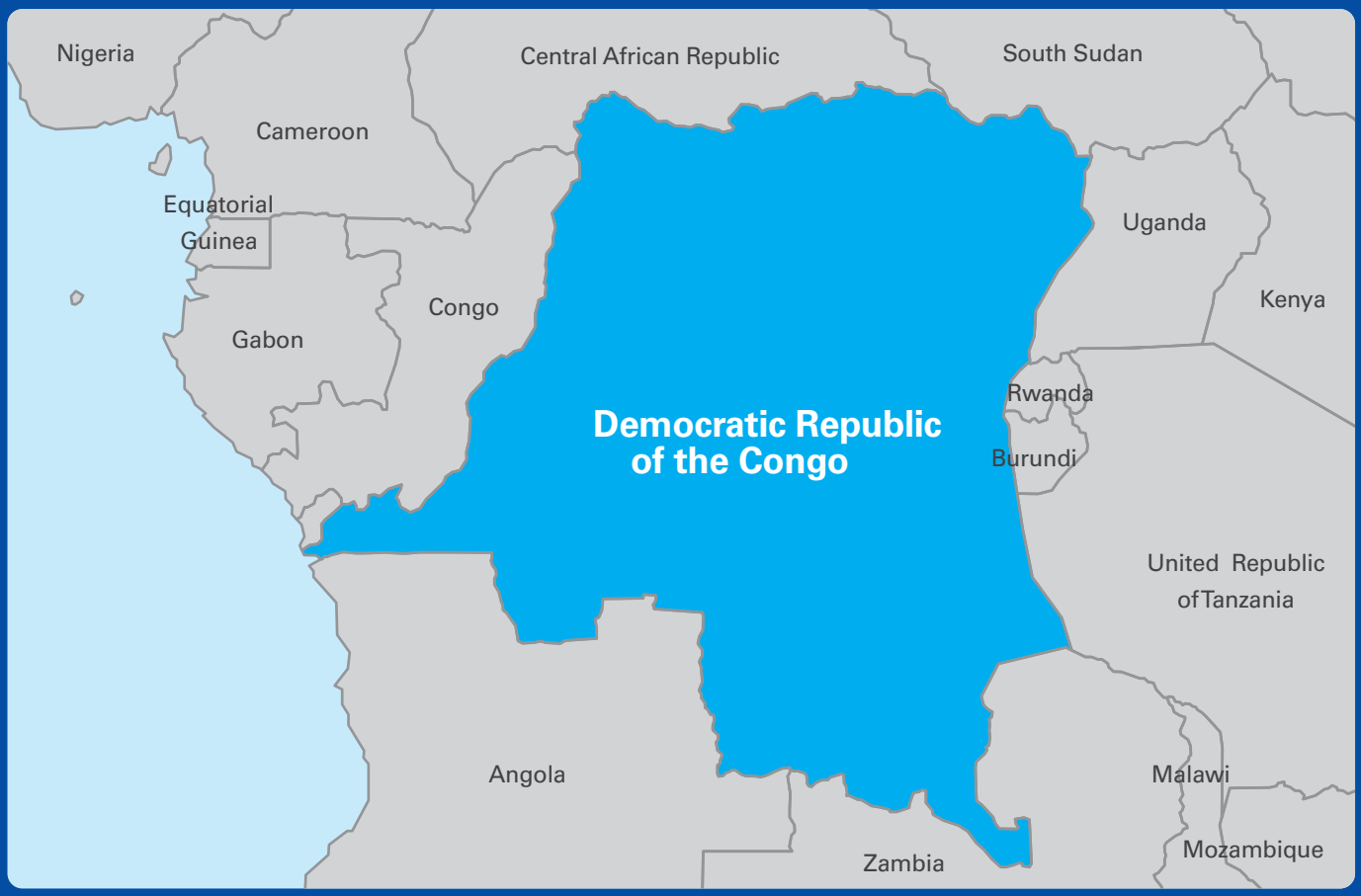
Recommendations for Health Sector Planning

1. Integrate emergency preparedness and response needs in RMNCAH Strategy and sector-wide planning
2. Continue to invest in fostering a culture of quality improvement across public and private sectors
3. Systematically analyze barriers to community-based health care and community engagement in MNH services
4. Build on successes of ENAP development and implementation to catalyze broader health system reforms and investments
5. Elevate attention in RMNCAH strategy development and budgeting to addressing inequities in MNH coverage, quality and outcomes – including varied impacts of conflict, displacement and returns across governorates

Recommendations for Humanitarian Policy and Programming

1. Ensure attention to health and health sector capacity in stabilization and transition plans
2. Orient humanitarian actors to national health sector priorities and strategies – including ENAP - so they are well positioned to support the MoH in aligning medium/long term plans while addressing immediate needs
3. Advocate for increased support from development partners for strengthening MNH planning and service quality in crisis-affected areas as humanitarian funding diminishes
4. Facilitate routine communication, coordination, and collaborative action planning among humanitarian and MNH stakeholders at national and sub-national levels

Case Study 3: Democratic Republic of the Congo (DRC)



DRC Congo

- Low income
- Medium intensity conflict
- Health Cluster est. 2006
- Grade 3 Health Emergency
- ENAP launched in 2018
- NMR 28
- SBR 27

Humanitarian needs in 2020

Approx. 15.6 million in need of humanitarian assistance

- 5.01 million IDPs

- The Democratic Republic of Congo (DRC) is a low-income country that has experienced civil and regional conflict over the past 25+ years.
- DRC has one of the highest NMRs in the world, as well as large displaced populations and other populations in need of humanitarian aid.
- Humanitarian crises have interrupted access to health and social services.
- DRC established their ENAP in 2018. The four strategic objectives include 1) improve provision of essential and emergency newborn care in targeted health facilities; 2) improve the quality of services and care in targeted health training; 3) improve the demand for newborn health care and services as well as community monitoring of newborn care in targeted health areas; and 4) improve governance and accountability at all levels.
- DRC demonstrates a national commitment to newborn health and survival, as shown with the ENAP and the integration of newborn health into other national health policies, guidelines, and education and training manuals.
- Overall, DRC illustrates that a strong ENAP and policy framework is critical, but not sufficient, to ensure access to quality newborn care for mothers and their newborns regardless of where they reside.

Protracted conflict and mistrust

- Pilot projects and site-specific initiatives demonstrate feasibility and potential impact of investment in MNH - from clinical mentoring to household birth preparedness and complication readiness counseling with related commodity distribution to introduction of KMC.
- Heavy reliance on NGOs and development donor support.

Strategies and guidelines reflect an ideal scenario as opposed to the realities of increasing insecurity and access constraints

- Protracted conflict has created rotating, on-and-off interest and programming from humanitarian, development, and other donors/agencies.
- Priorities related to both conflict and infectious diseases have pulled already-limited healthcare providers and funding away from MNH (e.g. Ebola, COVID-19)
- Despite existence of ENAP, limited and short-term financing remains a challenge, especially in light of other priorities

Protracted conflict and mistrust

- Heal Africa Hospital in North Kivu has a fully-functional newborn intensive care unit (NICU) (in tandem with the NGO Global Strategies) as well as a training program for providing basic newborn care in more rural areas.
- Home visiting services for newborns by nurses

Recommendations for Health Sector Planning

1. Provide free MNH services for pregnant women and children under 5, with a special focus on maternal and newborn survival
2. Expand MNH education and training to include local community healthcare workers (CHW), community animators and members, traditional leaders, and/or others as locally appropriate
3. Strengthen centralized government priorities to provide quality MNH services and better implement ENAP at all levels
4. Facilitate routine communication, coordination, and collaborative action planning among and between government and external partners at national, provincial, and local levels

Recommendations for Humanitarian Policy and Programming

1. Identify and communicate government priorities to better implement ENAP at all levels
2. Identify ways to better coordinate and support national newborn health policies at the provincial and local level; increasing access to MNH services, and tailoring national policies to the local context
3. Integrate newborn health into emergency preparedness and response plans
4. Identify and scale effective MNH services tailored for humanitarian contexts in DRC (home visits, KMC)
5. Prioritize training local healthcare workers to support MNH services

Case Study 4: Iraq

Iraq

- Upper middle income
- Medium intensity conflict
- Health Cluster est. 2014
- Grade 2 Health Emergency
- ENAP launched in 2016
- NMR 15
- SBR 15

Humanitarian needs in 2020

Approx. 4.1 million in need of humanitarian assistance

- 1.2 million IDPs
  (30% in camps, 70% in communities)
- 4.8 million IDP returnees
- 250,000 Syrian refugees

- Iraq is an upper-middle income country in its 8th consecutive year of humanitarian appeals to address needs resulting from the brutal Islamic State of Iraq and the Levant (ISIL) insurgency from 2014-2017, as well as refugees fleeing conflict in Syria.
- Although not a "high burden" country for neonatal mortality, Iraq was among earlier countries to join the ENAP movement. Development of the 2016-2020 Iraq **ENAP was initiated by the MoH, who also led costing and directly committed resources to implementation.**
- There was **no mention of the ongoing insurgency or humanitarian crisis** in ENAP documents. Target governorates for ENAP implementation were not among those most directly affected by the crisis.
- The five strategic objectives in Iraq's ENAP were all incorporated in the country's RMNCAH Strategy, developed shortly after the ENAP was endorsed.
- Stakeholders generally felt ENAP progress was on track prior to the COVID-19 pandemic. Notable achievements in target governorates included scaling up essential newborn care provision, introducing kangaroo mother care at 10 hospitals, establishing MNH quality standards, and supporting quality improvement (QI) initiatives.
- ENAP components not yet addressed included expansion of initiatives to other governorates and private sector, community engagement in MNH services and support for community-based newborn care services.

Newborn health was well addressed in humanitarian response, but the needs overshadowed capacity

- Humanitarian response in occupied and liberated areas included establishment of field hospitals, reconstruction and rehabilitation of health facilities, staff and essential supplies for care on the day of birth, while interventions in refugee and IDP camps focus primarily on preventive services (RH clinics, "Baby Huts", prenatal care (PNC) visits by CHWs, immunization and malnutrition screening).
- ENAP initiatives (QI, KMC, mortality surveillance) were well received as part of recovery efforts in Ninewa but hindered by COVID-19.

Support needs vary across and within governorates

- Diminishing funds for humanitarian health assistance in general, and RH/MNH specifically.
- Limited capacity within the MoH to takeover service delivery, workforce planning and supply management.
- Need to build trust in health system.
- Awareness of ENAP was limited outside of target governorates.

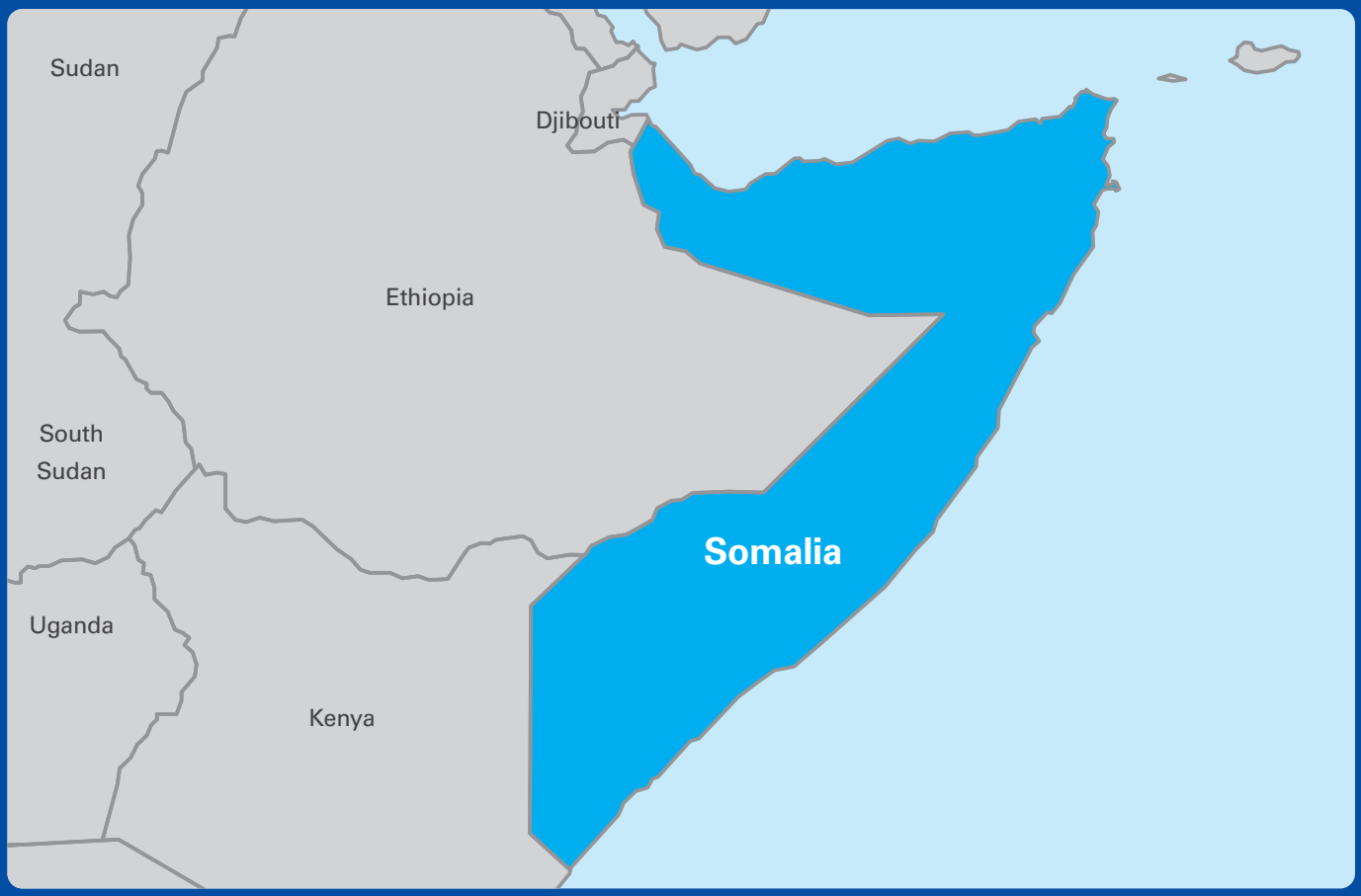
Recommendations for Health Sector Planning

1. Integrate emergency preparedness and response needs in RMNCAH Strategy and sector-wide planning
2. Continue to invest in fostering a culture of quality improvement across public and private sectors
3. Systematically analyze barriers to community-based health care and community engagement in MNH services
4. Build on successes of ENAP development and implementation to catalyze broader health system reforms and investments
5. Elevate attention in RMNCAH strategy development and budgeting to addressing inequities in MNH coverage, quality and outcomes – including varied impacts of conflict, displacement and returns across governorates

Recommendations for Humanitarian Policy and Programming

1. Ensure attention to health and health sector capacity in stabilization and transition plans
2. Orient humanitarian actors to national health sector priorities and strategies – including ENAP - so they are well positioned to support the MoH in aligning medium/long term plans while addressing immediate needs
3. Advocate for increased support from development partners for strengthening MNH planning and service quality in crisis-affected areas as humanitarian funding diminishes
4. Facilitate routine communication, coordination, and collaborative action planning among humanitarian and MNH stakeholders at national and sub-national levels

Case Study 5: Somalia



Somalia

- Low income
- High intensity conflict
- Health Cluster est. 2006
- Grade 3 Health Emergency
- ENAP launched in 2019
- NMR 37
- SBR 35

Humanitarian needs in 2020

Approx. 5.2 million in need of humanitarian assistance

- 3.5 million non-displaced
- 1.7 million IDPs
- 108,000 refugees/returnees and 42,000 asylum seekers

- Somalia has faced a complex humanitarian crisis for almost 3 decades aggravated by continued armed conflict and climatic shocks. The Federal Government is responsible for health governance in member states, while Somaliland (declared independence in 1991 but remains unrecognized) and Puntland (declared autonomy in 1998 but remains part of Somalia) largely operate independently. Somaliland has a separate ENAP.

- Development of the 2019-2023 Somalia **ENAP was initiated by UNICEF, with support of WHO and UNFPA but prompted the MoH to establish a Child Health Unit** to spearhead the process and support nationwide implementation.

- Somalia was the **first country to explicitly address humanitarian needs in ENAP objectives**: *"Strengthen capacity and preparedness for the maternal and newborn health response in humanitarian and fragile settings, amongst service providers, government agencies, and communities at risk of conflicts and other emergencies."*

- The Somalia ENAP was developed alongside the 2019-2023 RMNCAH Strategy with common baseline indicators, and key priorities included in the 2020-2024 National Development Plan. ENAP costing is underway but not completed, and roll-out was interrupted by COVID-19.

- Awareness of ENAP among federal member states and humanitarian partners is limited.

Starting from zero: Newborn health services largely unavailable

- ENAP is a significant first step in Somalia, bringing newborn health to the forefront for policymakers, health providers, and communities. However, newborn health interventions are missing extensively in crisis-affected areas. In many health facilities, newborn health services don't exist and will require significant resources to set up.

- Key stakeholders highlighted "starting from zero" as a significant challenge in prioritizing where, when, and how to implement newborn health services. Nonetheless, early achievements include the establishment of Somalia's first NICUs in 3 referral hospitals.

Shifting focus from the mother to mother-baby dyad

- In the past 10 years, Somalia has seen progress in maternal health service delivery. However, newborn care has not been the focus of most MCH programs. While the impact of a maternal death reverberates within a family and often affects survival of others, newborn deaths are often considered unavoidable and acceptable due to the harsh realities of the conflict, poverty, and the vulnerability that Somalia's population faces.

- Somalia ENAP development has initiated a shift in partner focus to emphasize the 'N' in Emergency Obstetric and Neonatal Care (EmONC) and has engendered improved coordination between maternal and neonatal health programs.

Recommendations for Health Sector Planning

1. Map donor commitments and target gaps for fundraising to support ENAP implementation
2. Integrate newborn health into Essential Public Health Services (EPHS), community health worker program, and other strategic initiatives
3. Translate ENAP into feasible localized implementation plans
4. Elaborate a comprehensive monitoring and evaluation (M&E) plan and empower a steering committee/working group to monitor implementation progress
5. Engage private sector in ENAP implementation

Recommendations for Humanitarian Policy and Programming

1. Map donor commitments and target gaps for fundraising to support ENAP implementation
2. Integrate newborn health into EPHS, community health worker program, and other strategic initiatives
3. Translate ENAP into feasible localized implementation plans
4. Elaborate a comprehensive M&E plan and empower a steering committee/ working group to monitor implementation progress
5. Engage private sector in ENAP implementation

Case Study 6: South Sudan

South Sudan

- Low income
- High intensity conflict
- Health Cluster est. 2010
- Protracted Grade 3 Emergency
- ENAP launched in 2018
- NMR 40
- SBR 30

Humanitarian needs in 2020

Approx. 8.3 million in need of humanitarian assistance

- 1.6 million IDPs (125,000 in protection of civilians (PoC) sites)
- 310,000 refugees
- 2.2 million South Sudanese refugees in neighboring countries

- South Sudan is a low-income country in its 7th consecutive year of humanitarian appeals to address cumulative effects of protracted conflict, unprecedented flooding, and hyperinflation, compounded by the COVID-19 pandemic.

- Development of the 2019-2023 **ENAP was initiated by UNICEF with input from the MOH** following a workshop disseminating findings from the pilot test of the Newborn Health Field Guide for Humanitarian Settings in 2018.

- **The South Sudan RMNCAH/N Strategic Plan was developed jointly, alongside the ENAP** with coordination between UNICEF and WHO. Strategic objectives, key actions and targets for neonatal mortality and stillbirth in both plans were aligned. Both plans were endorsed by the MOH in 2019.

- **The South Sudan ENAP included a strategic objective prioritizing newborn services in humanitarian settings,** with a focus on activities that improve the coordination mechanism, promote global guidance documents, enhance training and health worker capacity, and procure supplies for newborn care.

- Stakeholders were in agreement about the **importance of MOH leadership and ownership** to move beyond planning to implementation. This includes the need for a focal person in the MOH to support dissemination to subnational stakeholders.

Enhancing leadership and governance is vital for improving health outcomes

- Systematic integration of newborn care in health programming requires government leadership and effective dissemination and coordination of ENAP activities.

- Lack of central ownership has hindered setting recommendations and policies, sharing best practices, encouraging uptake of ENAP.

Balancing need for targeted investments and integrated programming

- Newborn care is not well addressed in MNCH and Integrated Management of Newborn and Childhood Illness (IMNCI) programs largely due to the lack of a designated unit in the MOH and associated technical working group (TWG). Some felt newborn care should fall under the Child Health TWG whereas most felt it should be strengthened in the Reproductive Health TWG (RHTWG) as part of MNH.

- National health budgets are limited, and stakeholders discouraged resource mobilization for vertical programs, noting primary health care, basic package of health services and vaccination as donor investment priorities.

- RMNCAH Strategy (including ENAP) was costed but anticipated resource needs for newborn health component are unknown.

Recommendations for Health Sector Planning

1. Establish a focal person and unit in the MoH and subworking groups to facilitate roll-out of ENAP and integration in primary health care initiatives
2. Widely disseminate ENAP and RMNCAH Strategy at national and subnational levels
3. Ensure integration of ENAP activities in Boma Health Initiative and other sector-wide planning efforts
4. Intensify ENAP awareness-raising and resource mobilization efforts

Recommendations for Humanitarian Policy and Programming

1. Ensure inclusion of newborn health in humanitarian response and contingency plans
2. Orient Health Cluster members and sub-working groups to ENAP objectives and technical resources available to support implementation (e.g. Newborn Health Field Guide for Humanitarian Settings)
3. Expand community-based health programming to include newborn care home visits and linkages with facilities
4. Pursue opportunities to expand newborn health programming to strengthen referral facility staff capacity and resources to care for small and sick newborns

Case Study 7: Yemen

Yemen

- Low income
- High intensity conflict
- Health Cluster est. 2011
- Grade 3 Health Emergency
- ENAP launched in 2017
- NMR 27
- SBR 29

Humanitarian needs in 2020

Approx. 20.7 million in need of humanitarian assistance

- 17.7 million non-displaced
- 3 million IDPs
- 275,000 refugees, asylum seekers and migrants

- Yemen is the world's largest humanitarian crisis and response. Six years of conflict combined with economic collapse and environmental disasters have had a devastating impact on civilians, resulting in the fourth largest internal displacement crisis globally. Ongoing conflict has paralyzed the health system, which is heavily reliant upon external support to provide health services.

- Development of the Yemen **ENAP was initiated by UNICEF in collaboration with UNFPA and WHO** in 2016 and later i**ncorporated as the Newborn Health Strategy in the 2019-2022 National Reproductive Health Strategy**.

- While there is no mention of humanitarian needs and considerations in the Newborn Health chapter, **humanitarian response was prioritized as the first strategic direction of the 2019-2022 National RH Strategy with close alignment with the interventions in the Minimum Initial Service Package (MISP) for sexual and reproductive health in crisis situations.**

- The 2019-2022 Reproductive Health Strategy was costed with developed implementation plans. Currently, **it is the only costed national strategy**.

- **The Ministry of Public Health and Population (MoPHP) has actively prioritized implementation** of the RH strategy via annual meetings, advocacy with donors, and administrative restructuring to integrate MNCH services for improved coordination. Despite competing health response priorities, stakeholders estimate that **30-50% of activities have been implemented in at least some locations**.

Difficulties addressing newborn health given competing needs and chronic underfunding of health sector

- Yemen faces challenges with chronic underfunding for the health sector which trickles down and translates to even less funding for newborn health. Most key informants expressed a growing concern of humanitarian funding cuts and shortages. With limited resources, resource allocation has prioritized response to communicable diseases, food insecurity, and protection rather than routine service delivery, and more specifically newborn care.

Constraints on humanitarian access has led to inequitable response and unmet need for newborn health care

- In Yemen, newborn health services are largely missing within crisis-affected areas, along with most healthcare. Areas with the highest need for newborn health care are remote or rural settings with active conflict (e.g., Sana'a, Al Hudaydah, Taizz, and Marib).

- While all partners expressed purposive efforts to provide support and programming to populations most in need, constraints on humanitarian access has led to inequitable response and unmet need. In particular, key informants described a current imbalance in newborn health programming and response between the North and South due to operational bottlenecks and humanitarian access limitations.

Recommendations for Health Sector Planning

System-wide investments are critical to rebuild the public health system with a humanitarian-development-peace nexus approach including:

1. **Health financing:** Advocate for dedicated long-term donor support in alignment with RH Strategy
2. **Governance:** Establish newborn health focal point/department within MoPHP
3. **Infrastructure:** Establish basic and comprehensive emergency obstetric and newborn care (BEmONC and CEmONC, respectively) facilities or MNCH hospitals through the rehabilitation, upgrade, and construction of new facilities
4. **Health workforce:** Formalize a national midwifery strategy and scale-up a midwifery-led community health system

Recommendations for Humanitarian Policy and Programming

1. Ensure humanitarian programming reflects MoPHP RH strategy and aligns with national priorities and action plans
2. Continue advocacy for RMNCH funding and resources
3. Standardize and integrate reporting within national data systems
4. Develop strategies and strengthen local capacity to ensure equity and sustainability of MNCH service deliver

Common findings and recommendations

ENAP Development and Implementation

- ENAP is generally perceived as a roadmap for development partners rather than a plan that promotes the humanitarian-development nexus.
- The level of government leadership/ownership and role of UNICEF technical advisors or international consultants in bottleneck analysis, stakeholder consultations, action plan drafting and costing differed by country.
- Accountability for progress in implementation varied even more, largely dependent on maturity of the ENAP, extent to which it was seen as an aspirational strategy vs. an operational plan, costing and commitment of resources for implementation.
- There is limited awareness of ENAP beyond those directly engaged in technical working groups, particularly at subnational level. In countries with established ENAPs, key initiatives are recognized as achievements but familiarity with ENAP as a roadmap or with specific objectives, targets and milestones is limited.

Promising Practices

- **In Iraq,** where government budgets are not itemized by technical area or activity, commitment of domestic resources in a budget line for ENAP implementation was seen as true leadership commitment and a catalyst for change.
- **In Yemen,** the MoPHP is leading annual planning meetings with implementing partners actively advocating for donors to support RH Strategy implementation.

Stakeholders in all countries highlighted gaps or limitations in availability (and reliability) of data on newborn health service coverage, quality and outcomes.

Engaging stakeholders in comprehensive bottleneck analyses provided valuable insights to inform ENAP development, but does not replace the need for more and better data to guide resource allocation and target setting.

Humanitarian Needs and Considerations

- There is limited awareness of ENAP amongst Health Cluster and humanitarian actors in all countries (beyond UN agencies). Only a small portion of humanitarian NGOs focus on MNH.
- Wide variation in services or interventions prioritized in affected areas.
- In areas with limited humanitarian access or reliance on mobile teams, the lack of capacity to address basic MNH needs was striking.
- Capacity to care for small and sick newborns was noted as a gap in all settings, but often with recognition that specialized care in urban centers will have limited reach and essential newborn care needs attention first.
- In many cases, newborn health needs are seen as priorities but not spotlighted or addressed with the same urgency as outbreak response, communicable disease prevention/control and malnutrition. MNH services are implicitly included in Humanitarian Response Plans for maintaining or expanding essential primary care services, but often without specific activities or indicators to guide resource allocation and performance monitoring.

Promising Practices

The two most recently launched ENAPs included objectives explicitly addressing humanitarian needs.

- Somalia ENAP objective 8: S*trengthen delivery of high quality maternal and newborn health interventions in humanitarian and emergency settings*
- South Sudan ENAP objective 3: *Strengthen maternal and newborn health response in humanitarian and fragile settings*

In **Colombia,** which currently hosts 1.8 million Venezuelan refugees and migrants, national health policies and insurance programs extend services to all mothers and newborns in the country, regardless of nationality or residency status. Law 1997, Resolution No. 8470 of the National Civil Registry, issued in 2019, grants Colombian citizenship to babies born in Colombia to Venezuelan parents after January 1, 2015.

Advocacy, Financing and Technical Assistance Needs

- Key informants did not see newborn care as a donor priority, noting most have broader interests in MCH, primary health care, or general health sector support.
- Although all countries had costed ENAPs (or plans or costing), none had sustainable financing strategies. Effective integration in flagship national health initiatives and technical assistance to ensure quality implementation within broader health packages was seen as critical to achieving lasting impacts.
- Community-based health services are challenging to introduce, resource at scale, and support, but were consistently highlighted as a critical strategy for reaching populations with limited or inconsistent access to functional health facilities.
- In addition to health workforce capacity building needs, particularly where newborn care has not been emphasized in midwifery and nursing curricula, key informants called attention to needs for engagement and capacity building of subnational health officials ultimately responsible for planning and oversight of health services.

" One of the huge challenges we're facing right now is that we don't have donors who can support us fully… So, if we reach 2022 or 2023 and our neonatal mortality rate is still 37, that means we couldn't do anything. We just developed the document and put it on the shelf."

– Key informant, Somalia case study

" There was an increase in staff at the structures that moved towards the Ebola response, abandoning the area of primary health care activities. It was found there was a real need for support, especially in the case of maternal and child health."

– Key informant, DRC case study

" Newborn deaths are accepted, and even expected.... Communities do not see newborn death as a big issue. Families are waiting until the last moment to bring them [sick newborns] to the facility, especially in humanitarian settings.

– Key informant, Afghanistan case study

Impact of COVID-19 on ENAP implementation

- The launch and roll-out efforts were interrupted in countries with recently developed ENAPs (Somalia, South Sudan)
- ENAP and RMNCAH strategy revisions planned for 2020/2021 have been delayed, and current plans extended for 1-2 years (Afghanistan, DRC, Iraq)
- Interruption of health professional education/training programs, quality improvement initiatives and other ENAP activities in some cases
- Overburdened health workforce and resources
- Supply chain disruption
- Decline in essential service coverage/utilization
- Shifts in donor priorities

> *" Because of COVID, we moved one step forward and two steps back. Nearly all resources for training, staff, supplies, etc. have been reallocated to COVID."*
>
> – Key informant, Iraq case study

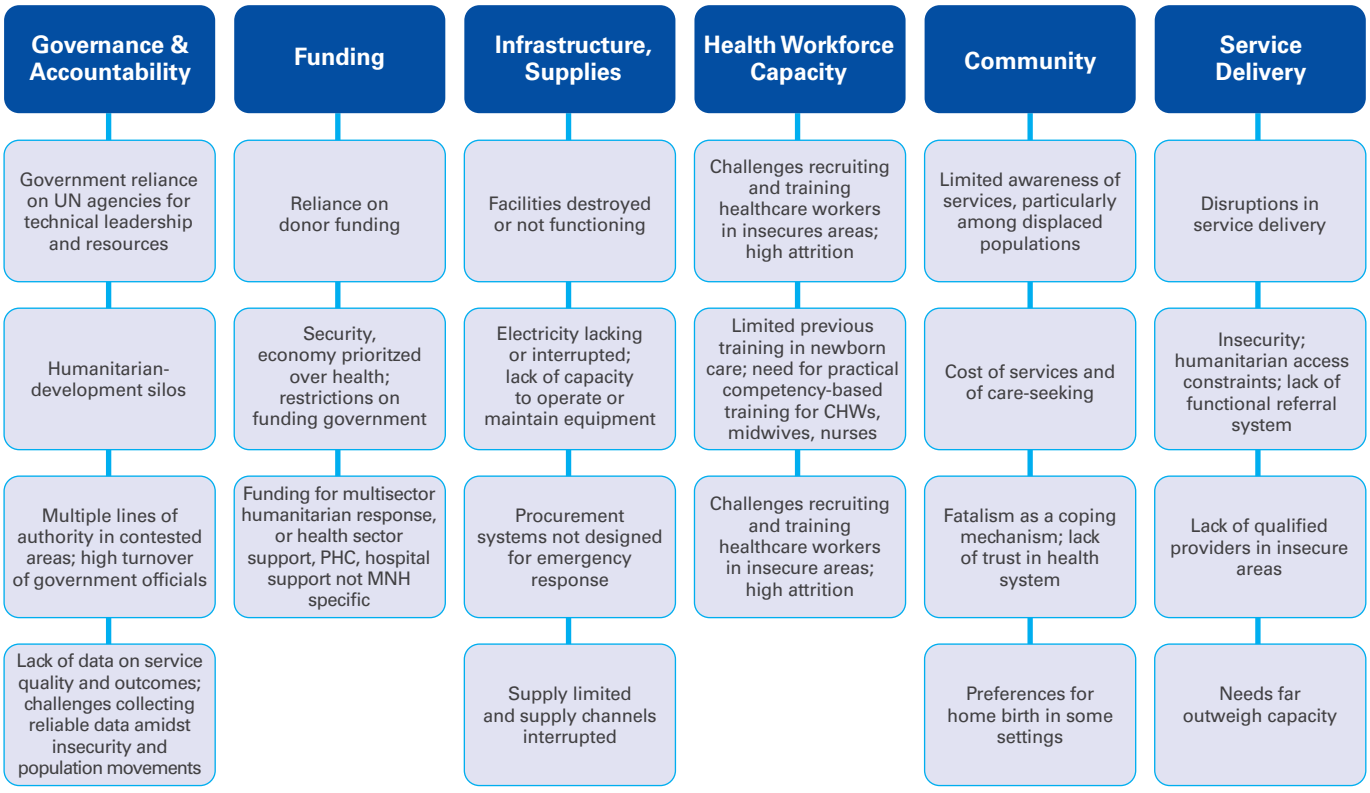
Illustrative example - Yemen:

Due to ongoing conflict and structural damage, only 51% of health facilities are fully functional in Yemen – of which only 20% provide MNCH services. The COVID-19 pandemic has further disrupted health service provision and exacerbated disparities in access. Approximately 15% of functioning health facilities have been transformed into COVID-19 isolation wards, resulting in an additional decline in health service coverage by 20-30% during the pandemic. Key informants shared stories of pregnant women reaching health facilities and being turned away or referred to facilities far away since MNCH care was no longer provided.

Note: Impact of COVID-19 on ENAP implementation was not a focus of case studies. Findings presented here are those that emerged through discussions related to progress in ENAP implementation.

Bottlenecks and Challenges in Humanitarian Settings

Bottlenecks and challenges are context-dependent. The following are challenges identified in two or more case studies, but not all challenges were seen in all settings.



Recommendations for ENAP development and implementation in humanitarian and fragile settings

1. **Establish a common understanding of country-level ENAP objectives, and critically review targets and costed implementation plan to ensure contents are fit for purpose and context.**

   Striking the right balance between an aspirational, forward-looking strategy and realistic, achievable action plan is a challenge for any movement. This balance is particularly critical in countries with armed conflict or increasing levels of instability, where strategies that do not account for operational considerations will be more difficult to finance and implement. Understanding the uncertainties and limitations of available mortality and health service data, particularly in insecure areas and displaced populations, is also critical for target setting and progress monitoring.

2. **Integrate considerations for crisis-affected areas and populations. This may include differentiating targets for stable and crisis-affected areas of the country, articulating distinct approaches and activities for crisis-affected populations, or identifying conditions under which activities can and cannot be implemented.**

   This recommendation is of particular importance for countries with sub-national humanitarian crises (conflict, extreme weather events, and/or displacement) or significant variation in the severity of insecurity, health service disruptions and access constraints across the country, and may help ensure that ENAP objectives and implementation plans are both global target driven and fit-for-context.

3. **Engage representatives of crisis-affected populations, as well as humanitarian actors, in ENAP development, implementation and progress monitoring.**

   Limited awareness of newborn health initiatives was most evident among stakeholders in crisis-affected areas of countries with newer ENAPs, and with subnational humanitarian crises. Pragmatic steps to addressing this disconnect may include orienting humanitarian actors to ENAP and related national strategies, capacity building of humanitarian responders to ensure maternal and newborn health needs are addressed in humanitarian service delivery programs, and facilitating linkages between humanitarian and MNH technical working groups at national and subnational levels.

4. **Consider additional engagement and investments in health system strengthening that may be required to ensure government ownership and accountability for ENAP implementation in crisis-affected countries.**

   Many of the barriers to ENAP implementation identified were embodiments of broader challenges of weak or disrupted health systems. Participants highlighted the need for national and sub-national leadership, political influence and financing to address regulatory, workforce and infrastructure-related bottlenecks to newborn health service delivery and quality improvement. Preparedness plans that account for health workforce, supply, equipment, information and coordination needs in varied scenarios can also help mitigate challenges in mobilizing resources and maintaining essential services when crisis dynamics shift or escalate.

5. **Ensure ENAP development and implementation efforts are aligned and integrated with broader health initiatives, and promote a continuum of care for the mother/newborn dyad.**

   Common themes across case studies were the importance of ENAP alignment and integration with other health sector strategies (*e.g. maternal health, RMNCAH, and PHC strategies*), challenges of financing siloed or vertical health initiatives in crisis-affected areas, and disconnect between maternal and newborn health capacity development or quality improvement efforts. Moving forward, close collaboration between ENAP and EPMM stakeholders, including joint advocacy and technical support for considering humanitarian needs in country-level target setting and implementation strategies, can help reinforce focus on the dyad in crisis-affected settings. Streamlined coordination and progress monitoring can also help promote and foster national alliances in leveraging opportunities to address both maternal and newborn health, where resources allow.

Endnotes

1 UN Inter-agency Group for Child Mortality Estimation – 2022.
WHO, UNICEF, World Bank, UN. 2023.

2 UN Inter-agency Group for Child Mortality Estimation – 2021.
WHO, UNICEF, World Bank, UN. 2021.

3 Never Forgotten The situation of stillbirth around the globe
Report of the United Nations Inter-agency Group for Child Mortality Estimation, 2022. WHO, UNICEF, World Bank, UN. 2023.

4 Trends in maternal mortality 2000 to 2020
Estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division. WHO, UNICEF, UNFPA, World Bank, UN. 2023.

5 Neonatal mortality. UNICEF. 2023.

6 Appeals and response plans 2021. OCHA. 2021.

7 Every newborn action plan. WHO. 2014.

8 Every woman every child. Accessed on March 14, 2023.

9 Ending preventable maternal mortality (EPMM). WHO and UNFPA. 2015.

10 Inter-Agency Working Group on Reproductive Health in Crises (IAWG).
Accessed on March 14, 2023.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Stanford
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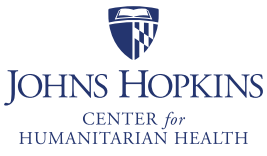
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