**Improving and ensuring KMC services in every delivery center of Rohingya Refugee camp in Bangladesh**

Key technical areas: Supportive supervision, monitoring of service, technical and logistic support

Background:

For more than a decade, Kangaroo Mother Care (KMC) has been recognized as a crucial technique for newborn care in Bangladesh. KMC involves close skin-to-skin contact between a low birth weight (LBW) infant and their mother or caregiver. This method promotes breastfeeding and aids in the early discharge of mothers by reducing stress levels. The World Health Organization (WHO) strongly recommends KMC to improve health outcomes for vulnerable newborns. Bangladesh integrated KMC into neonatal care as part of its commitment to reducing child mortality when it signed "A Promise Renewed" in 2013, indicating its relatively recent adoption of KMC. However, Bangladesh has faced implementation challenges, with only around 22% of eligible LBW newborns undergoing KMC as of 2020. Nonetheless, one of the country's goals is to reduce the under-five mortality rate to 20 per 1000 live births by 2035 through various strategies, including the promotion of Kangaroo Mother Care for low-birth-weight babies.

Since August 25, 2017, nearly a million Rohingya people forcibly displaced from Myanmar have sought refuge in Bangladesh's Cox's Bazar area. The rapid and massive influx has created a critical refugee emergency, particularly impacting vulnerable populations like women and children. Without a swift and comprehensive response, the consequences on refugees' lives would have been severe. Challenges such as poor nutrition, communicable diseases (including those preventable by vaccination and waterborne diseases), injuries, and mental health issues pose significant public health challenges. The term "KMC" is relatively new within the Rohingya community in Bangladesh. While several international organizations have contributed to increasing the number of KMC facilities in recent years, further expansion is required as the intervention is currently only available at specific camps and facilities. UNICEF, for instance, provided KMC to 950 newborns in the Special Care Newborn Unit (SCANU) (421) and National Screening Unit (NSU) (529) between January and August 2023 among Forcibly Displaced Myanmar Nationals (FDMN). They ensure the availability of KMC spaces adjacent to every Primary Health Care (PHC), NSU, and SCANU. In 2019, Save the Children successfully managed 24 cases of direct maternal complications at the primary health care center it supports in Camp 21. Newborns delivered in this facility received essential care following WHO protocols, including thermal management, infection prevention, breathing support initiation, feeding assistance, and postnatal care. For the 11% of newborns born prematurely or with low birth weight, skilled providers-initiated kangaroo mother care and assisted mothers in breastfeeding initiation.

In Cox's Bazar, the health sector, equivalent to a "cluster" in other humanitarian contexts, is coordinated by the Ministry of Health's Civil Surgeon's Office of Cox's Bazar, the Ministry of Health and Family Welfare Coordination Centre, and the World Health Organization (WHO). Despite being in its sixth year, the crisis is still ongoing, with over 100 partners involved in the health sector coordination group, including various UN agencies and government bodies in the refugee camps. This coordination covers primary, secondary, and specialized health services. Studies have shown that KMC can significantly reduce neonatal mortality, a significant public health concern in Rohingya Refugee Camps. Therefore, it's essential to make KMC services more accessible to all eligible LBW babies across the camps. Educating women and providing adequate training to healthcare professionals is crucial for the successful implementation of KMC. Thanks to substantial support from UNICEF, KMC is being implemented in Rohingya refugee camps to enhance neonatal care. In these challenging conditions with limited resources and high susceptibility to illness and death among newborns, organizations like UNICEF and WHO advocate for evidence-based treatments and care like KMC to improve maternal and child health. Compared to traditional neonatal care, KMC is a safe and cost-effective method that can reduce newborn morbidity and mortality rates and promote breastfeeding, particularly in the crucial hours following delivery.

The objective of this project is to tackle the current situation comprehensively and offer suggestions to the Government of Bangladesh (GoB), Camp-in-Charge (CiC), Health Professionals, and the Health Sector to enhance and guarantee KMC services in every delivery center within Rohingya Refugee camps in Bangladesh.

Proposed approach:

The team will collaborate with UNICEF and other partners to collectively determine the roles of each level of care (community and health facility) in managing LBW newborns. This includes identifying the facilitators and challenges in implementing KMC services throughout the Rohingya refugee camps to enhance the systematic collection, analysis, and interpretation of service data. Specifically, this involves ensuring counseling on KMC at healthcare facilities, providing follow-up KMC services in the community, establishing centers of excellence for KMC at secondary and tertiary level facilities, and setting targets for the initiation of KMC. Activities in the first phase of the project aim to comprehend the existing reporting and tracking mechanisms in the camps, as well as the response system. This will be achieved through meetings and workshops to outline or map the current situation. The latter part of the project will concentrate on organizing and conducting multiple workshops to disseminate findings and propose recommendations on improving the organization and analysis of information. This includes incorporating other maternity services, implementing automated data collection to expedite reporting and enhance reporting accuracy, and facilitating better forecasting and detection of vulnerable areas. These efforts are aimed at improving responses by the GoB to optimize the prevention and control of neonatal mortality. Furthermore, this project will provide a platform for policy dialogues to facilitate necessary changes for an integrated system within Rohingya refugee camps.

Objectives and Key Activities:

1. The WHO team will maintain regular communication with the Sexual and Reproductive Health (SRH) sector, nutrition sector, Health Sector, and other pertinent stakeholders. They will closely collaborate with all relevant partners and stakeholders, organizing and conducting meetings, workshops, focus group discussions, and other necessary tasks. A detailed work plan, including a GANTT chart, will be provided later in 2024.
2. All relevant teams will conduct a comprehensive assessment, including a desk review, to understand the current monitoring and reporting system operational in the camps. Tasks will involve analyzing how KMC reporting is conducted, identifying the individuals responsible for capturing and reporting data, and examining the process of submitting reports from the camps to the central level. Details will be gathered on the roles of different actors, operational methods, and geographic areas of focus, including tracking neonatal health from the ground level to reporting symptomatic cases.
3. A literature review specific to Bangladesh will be conducted, with knowledge gained linked to lessons learned from past KMC interventions. This information will provide insight into the readiness of camp KMC practices, informing the development of response plans for future neonatal mortality.
4. Following a comprehensive understanding of current KMC practices, designated staff will conduct a SWOT analysis of the existing system to identify bottlenecks and formulate solutions for enhancing effectiveness and efficiency. Recommendations may include fostering improved collaboration between existing entities and automating data collection and processing within platforms for future implementation by the Government of Bangladesh.
5. Cox's Bazar Health Sector will organize camp and sectoral-level meetings in collaboration with other relevant partners, facilitated by WHO throughout the project, to outline project objectives. Additional meetings will be convened to expand on findings, elucidate analyses, and provide concrete recommendations for improvement.
6. In the latter part of the project, a detailed report of activities performed will be generated, outlining strategies for enhancing the current system. This report will be disseminated to a broader range of stakeholders.
7. Subsequently, WHO will facilitate policy dialogues with relevant Government of Bangladesh bodies and stakeholders on proposed recommendations, aiming to understand newborn care practices and decision-making concerning newborn care in Rohingya Refugee Camps.

Outputs:

1. Recruitment of a local Nutrition Officer and Assistant, tasked with traveling to various health facilities in Cox’s Bazar throughout the project's duration.
2. Conducting desk and literature reviews, along with meetings, workshops, Focus Group Discussions (FGD), Key Informant Interviews (KII), and other activities to assess the current situation in the camps. This includes identifying existing initiatives and active entities in specific geographic locations.
3. Analyzing the collected data and providing recommendations for actions required to enhance the effectiveness and efficiency of KMC systems.
4. Documenting meeting minutes and action items for reference and follow-up.
5. Producing a comprehensive report detailing the assessment findings, analysis, and proposed changes, including a strategic plan for improving KMC practice in Bangladesh.
6. Organizing workshops with key stakeholders, including various NGOs and other Government of Bangladesh entities, to review proposed recommendations for the KMC system. This includes advocating for necessary policy changes to institutionalize improvements.
7. Compiling a report on the Policy Dialogue Workshop, including meeting minutes and outcomes, to document discussions and decisions made regarding KMC system enhancements and policy advocacy efforts.

Outcomes:

1. Guaranteeing access to Kangaroo Mother Care (KMC) services for every newborn in Rohingya refugee camps.
2. Developing clear admission, discharge, and referral criteria for low-birth-weight newborns, harmonized across all levels of care.
3. Exploring the possibility of enhancing or establishing dedicated facilities such as Newborn Care Units, Newborn Care Corners, or allocated beds for Kangaroo Mother Care within postnatal areas.
4. Ensuring the availability of essential equipment, supplies, and written protocols, along with maintaining comprehensive clinical records.
5. Expanding KMC programs in the camps through a strategic scaling-up approach. This involves providing training on low-birth-weight care and KMC to frontline health providers and community health workers.
6. Implementing outpatient follow-up visits for discharged low-birth-weight newborns to monitor their progress.
7. Soliciting suggestions for designing a community-based program aimed at promoting Kangaroo Mother Care.
8. Gathering feedback from community members and stakeholders regarding their perceptions and reactions to Kangaroo Mother Care.

**IMPLEMENTATION PLAN**

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| **Activity** | **Unit** |
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| * Situational Analysis of LBW Babies * Convene a Stakeholders’ Meeting * Visit Functioning KMC Sites |  |
| * National KMC policy and service guidelines * KMC training materials and job aids * KMC information, education, and communication (IEC) and behavior change communication (BCC) materials * KMC monitoring and evaluation (M&E) plans/tools including the supervisory checklist |  |
| * Key features of effective clinical training * Selection of trainers and learners * Selection of training site * Kangaroo mother care training materials |  |
| * Components of supportive supervision * Preparation for and introduction of supportive * Supervision * Challenges of quality improvement and supportive * Supervision * Tools for supportive supervision * Funding for kangaroo mother care resources |  |
| * National-level sensitization and mobilization * Health-facility-level sensitization and mobilization * Community-level sensitization and mobilization |  |
| * Rationale for the monitoring and evaluation of kangaroo mother care * Selection of key indicators * Utilization of data for program improvement and advocacy |  |
| * National-level action plan * Implementation and scale-up |  |
| * Introduction to the kangaroo mother care resources * Visual materials * Kangaroo mother care implementation * Kangaroo mother care training materials * Kangaroo mother care practice * Kangaroo mother care monitoring and evaluation * Community kangaroo mother care * Miscellaneous |  |