

REACHING THE EVERY NEWBORN NATIONAL 2020 MILESTONES

COUNTRY PROGRESS, PLANS AND MOVING FORWARD



MAY 2017



About the *Every Newborn Action Plan*

In 2014, at the Sixty-seventh World Health Assembly, 194 Member States endorsed the **Every Newborn: an action plan to end preventable deaths** (Resolution WHA67.10), a road map of strategic actions to end preventable newborn mortality and stillbirths and contribute to reducing maternal mortality and morbidity. The Every Newborn Action Plan presents evidence-based solutions and sets out a clear path to 2020 with eight specific milestones for what needs to be done differently to greatly reduce mortality rates and improve maternal and newborn health by 2030. Member States requested that WHO's Director General monitors progress towards the achievement of the global goal and targets and reports periodically to the Health Assembly until 2030.

For the 2017 World Health Assembly, reporting on the Every Newborn Resolution is part of the progress reporting on the Global Strategy for Women's Children's and Adolescent Health. Achieving the goals and targets set out in the Sustainable Development Goals (2016-2030) and the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) is underpinned by achieving the Every Newborn National and Global Milestones by 2020.

To complement the Global Strategy progress reporting, this report provides a detailed look at country leadership and action toward the Every Newborn National Milestones by 2020. Countries have taken the initiative to show the way forward and have demonstrated significant progress. As part of monitoring this progress, countries have adopted the *Every Newborn Tracking Tool*. This report presents a compilation of the data collated by the *Every Newborn Tracking Tool* in 2016, when 51 countries adopted the tool; it also spotlights examples of specific country activity for each National Milestone. Finally, Global Milestones for 2020 were part of the Every Newborn Action Plan to guide global and regional work in support of country efforts and this report highlights relevant progress towards those Global Milestones.

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Executive summary

The day of birth and the first 28-days of life - the neonatal period – are the most vulnerable time for a child's survival and health.

Neonatal deaths as a share of under-five deaths declined more slowly than other under-five deaths during the Millennium Development Goal period (1990 to 2015), a period that saw a great drop in under-five mortality. Newborn deaths now account for 45 percent of under-five deaths globally, up from 40 percent in 1990. Moreover, half of all stillborn babies begin labour alive but die before birth. Beyond survival, the health of each child and adolescent of the Sustainable Development Goals (SDG) period begins with a healthy mother, a healthy birth and good health in the critical first days of life.

Country leadership has been critical to strengthen engagement, action and partner harmonization efforts toward the implementation of the Every Newborn Action Plan which targets the reduction of the neonatal mortality rate (NMR) to 12 or fewer per 1,000 live births and stillbirths to 12 or fewer per 1,000 births in all countries by 2030. In doing so, we also improve the care provided to all mothers and their children. The Every Newborn targets are echoed in the Every Woman Every Child (EWEC) Global Strategy for Women's, Children's and Adolescents' Health (2015-2030). The neonatal target is SDG Goal 3.2, and is closely linked to SDG 3.1 for ending preventable maternal mortality. As the SDG era is underway, many countries are revising their relevant plans, policies and programmes.

To reach these targets to end preventable deaths^[1] and ensure available, accessible and quality care, the Every Newborn National Milestones by 2020 which track the processes of country ownership and action are fundamental. A simple Tracking Tool was developed by maternal and newborn health partners to annually measure progress or lack thereof on the eight national milestones.

The Every Newborn Tracking Tool was adopted by 51 countries in 2016, up significantly from 18 countries in 2015. This increase was enabled by preparatory work and follow-up after the UN interagency meetings with 37 countries in the Middle East and North Africa, and West and Central Africa in 2016. These forums provided the opportunity for country teams with high burdens of preventable mortality to understand the strategic objectives, milestones and recommended actions of the Every Newborn Action Plan, and learn about best practices and formulate their follow-up action plans. This exercise helped to identify

gaps and prioritize action, and along with the inclusion of the NMR target as an SDG Indicator, and the NMR and Stillbirth Reduction targets as Global Strategy Indicators, has accelerated country actions. To further support countries, a regional task force was agreed on for the West and Central Africa region, in light of high newborn mortality and stillbirths in most countries in the region and a need for concerted action by partners.

Overall, by January 2017:

- Forty-eight countries and territories have strengthened maternal and newborn components of their reproductive, maternal, newborn, child and adolescent health (RMNCAH) plans, and 40 countries have set NMR targets. In addition, 16 countries have developed subnational plans and 21 countries have completed the costing of their national plans.
- Nineteen of the 20 countries with the highest burden of newborn mortality have completed a newborn action plan or strengthened the newborn component in their RMNCAH plan.
- Fifteen of the 20 countries with the highest rates of newborn mortality have similarly strengthened their plans.

Our in-depth look at those 51 countries and territories that completed the Every Newborn Tracking Tool found:

- Forty-one countries report having a national quality improvement programme and 30 of these have a specific focus on maternal and newborn care.
- Forty-five countries report having health workers at appropriate levels of care authorized to administer life-saving interventions and commodities.
- Thirty-four countries have adopted legislation or policies on the notification of maternal death within 24 hours.
- Thirty countries have a human resource strategy for skilled attendants at birth and 18 countries have a strategy for retention of these cadres.
- Twenty-three countries have included all the seven essential medical products and technologies in their National Essential Medicines List.
- A Maternal Death Surveillance and Review mechanism is in place for 44 countries.
- Twenty-three countries have started perinatal death reviews.
- Thirty-four countries have a national health insurance scheme/policy for free maternal and

[1] UN Inter-agency Group for Child Mortality Estimation (IGME). Levels and trends in child mortality: Report 2015. New York, USA: UNICEF, 2015. (www.childmortality.org)

newborn services including care for sick newborns.

- Eighteen countries have developed a national communication strategy on newborn survival and 28 countries have a community engagement or social mobilization strategy for maternal and newborn health.
- Only ten countries have established a stillbirth reduction target.
- Small and sick newborns remain a critical focus for action, in terms of addressing both the causes of preterm birth and ensure quality of care for mothers and newborns in the time around birth and postnatal period.
- National Health Monitoring Information Systems and data collection needs improvement.

Of the global efforts to support country work, it is particularly worth mentioning two: quality of care, and data collection.

Greater momentum was achieved toward improving the quality of care with the launch in Malawi in February 2017 of a Network for Improving Quality of Care for Maternal, Newborn and Child Health which fosters cross-country exchange and planning with nine first-wave countries. Additionally, large-scale quality improvement learning activities are progressing through regional leadership in South and Southeast Asia and the Pacific region, including a regional quality improvement learning hub and extensive coaching and mentoring in facilities.

The urgent need for improved national data was one of the main messages during the development of the Every Newborn Action Plan, specifically the need for programmatically relevant data to drive coverage, and also understand the equity and quality gaps.

Guidance and tools for audit and response for perinatal mortality were released and piloted by WHO in 2016; “Making Every Baby Count: Audit and Review of Stillbirths and Neonatal Deaths” and partners are supporting countries with implementation. The ENAP Measurement Improvement Plan, developed in 2015, provides an

ambitious, multi-country, multi-partner approach to improving data gathering by 2020 and progress has been made, notably the following: (a) coverage of care indicators have been defined for selected interventions and are being validated through a three-country study to observe 20,000 births; (b) service readiness for the small and sick newborn is a major measurement gap and a situation analysis on who cares for the small and sick newborn as well as a survey of practitioners on around the world will help to define levels of care and support the development of new WHO guidance in 2018 to improve the quality of care for small and sick newborns. The INDEPTH network, with leadership from Makerere University, Uganda, are working with 5 country sites to compare different survey methods for pregnancy outcomes in a study of 70,000 births. The Demographic Health Survey, UNICEF (Multiple Indicator Cluster Surveys), and the Centre for Disease Control are working together closely on this. Moreover, the harmonization of newborn and maternal metrics has been improved through the establishment of MoNITOR (Maternal and Newborn Information for Tracking Outcomes and Results), with six-monthly meetings hosted by WHO. To accelerate progress, countries need additional support with updating their Health Management Information Systems (HMIS) with key indicators, including quality of care indicators, as well as exposure to innovations in data collection and use.

The ambitious goals for maternal and newborn survival and well being can only be met with the consistent and harmonized support of partners.

A joint Results Framework was endorsed by partners that sets forth key activities for 2017 and 2018 and partners are rallying behind this one work plan (Every Newborn Results Framework 2017-2018^[2]). Available, accessible, acceptable and quality maternal and newborn care is the foundation for good health at all life stages for everyone, everywhere. Achieving the goals and targets set out in the SDGs and the EWEC Global Strategy for Women’s, Children’s and Adolescents’ Health is underpinned by achieving the Every Newborn 2020 Milestones.

[2] Every Newborn Results Framework (2017-2018) at Healthy Newborn Network <http://www.healthynewbornnetwork.org/>



Newborn health in the Sustainable Development Goals era

Sustainable Development Goal framework and the Global Strategy for Women's, Children's and Adolescents Health (2015-2030)

The SDG^[3] framework has set the global agenda on social, economic and environmental development for the next 15 years. The updated Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)^[4] was developed in 2015 to improve women's and children's health and accelerate progress towards the SDGs. It aligns with the targets and indicators developed for the SDG framework and outlines opportunities for implementation.

The Global Strategy sets out to ensure every woman, child and adolescent, in any setting, anywhere in the world, is able to survive and thrive by 2030. This Strategy was adopted as a World Health Assembly resolution in 2016 (A69/A/CONF./2) and places a strong emphasis on country leadership. It aligns with the targets and indicators developed for the SDG framework and outlines opportunities for implementation.

The Every Woman Every Child partnership (EWEC) puts the Global Strategy into action.

Ending preventable maternal and newborn mortality and stillbirths is a high priority within this movement. The Every Newborn Action Plan^[5] and WHO's Ending Preventable Maternal Mortality (EPMM)^[6], which was released in 2015, were developed to support EWEC, and the goal and targets of both have been incorporated into the SDGs and Global Strategy (2016-2030).

Newborn Health is an increasingly important issue in the SDG period

The day of birth and the first 28-days of life - the neonatal period – are the most vulnerable time for a child's survival and health. Neonatal deaths as a share of under-five deaths declined far more slowly than other under-five deaths during the MDG period (1990 to 2015), a period that saw a great drop in under-five mortality. Newborn deaths now account for 45 percent of under-five deaths globally, up from 40 percent in 1990^[7] and half of all stillborn babies began labour alive but died before birth.^[8]

Each day, an estimated 830 women^[9] and 7,300 newborns die from complications during pregnancy, childbirth and further neonatal causes. In addition, 7,000 women experience a stillbirth and half of these occur after labour has begun.^[10] Three-quarters of all newborn deaths result from three preventable and treatable conditions – complications due to prematurity, intrapartum-related deaths (including birth asphyxia) and neonatal infections. Additionally, maternal deaths and the estimated 1.3 million stillbirths that occur during labour can be prevented with quality care during childbirth.^[11]

Ensuring newborn survival and health as well as preventing stillbirths are intrinsically linked to maternal health. Interventions that address the major causes of neonatal death generally differ from those needed to address other under-five deaths and are closely linked to those necessary to protect maternal health.^[12] This starts with the survival and health of women before conception, during pregnancy and after delivery, along the continuum of care. The synergies between the Every Newborn Action Plan will further advance efforts to end preventable deaths and improve health outcomes.

We have the solutions to address the main causes of newborn death and stillbirths. Cost-effective, proven interventions exist. Improving the quality and

[3] Sustainable Development Goals New York: United Nations, 2015. <https://sustainabledevelopment.un.org>

[4] Ban K. Global Strategy for Women's and Children's Health. New York, NY, USA: United Nations, 2015. (http://everywomaneverychild.org/images/content/files/global_strategy/full/20100914_gswch_en.pdf)

[5] UNICEF, WHO. Every Newborn: An action plan to end preventable deaths. Geneva: World Health Organization, 2014. (<http://www.everynewborn.org/every-newborn-action-plan/>)

[6] WHO (2015). Strategies toward ending preventable maternal mortality (EPMM). Geneva: World Health Organization, 2015. (http://who.int/reproductivehealth/topics/maternal_perinatal/epmm/en/)

[7] UN Inter-agency Group for Child Mortality Estimation (IGME). Levels and trends in child mortality: Report 2015. New York, USA: UNICEF, 2015. (www.childmortality.org)

[8] Lawn et al (2016), Lancet Preventable Stillbirth Series. ([http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(15\)00954-X/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)00954-X/fulltext))

[9] WHO, UNICEF, UNFPA, The World Bank, United Nations Population Division. Trends in maternal mortality: 1990 to 2015. Geneva: WHO, 2015

[10] UN Inter-agency Group for Child Mortality Estimation (IGME). Levels and trends in child mortality: Report 2015. New York, USA: UNICEF, 2015. (www.childmortality.org)

[11] Lawn et al (2016), Lancet Preventable Stillbirth Series. ([http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(15\)00954-X/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)00954-X/fulltext))

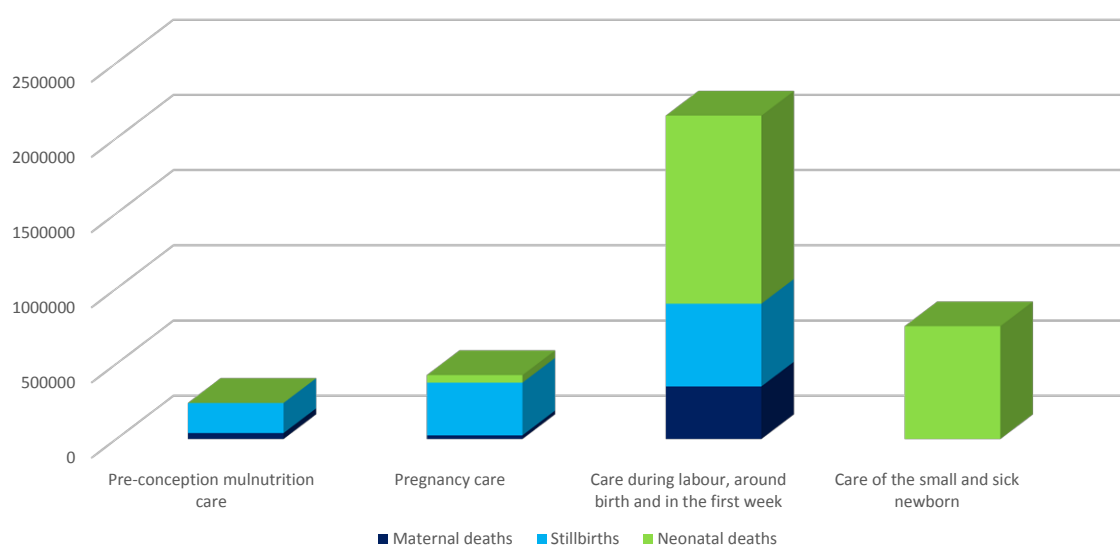
[12] UN Inter-agency Group for Child Mortality Estimation (IGME). Levels and trends in child mortality: Report 2015. New York, USA: UNICEF, 2015. (www.childmortality.org)

accessibility of care around the time of birth and special care for sick and small newborns will save the most lives. This requires educated and equipped health workers, including those with midwifery skills, and the availability of essential commodities.

Women's and children's health is a smart investment, particularly care at birth. Nearly 3 million lives could be saved each year with universal

coverage of the evidence-based solutions presented in ENAP (See Figure 1). Focussing on high coverage of care around the time of birth and the care of the small and sick newborn could save nearly 3 million lives each year at an additional cost of only US\$ 1.15 per person in 75 high burden countries.^[13] This is a triple impact on the return from investments: saving women, saving newborns and preventing stillbirths.

Figure 1. Projection for 2025 of the lives that could be saved each year with universal coverage of care



[13] Bhutta ZA, et al. What will it take to avert preventable newborn deaths and stillbirths and at what cost? Lancet 2014; doi:10.1016/S0140-6736(14)60792-3.



The Every Newborn Action Plan was developed in response to country demand and sets out a clear roadmap for how to improve newborn health and prevent stillbirths by 2030. It presents evidence-based solutions to prevent deaths and improve health and sets out a clear path to 2020 with eight specific milestones for what needs to be done differently to greatly reduce mortality rates and improve health by 2030. It is based on the latest epidemiology, evidence of essential interventions and global and country learning about effective programme implementation.

The Every Newborn Action Plan builds on the EWEK Global Strategy for Women's and Children's Health by supporting government leadership and providing guidance on how to strengthen newborn health components in existing health sector plans and strategies within the context of reproductive, maternal, child and adolescent health. Its goal is to achieve equitable coverage and high-quality care for women and newborns. The Every Newborn Action Plan calls upon all stakeholders to take specific actions to improve access to, and quality of, health care for women and newborns within the continuum of care.

Every Newborn Vision: Goals, guiding principles and strategic objectives

The preparation and implementation of the Every Newborn Action Plan has been led by WHO and UNICEF guided by the advice of experts and partners and by the outcomes of numerous multi-stakeholder consultations.

Vision

A world in which there are no preventable deaths of newborns or stillbirths, where every pregnancy is wanted, every birth celebrated, and women, babies and

children survive, thrive and reach their full potential.

Goals

Goal 1: Ending preventable newborn deaths

By 2030, all countries will have reached the target of 12 or less newborn deaths per 1,000 live births and continue to reduce death and disability, ensuring that no newborn is left behind.

Goal 2: Ending preventable stillbirths

By 2030, all countries will have reached the target of 12 or less stillbirths per 1,000 total births and to continue to close equity gaps.

Guiding principles

- | | |
|-----------------------|-----------------|
| 1. Country leadership | 2. Human rights |
| 3. Integration | 4. Equity |
| 5. Accountability | 6. Innovation |

Strategic objectives for Every Newborn and Ending Preventable Maternal Mortality^[14]

1. Strengthen and invest in care around the time of birth, with a focus on improving quality and experience of care, while ensuring full integration of services for mothers and babies across the continuum of care.
2. Strengthen health systems to optimize the organization and delivery of care through the workforce, commodities and innovation.
3. Reach every woman and newborn by minimizing inequities in access to and coverage of care.
4. Harness the power of parents, families and communities, and engage with society.
5. Improve data for decision-making and accountability.

[14] Chou et al (2015). Ending preventable maternal and newborn mortality and stillbirths. BMJ, 2015;351:h4255



Every Newborn 2020 National Milestones

National Plans	Review and sharpen national strategies, policies and guidelines for reproductive, maternal, newborn, child and adolescent health (RMNCAH) in line with the goals, targets and indicators in the Every Newborn Action Plan, including a clear focus on care around the time of birth and small or sick newborns.
Quality of Care	Adopt standards of quality and indicators for assessing quality of maternal and newborn care at all levels of the health system; and ensure access to essential commodities for RMNCAH.
Investment in Health Workforce	Develop or integrate costed human resources for health strategy into RMNCAH plans and ensure sufficient financial resources are budgeted and allocated.
Health Workforce Capacity and Support	Ensure the training, deployment and support of health workers, in particular midwifery personnel, nurses and community health workers.
Community Engagement	Involve communities, civil society and other stakeholders to increase demand and ensure access to and coverage of essential maternal and newborn care.
Parents' Voices and Champions	Parents' Voices and Champions shift social norms so that it is no longer acceptable for newborns to die needlessly, just as it has become unacceptable for women to die when giving birth.
Data	Count every newborn by using and improving programmatic coverage data including equity and quality gap assessments. Institutionalize civil registration and vital statistics, adapt and use a minimum perinatal dataset, implement maternal and perinatal death surveillance and response.
Research and innovation	Develop, adapt and promote access to devices and commodities to improve care for mothers and newborns around the time of birth, and agree on, disseminate and invest in a prioritized and coordinated research agenda for improving preterm and newborn health outcomes. Particular focus is required for stillbirths, who have been left out or left behind.

Tracking progress in the SDG era

SDG 3 on Health is annotated with the Every Newborn Action Plan target to reduce newborn mortality to no more than 12 per 1,000 live births by 2030 in any country (SDG 3.2.2) and the EPMM target to reduce maternal mortality to no more than a global average of 70 per 100,000 live births (SDG 3.1.1).

The Global Strategy Monitoring Framework is aligned with the SDGs and monitors key indicators; the newborn and maternal mortality targets, and additionally will monitor stillbirth reduction in line with the target set out the Every Newborn Action Plan:

- *By 2030, all countries will have reached the target of 12 or fewer stillbirths per 1,000 total births and continue to close equity gaps.*

Further key indicators significant to maternal and newborn health and stillbirth are being developed and tracked as part of the Global Strategy. These include:

- *the coverage index of essential health services; including for infectious diseases, non-communicable diseases and RMNCAH, family planning, antenatal care, midwifery care during and after birth, breastfeeding, immunization, treatment of childhood illnesses (SDGs 3.1.2, 3.7.1)*
- *achieve universal health coverage, including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all (SDG 3.8), as well as the proportion of children under five years of age whose births have been registered with a civil authority (SDG 16.9.1),*
- *the adolescent birth rate (10-14, 15-19) per 1,000 women in that age group (SDG 3.7.2),*
- *out-of-pocket health expenditure as a percentage of total health expenditure and the percentage of the population using safely managed sanitation services including a hand-washing facility with soap and water (SDG 6.2.1).^[15]*

Tracking country progress toward the Every Newborn National Milestones for 2020

Complementing the Global Strategy progress monitoring, the Every Newborn Tracking Tool was developed during 2014 and 2015 and tracks the processes of country ownership and action for key facets of newborn health as set out in the Every Newborn 2020 National Milestones. This tool is currently being improved to capture broader elements of policy and programmatic implementation for maternal and newborn health and will continue to complement the relevant monitoring for the Global Strategy.

In 2016, 51 countries adopted the Every Newborn Tracking Tool which was a 150 percent increase on

the 18 countries that adopted the tool in 2015, and more countries have reported that they have begun using this tool in 2017.

Year-on-year tracking of progress is fundamental to capture the processes of country ownership and action in order to further accelerate progress towards the eight national milestones. This process has helped countries to:

- *assess the status of progress and identify barriers to implementation in line with Every Newborn Action Plan recommendations;*
- *use the information gathered to define potential solutions and identify the type of technical assistance available or needed on a continuous basis;*
- *provide information to country, regional and global partners to facilitate country technical support as needed.*



Country progress toward the Every Newborn National Milestones for 2020

This section presents a compilation of the data for each of the eight milestones and also spotlights specific country activity, as well as regional and global efforts in support of national level progress.

The 51 countries and territories that completed the Every Newborn Tracking Tool in 2016 were: Afghanistan, Angola, Bangladesh, Benin, Bhutan, Burkina Faso, Cameroon, Chad, China, Côte d'Ivoire, Djibouti, Democratic Republic of Congo, Egypt, Ethiopia, Gambia, Ghana, Guinea, Guinea Bissau, India, Indonesia, Islamic Republic of Iran, Iraq, Jordan, Kenya, Lebanon, Lesotho, Liberia, Libya, Mali,

Mauritania, Morocco, Myanmar, Namibia, Nepal, Niger, Nigeria, Pakistan, Palestine, the Philippines, Senegal, Sierra Leone, Sri Lanka, Sudan, Syrian Arab Republic, Togo, Tunisia, Uganda, United Republic of Tanzania, Viet Nam, Yemen and Zimbabwe. All the data that follows is in respect to these 51 countries and territories, with the exception of Table 1 and 2 which were prepared for the official reporting purposes to the World Health Assembly 2017 and draws together the data compiled by the Every Newborn Tracking Tool and additional information from outreach to WHO Regional Offices.



1. Every Newborn National Milestone: National plans

Review and sharpen national strategies, policies and guidelines for reproductive, maternal, newborn, child and adolescent health (RMNCAH) in line with the goals, targets and indicators in the Every Newborn Action Plan, including a clear focus on care around the time of birth and on small or sick babies.

a. Status of integration of Every Newborn Action Plan into national health strategies

By the end of January 2017, 48 countries and territories with a high burden of newborn mortality and stillbirth had finalized national Newborn Plans or strengthened the relevant components within national health strategies (see Table 1).

Table 1. Status of integration of Every Newborn Action Plan into national health strategies as of 31 January 2017

Completed	Afghanistan, Angola, Bangladesh, Benin, Bhutan, Burkina Faso, Cameroon, China, Côte d'Ivoire, Democratic Republic of Congo, Djibouti, Egypt, Eritrea*, Ethiopia, Ghana, Guinea, India, Indonesia, Iraq, Jordan, Kenya, Lao People's Democratic Republic*, Lebanon, Liberia, Malawi*, Mali, Mauritania, Mongolia*, Morocco, Myanmar, Namibia*, Nepal, Niger, Nigeria, Pakistan, Palestine, Papua New Guinea*, the Philippines, Rwanda*, Senegal, Sri Lanka, Solomon Islands*, Sudan, Thailand*, Timor-Leste*, Uganda, United Republic of Tanzania, Viet Nam (48)
In Progress	Azerbaijan*, Central African Republic, Chad, Guinea, Guinea Bissau, Islamic Republic of Iran, Lesotho, Mozambique, Republic of Moldova*, Pakistan, Sierra Leone, South Sudan, Somalia, Syrian Arab Republic, Zambia*, Zimbabwe (16)

Source: Data for the countries marked with an asterisk comes from the WPRO Progress Report 2016 and WHO Regional Offices. All other data is from the Every Newborn Tracking Tool 2016.

Progress in preparing national plans in those countries with the highest burdens and rates of newborn mortality

Nineteen of the 20 countries with the highest burden of newborn mortality have completed a newborn action plan or strengthened the newborn component in the existing health sector or RMNCAH plans. Mozambique, the 20th country, is in progress. Nineteen have NMR targets; however, only 10 countries have set SBR targets (see Table 2).

Fifteen of the 20 countries with the highest NMR have strengthened their plans and/or prepared a newborn action plan. While 13 of these 20 countries have low numbers of deaths compared to many other countries, the rate of death per birth is alarmingly high. Chad, Central African Republic, Guinea, Guinea-Bissau, Lesotho, Somalia and South Sudan need support to strengthen national plans and set targets for newborn and stillbirth reduction (See Table 2).

Table 2. Progress towards national newborn health plans in countries with the highest newborn mortality rates and/or burden of neonatal deaths

Countries and territories	Neonatal deaths 2015 ^[16]	Neonatal mortality rate 2015 ^[17]	Top 20 Global Ranking for stillbirth rates ^[18]	National Newborn plan	Newborn component strengthened in RMNCH plan	National plan costed	Neonatal mortality rate target	Stillbirth rate target
India	695,850	28						
Pakistan	244,750	46	*					
Nigeria	240,110	34	*					
Democratic Republic of the Congo	94,250	30	*					
China	93,440	6						
Ethiopia	87,410	28	*					
Bangladesh	74,380	23						
Indonesia	73,920	14						
Angola	53,160	49	*					
United Republic of Tanzania	38,580	19						
Sudan	38,570	30						
Afghanistan	36,240	36	*					
Egypt	35,820	13						
Kenya	33,740	22						
Côte d'Ivoire	31,470	38	*					
Uganda	29,740	19						
Philippines	29,600	13						
Mozambique	28,800	27						
Brazil	28,600	9						
Mali	27,440	38	*					
Chad	23,790	39	*					
Somalia	17,690	40	*					
South Sudan	17,030	39	*					
Guinea	14,290	31						
Benin	11,960	32	*					
Sierra Leone	7,620	35						
Central African Republic	6,990	43	*					
Mauritania	4,700	36	*					
Guinea-Bissau	2,590	40	*					
Lesotho	2,050	33						
Equatorial Guinea	940	33						
Comoros	890	34	*					
Djibouti	740	33	*					

KEY:

20 countries with the highest number of newborn deaths

20 countries with the highest newborn mortality rate

In both categories

No response provided

Complete

In process

Not in process

Did not complete the tool

[16] WPRO Progress report

[17] UN Inter-agency Group for Child Mortality Estimation (IGME). Levels and trends in child mortality: Report 2015. New York, USA: UNICEF, 2015. (www.childmortality.org)

[18] Ibid

b. Status of setting newborn and stillbirth reduction targets

- 40 countries and territories have defined a newborn mortality reduction target.
- Only 10 of 51 countries have defined a Stillbirth Reduction target (SBR) (see Table 3)

Table 3. Setting Newborn Mortality Reduction and Stillbirth Reduction targets

Defined a Newborn Mortality Reduction target	Defined Stillbirth Reduction targets target
Afghanistan, Angola, Bangladesh, Bhutan, Burkina Faso, Cambodia, Cameroon, China, Côte d'Ivoire, Democratic Republic of Congo, Egypt, Ethiopia, Ghana, Guinea, India, Indonesia, Kenya, Lao People's Democratic Republic, Liberia, Malawi, Mali, Mauritania, Mongolia, Morocco, Myanmar, Nepal, Niger, Nigeria, Pakistan, Palestine, Papua New Guinea, the Philippines, Rwanda, Senegal, Sri Lanka, Solomon Islands, Sudan, Syrian Arab Republic, Timor Leste, Uganda, United Republic of Tanzania, Vietnam, Zimbabwe (43) <ul style="list-style-type: none">• Iraq reports that this is in progress	Bangladesh, Bhutan, Ethiopia, India, Indonesia, Nepal, Nigeria, Sri Lanka, Sudan, United Republic of Tanzania (10) <ul style="list-style-type: none">• Cameroon and Iraq report that this is in progress

Source: Every Newborn Tracking Tool 2016



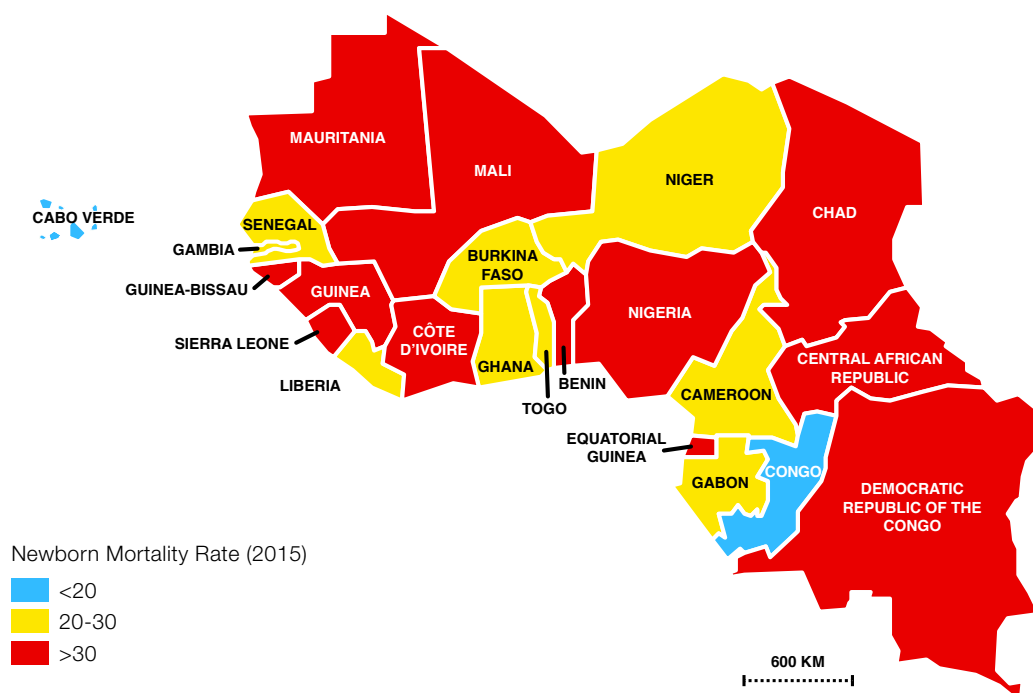
- Of the 20 countries with the highest rates of stillbirth, 9 have finalised national plans for maternal and newborn health; however, most have not included a SBR target in the plan. A SBR target was included in only 2 country plans (Ethiopia and Nigeria).
- A further 11 countries are currently in the process of developing a plan. Including an SBR target is important for national accountability for reducing preventable stillbirths.

Addressing high burden of newborn mortality and stillbirths in West and Central Africa: establishing a regional taskforce for newborn health

In West and Central Africa, almost all countries have significantly high maternal and newborn mortality rates and stillbirth rates. Work is progressing in earnest to improve outcomes for mothers and their children. In November 2016, 24 countries in the region convened in a joint intercountry meeting led by UNICEF, WHO and the United Nations Population Fund (UNFPA) to strengthen country actions based on Every Newborn Action Plan recommendations.

Recognizing the need for concerted and coordinated action by partners, one of the outcomes of the meeting was the decision by all partners to establish a Regional Task Force in order to accelerate and improve efficacy and efficiency of newborn health interventions by global and regional partners through better coordination. WHO, UNICEF and UNFPA will lead the task force which will convene in Dakar in June 2017 to prepare a work plan.

Figure 2. High mortality in West and Central Africa: Neonatal Mortality Rate per country



Data Source: NMR data is from UN Inter-agency Group for Child Mortality Estimation (IGME). Levels and trends in child mortality: Report 2015. New York, USA: UNICEF, 2015. Map Production: UNICEF

Disclaimer: The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Addressing Stillbirths in national plans: opportunity for impact

While maternal and newborn health is receiving increasing focus, and these investments are leading to substantial health gains, stillbirths remain incompletely integrated into this agenda.

Half of stillbirths, 1.3 million, are babies who begin labour alive and die before birth. The Lancet Ending Preventable Stillbirth Series (2016)^[19] provides a risk factor analysis which highlights priority programmatic actions in high quality intrapartum and antenatal care required to prevent stillbirths,

including management of infections such as syphilis and malaria, and non-communicable diseases. The Series lays out the status of stillbirths today and what must happen to end preventable stillbirths by 2030.

- 52 million stillbirths are expected to take place in the next 20 years.
- A staggering 98 per cent of all stillbirths occur in low- and middle-income countries depicting a clear inequity

Figure 3: Stillbirths: A neglected tragedy



[19] Blencowe H et al. 2016. Group National, regional, and worldwide estimates of stillbirth rates in 2015 with trends from 2000. The Lancet Global Health Group [www.thelancet.com/journals/langlo/article/PIIS2214-109X\(15\)00275-2/references](http://www.thelancet.com/journals/langlo/article/PIIS2214-109X(15)00275-2/references)

The required programmatic actions include not only meeting the Every Newborn Milestones but also addressing the impact of stigma and bereavement. This will require their integration into national newborn plans and the wider maternal, newborn and child health national strategies.

The Global Strategy for Women's Children's and Adolescents Health (2016-2030) has included the SBR as one of 16 core indicators to be monitored in the SDG era. All countries need to set an SBR target to hold themselves accountable so that the necessary measures can be taken to end the large number of preventable stillbirths.

Country spotlight: Nigeria's Every Newborn Action Plan

Neonatal deaths now account for 32 percent of all under-five child deaths, representing a total of 240,000 deaths per year for babies in their first month of life in Nigeria. Additionally, Nigeria has a high stillbirth rate (42.9 per 1,000 total births in 2015). Over half of these stillbirths occur in labour and childbirth and are mostly preventable through quality intrapartum care. The proportion of women not receiving any antenatal care is high, especially in the northern zones. Only 38 percent of women across Nigeria deliver in a health facility and a similar proportion receive a postnatal care check in the two days after birth.

The Nigeria Every Newborn Action Plan (2016-2020) (NiENAP) was launched by the Federal Ministry of Health in November 2016^[20]. It sets forth specific actions necessary to achieve significant mortality and coverage targets by 2030. The plan lays out Nigeria's vision of a country "with no preventable deaths of newborns and stillbirths, where every pregnancy is wanted, every birth celebrated; and women, babies, and children survive, thrive, and reach their full potential". The aim is that this document will serve as a framework for each of Nigeria's 36 states and the Federal Capital Territory – in collaboration with many stakeholders and partners – to develop their own action plans, adapting the NiENAP as needed to their unique contexts.

NiENAP presents a set of intervention packages aligned with the 10 key areas of the National Health Policy 2017–2021. The intervention packages follow a four-pronged approach:

1. promotion of facility-based deliveries at scale addressing equity issues;
2. strengthening of community-based interventions;
3. strengthening of facility readiness for providing quality care for the newborn;
4. provision of quality care for the newborn with a focus on labour, birth and immediate care after birth during the first week of life.

The document also defines a set of preliminary national milestones and steps taken to identify core indicators that should be tracked to ascertain progress towards meeting targets.

In 2016, the Federal Ministry of Health also launched the Essential Newborn Care Course training package and the National Chlorhexidine Scale Up Strategy. The Essential Newborn Care Course presents nationally recommended standards for use at all levels of health care delivery by decision-makers, programme managers and development partners for the capacity-building of frontline health workers, provision of quality newborn health services and the overall development of newborns into childhood.

NiENAP will be incorporated in the **National Strategy for Reproductive, Maternal, Newborn, Child and Adolescent Health Quality of Care** which is currently in process and planned to be completed in 2017.

[20] The Lancet Ending Preventable Stillbirth Series (2016) [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(15\)00954-X/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)00954-X/abstract)

c. Status of the development of the newborn plan at subnational levels

16 countries have reported developing subnational level plans (Afghanistan, Cameroon, China, Democratic Republic of Congo, Egypt, Ethiopia, Ghana, India, Indonesia, Niger, Pakistan, Palestine, Sri Lanka, Sudan, Syrian Arab Republic, United Republic of Tanzania). Three countries (Iraq, Kenya, Morocco) reported that they are in the process of developing subnational plans.

Country spotlight: Pakistan – Subnational planning in a devolved setting

Pakistan has one of the highest burdens of newborn mortality with a newborn mortality rate of 46 per 1,000 live births and an estimated 244,000 newborn deaths each year. Since 2011, the Ministry of Health has been decentralizing many health services, functions and responsibilities for policy direction and planning to the provincial governments.

Considerable progress has been made in finalizing and costing Provincial Newborn Plans. These plans began development at nationwide, provincial consultations on how to scale-up newborn programmes and thereafter at national consultations in Islamabad in 2013. Each province identified bottlenecks and challenges in their maternal and newborn health system. Each province has designated funding from the national budget based on population size and development indices. In 2016, provincial sector strategies defined NMR targets, and budgets have been allocated in Provincial Planning Commission documents. Overseeing this at the federal level, the Ministry of National Health Services, Regulation and Coordination in Islamabad (MNHSRC) has finalized the MNCH strategic planning for 2016-2020. The MNHSRC has appointed the current Director of General Health as the focal point for newborn care activities within the integrated MNCH Planning Commission.

Punjab province, home to half of the national population of Pakistan, completed and costed a Newborn Action Plan in 2015, and has begun implementation. In 2016, Sindh, Balochistan and Khyber-Pakhtunkhwa Provinces drafted and costed Newborn Survival Strategies. Punjab is leading by example, undertaking a progress update of their Bottleneck Analysis in 2016 and spearheading a large volume of activity including preparing training materials in Urdu and translating these into local languages, engaging in large-scale training programmes for health-workers and working to establishing a national Kangaroo Mother Care Centre of Excellence.





Country spotlight: Implementing the India Newborn Action Plan for the urban poor

The National Urban Health Mission has initiated planning and developing city-specific models to improve maternal and newborn health services. This supports the implementation of the India Newborn Action Plan in large cities. In the state of Maharashtra, the Pune Municipal Corporation incorporated recommendations from the maternal and newborn health situation assessment to launch a City Health Plan and further municipalities are preparing similar municipal plans.

Globally, more than one billion people are living in slums and slum-like informal settlements and this population is increasing rapidly. In Africa, 61.7 percent and in Asia, 30 percent of the urban population live in slums.^[21] A 2016 assessment of maternal and newborn health among the urban poor undertaken by Save the Children and Averting Maternal Death and Disability at Columbia University recommends developing our understanding of the situation, and undertaking strategic programmatic and research initiatives to improve maternal and newborn health outcomes in slums.^[22] In support of a deliberate focus on the urban poor, participants at the UN Habitat III conference, held in Quito (Ecuador) in October 2016, committed to reducing newborn deaths and declared it a priority for the first time.^[23]

[21] Nigeria Every Newborn Action Plan (2016) : <http://www.healthynewbornnetwork.org/hnn-content/uploads/2033-Nigeria-Every-Child-Action-Plan-151216.pdf>.

[22] State of the World's Cities, 2012/2013.

[23] See http://www.healthynewbornnetwork.org/hnn-content/uploads/AMDD-Urban-MNH-Report_July-20-2016-Final-Report.pdf

d. Status of costing plans

Twenty-two countries and territories (Afghanistan, Bangladesh, Burkina Faso, Cameroon, China, Côte d'Ivoire, Democratic Republic of Congo, Ghana, India, Indonesia, Kenya, Liberia, Mali, Mauritania, Myanmar, Pakistan, Palestine, the Philippines, Sudan, Uganda, United Republic of Tanzania, Viet Nam) have so far been able to cost their national plans. Eight countries (Bhutan, Djibouti, Egypt, Ethiopia, Iraq, Nepal, Syrian Arab Republic, Zimbabwe) are in progress.

Country spotlight: Global Financing Facility (GFF) investments in maternal and newborn health in Cameroon

In Cameroon, neonatal and stillbirth rates have remained stagnant for almost a decade. Malnutrition has increased and there are enormous disparities between geographical regions. An SRMNCAN/N Investment Case supported by GFF was validated in October 2016 and has a specific focus on the four regions that have the worst SRMNCAN/N indicators. This includes effective actions to be implemented including innovative initiatives like the Development Impact Bond for Kangaroo Mother Care and conditional cash transfers for girls' education, with priorities given to deadly pathologies, vulnerable and most at-risk populations and high-impact interventions.

Key components of Cameroon's SRMNCAN/N Investment Case are:

- Elaboration of regional investment cases in priority regions to operationalize the investment case;
- Awareness activities related to stillbirth reduction, including addressing specific challenges of stillbirth registration by advocating for a revision of laws to include birth and death registration certificates for stillbirths;
- Preparing a Draft National CRVS Strategic Plan 2016-2020;
- Capacity building within the Development Impact Bond KMC programme of health workers in selected health facilities of the priority regions;
- An advocacy and communication strategy is currently being designed for a launch in mid-September 2017;
- Availability of a draft action plan for early childhood development to address childhood related problems including nutrition in early years.

The GFF was launched in July 2015 as a financing mechanism for the Global Strategy, intended to close the \$33.3 billion financing gap (2015) in 62 high-burden countries. The objective of the GFF is to deliver smart, scaled, and sustainable financing that accelerates progress on improving the health and wellbeing of women, children, and adolescents while supporting countries to get on the trajectory to achieve the SDGs. It employs a country-driven approach with national governments leading the process to develop an investment case and finance plan for RMNCAH-N, supported by a broad set of stakeholders working together to advance the health of women, children and adolescents through a coordinated country platform. The country platform draws on the comparative advantages of the stakeholders, includes the financing of the World Bank Group, Gavi, the Vaccine Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and bilateral donors; the technical expertise and normative mandates of United Nations agencies; the reach and community-connectedness of non-governmental organizations; and the capacity and speed of the private sector.

The GFF focuses on coordinated financing and implementation, which includes an emphasis on improving efficiency, mobilizing domestic resources, increasing and better aligning external financing, and leveraging private sector resources. This effort is catalyzed by a multi-donor trust fund – the GFF Trust Fund – that is based at the World Bank. Resources from the trust fund are amplified by the ability of the trust fund to link to financing from IDA and IBRD. The GFF Trust Fund was established with an initial US\$875 million in pledges from the Governments of Canada and Norway, and the Bill and Melinda Gates Foundation. The GFF Trust Fund has almost completed allocations for its current phase in which it supports 16 countries (Bangladesh, Cameroon, Democratic Republic of the Congo, Ethiopia, Guatemala, Guinea, Kenya, Liberia, Mozambique, Myanmar, Nigeria, Senegal, Sierra Leone, Uganda, United Republic of Tanzania and Vietnam) and aims to replenish funds to meet the growing demand from the remaining 46 GFF-eligible countries.

e. Supporting free maternal and newborn care

Thirty-four countries have policies on both free maternal and newborn care, however implementation of these policies vary.

A number of countries report having a national health insurance or incentive schemes or a free health policy in place for either mother or baby but not both:

- maternal only (Benin, Burkina Faso, Chad, Lesotho, Palestine and Yemen);
- newborns only (Nigeria and Zimbabwe, and in progress in Guinea).

Notably in Africa, eight countries namely Benin,

Cameroon, Chad, Djibouti, Democratic Republic of Congo, Guinea, Lesotho and Togo do not have insurance policies in place to cover care for sick newborns. In Asia, only Pakistan reported the lack of such a policy, while in the Middle East, Yemen, Jordan, Lebanon and Libya lack a relevant policy.

- Angola reports having a free maternal and newborn care policy including for sick newborns, but challenges remain with regard to out-of-pocket expenses and the supply of care
- Community-based health insurance is being piloted in selected districts of Ethiopia while the national health insurance agency is finalizing preparations to initiate the implementation of social health insurance
- In Ghana, 6 ante-natal care visits are covered under the free maternal care policy

Table 4: Investment in free maternal and newborn care

Indicator	2016 (n=51)		
	Yes	In process	No
National health insurance scheme/free policy in place covering both maternal and newborn care including sick newborns	Afghanistan, Angola, Bhutan, China, Côte d'Ivoire, Egypt, Ethiopia, Gambia, Ghana, Guinea-Bissau, India, Indonesia, Islamic Republic of Iran, Iraq, Kenya, Liberia, Mali, Mauritania, Morocco, Myanmar, Namibia, Nepal, Niger, Palestine, the Philippines, Senegal, Sierra Leone, Sri Lanka, Sudan, Syrian Arab Republic, Uganda, United Republic of Tanzania, Viet Nam (34)	Burkina Faso, Nigeria (2)	Benin, Cameroon, Chad, Djibouti, Democratic Republic of Congo, Guinea, Jordan, Lebanon, Lesotho, Libya, Pakistan, Togo, Yemen (14)

Source: Every Newborn Tracking Tool 2016.



Country spotlight: The Philippines' PhilHealth Newborn Care Insurance Package

The decline of under-five mortality has stalled in the Philippines largely due to persistently high levels of neonatal deaths. Of Filipino babies who die during the neonatal period, 60 percent succumb to complications brought about by prematurity and/or low birth weight^[24]. Countless other babies survive and suffer lifelong physical, neurological or educational disabilities.

A Newborn Care Package was developed as part of the prioritization for newborn health in the national Newborn Assessment and the national Bottleneck Analysis undertaken in 2013. In this package, babies are guaranteed the Newborn Care Package in accredited hospitals and lying-in clinics, which includes a physical examination, eye prophylaxis, Vitamin K, newborn screening tests and breastfeeding advice. However, these interventions remain inaccessible to many because of critical socioeconomic disparities that results in low demand for care-seeking.

In 2016, the Ministry of Health and the national health insurance programme PhilHealth with support from UNICEF developed a nationwide health insurance package for premature and small newborns. The package covers the conditions related to preterm birth: risk of preterm delivery, minor complications including jaundice and hypothermia, major complications such as sepsis, Respiratory Distress Syndrome, intraventricular haemorrhage and anaemia. It also conducts testing for hearing and basic newborn metabolic panel testing and retinopathy as a result of prematurity.

By mid-2017, the Philhealth benefit package for premature and small babies can be availed at both private and public accredited providers (covering 85 percent of the Filipino population). This innovative package will reach an estimated 350,000 newborns every year, enabling families to access the necessary care for newborns with preterm and low birth weight complications.

Country spotlight: Six months maternity leave for exclusive breastfeeding in Bhutan

In 2016, Bhutan made into law the extension of maternity leave from three to six months for civil servants to protect exclusive breastfeeding, making Bhutan the second country in the WHO South East Asia Region, after Bangladesh, to increase support to six months maternity leave. This law complements Bhutan's free health care policy.

[24]The New Urban Agenda (2016) at <https://unhabitat.org/new-urban-agenda-adopted-at-habitat-iii/>



f. Status of inclusion of newborn care within national plans for emergency preparedness

Seven countries (Democratic Republic of Congo, Liberia, Myanmar, Nepal, Niger, Nigeria and Sri Lanka) have so far reported including newborn care within their emergency plans. China is in the process of preparing the newborn component of the national emergency plan.

Pregnant and newly delivered women and their newborns are particularly vulnerable groups in conflict and disaster-affected settings. As the first hours of a baby's life are the most critical for survival, if appropriate equipment and medications are not available, a newborn's condition can deteriorate quickly, even within minutes. Yet, care around the time of birth is neglected in both existing humanitarian emergency planning and routine systems in many low-resource settings. Care during the first month of life, or the newborn period, has been missing in emergency response assessments, supply kits, intervention packages and monitoring indicators.

Efforts to improve delivering for newborns in humanitarian and fragile settings

In 2016, the *Newborn Health in Humanitarian Settings Field Guide*^[25] was developed to rapidly introduce newborn health training, supplies, and indicators in crisis situations, with the intention of also strengthening routine systems and resilience before and after crises arise. The Field Guide is intended to complement and serve as a companion guide to the *Minimum Initial Service Package for Reproductive Health in Crisis Situations*^[26] and the *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings (IAFM)*^[27]. The guide is a compilation and summary of WHO standards of care for newborn health with additional guidance on how to provide newborn services in the

context of a humanitarian setting. It prioritizes the most critical health services and supplies to prevent and manage the three main causes of newborn death at three levels of care: community care, primary-level clinics and hospitals.

Additionally, training curriculums and tools are included in the Field Guide for programme staff and health workers, which is to be complemented by newborn care supply kits – pre-packaged kits containing appropriate doses of certain medicines, supplies and newborn-sized devices.

WHO Maternal, Child and Adolescent Health is currently conducting a scoping exercise to review existing guidance and guidelines on maternal, newborn and child health humanitarian settings. The exercise will lead to identification of gaps that need to be addressed through research and or guideline development.

Meeting programme demands by developing pre-packaged newborn health kits

A list of key drugs, equipment and mother-baby items were developed and included in the Field Guide on Newborn Care in Humanitarian settings. The testing of the field guide in South Sudan and Somalia has highlighted the need for pre-packaged newborn kits for ease of procurement in emergency situations.

Revisions are needed to the newborn commodities list prior to integration into existing kits for reproductive and child health. In February 2017, a stakeholder workshop was held at UNICEF Supply Division in Copenhagen (Denmark) to revise and finalize the contents of the Newborn Health Kits for community health workers, primary level and referral level service points. UNICEF is working with partners to complete a contents list for the kit based on recommendations from the workshop. After revising, the kits will soon be made available for procurement.

[25] The Philippine Department of Health Survey, 2012.

[26] Newborn Health in Humanitarian Settings Field Guide (2016) <http://www.healthynewbornnetwork.org/resource/newborn-health-humanitarian-settings-field-guide-interim-version/>.

[27] <http://www.unfpa.org/resources/what-minimum-initial-service-package>.

Feasibility Testing of the *Newborn Health in Humanitarian Settings Field Guide* in South Sudan and Somalia

To understand the feasibility of implementing the field guide, studies are being undertaken in South Sudan and Somalia. In addition, UNHCR has developed complementary guidelines specific to refugees, and these are being tested in camps in Jordan, Kenya and South Sudan. Lessons learnt from the studies will feed into the final version of the field guide, and will be further integrated into the *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*.

Preliminary results^[28] from the study in South Sudan and the baseline survey in Somalia show:

Problem:

- Newborn-specific medicines and supplies are often lacking, and more coordination is needed with existing pre-packaged kits.
- Programme managers in emergency settings tend to be more generalist and not aware of the special needs of newborns compared to older children.

Preliminary findings:

- It is feasible to provide quality newborn care services in humanitarian settings.
- Both community and facility-based health workers recognize the importance of newborn care practices, although they have inadequate knowledge about newborn danger signs, essential practices and health promotion messages.
- Lack of training and lack of newborn-specific commodities are the two major barriers to providing quality care.
- A tailored training package for healthcare workers will support capacity-building efforts, quality of training and the impact in the field when qualified trainers are often not available.
- High-quality newborn care can be effectively provided as a standard part of humanitarian responses, but some adaptations to newborn care kits may be needed to disseminate it, alongside complementary pre-packaged kits for reproductive and child health.

Gaps:

- More focused advocacy on newborn health and coordinated efforts are needed to strengthen routine health systems even during a crisis so as to reach the most vulnerable outside of camp settings.
- Further research is needed to understand and improve care, especially for small and sick newborns, and to connect care between community and health facilities and across the life cycle.

[28] http://www.who.int/reproductivehealth/publications/emergencies/field_manual/en/.



2. Every Newborn Milestone: Quality of care

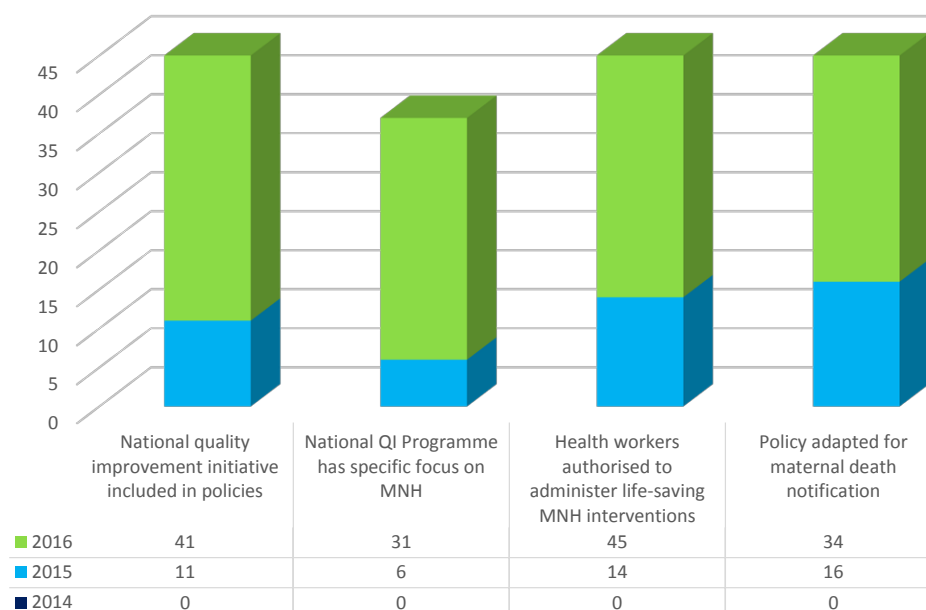
Adopt standards of quality and indicators for assessing quality of maternal and newborn care at all levels of the health system; and ensure access to essential commodities for RMNCAH

Countries have made remarkable progress in establishing appropriate policies and plans to improve the quality of maternal and newborn care at all levels of the health system and ensure access to essential commodities for RMNCAH.

Between 2014 and 2016, there was a large increase

in the number of countries preparing specific quality of care plans, updating policies required for quality of care improvements (including health workers at appropriate levels of care authorized to administer life-saving interventions and commodities) and adopting legislation or policies on the notification of maternal death within 24 hours (see Figure 4 and Table 5).

Figure 4: Number of countries reporting having national policies supporting quality of care for mothers and newborns around time of birth



Source: Every Newborn Tracking Tool 2016.

- Forty-one countries reported having a national Quality Improvement (QI) programme or initiative for healthcare (see Table 6) and 29 of these have a specific focus on maternal and newborn care.
- Forty-five countries report having health workers at appropriate levels of care authorized to administer life-saving interventions and commodities. Angola, Djibouti, Egypt, Jordan, Libya and Morocco need focused attention on health worker authorization issues.
- Thirty-four of the 51 countries reported having adopted legislation or policies on the notification of maternal death within 24 hours and 24 reported having perinatal death audit policies in place.

Table 5: Status of policies supporting quality of care

Status of policies supporting quality of care	Yes	In process	No
1. National Quality Improvement initiative included in policies	Afghanistan, Angola, Bangladesh, Benin, Bhutan, Burkina Faso, Chad, China, Côte d'Ivoire, Djibouti, Democratic Republic of Congo, Egypt, Ethiopia, Ghana, Guinea, India, Indonesia, Islamic Republic of Iran, Iraq, Jordan, Kenya, Lebanon, Lesotho, Liberia, Libya, Mali, Morocco, Myanmar, Nepal, Niger, Palestine, the Philippines, Senegal, Sierra Leone, Sri Lanka, Sudan, Togo, Uganda, United Republic of Tanzania, Viet Nam, Yemen, Zimbabwe (43)	Nigeria (1)	Cameroon, Gambia, Guinea-Bissau, Mauritania, Namibia, Pakistan, Syrian Arab Republic, Tunisia (8)
2. National QI programme has specific focus on MNH	Afghanistan, Angola, Burkina Faso, Chad, China, Côte d'Ivoire, Democratic Republic of Congo, Egypt, Ethiopia, Ghana, Guinea, India, Islamic Republic of Iran, Jordan, Kenya, Lesotho, Liberia, Libya, Myanmar, Nepal, Nigeria, Palestine, the Philippines, Sri Lanka, Sudan, Togo, Uganda, Zimbabwe (29)	Bangladesh	Benin, Bhutan, Indonesia, Iraq, Mali, Senegal, Sierra Leone, (7)
3. Health workers authorized to administer life-saving MNH interventions	Afghanistan, Bangladesh, Benin, Bhutan, Burkina Faso, Cameroon, Chad, China, Côte d'Ivoire, Democratic Republic of Congo, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, India, Indonesia, Islamic Republic of Iran, Iraq, Kenya, Lesotho, Liberia, Mali, Mauritania, Myanmar, Namibia, Nepal, Niger, Nigeria, Pakistan, Palestine, Philippines, Senegal, Sierra Leone, Sri Lanka, Sudan, Syrian Arab Republic, Togo, Tunisia, Uganda, United Republic of Tanzania, Viet Nam, Yemen, Zimbabwe (45)	-	Angola, Djibouti, Egypt, Jordan, Libya, Morocco (6)
4. Policy adapted for maternal death notification	Afghanistan, Angola, Benin, Burkina Faso, Cameroon, China, Côte d'Ivoire, Democratic Republic of Congo, Ethiopia, Ghana, Guinea-Bissau, India, Indonesia, Islamic Republic of Iran, Iraq, Jordan, Kenya, Lebanon, Lesotho, Libya, Myanmar, Niger, Nigeria, Palestine, Senegal, Sierra Leone, Sri Lanka, Sudan, Tunisia, Uganda, United Republic of Tanzania, Viet Nam, Yemen, Zimbabwe (34)	-	Bhutan, Chad, Djibouti, Egypt, Gambia, Guinea, Liberia, Mali, Mauritania, Morocco, Namibia, Nepal, Pakistan, the Philippines, Syrian Arab Republic, Togo (16)
5. Perinatal audit and newborn death notification	Angola, Cameroon, Chad, China, Democratic Republic of Congo, Egypt, Gambia, Ghana, Indonesia, Islamic Republic of Iran, Kenya, Lebanon, Myanmar, Namibia, Nepal, Nigeria, Palestine, Sri Lanka, Togo, Tunisia, Uganda, United Republic of Tanzania, Zimbabwe (24)	India, Jordan, Lesotho (3)	Afghanistan, Bangladesh Benin, Bhutan, Burkina Faso, Côte d'Ivoire, Djibouti, Ethiopia, Guinea, Guinea-Bissau, Iraq, Liberia, Libya, Mali, Mauritania, Morocco, Niger, Pakistan, Senegal, Sierra Leone, Sudan, Syrian Arab Republic, Viet Nam, Yemen (24)

Source: Every Newborn Tracking Tool 2016.

Status of including essential medical products and technologies on the National Essential Medicines list

The addition of recommended essential medicines and commodities for high-impact interventions in the National Essential Medicines List (NEML) is one of the greatest areas of progress. Twenty-six countries have included all the seven essential medical products and technologies on their NEML. Notably, oxytocin, magnesium sulphate and injectable antibiotics have been incorporated in the NEML by almost all the countries.

The inclusion of essential maternal, newborn and child health (MNCH) commodities in Logistic Management and Information Systems (LMIS) is important to ensure the regular supply of these medicines and avoid stock-outs.

- Twelve countries have incorporated all the seven essential maternal and newborn commodities in their LMIS while 10 countries are yet to include any of them.
- More effort is required to have oxytocin, magnesium sulphate and injectable antibiotics included in the LMIS of countries, which have already included them in their NEML.

Country Spotlight: Electronic LMIS developed to improve the availability of priority MNCH medicines in Bangladesh

To ensure the uninterrupted availability of and access to priority MNCH medicines, the Directorate General of Health Services developed an electronic LMIS (eLMIS) that tracks the availability of 25 priority MNCH medicines at the service delivery point level. The eLMIS was developed with technical assistance from the USAID-funded Systems for Improved Access to Pharmaceuticals and Services Program, implemented by Management Sciences for Health.

A total of 2,393 health facilities in 11 districts [Gazipur, Pabna, Khulna, Faridpur, Lakshmipur, Jamalpur, Lalmonirhat, Natore, Cox's Bazar, Moulvibazar and Khustia] under the Directorate General of Health Services are currently registered in the eLMIS. Of these, 2,288 facilities (95.6 per cent) had submitted their logistics reports through the eLMIS as of February 2017^[29]. The Systems for Improved Access to Pharmaceuticals and Services Program has continued to provide support to eLMIS users through on-the-job training and coaching via telephone to ensure the efficient and effective use of the tool.

[29] Preliminary results provided by partners involved in the studies including Johns Hopkins University, Save the Children, International Medical Corps, Centre for Disease Control, UNICEF, and Ministries of Health. Publication forthcoming.



Table 6: Progress on the inclusion of essential medical products and technologies in the National Essential Medicines List.

Essential Medicine	Yes	In process	No
Oxytocin	Afghanistan, Angola, Bangladesh, Benin, Bhutan, Burkina Faso, Cameroon, Chad, China, Côte d'Ivoire, Djibouti, Democratic Republic of Congo, Egypt, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, India, Indonesia, Islamic Republic of Iran, Iraq, Jordan, Kenya, Lebanon, Lesotho, Liberia, Libya, Mali, Mauritania, Morocco, Myanmar, Namibia, Nepal, Niger, Nigeria, Pakistan, Palestine, the Philippines, Senegal, Sierra Leone, Sri Lanka, Sudan, Togo, Tunisia, Uganda, United Republic of Tanzania, Viet Nam, Yemen, Zimbabwe (50)	Syrian Arab Republic (1)	(0)
Misoprostol	Angola, Bangladesh, Benin, Bhutan, Burkina Faso, Cameroon, Chad, China, Côte d'Ivoire, Djibouti, Democratic Republic of Congo, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, India, Islamic Republic of Iran, Iraq, Jordan, Lesotho, Liberia, Mali, Morocco, Myanmar, Namibia, Nepal, Niger, Nigeria, Pakistan, Senegal, Sierra Leone, Sudan, Togo, Tunisia, Uganda, United Republic of Tanzania, Viet Nam, Zimbabwe (39)	Afghanistan, Kenya, Syrian Arab Republic (3)	Egypt, Indonesia, Libya, Mauritania, Palestine, the Philippines, Sri Lanka, Yemen (8)
Magnesium sulphate	Afghanistan, Angola, Bangladesh, Benin, Bhutan, Burkina Faso, Cameroon, Chad, China, Côte d'Ivoire, Djibouti, Democratic Republic of Congo, Egypt, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, India, Indonesia, Islamic Republic of Iran, Iraq, Jordan, Kenya, Lesotho, Liberia, Libya, Mali, Mauritania, Morocco, Myanmar, Namibia, Nepal, Niger, Nigeria, Pakistan, Palestine, the Philippines, Senegal, Sierra Leone, Sri Lanka, Sudan, Togo, Tunisia, Uganda, United Republic of Tanzania, Viet Nam, Yemen, Zimbabwe (50)	Syrian Arab Republic (1)	(0)
Injectable antibiotics	Afghanistan, Angola, Bangladesh, Benin, Bhutan, Burkina Faso, Cameroon, Chad, China, Côte d'Ivoire, Djibouti, Democratic Republic of Congo, Egypt, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, India, Indonesia, Islamic Republic of Iran, Iraq, Jordan, Kenya, Lebanon, Lesotho, Liberia, Libya, Mali, Mauritania, Morocco, Myanmar, Namibia, Nepal, Niger, Nigeria, Pakistan, Palestine, the Philippines, Senegal, Sierra Leone, Sri Lanka, Sudan, Togo, Tunisia, Uganda, United Republic of Tanzania, Viet Nam, Yemen, Zimbabwe (49)	Syrian Arab Republic (1)	(0)
Antenatal corticosteroids	Afghanistan, Angola, Benin, Bhutan, Burkina Faso, Chad, China, Côte d'Ivoire, Djibouti, Democratic Republic of Congo, Egypt, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, India, Indonesia, Islamic Republic of Iran, Iraq, Jordan, Kenya, Lesotho, Liberia, Mali, Niger, Nigeria, Pakistan, Palestine, the Philippines, Senegal, Sierra Leone, Sri Lanka, Sudan, Togo, Tunisia, Uganda, United Republic of Tanzania, Viet Nam, Zimbabwe (39)	Morocco, Syrian Arab Republic, Tanzania (3)	Cameroon, Libya, Mauritania, Myanmar, Nepal, Yemen (6)

Chlorhexidine	Afghanistan, Bangladesh, Benin, Bhutan, Cameroon, Chad, Côte d'Ivoire, Djibouti, Democratic Republic of Congo, Egypt, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Islamic Republic of Iran, Lesotho, Liberia, Libya, Mali, Mauritania, Myanmar, Nepal, Niger, Nigeria, Pakistan, Palestine, Senegal, Sierra Leone, Sri Lanka, Sudan, Togo, Tunisia, Uganda (34)	Kenya, Syrian Arab Republic (2)	Angola, Burkina Faso, China, India, Indonesia, Iraq, Jordan, Morocco, Namibia, the Philippines, United Republic of Tanzania Viet Nam, Yemen (13)
Newborn resuscitation devices (Ambu bag and mask)	Afghanistan, Angola, Benin, Bhutan, Chad, China, Côte d'Ivoire, Djibouti, Democratic Republic of Congo, Egypt, Gambia, Ghana, Guinea, Guinea-Bissau, India, Indonesia, Islamic Republic of Iran, Iraq, Jordan, Kenya, Lesotho, Liberia, Libya, Mali, Morocco, Namibia, Niger, Nigeria, Pakistan, Palestine, Senegal, Sierra Leone, Sudan, Togo, Tunisia, Uganda, Viet Nam, Zimbabwe (38)	Syrian Arab Republic, United Republic of Tanzania (2)	Burkina Faso, Cameroon, Ethiopia, Mauritania, Myanmar, Nepal, the Philippines, Sri Lanka, Yemen (9)

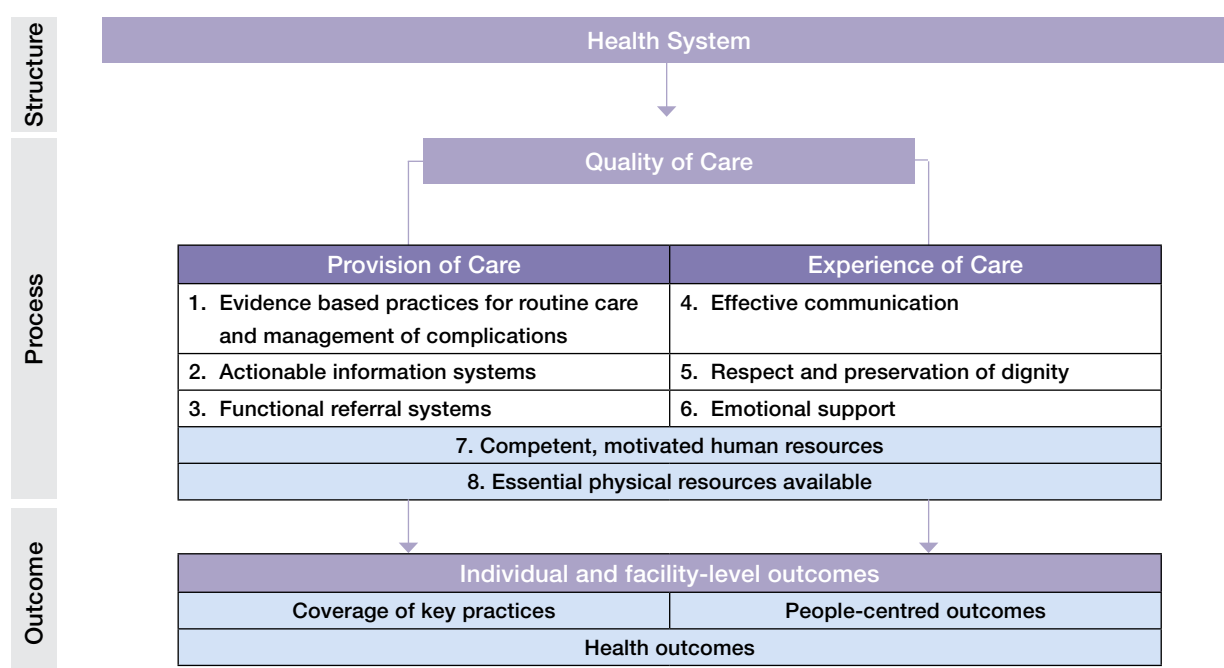
Standards for Improving Quality of Maternal and Newborn Care in Health Facilities

In October 2016, WHO released Standards for improving quality of maternal and newborn care in health facilities^[30] that pertain to the time around birth to be integrated in national RMNCAH and quality improvement plans. The Standards and the accompanying implementation framework aim to ensure that “every pregnant woman and newborn receives quality care

throughout pregnancy, childbirth and the postnatal period.”

The implementation framework encompasses both the provision and the experience of care. It identifies eight domains of quality of care that should be assessed, improved and monitored in the health system. (See Figure 5) Within this framework and in line with the WHO's mandate, six strategic areas have been identified upon which to build a systematic, evidence-based approach to QI guidance. They are the following: clinical guidelines, standards of care, effective interventions, quality measures, research and capacity-building.

Figure 5: WHO Quality of Care Framework 2016



[30] National Newborn Health Bulletin Issue 2, March 2017, Ministry of Health Bangladesh.

Launch of the Network for Improving Quality of Care for Maternal, Newborn and Child Health

To support the implementation of these Standards and Quality of Care, WHO, UNICEF and UNFPA are leading a global network, The Network for Improving Quality of Care for Maternal, Newborn and Child Health, in order to improve quality of care for maternal, newborn and child health. This is aligned with the Every Newborn and EPMM objectives to achieve universal health coverage of recommended MNCH interventions with a key focus required on improving the quality of care.

What are the goals of the network?

- Reduce maternal and newborn mortality in health facilities in target country districts by 50 per cent over five years and halve intra-partum stillbirths;
- Reduce avoidable morbidity due to reducing severe post-partum haemorrhage by 50 per cent, and neonatal sepsis;
- Improve the experience of care.

What will the network do?

- Focus on national leadership by strengthening national and district governance quality of care structures, and helping develop national plans and advocacy strategies for improving quality of care.
- Accelerate action by adapting and adopting WHO's eight standards for improving quality of maternal and newborn care in health facilities at the country level, creating national packages of Quality Improvement interventions and develop, strengthen and sustain clinical and managerial capabilities to support quality of care improvement.
- Foster learning and generate evidence on quality of care through a Learning Platform, a community of health practitioners from around the world co-developing and sharing knowledge, country data and

research to inform maternal and newborn quality of care improvement work in countries (*Visit the Learning Platform at www.qualityofcarenetwork.org*). The Learning Platform's outcomes will feed into the WHO-led Global Learning Laboratory for Quality Universal Health Coverage.

- Develop and support institutions and mechanisms for accountability for quality of care by designing a national accountability framework, and monitoring the progress of the Network for Improving Quality of Care for Maternal, Newborn and Child Health.

What impact will the network have? If successful:

- millions of women and their newborn infants who endure unnecessary and preventable risks in childbirth will benefit from better care;
- health workers who face enormous challenges in resource-poor settings will have access to quality of care improvement solutions that are adapted to their context;
- nations which see investment in healthy women and children as the bedrock of economic and social development will implement their maternal, newborn and children health strategies more efficiently;
- global development partners will see rapid progress towards the SDGs and the targets of EWEC's Global Strategy.

Who are the partners?

In 2017, the first group of nine countries have joined the network: Bangladesh, Côte d'Ivoire, Ethiopia, Ghana, India, Malawi, Nigeria, Uganda and United Republic of Tanzania, with more countries to join subsequently. Table 7 captures a snapshot of the readiness for quality improvement in the nine countries. These nine countries are in various stage of progress and are convening in a network for shared learning. The network brings together officials from ministries of health, health care professionals and providers, and bilateral and multilateral development partners. The resources of the network are open to all countries.

¹⁸ http://www.who.int/maternal_child_adolescent/documents/improving-maternal-newborn-care-quality/en/

Table 7: Snapshot of readiness for Quality Improvement in the nine first wave countries

Leadership

Functional Leadership Structure for Quality Improvement

Quality of Care Committees established in District Health Management Teams

Plans, strategies & standards

National Quality of Care Strategy for the Health Sector

National Strategy for Maternal and Newborn Health addresses Quality of Care

National Quality of Care Standards and Protocols

Data

National Situational Analysis for Quality of Care up-to-date

Assessment of Quality of Care in Health Facilities completed in the past two years

Supporting systems

Maternal and Perinatal Death Surveillance and Response System established

Maternal and Newborn Lifesaving Commodities on the Essential Medicine list

Water Coverage in Health Care Facilities (%)

Skilled attendance at delivery (%)

National Availability of EmOC (%)



Source: www.qualityofcarenetwork.org

²⁹ http://ipa-world.org/uploadedbyfck/JointStatement_ImprovingMNHQoC_2016_Final.pdf



Country spotlight: Uganda's development of a National Quality Improvement Framework

The National Quality Improvement Framework defines and provides guidelines on governance and management structures for quality improvement. At the national level, a technical working group oversees QI across the board, including for MNH. Similar structures exist sub-nationally.

Role: The national Technical Working Groups' main role is to advise the sector on policy-related QI issues, advocate for QI, monitor QI implementation by different players and at different levels of the health system, support districts and partners to build capacity and supervise implementation, mobilize resources and review programs.

Results:

- Quality improvement activities have been harmonized and mainstreamed QI based on a national QI framework and strategic plan launched in 2016.
- Clear QI tools, standards, indicators have been developed as well as plans for how to measure them, QI approaches prioritized and implementation materials agreed upon.
- Team of national trainers and supervisors are trained
- Standardized reporting tool for all partner activities - meeting on a monthly basis.
- Programs across nutrition, HIV and MNCH have developed their specific QI indicators and some have even developed a scoring system for use during verification.
- Capacity has been built to host learning collaboratives
- MPDR and perinatal death audits have been scaled-up, focusing on establishing subnational MPDSR and integrating this in HMIS/disease surveillance system.

Quality of Care Plans and Strategies

The National Quality Improvement Framework and Strategic Plan 2015/6 to 2019/20 are in place. As are the Reproductive Maternal Neonatal Child and Adolescent Health Improvement Project Plans and Strategies. Quality Improvement has been identified in the GFF Investment Case (2016-2020) as a priority for addressing key bottlenecks to delivering Reproductive, Maternal, Newborn, Child and Adolescent Health.

Standards

The first draft of Standards for Improving Quality of Maternal and Newborn Care in Health Facilities is complete. This will be integrated within the National Service Delivery Standards.

The RMCNAH Facility and Provider Quality Improvement tool and Essential Maternal and Newborn Care guidelines are in place.

Source: Ministry of Health, Uganda, 2017.

In 2016, Council of International Neonatal Nurses, the International Confederation of Midwives, the International Council of Nurses, the International Federation of Gynaecology and Obstetrics, and the International Pediatric Association issued a Joint Statement in which the group assumed critical leadership and committed to actions to improve maternal and newborn care worldwide.³¹

Country spotlight: National Health Care Quality Strategy and implementation in Ethiopia

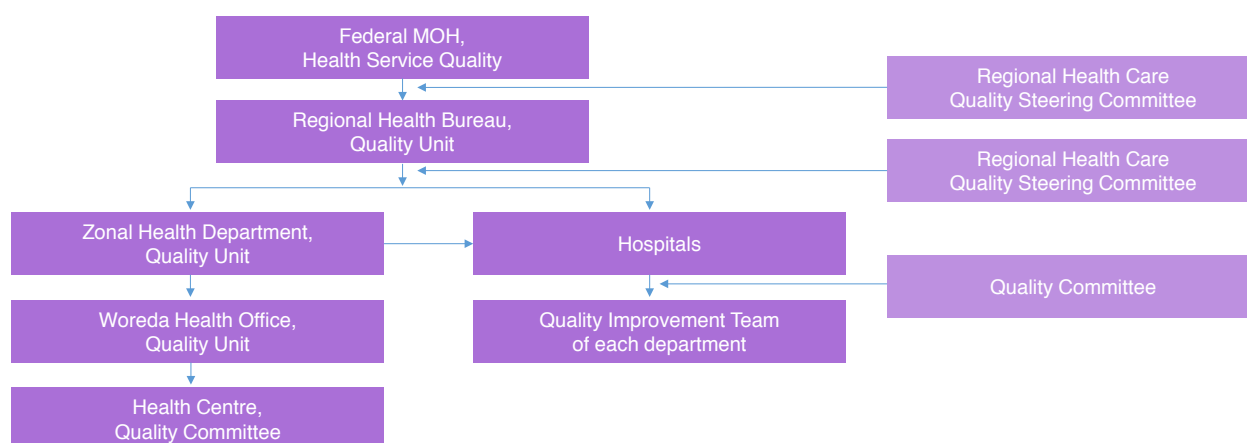
Quality of care is a core element of the Ethiopia's General Health Sector Growth and Transformation Plan (2015/16 – 2019/20). To this end, the Ethiopian National Health Care Quality Strategy (2016-2020) provides a clear road map with a strategic focus. To date, much progress has been made in establishing the structures, governance, standards and guidance, as well as the completion of a Landscape Analysis (2014) and numerous rounds of health facility assessments (2014, 2015 and 2016) to establish the baseline and progress over time. Key results to date:

1. Quality standards developed for the five priority health conditions, including for MNCH (completed in September 2016);
2. Service standards developed by the regulatory body;
3. Quality improvement and clinical audit tool prepared based on the WHO MNH quality standards;
4. Ethiopian Health Service Transformation Guide and Health Centre Service Management Standards prepared;
5. Orientation provided to 2,500 participants from 244 hospitals on Quality Improvement methods, Health Service Transformation for Quality Guidelines and the Ethiopian Health Service Transformation Guide;
6. A master's degree level Quality Improvement course is under development;
7. The largest partnership network established among Ethiopian health institutions to catalyse collaborative learning.

Figure 6: Updated National Quality of Care Plans, Standards and Guidance



Figure 7: National to district quality of care governance structure established



Country spotlight: Mother and Baby Friendly Facility, Bangladesh

In Bangladesh, the Health Sector Plan (2017-2021) established that quality of care in health is a government priority and is a key health objective. In 2015, the National Quality Improvement Strategy was completed and now all 64 districts are covered by QI implementation. National health leadership is in the process of building institutional mechanisms at national, division and district levels and continuous building capacity for quality planning, improvement and control.

In one district, Kurigram, a partnership between the Government of Bangladesh, UNICEF and the Bill and Melinda Gates Foundation has supported a Mother Baby Friendly Facility Initiative that aims to improve the quality of care during labour and birth. One focus of work has been to improve essential newborn care. In 2016, immediate drying which is important to prevent hypothermia was identified as a component of quality care that required improvement. Within a short period of three months, the number of newborns who were dried immediately after birth doubled in one primary health care facility. This example demonstrated to the facility that implementation of a simple step-wise approach for quality improvement at the point of care in health facilities can be effective by focusing on simply reorganization of care within existing resources.



Spotlight: Quality Improvement acceleration in India

In India, a Quality Assurance Committee in each state ensures the implementation of the Quality Improvement Programme, including the strategic planning and roll-out of the programme to QI units in districts. Supported by USAID, the Applying Science to Strengthen and Improve Systems (ASSIST) Project is working in 27 high priority districts covering 30 million people in six states - Delhi, Haryana, Himachal Pradesh, Jharkhand, Punjab, and Uttarakhand.³² This effort has resulted in the establishment of over 400 quality teams that have identified quality gaps in maternal and newborn care, developed and tested changes, and sustained improvements. Within two years, the quality improvement efforts resulted in a 15 percent reduction in perinatal mortality in the 27 districts.³³

[32] Health Professional Associations Joint Statement Improving Quality of Maternal and Newborn Care in Low- and Middle-Income Countries (2016) http://ipa-world.org/uploadedbyfck/JointStatement_ImprovingMNHQoC_2016_Final.pdf

[33] Sarin et al (2017). Evaluation of a quality improvement intervention for obstetric and neonatal care in selected public health facilities across six states of India. BMC Pregnancy and Childbirth (2017) 17:134



Status of Post-natal Home visits

Among the 75 countries included in the Countdown 2015 report, 59 reported having a policy for post-natal home visits during the first week after childbirth.³⁶

However, implementation of this policy is in varying stages of progress. Thirty-two of the 51 countries

using the Every Newborn Tracking Tool reported that the home-based post-natal care policy was being implemented. Guinea reported having a tool for collection and storage of data on maternal death notification in 24 hours despite the absence of a supporting policy.

Table 8: Countries reported status of implementation of policies on home-based postnatal care

Yes	In process	No
Benin, Bhutan, Burkina Faso, Cameroon, China, Côte d'Ivoire, Djibouti, Democratic Republic of Congo, Egypt, Ethiopia, Gambia, Ghana, Guinea-Bissau, India, Indonesia, Islamic Republic of Iran, Kenya, Liberia, Mali, Namibia, Niger, Nigeria, Pakistan, Palestine, Senegal, Sierra Leone, Sri Lanka, Sudan, Uganda, United Republic of Tanzania, Viet Nam, Zimbabwe (32)	Afghanistan (1)	Angola, Chad, Guinea, Iraq, Jordan, Lebanon, Lesotho, Libya, Mauritania, Morocco, Myanmar, Nepal, the Philippines, Syrian Arab Republic, Togo, Tunisia, Yemen (17)

Source: Every Newborn Tracking Tool 2016.

Reaching the most vulnerable community members requires ensuring availability of services in communities – community health workers pivotal role in providing accessible and quality postnatal care

Postnatal care delivered by community-based integrated approaches, in particular postnatal care delivered by community health workers. World Vision's Access-Infant and Maternal Health (AIM Health) programme implemented in Kenya, Mauritania, Sierra Leone, Uganda, United Republic of Tanzania (2012 – 2015), aimed to reduce newborn mortality rates by 20% from baseline. Improved practices at home such as breastfeeding in the first hour (77% increase), sustained exclusive breastfeeding, increased skilled birth attendance³⁴, and increased postnatal care— have all attributed to a strengthened Community Health workforce. The Australia Africa Community Engagement Scheme – East Africa Maternal, Newborn and Child Health³⁶ programme implemented in Kenya, Rwanda, Uganda, United Republic of Tanzania (2011 – 2016) demonstrated that postnatal care consultations increased by more than one-third, and early initiation of breastfeeding increased from 46.1% to 72.2%. These practices are reputed to impact newborn and child mortality and were attributable to CHW increased activity over the life of the programme.³⁵

[34] USAID ASSIST (2016) https://www.usaidassist.org/sites/assist/files/annual_performance_monitoring_report_nov16_final.pdf

[35] Year in Review 2016, World Vision International (2017) http://www.wvi.org/sites/default/files/ISH_25003_WV_HR_2016_Digital_FA.pdf

[36] Ibid

Country spotlight: Home visits for the newborn child in Afghanistan

Despite progress in reducing newborn mortality, about half of all births in Afghanistan occur at home and without skilled care. Forty-eight per cent of births are delivered in a health facility and only one third of women had postnatal care within two days of giving birth.

In March 2017, the Ministry of Public Health launched a position paper certifying at least two home visits for all home births: the first visit should occur within 24 hours of birth and the second visit on day three. If possible, a third visit should be made before the end of the first week of life. For babies born in a health facility, the first home visit should be made as soon as possible after the mother and baby come home. The remaining visits should follow the same schedule as for home births.

Programme components identified for implementation by the Ministry of Public Health:

- Identifying whether Community health workers (CHW) through the Community-Based Health Care department are the best channel for delivering postnatal home care, based on cost effectiveness and sustainability;
- Assessing the level and distribution of CHW and their competencies to deliver the required services and care for newborn survival;
- Developing regulatory and legal framework for CHWs to provide postnatal care;
- Recruiting, training and deploying health workers, including community level workers, to provide newborn care through postnatal home visits;
- Ensuring continued professional development and motivation of health workers, including CHWs;
- Strengthening the health system to support health workers to deliver postnatal newborn services and care, including regular supplies, supervision and referral links;
- Supporting communication efforts for community awareness and involvement in postnatal care.

UNICEF, WHO and partners are asked to support these actions by:

- Advocating, assisting and investing resources for the implementation of home visits for newborn care interventions;
- Working with government and non-government organizations to rapidly disseminate the Ministry of Public Health's position paper; NGOs and communities to start implementation of this strategy;
- Assisting capacity-building and functioning of health care providers and CHWs to provide home-based newborn care through the development and use of guidelines, training materials on community-based newborn care and other activities as needed;
- Helping with communication efforts promoting antenatal care, skilled care at birth and postnatal care for mothers and newborns.

Country spotlight: Barriers to uptake of community-based newborn care in Ethiopia

Supported by UNICEF, a qualitative barrier analysis study was conducted in October and November 2015 to identify the root causes of the low utilization of integrated community case management of childhood illnesses (ICCM) and community based newborn care (CBNC) services by exploring both demand-side and supply-side factors among 11 low-performing and four high-performing districts in Ethiopia: Amhara, Oromia, SNNP and Tigray Regions. Overall, knowledge of childhood illnesses, awareness about newborn care services, traditional beliefs and healing practices, perceived low quality of care, cost of care and distance and gender roles were the major demand-side barriers to utilization. On the supply side, three main barriers were identified; drug shortage, health post closures and limited skills and confidence of health extension workers in treating newborns. Weak ownership of ICCM/ CBNC programmes was considered to be the root cause for these barriers. The Federal Ministry of Health and UNICEF are building on these findings to improve care-seeking and provision of quality care through community-based programmes.

Country spotlight: Community Based Newborn Care Programme in Myanmar

The Community Based Newborn Care Programme (CBNBC) began implementation by the Ministry of Health of Myanmar in 2011 with support from UNICEF, through a range of interventions with an expanded role of auxiliary midwives and volunteers to scale it up across the country. It emphasizes early postnatal contacts: three home visits for normal deliveries and five visits for sick newborns (preterm or low birth weight). During the visit, the auxiliary midwives and volunteers promote and support early and exclusive breastfeeding; keeping the newborn warm through skin to-skin care; hygienic umbilical cord and skin care; assessment of danger signs and counsel on prompt recognition and care seeking; birth registration and support for sick newborns. The programme is contributing to increased coverage of home-based early newborn care and prompt referral of sick newborns. The National Strategic Plan for Newborn and Child Health Development 2015-2018 indicates CBNBC as one of the core programme strategies.³⁷

Country spotlight: Supporting work to improve community newborn health in Afghanistan, Djibouti, Iraq, Morocco, Pakistan, Somalia, Sudan and Yemen

A section called Guidance for Health Promotion was included in the Caring for The Newborn at Home package (WHO and UNICEF, 2015) which provides information for families seeking care from a skilled health professional for antenatal care and care at birth, and helping families adopt appropriate home care practices for the mother and baby during pregnancy and after childbirth³⁸. In 2016, programme managers from Ministries of Health in Afghanistan, Djibouti, Iraq, Morocco, Pakistan, Somalia, Sudan and Yemen convened to review and adapt the training contents of the 2015 global guidance to the local context and to incorporate it into existing platforms for maternal, newborn and child health and other relevant programmes. WHO and UNICEF are supporting country activities in coordination with international and national NGOs as well as other partners to make use of the existing elements of the health system to facilitate capacity-building and monitoring, to incorporate the training into pre-service curricula for relevant cadres and to establish a core team of national facilitators to support the training at the national and subnational level.

[37] Countdown to 2015: A Decade of Tracking Progress for Maternal, Newborn and Child Survival report (2015)

[38] UNICEF (2016). See [https://www.unicef.org/myanmar/NSP_for_Newborn_and_Child_Health_Dev\(Final\).pdf](https://www.unicef.org/myanmar/NSP_for_Newborn_and_Child_Health_Dev(Final).pdf)

Delivering for small and sick newborns

The Every Newborn Milestones on National Plans and on Quality of Care both call for particular action for small and sick newborns. Small and sick refers to newborns who are of low birth weight, preterm (that is to say born before 37 weeks gestation) and also includes newborns of normal weight and gestational age who are acutely ill and require inpatient care. These babies have the highest risk of death and morbidity and are associated with preterm birth and respiratory disorders, systemic infections, neonatal encephalopathy, pathological jaundice and congenital abnormalities. These newborns require inpatient care to survive, which necessitates readiness within services including preventive care (feeding support and thermal control, such as Kangaroo Mother Care [KMC] and prevention of infection), as well as treating complications like infections and jaundice. Service readiness involves infrastructure, equipment and commodities, as well as health workers with the correct training and skills and the involvement of the family in inpatient care.

The identification and timely management of care for small and sick babies is an area that needs to be addressed. Additionally, existing in-patient care is not well defined or standardized. A systematic approach to delivering high-quality inpatient newborn care is lacking. Currently, a situation analysis is under design to characterize the current landscape of inpatient facility-based care of small and sick newborns that can inform global dialogue, strategies and recommendations for programming.

Preterm birth complications, intrapartum related complications (including birth asphyxia) and neonatal infections cause 74 per cent of newborn mortality. The Every Newborn Tracking Tool maps the coverage of the following four specific newborn care interventions that address these primary causes of mortality for small and sick babies:

1. Use of antenatal corticosteroids
2. Resuscitation
3. Kangaroo Mother Care
4. Management of neonatal sepsis

Most countries have not included these four indicators in their national Health Management Information Systems (HMIS). This important area of work needs to be supported in 2017 and 2018 so that countries adopt and track these indicators in a consistent fashion (see Tables 9-12)

- 24 countries lack all four indicators in their national HMIS;
- India and Guinea are the only countries with all four newborn-specific indicators included in the national HMIS;
- Democratic Republic of Congo, Senegal and United Republic of Tanzania reported three indicators included in the HMIS: measuring resuscitation, KMC and management of sepsis;
- In Uganda, the existing system tracks cases of newborn-specific interventions like the treatment of neonatal sepsis, but does not record the treatment of cases.



1. Use of antenatal corticosteroids

Table 9: Inclusion of an indicator for the use of antenatal corticosteroids in the national HMIS

Only five countries have included an indicator to ensure measurement of the use of antenatal corticosteroids on their HMIS. This is despite the fact that 39 countries reported having antenatal corticosteroids on their NEML.

2016 (n=51)		
Yes	In process	No
Guinea, India, Islamic Republic of Iran, Jordan, Palestine (5)	Ethiopia, Ghana, Nigeria, Syrian Arab Republic, Togo, Uganda (6)	Afghanistan, Angola, Benin, Bhutan, Burkina Faso, Cameroon, Chad, China, Côte d'Ivoire, Djibouti, Democratic Republic of Congo, Egypt, Gambia, Guinea-Bissau, Indonesia, Iraq, Kenya, Lebanon, Lesotho, Liberia, Libya, Mali, Mauritania, Morocco, Myanmar, Nepal, Niger, Pakistan, the Philippines, Senegal, Sierra Leone, Sri Lanka, Sudan, Tunisia, United Republic of Tanzania, Viet Nam, Yemen, Zimbabwe (39)

Source: Every Newborn Tracking Tool 2016

In June 2016, Every Premie—SCALE project³⁹ conducted a study titled 'Policy and Implementation Landscape Analysis⁴⁰ on Antenatal Corticosteroids for Women at Risk of Imminent Preterm Birth' on behalf of the Newborn Health Technical Resource Team under the UN Commission for Life-Saving Commodities for Women and Children. The study looked at 6 countries; Democratic Republic of the Congo, Ethiopia, Malawi, Nigeria, Sierra Leone, Uganda and United Republic of Tanzania.

The study identifies crucial needs within health care systems for safe and effective use of antenatal

corticosteroids (ACS) that must be addressed by the international community as well as by national stakeholders. The document provides information on the levels of care where ACS is being used, which providers are authorized to prescribe and/or administer ACS, and the availability of critical maternal and newborn health care services in each country for safe and effective use of ACS. The analysis also explores how ACS use is being tracked in each country.

Research is ongoing at WHO on efficacy of antenatal corticosteroids in resource-limited settings.

[39] WHO (2015). See http://www.who.int/maternal_child_adolescent/documents/caring-for-the-newborn-at-home/en/

[40] Every Premie-SCALE project is funded by USAID and is a consortium of Project Concern International (PCI), Global Alliance to Prevent Prematurity and Stillbirth (GAPPS) and American College of Nurse-Midwives (ACNM)



2. Resuscitation

Table 10: National HMIS includes an indicator for the performance of resuscitation

Eleven countries reported having included an indicator on newborn resuscitation on the HMIS.

Yes	In process	No
Afghanistan, Djibouti, Democratic Republic of Congo, Ethiopia, Guinea, India, Islamic Republic of Iran, Palestine, Senegal, Uganda, United Republic of Tanzania (11)	Ghana, Nigeria, Syria, Togo (4)	Angola, Benin, Bhutan, Burkina Faso, Cameroon, Chad, China, Côte d'Ivoire, Egypt, Gambia, Guinea-Bissau, Indonesia, Iraq, Jordan, Kenya, Lebanon, Lesotho, Liberia, Libya, Mali, Mauritania, Morocco, Myanmar, Namibia, Nepal, Niger, Pakistan, the Philippines, Sierra Leone, Sri Lanka, Sudan, Tunisia, Viet Nam, Yemen (34)

Source: Every Newborn Tracking Tool 2016

Country spotlight: Improving Newborn Resuscitation in Rwanda

In 2015, Rwanda's National Neonatal Death Audit Report indicated birth asphyxia contributed to 38 percent of newborn deaths, with 60 to 70 percent of deaths occurring within the first 48 hours of birth. This was in a situation where over 90 percent of births were occurring in facilities (Rwanda DHS 2015). In 2011, the Ministry of Health of Rwanda had led the introduction and roll-out of the newborn resuscitation programme, Helping Babies Breathe (HBB), as part of in-service and pre-service midwifery training. However, a 2015 performance assessment for health providers conducted in 10 districts showed a low average score on newborn resuscitation skills (57 percent). Maintenance of skills among healthcare providers was therefore identified as a key bottleneck to improving care.

To address this, the Ministry of Health and its partners initiated a programme to improve newborn resuscitation practice starting with 10 districts. The programme included capacity-building on Essential Newborn Care, Helping Babies Breathe, post-training follow-up and mentoring, along with targeted Quality Improvement activities focused on facility readiness, data use for management and improvement and strengthening of newborn asphyxia audits. Five to six mentors per district utilized a low dose high-frequency modularized workplace training approach to build critical skills required by all health providers attending births. In one year, the district-based mentors could train and mentor around 500 health providers. HMIS data from the programme districts have shown a decrease in neonatal mortality due to birth asphyxia from 16.7 percent in 2015 to 15.5 percent in 2016. Birth asphyxia which used to be the highest cause of neonatal deaths in country is now the second highest cause of newborn death according to HMIS and the national Neonatal Death Audit Report 2016. A costing exercise for this program in four programme districts estimates that implementing the package at scale at approximately \$15,000 per district per year.

In addition, the Ministry of Health and partners have also implemented an integrated, low-cost health system capacity strengthening model called All Babies Count (ABC) in two districts. ABC increases provision of services by quality of care measures such as equipping health workers with essential supplies, provision of onsite, regular clinical mentorship and launching learning collaborative to promote peer learning, motivation and data utilization for continuous improvement. The ABC model showed a reduction in overall neonatal mortality by more than a third after 18 months, alongside a reduction in the overall number of cases of birth asphyxia. Four additional districts are now implementing ABC. A Paediatric Development Clinic has also been launched to follow up children with hypoxic ischemic encephalopathy, among other conditions, in two districts.

In December 2016, in collaboration with partners, the Ministry of Health convened a stakeholders' planning workshop to develop a national plan for birth asphyxia management through the systematic scale-up of in-country proven approaches. The national plan is now under development. The Rwandan Ministry of Health and partners exemplify the success of effective coordination in the practice of essential newborn care and newborn resuscitation within a very short period of time.

3. Kangaroo mother care/Skin-to-skin care

Kangaroo mother care (KMC) refers to the practice of providing continuous skin-to-skin contact between mother and baby and exclusive breastmilk feeding. Current evidence shows that KMC improves survival of preterm babies by 40%, with clear benefits when practiced continuously, reduces infection by 44 percent, reduced the risk of hypothermia by 66 per cent, increases exclusive breastfeeding by 20 percent, reduces stress in the baby, promotes bonding between mother and baby, and increases maternal confidence in caring for the baby.⁴¹ Promising research indicates

that KMC promotes better brain development with positive cognitive and social outcomes and potential cost benefits later in life. WHO is coordinating new research to address barriers to scale-up, and evaluate efficacy in the period of greatest risk, including KMC starting from birth and KMC at home. In 2016, eight professional associations issued a joint statement as a *Commitment to Action on KMC*.⁴² In 2016, only 11 of the 51 countries reported that an indicator on KMC was included in the national HMIS. (See Table 11)

Table 11: Countries reporting that the national HMIS includes an indicator for newborn's benefiting from Kangaroo Mother Care

Yes	In process	No
Bangladesh, Ethiopia, Democratic Republic of Congo, Ghana, Guinea, India, Mali, Nigeria, Senegal, Sri Lanka, United Republic of Tanzania (11)	Islamic Republic of Iran, Kenya, Liberia, Togo (4)	Afghanistan, Angola, Benin, Bhutan, Burkina Faso, Cameroon, Chad, China, Côte d'Ivoire, Djibouti, Egypt, Gambia, Guinea-Bissau, Indonesia, Iraq, Jordan, Lebanon, Lesotho, Libya, Mauritania, Morocco, Myanmar, Namibia, Nepal, Niger, Pakistan, Palestine, the Philippines, Sierra Leone, Sudan, Syrian Arab Republic, Tunisia, Uganda, Viet Nam, Yemen (35)

Source: Every Newborn Tracking Tool 2016

Country spotlight: One year of KMC in Pakistan

Four out of every 10 newborn deaths in Pakistan are due to prematurity and 25 per cent percent of babies have a low birth weight (DHS 2012-2013). Following an extensive training for master trainers from Pakistan on KMC at Da Nang Hospital in Viet Nam in June 2016, a four-bed KMC ward was established at the Services Hospital in Punjab province. By March 2017, 140 preterm babies had received KMC. This first KMC site supports roll-out to other hospitals, and master trainers have trained 80 health care providers from hospitals in Lahore, Punjab and Larkana, in Sindh. The Ministry of Health planned an advocacy seminar on KMC in mid-April 2017 to seek higher level political commitment and partner support for KMC implementation and towards the development of a national KMC Centre of Excellence.

11th Annual Workshop and Congress of the International Network on Kangaroo Mother Care

In November 2016, stakeholders including Ministries of Health, UN agencies, donors and implementing partners convened at the 11th International Network

on KMC Conference hosted by the WHO Collaborating Centre on Maternal and Child Health Burlo Garofolo in Trieste (Italy). The aim was to share knowledge on implementation of KMC including planning, training, coverage, quality of care, monitoring and evaluation, and priorities for investment, in different contexts and levels of care.

[41] <http://www.everypreemie.org/wp-content/uploads/2017/04/ACS-Landscape-Analysis-Updated-6Apr2017-Final.pdf>

[42] WHO recommendations on interventions to improve preterm birth outcomes (2016) http://apps.who.int/iris/bitstream/10665/183037/1/9789241508988_eng.pdf

Community of Practice for KMC

The Kangaroo Mother Care Acceleration Partnership (KAP) established a KMC community of practice among 7 priority countries with the goal of accelerating global and national level action to achieve 50 percent coverage of KMC among preterm newborns by the year 2020. KAP conducted a prioritization exercise to identify countries for the targeting of technical support to increase the coverage and quality of KMC. Bangladesh, Ethiopia, India, Indonesia, Malawi, Nigeria and Rwanda were selected based on the burden of preterm births, facility delivery rates, existence of national policy on KMC, presence of KMC champions and commitment and political will to support KMC implementation. In December 2016, experts and champions from the seven countries convened to develop action plans for accelerating KMC in their countries and to share knowledge and lessons learnt on implementation of KMC within health facilities. The Ministry of Health, Malawi will host the 2017 KAP community of practice meeting, when all seven priority countries will reconvene to share their progress and learning.

Improving the quality of care for breastfeeding mothers –Baby Friendly Hospital Initiative

‘Some 77 million newborns, or 1 in 2 are not put to the breast within an hour of birth, depriving them of the essential nutrients, antibodies and skin-to-skin contact with their mother that protect them from disease and death. Additionally, while the case of exclusive breastfeeding is sound and compelling, less than half of children under 6 months of age receive nothing but breastmilk for the first 6 months of life. Progress on exclusive breastfeeding is also slow – with only South Asia making notable strides the past 15 years’⁴².

“What, when and how children are fed, particularly in the first two years of life, is critical to health, development and survival.”⁴³ The Lancet Breastfeeding Series (2016) set out that 823,000 lives could be saved if all babies are fed nothing but breastmilk from the moment they are born until they are six months old⁴⁴. The Series presents a compelling case on the benefits for breastfeeding in protecting against child infections and malocclusion, increases in intelligence, and probable reductions in overweight and diabetes. For nursing women, breastfeeding gave protection against breast cancer and it improved birth spacing, and it

might also protect against ovarian cancer and type 2 diabetes.

In October 2016, UNICEF published *From the First Hour of Life: Making the case for improved infant and young child feeding everywhere*, which provides a global status update on infant and young child feeding practices and puts forth recommendations for improving them.

WHO and UNICEF continue to support the Baby-friendly Hospital Initiative (BFHI) as a means to encourage maternity facilities worldwide to adopt the Ten Steps to Successful Breastfeeding. In October, WHO hosted the 2016 Baby-Friendly Hospital Initiative Congress to celebrate the 25th anniversary of the initiative. Over 300 participants from 130 countries celebrated achievements in improving quality of care for breastfeeding mothers, but also worked on new guidance to implement the initiative. In May 2017, WHO are releasing a report on the current status of BFHI implementation globally⁴⁵. New guidance from WHO and UNICEF on the Ten Steps and their application will be published in the Fall of 2017.

[42] WHO recommendations on interventions to improve preterm birth outcomes (2016) http://apps.who.int/iris/bitstream/10665/183037/1/9789241508988_eng.pdf

[43] Health Professional Associations Commitment to Action on KMC (2017). See http://www.healthynewbornnetwork.org/hnn-content/uploads/PA-KMC-Joint-Statement_final_2017.pdf

[44] UNICEF, 2016 *From the First Hour of Life: Making the case for improved infant and young child feeding everywhere*. <https://data.unicef.org/wp-content/uploads/2016/10/From-the-first-hour-key-findings2016-for-web.pdf>

[45] The Lancet Breastfeeding Series (2016). See <http://www.thelancet.com/series/breastfeeding>

4. Management of Neonatal Sepsis

Table 12: Countries reporting that the national HMIS includes an indicator for the management of neonatal sepsis

Only 15 countries report having an indicator to capture the management of neonatal sepsis in national HMISs.

Yes	In process	No
Afghanistan, Burkina Faso, Djibouti, Democratic Republic of Congo, Ethiopia, Gambia, Guinea, India, Islamic Republic of Iran, Nepal, Pakistan, Palestine, Senegal, Sri Lanka, United Republic of Tanzania (15)	Ghana, Kenya, Liberia, Nigeria, Syrian Arab Republic, Togo (6)	Angola, Benin, Bhutan, Cameroon, Chad, China, Côte d'Ivoire, Egypt, Guinea-Bissau, Indonesia, Iraq, Jordan, Lebanon, Lesotho, Libya, Mali, Mauritania, Morocco, Myanmar, Niger, the Philippines, Sierra Leone, Sudan, Tunisia, Uganda, Viet Nam, Yemen (27)

Source: Every Newborn Tracking Tool 2016



Country spotlight: Supporting Bangladesh, Democratic Republic of Congo, Ethiopia, India, Malawi, Nigeria and Pakistan in implementing guidelines on managing possible serious bacterial infection in young infants when referral is not feasible

Infections are responsible for about one fifth of the world's annual 2.7 million neonatal deaths; up to 400 000 of these deaths were attributed to sepsis and meningitis, and 160,000 to pneumonia in 2015. In South Asia and Sub-Saharan Africa, about one quarter of all neonatal deaths is due to infections. Many sick infants have non-specific signs, and thus are not recognized to have infection. Even when the signs are detected, hospitalization and life-saving treatment may not be accessible, acceptable or affordable to families in settings with high newborn mortality.

Key studies in South Asia and in Africa indicate that up to two thirds or more of families do not accept referral for hospitalization of a young infant with signs of infection. To address this, in 2015, WHO developed a guideline, '*Managing possible serious bacterial infection in young infants when referral is not feasible*' (PSBI) that provides programmatic guidance on the role of community health workers and home visits in identifying signs of serious infections in neonates and young infants.⁴⁶

To support the implementation of the guideline, WHO, UNICEF and other partners developed a **Joint Statement** (2017)⁴⁷ to summarize a systematic process for managing sick young infants up to 59 days of age with Possible Severe Bacterial Infections in resource-limited settings. The Joint Statement provides options for the use of simplified antibiotic regimens that are both safe and effective for outpatient treatment of clinical severe infection and fast-breathing pneumonia among young infants weighing at least 1,5kg. It emphasizes that the standard of care remains referral to hospital for inpatient treatment for sick young infants with any sign of clinical severe infection or critical illness.

Stakeholders including WHO, UNICEF, USAID, Save the Children, John Hopkins University, Bill and Melinda Gates Foundation and Medicine Sans Frontiers are supporting, as part of implementation research, "an innovative approach to jump start simplified management of sick young infants with Possible Serious Bacterial Infection where referral is not possible". Currently, implementation has started in all the sites in Bangladesh, Democratic Republic of Congo, Ethiopia, India, Malawi, Nigeria and Pakistan. Tools and guidelines for implementation, monitoring and evaluation have been developed to facilitate action in countries. Next steps include:

- identifying and integrating critical indicators that are relevant to monitor PSBI implementation into the routine HMIS of the country such as DHIS2, to ensure real time monitoring of core PSBI indicators;
- organizing, by Technical Support Units in each country, of an orientation and dissemination meeting to share experiences gained and to create a platform for discussion on scaling up PSBI management as part of the overall child/newborn health strategy in the country;
- supporting countries in documenting their experiences and creating or integrating a newborn learning platform for wide dissemination and sharing of community practices within existing platforms.

[46] See more at <http://www.who.int/nutrition/publications/infantfeeding/bfhi-national-implementation2017/en/>

[47] Managing possible serious bacterial infection in young infants 0-59 days old when referral is not feasible (WHO, 2016) http://apps.who.int/iris/bitstream/10665/181426/1/9789241509268_eng.pdf.

Country spotlight: Service readiness for small and sick newborns in Malawi

The Every Newborn Measurement Improvement Road Map is following a systematic approach to:

1. Define the content (service readiness functions) needed to provide inpatient care of small and sick newborns at different levels of the health system;
2. Evaluate current measures of service readiness and develop a consistent set of measures that could be used in Health Facility Assessment or HMIS;
3. Undertake quantitative analyses comparing data available in Health Facility Assessment and HMIS for one country;
4. Apply qualitative methods to identify both barriers and facilitators in order to improve the data.

Malawi showed the fastest progress among African countries in reducing NMR during the MDGs, and has recent Health Facility Assessment data as well as relevant HMIS indicators. Hence, an analysis of data from 87 hospitals in Malawi is being undertaken, comparing estimates of select maternal and newborn indicators from routine facility-based systems (DHIS-2), with a national Emergency Obstetric Care health facility assessment. Qualitative methods are being applied to identify barriers and facilitators needed to improve these data, and perception of value and the use of data, with the aim of informing the refinement of existing measurement tools in Malawi with implications for measurement approaches in other settings.

In order to contribute to the wider global learning and development of new approaches to measure service readiness for inpatient care for small and sick newborns, discussions are underway with further country teams to consider the possibility of this analysis being replicated in other settings. This was recently discussed at a formal workshop in December in Kigali (Rwanda) in 2016, coordinated by Saving Newborn Lives, Save the Children and the Kangaroo Mother Care Acceleration Partnership. It was attended by teams from Nigeria, Rwanda and Ethiopia. Research is currently underway in Malawi.

Responding to the Zika epidemic

The emergence of Zika and its implications in terms of reproductive health and impact on the newborn have posed a great challenge. In 2016, in the Latin America and the Caribbean Region, activities focused mainly on providing technical cooperation to countries in order to respond to needs within the framework of activities coordinated from the Incident Management System, participation and/or coordination of technical meetings, development of technical documents, development of specific materials and tools, and inter-programmatic coordination. Technical cooperation missions initially focused on affected countries, but extended to all countries in the region. In the context of interagency

cooperation, it was part of the consolidation and systematization of the available information in order to progress towards a characterization of the consequences in the newborn, the characterization of the congenital syndrome associated with Zika and the strengthening of actions related to prevention, diagnosis, surveillance and monitoring of newborns. To this end, technical documents with specific guidelines, tools for the evaluation of microcephaly and prenatal diagnosis of the congenital syndrome associated with Zika at the time of birth of were developed. Activities were also coordinated to harmonize research studies in development in Latin America.

Global Working Group on Improving Care for Small and Sick Newborns

The care of small and sick newborns is a critical area of effort required in order to accelerate progress to end preventable newborn mortality. A global working group is providing leadership in these areas:

1. Knowledge: Improve our understanding of the situation of and barriers to improved care for small and sick newborns

- Prepare and publish a situational analysis of sick newborn care and disseminate in countries;
- Prepare a State of the World's Care of Small and Sick Newborn to be published in 2018 with guidance from health care professional associations.

2. Improve policy and guidance:

- Support countries in including the coverage of the four essential interventions in national HMIS;
- Support the careful introduction and implementation WHO 'Recommendations to Improve Preterm Birth Outcomes' (2016)⁴⁸
- Prepare National, District and Facility Guidance and Standards on the Quality of Care the Care for Small and Sick Newborns.

3. Improve the capacity of health caregivers to care for the small and sick newborn: Define the neonatal nurse cadre, commence the tracking of numbers at a national level and define a standard training package.

In 2016, a Commitment to Action from Professional Health was issued in a *Joint Statement on Recommendation to Improve Preterm Birth Outcomes*. This was endorsed by the Council of International Neonatal Nurses (COINN), the International Confederation of Midwives (ICM), the International Council of Nurses (ICN), UNICEF, WHO and John Hopkins University, the International Federation of Gynaecology and Obstetrics (FIGO), and the International Paediatric Association (IPA). This statement was also reviewed and endorsed by the American Academy of Paediatrics (AAP), the American College of Nurse-Midwives (ACNM), and the American Congress of Obstetricians and Gynaecologists (ACOG). This statement was developed by USAID's Every Premie-SCALE project and the Global Alliance to Prevent Prematurity and Stillbirth (GAPPS).⁴⁹

Revised preterm estimates 2017

The first national and global preterm birth estimates were published in 2012 in *The Lancet*⁵⁰ and 'Born Too Soon'⁵¹, and are now being repeated by WHO and are expected to be released by World Prematurity Day (November 17) 2017.

Low birth weight birth estimates

In 2012, the World Health Assembly adopted the target of reducing low birthweight (LBW) by 30 per cent between 2012 and 2025⁵², but as yet there have not been systematic estimates or time trends, and gathering data has proved to be challenging especially since many newborns are not weighed at birth. In order to improve the country-level and time-series data, the London School of Hygiene & Tropical Medicine has been working with UNICEF, WHO and John Hopkins University to increase the quantity and quality of LBW data through different measures including the following:

- Expansion of data from routine reporting systems;
- Improved methods to adjust LBW rate estimates from household survey data;
- Development of a model to estimate LBW rates and enhance comparability across countries in a transparent and objective manner.

Estimates are currently being finalized, and are scheduled for release late 2017. Despite improvements in data inputs and estimation methods, global LBW estimates continue to be hampered by substandard input data. Work is underway to improve the understanding of barriers to weighing at birth to improve the quantity and quality of data.⁵³

[46] See more at <http://www.who.int/nutrition/publications/infantfeeding/bfhi-national-implementation2017/en/>

[47] Managing possible serious bacterial infection in young infants 0-59 days old when referral is not feasible (WHO, 2016) http://apps.who.int/iris/bitstream/10665/181426/1/9789241509268_eng.pdf.

[48] WHO and UNICEF Joint Statement (2017) Managing possible serious bacterial infection in young infants 0-59 days old when referral is not feasible <http://apps.who.int/iris/bitstream/10665/254502/1/WHO-MCA-17.01-eng.pdf>

[49] WHO Recommendations to Improve on Preterm Birth Outcomes' (2016). See http://apps.who.int/iris/bitstream/10665/183037/1/9789241508988_eng.pdf

[50] http://www.who.int/pmnch/media/events/2017/lilongwe_statement_ptb.pdf?ua=1

[51] *The Lancet* (2012) See http://researchonline.lshtm.ac.uk/40396/1/1-s2.0-S0140673612608204-main.pdf__tid%3D6e9a5226-c455-11e5-8722-00000aacb362%26acd-nat%3D1453830871_1bfa5cad3ce2895d33a963f1f360c67a

[52] Born too Soon (2012). See http://www.who.int/maternal_child_adolescent/documents/born_too_soon/en/

[53] WHO Global Nutrition Targets 2025. See <http://www.who.int/nutrition/global-target-2025/en/>

Country spotlight: Born on Time - a Public-Private Partnership for Preterm Births in Mali

In 2016, in Mali, detailed needs assessment of 97 primary healthcare facilities were completed for provision of quality, gender-responsive, and adolescent friendly RMNCAH services. Mapping of existing community systems was undertaken to build a community supportive environment for timely accessing such RMNCAH services. Initial community mobilization has been conducted to raise awareness about preterm birth amongst public authorities, decision-makers and the community at-large. This work is supported by Save the Children and 'Born on Time: A Public Private Partnership to Prevent Preterm Birth in Mali' in five districts of the Sikasso region with financial support of Global Affairs Canada and Johnson and Johnson (2016-2020). This holistic, integrated initiative supports the acceleration of national efforts to reduce the newborn mortality rate of 38 per 1,000 live births and leverages the strengthened newborn component of the national RMNCAH plan.

Born on Time is working closely with local governments and community stakeholders in Bangladesh, Ethiopia and Mali. Born on Time is a five year initiative brings together expertise and resources from World Vision, Plan International, Save the Children, the Government of Canada and Johnson & Johnson to help ensure every child is born on time. The Born on Time Partnership⁵⁴ targets four areas termed the LINC factors (a) lifestyle, (b) infection, (c) nutrition and (d) contraception and specifically the leading risk factors for spontaneous preterm birth identified in Born Too Soon (2012), which include the age of pregnancy, pregnancy spacing, multiple pregnancies, infections, underlying maternal conditions (e.g. non-communicable diseases like high blood pressure and pre-gestational and gestational diabetes) and poor nutrition, lifestyle, occupation and psychosocial factors.

[54] <http://march.lshtm.ac.uk/2017/04/05/research-implementation-planning-workshop-next-steps-every-newborn-metrics-facility-based-study/>



3. Every Newborn Milestone: Investment in the health workforce

Develop or integrate costed human resources for health strategy into RMNCAH plans and ensure sufficient financial resources are allocated

Thirty countries reported that they have developed a human resources plan or strategy for skilled attendance at birth. In 2016, Afghanistan finalised a National Human Resources Strategy which is cross-referenced with the RMNCAH Strategy (2017-2021).

Table 13: Health workforce strategies

	Yes	In process	No
A human resource plan/strategy for skilled attendance at birth is in place	Afghanistan, Angola, Bhutan, Burkina Faso, Cameroon, Chad, Côte d'Ivoire, Djibouti, Democratic Republic of Congo, Egypt, Ethiopia, Ghana, Guinea, Guinea-Bissau, India, Indonesia, Islamic Republic of Iran, Kenya, Liberia, Morocco, Myanmar, Nepal, Niger, Pakistan, Palestine, Sri Lanka, Sudan, United Republic of Tanzania, Viet Nam, Zimbabwe (30)	Jordan, Libya, Nigeria, Senegal, Syrian Arab Republic (5)	Benin, China, Gambia, Iraq, Lebanon, Lesotho, Mali, Mauritania, Namibia, the Philippines, Sierra Leone, Togo, Tunisia, Yemen (14)

Source: Every Newborn Tracking Tool 2016

WHO and partners are supporting countries to implement the Global Strategy for Health Workforce (2016)⁵⁵ which was endorsed at the 69th World Health Assembly in 2016.

Health systems can only function with health workers; improving health service coverage and realizing the right to enjoy the highest attainable standard of health is dependent on their availability, accessibility, acceptability and quality. Mere availability of health workers is not sufficient: only when they are equitably distributed and accessible by the population, when they possess

the required competency, and are motivated and empowered to deliver quality care that is appropriate and acceptable to the sociocultural expectations of the population, and when they are adequately supported by the health system, can theoretical coverage translate into effective service coverage.

The Global Strategy on Human Resources for Health: Workforce 2030 is primarily aimed at planners and policy makers of Member States, but its contents are of value to all relevant stakeholders in the health workforce area, including public and private sector employers, professional associations, education and training institutions, labour unions, bilateral and multilateral development partners, international organizations and civil society.

[55] Born on Time. See <http://www.bornontime.org/>

4. Every Newborn Milestone: Health workforce capacity and support

Ensure the training, deployment and support of health workers, in particular midwifery personnel, nurses and community health workers.

Table 14: Countries reporting policies to support health workers' retention and competencies

Indicator	2016 (n=51)		
	Yes	In process	No
A retention policy/ strategy for skilled attendance at birth or relevant cadres is in place	Afghanistan, Burkina Faso, Cameroon, Egypt, Ethiopia, Gambia, India, Islamic Republic of Iran, Nepal, Niger, Palestine, Senegal, Sudan, Syrian Arab Republic, Uganda, United Republic of Tanzania, Uganda, Viet Nam, Zimbabwe (18)	Liberia, Nigeria (2)	Angola, Benin, Bhutan, China, Côte d'Ivoire, Djibouti, Democratic Republic of Congo, Ghana, Guinea, Guinea-Bissau, Indonesia, Iraq, Jordan, Kenya, Lebanon, Lesotho, Libya, Mali, Mauritania, Myanmar, Namibia, Pakistan, the Philippines, Sierra Leone, Sri Lanka, Togo, Tunisia, Yemen (28)
Competency- and skill-based service/ training/ education for maternal and newborn health	Afghanistan, Angola, Benin, Bhutan, Burkina Faso, Cameroon, Chad, China, Côte d'Ivoire, Djibouti, Democratic Republic of Congo, Egypt, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, India, Indonesia, Islamic Republic of Iran, Iraq, Kenya, Lesotho, Liberia, Libya, Mali, Myanmar, Nepal, Niger, Nigeria, Pakistan, Palestine, Senegal, Sierra Leone, Sri Lanka, Sudan, Syrian Arab Republic, Togo, Tunisia, Uganda, United Republic of Tanzania, Viet Nam, Yemen, Zimbabwe (44)	Lebanon (1)	Jordan, Mauritania, the Philippines (3)

Source: Every Newborn Tracking Tool 2016

Table 14 shows the reported policies in place to support health workers' competencies and retention in the 51 countries. Only 18 reported having a retention policy or strategy for skilled attendance at birth.

- Gambia reported providing an allowance to staff as a retention strategy.
- In Senegal, the government is engaged in a process to make midwives available in health posts in 12 out of 14 regions by doubling the number of agents at the level of health posts.
- To retain staff in difficult or remote areas, Senegal offers contracts with higher salaries than those of public service staff and binds the position to health training.
- India drafted a national policy in 2014 to provide performance-based incentives for Skilled Birth Attendants who perform above a certain benchmark.
- Implementation of private wing schemes, education opportunities and career paths are retention mechanisms in place in Ethiopia.
- Uganda has a strategy in place for investing in housing for health workers in selected hospitals and paying bonuses to health workers in hard-to-reach areas.
- Liberia has developed a pay-per-performance scheme for health workers.

Forty-four countries report having a competency and skill-based training curriculum for maternal and newborn care. More information is needed on the content of the competency based training and maintenance of skills.

Country spotlight: Midwifery in Somalia

In Somalia, though the trend of maternal deaths burden reduced from 1990 to 2015 by 39 percent, the MMR remains very high 732 per 100,000 maternal deaths which includes deaths due to well-known causes: haemorrhage, sepsis and eclampsia. Newborn deaths have decreased to 40 per 1,000 live births in 2015 from 45 in 1990. The Somali Ministry of Health found the main challenges to be the shortage of maternal and child health human resources in all categories, low coverage for midwifery care with poor quality of care and limited capacity-building and skills strengthening. An effective response to the population needs to include addressing the shortage and misdistribution of health workers, the poor skills, limited financing and the lack of regulations. Although the supply of midwives is increasing in the country, the change in the density of midwives has not been significant over the past 10 years. Somalia is one of 22 Member states with less than 15 midwives per 10,000 population.

The National RMNCH Strategy 2016-2020 has a focus on improving midwifery care starting with increasing the number of qualified midwives by providing better support to education. Improving midwifery competencies in line with the International Confederation of Midwives and WHO mandates includes the development of norms, standards and guidelines, and ensuring that tools to strengthen midwifery are in place and adopted by policy-makers and programme managers. The UNFPA Country Office and WHO's East Mediterranean Regional Office jointly conducted a midwifery strengthening workshop with national midwifery programme managers, academia and researchers from 31 October to 2 November 2016, with the following objectives:

1. Update the situation Analysis on Somali midwifery programmes and care including components on education, regulation and service care;
2. Prioritize the main gaps to be addressed for strengthening Somali midwifery programmes;
3. Agree on selecting evidence-based interventions and addressing the main prioritized gaps.

Work is underway to take forward this planning.

Training package to improve the Quality of Care for Mothers and Newborns in Health Facilities: Learner Manual: Point of Care Quality Improvement⁵⁶

WHO South East Asia Regional Office in partnership with the All India Institute for Medical Science (a WHO Collaborating Centre), UNICEF, UNFPA and USAID prepared a training package for building capacity of healthcare teams in health facilities for continuous quality improvement of maternal and newborn healthcare. The focus is on the care of mothers and

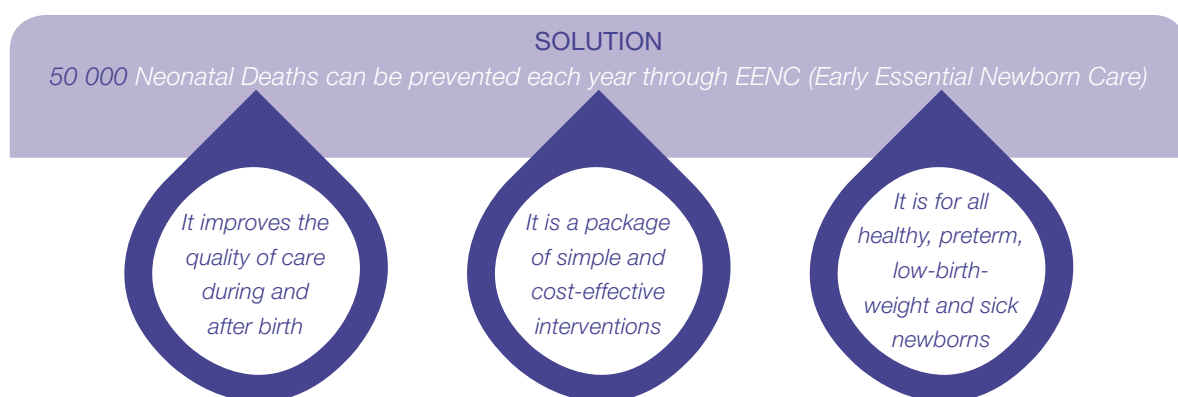
newborns at the time of child birth since a significantly large proportion of maternal deaths, newborn deaths and stillbirths happen around that time in the region. The 4-Step POCQI (Point of care Quality Improvement) package includes Coaching Manual and Learner Manual that present a demystified and simple model of quality improvement at the level of health facilities using local data to identify quality gaps, analyse underlying causes and improve health care practices in their own specific context without much additional resources. The learning methods include short presentations, group work, activities, games and video clips. The POCQI package will be used to build capacity of healthcare teams in the countries of the region and beyond.

[56] Global Strategy on Human Resources for Health: Workforce 2030 (2016) http://www.who.int/hrh/resources/global_strategy_workforce2030_14_print.pdf?ua=1

Coaching and mentoring to support the delivery of newborn care in the Pacific Region⁵⁷

Coaching and mentoring to support the delivery of newborn care has been introduced in 12 countries including in 8 priority countries that account for 98 percent of neonatal mortality in South East Asia (Cambodia, China, Lao People's Democratic Republic, Mongolia, Papua New Guinea, Solomon Islands, the Philippines and Viet Nam). Early Essential Newborn Care (EENC) is a package of evidence-based interventions demonstrated to reduce newborn mortality from the three largest causes: prematurity, birth asphyxia and sepsis. *Coaching has been found to vastly improve skills even where staff has been trained multiple times by other methods.* EENC has been introduced using a coaching approach that emphasizes changing health worker practices. Unlike traditional training, EENC coaching takes place on the job.

Figure 8: Early Essential Newborn Care Approach in the Pacific Region



Steady progress has been made in scaling up EENC in eight priority countries reaching 27,727 health workers in 2,258 health facilities with skills building through coaching (see Figure 21). EENC coaching for health providers has been conducted for routine childbirth and newborn care.

Principle features of the approach include:

- Two-day coaching in a delivery room to create a realistic environment;
- No lectures or presentations: facilitators must phrase what they want to say as questions, akin to the Socratic method;
- Health workers demonstrating their current practices unassisted to establish a baseline and coaching begins
- Facilitators coach participants until newborn care steps are mastered;
- Hand hygiene practice is always included

pre- and post-coaching evaluations of clinical practice, knowledge and hand hygiene ensure participants meet minimum standards;

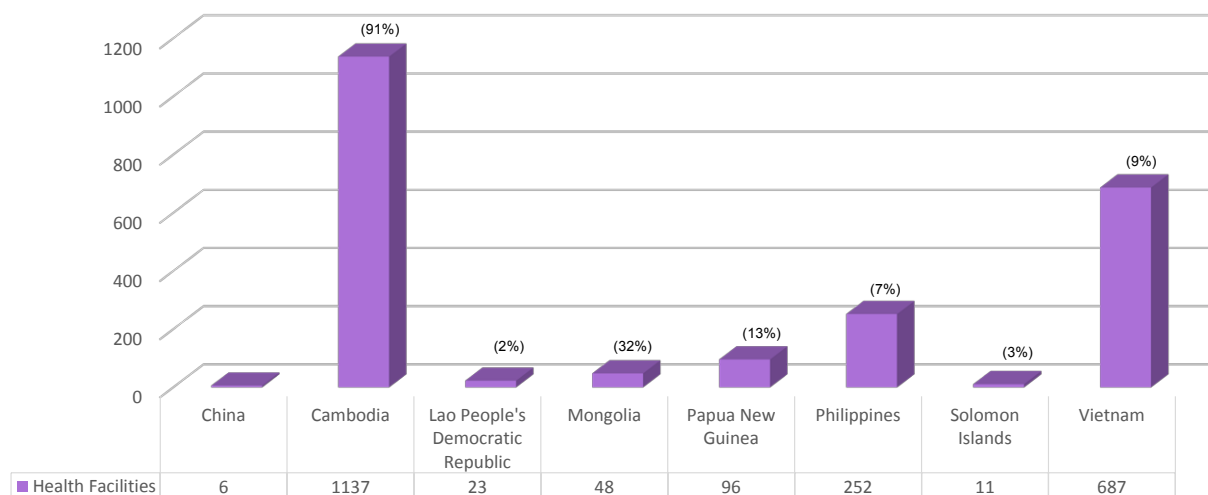
- A recommended facilitator-to-participant ratio of no more than 1:6 as the approach is practice-based.

Five Modules have now been prepared and two were published in 2016.

- Module 2: Coaching for the first embrace : facilitator's guide
- Module 3: Introducing and sustaining EENC in hospitals: routine childbirth and newborn care

Modules 1 (annual implementation review) and 4 (management of preterm and low birth weight babies) should be published this year; Module 5 (maternal complications should be published in 2018).

Figure 9: Total number of health facilities providing child birth services that has begun EENC coaching, by country, (July 2016)



WHO recommendations on antenatal care for a positive pregnancy experience (2016)

Endorsed, by the UN Secretary-General, WHO's new antenatal care model increases the number of contacts a pregnant woman has with health providers throughout her pregnancy from four to eight. Recent evidence indicates that a higher frequency of antenatal contacts by women and adolescent girls with the health system is associated with a reduced likelihood of stillbirths. This is because of the increased opportunities to detect and manage potential problems. Eight or more contacts for antenatal care can reduce perinatal deaths by up to 8 per 1000 births when compared to four or more visits.⁵⁸ A woman's 'contact' with her antenatal care provider should be more than a simple 'visit' but rather the provision of care and support throughout pregnancy. WHO recommendations allow flexibility for countries to employ different options for the delivery of antenatal care (ANC) based on their specific needs. This means, for example, care can be provided through midwives or other trained health personnel delivered at health facilities or through community outreach services.

Early Essential Newborn Care Course

The *Early Essential Newborn Care (EENC)* course offered by WHO is being updated to reflect the newly

published ANC guidelines, the updated *Pregnancy Childbirth Postpartum and Newborn Care: a guide for essential practice (PCPNC)* 3rd edition, and comments from users. The course has been enriched with video materials and linkages to tools for strengthening quality of newborn care. The EENC course is intended to be a resource for in-service and pre-service training. The course aims at improving health providers' skills in caring for newborns at the time of birth, before discharge and in the postnatal period at all levels of care, providing guidance for assessing and keeping the newborn healthy and identifying and managing high risk and sick newborns. It will be available by the end of 2017. This is aligned to the Early essential newborn care clinical practice pocket guide a Clinical Practice Guide developed by WHO Western Pacific Regional Office and which has now been translated into 7 languages.⁵⁹

Essential Child Birth Course

This is currently being prepared through a consortium of partners, led by WHO. The course is planned to be designed for skilled birth attendants (SBAs) who may wish to refresh their knowledge and understanding of intrapartum care with the aim for SBAs to reflect on their own provision of childbirth care in their local setting, review childbirth care, apply evidence-based guidance for clinical decision-making and enhance knowledge, skills and clinical decision making.

[58] Progress Report for the WHO Western Pacific Regional Office at <http://iris.wpro.who.int/bitstream/handle/10665.1/13424/9789290617822-eng.pdf>.

[59] WHO recommendations on antenatal care for a positive pregnancy experience (2016). See http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/anc-positive-pregnancy-experience/en/

Quality maternal and newborn care provision in the Global Strategy era

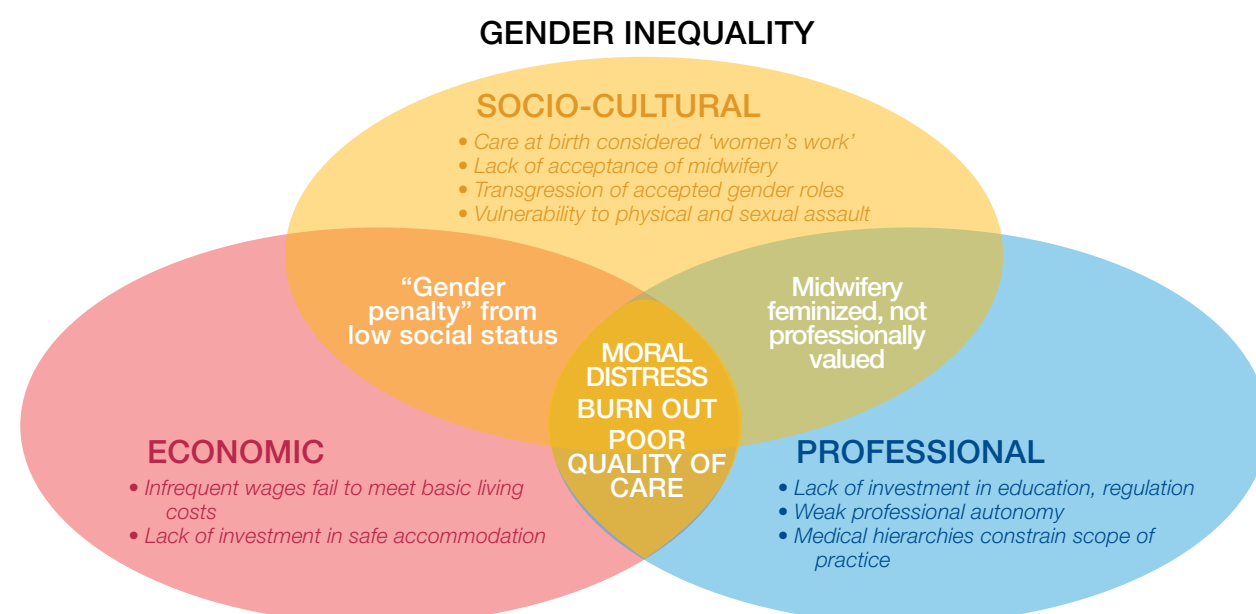
The Lancet Series Midwifery (2014)^[60] provides a framework for quality maternal and newborn care that firmly places the needs of women and their newborn infants at the center and defines midwifery as skills, attitudes and behaviours rather than a specific professional role. Maternal and newborn health care services are highly dependent on midwifery care for sustaining and strengthening services and improving health outcomes for mothers and newborns. Midwifery is associated with more efficient use of resources and improved outcomes when provided by health workers who are educated, trained, licensed and regulated, and midwives are only effective when integrated into a health system with effective teamwork and referral mechanisms and sufficient resources. As we know from the *State of the World's Midwifery (2014)*,^[61] there is a large shortage of health workers to provide the essential care for mothers and their babies. Seventy-eight per cent of the countries of highest burden of maternal and newborn mortality and stillbirth are facing serious shortages in midwifery that will result in preventable deaths of women and babies. This situation results in significant negative impact on health workers.

The **'Midwives voices midwives realities'**^[62] report published by WHO in 2016 documents the mental

distress, burnout and fear that professionals experience due to being unable to provide the care that they wanted to. The themes that emerge in the report show that midwives are deeply committed to providing the best quality of care for women, newborns and their families. But they are also deeply frustrated by the realities they experience that constrain their efforts. Importantly, they express how they are hindered through a lack of voice in creating the change and delivering the creative solutions they know are so badly needed. These experiences are universal across the information collected regardless of whether midwives care for women and newborns in high-, middle- or low-income countries. The report highlights that it is not just about fixing financial resources or health systems, but about addressing complex hierarchies of power and transforming gender dynamics. Respondents highlighted that "power, agency and status" is important for midwifery personnel if progress is to be made in delivering quality care.

The barriers described by midwives align with an analytical framework developed by WHO's systematic mapping of social, economic and professional barriers that prevent quality care and a systematic review of interventions that help overcome these difficulties. Responding to the urgent need to support health professionals, global partners are collaborating on a global mapping on competencies reported by educators, and a situation analysis on the care of small and sick newborns.

Figure 10: Barriers to the Provision of Quality Care by Midwifery Personnel



[60] Early essential newborn care clinical practice pocket guide (translated into 6 and soon 7 languages, WHO Western Pacific Regional Office) http://iris.wpro.who.int/bitstream/handle/10665.1/10798/9789290616856_eng.pdf?sequence=3.

[61] The Lancet Midwifery Series (2014) <http://www.thelancet.com/series/midwifery>

[62] The State of the World's Midwifery (2014). See <http://www.unfpa.org/sowmy>

5. Every Newborn Milestone: Community engagement

Involve communities, civil society and other stakeholders to increase demand and ensure access and coverage of essential maternal and newborn care

By 2016;

- 20 countries had developed national communication strategies while another 2 were in process.
- 29 countries have a community engagement strategy for maternal and newborn health.

Social, behavioural and community engagement (SBCE) interventions are increasingly recognized as an essential element of health strategies for women, children and adolescents. Countries have reported using existing networks and mechanisms of community mobilization including local community health workers, mothers' groups and village health teams or village development committees.

- Nepal reported to have implemented a national community engagement strategy across all 75 districts of the country through more than 55,000

female community health volunteers and mothers' groups established under each volunteer.

- Guinea reports on a Maternal and Newborn Health community engagement strategy in all 38 districts.
- Côte d'Ivoire has implemented a community engagement strategy as part of the community Integrated Management of Childhood Interventions in 45 districts and this includes a Husband's school and community dialogue programme in 14 out of 82 districts.
- Seventy-one districts are covered under the community mobilization strategy in Niger.
- Bhutan reported to have a 'National Health Promotion Strategic Plan 2015-2023' across all the 20 districts which is guided by 'life course interventions' that cover newborns.
- Sri Lanka is also implementing a community engagement strategy across all 25 districts.

Table 15: Status of National Community Maternal and Newborn Engagement Strategies

	Yes	In process	No
A maternal and newborn health community engagement/ mobilization strategy in place	Afghanistan, Bangladesh, Bhutan, Burkina Faso, Cameroon, Côte d'Ivoire, Democratic Republic of Congo, Egypt, Ethiopia, Ghana, Guinea, Guinea-Bissau, India, Indonesia, Kenya, Liberia, Morocco, Myanmar, Namibia, Nepal, Niger, Nigeria, Pakistan, Palestine, Senegal, Sierra Leone, Sri Lanka, Uganda, United Republic of Tanzania (29)	(0)	Angola, Benin, Chad, Djibouti, Gambia, Islamic Republic of Iran, Iraq, Jordan, Lesotho, Libya, Mali, Mauritania, the Philippines, Sudan, Syrian Arab Republic, Togo, Tunisia, Viet Nam, Yemen (19)

Source: Every Newborn Tracking Tool 2016

Country spotlight: Bangladesh's strategy for behavioural change communication

Bangladesh has launched a Social Behavioural Change Communication and Engagement activity to promote healthy maternal and newborn behaviour to ensure immediate and essential newborn care at all levels of service provision and provide special care for small and sick babies. The 4th Health Population Nutrition Sector Programme (2017-2021), approved in March 2017, includes the National Newborn Health Program and plans which includes implementation of SBCC activities as part of the comprehensive newborn care package.

In 2015, the Ministry of Health and Family Welfare piloted a comprehensive newborn health package in Kushtia district. The package included a set of evidence-based high-impact interventions for delivering services and improving household practices. The package includes a well-designed strategy to promote high-impact newborn care practices and care-seeking for complications. The strategy was developed with technical assistance from Save the Children. The SBCC approaches are undertaken at four levels:

1. Through health system contacts: counseling during home visits by health workers, during ANC and at discharge after deliveries in facilities.
2. Through community engagement: mobilizing community groups through community clinics.
3. Through multi-sectoral engagement: engaging public representatives, NGO workers, schoolteachers and community leaders to create an enabling environment for community care.
4. Through mass media: using both local and national mass media raise awareness regarding newborn care, and to improve care-seeking practices.

Community Empowerment in the Global Strategy era

The Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health and SDG targets aim to ensure women, children and adolescents 'survive', 'thrive' and 'transform'. The key focus of the 'Transform' pillar of work is on 'Empowering women, girls, families and communities as agents of change for the 2030 Agenda through a partnerships approach'.

Synthesizing research and guidance on community engagement - and research on the experience of care

In 2015, WHO recommendations on health promotion interventions for maternal and newborn health were published.⁶³ Since then, additional efforts have been undertaken to strengthen the evidence base for a broader package of social, behavioural and community

engagement interventions for RMNCH. This work is intended to strengthen the uptake of interventions designed to strengthen women, family and community capacity to contribute to improved MNCH as well as strengthen mechanisms for community engagement for health within country strategies. This activity can improve the information and learning that is available such as developing greater understandings of outcomes and the ways to strengthen impact. The following two products are to be released later in 2017:

1. Evidence Gap-Map for social, behavioural and community engagement interventions for RMNCH

To support the implementation of effective and sustainable programmes, decision makers need

access to high quality evidence on intervention effects, particularly for SBCE interventions where global guidance is currently less prevalent. A large number of impact evaluations and systematic reviews on the effects of SBCE interventions are produced every year, but these studies are not always published and are scattered across different academic databases and websites. As a result, existing research may not be accessed and used optimal, and it is also not clear that new research is strategically targeted to address important evidence gaps. WHO has worked together with the International Initiative for Impact Evaluation (3ie) to develop an evidence Gap Map, with input from an expert group to inform policy makers and programme managers of the current state of evidence (existing primary research and systematic reviews) of selected SBCE interventions, and also help to highlight potential priorities for guidelines for those areas where substantial primary research and/or evidence reviews already exist. The Partnership for Maternal, Newborn & Child Health, Norwegian Agency for Development Cooperation and USAID have helped to fund the activity.

2. Toolkit to strengthen district-level integration of health promotion/SBCE interventions for Maternal and Newborn Health

WHO and the Swiss NGO Enfants du Monde have published a toolkit to support countries in strengthening the integration of health promotion/SBCE interventions for MNH in strategies at the district level as well as strengthen processes to ensure that these strategies and plans are developed with the voices of women, communities and local authorities along with the health services. One effective way to contribute to the empowerment of individuals, families and communities is to enlist their participation throughout the health programming cycle, beginning at planning and continuing through the implementation of interventions, monitoring and evaluation. Five modules were designed to support district health teams in strengthening participation in these different steps.



6. Every Newborn Milestone: Parents voices and Champions

Shift social norms so that it is no longer acceptable for babies to die needlessly, just as it has become unacceptable for women to die giving birth

Developing and supporting champions that advocate for newborn health is a core component of shifting social norms so that it is no longer acceptable for babies to die needlessly, just as it has become unacceptable for women to die giving

birth. This is an enabling and effective component of a national communication strategy. By 2016, 20 countries reported that they had developed national communication strategies while this is in process in China and India

Table 17: Status of National Communication/Advocacy Strategies

	Yes	In process	No
A national communication strategy on newborn health developed	Afghanistan, Bangladesh, Benin, Bhutan, Cameroon, Côte d'Ivoire, Djibouti, Ghana, Kenya, Liberia, Morocco, Nepal, Niger, Nigeria, Pakistan, Palestine, Senegal, Sri Lanka, Uganda, United Republic of Tanzania (20)	China, India (2)	Angola, Burkina Faso, Chad, Democratic Republic of Congo, Egypt, Ethiopia, Gambia, Guinea, Guinea-Bissau, Indonesia, Islamic Republic of Iran, Iraq, Jordan, Lebanon, Lesotho, Libya, Mali, Mauritania, Myanmar, Namibia, the Philippines, Sierra Leone, Sudan, Syrian Arab Republic, Togo, Tunisia, Viet Nam, Yemen, Zimbabwe (29)

Everyone can be a champion for newborns and stillborns who are a group without a voice that depend on others to champion their cause.

Newborn health champions have been at the forefront of advocating for robust policies and programmes to reduce global neonatal mortality. Clinicians (midwives, paediatricians, obstetricians), members of parliament, ministers of health and finance, parents, journalists, celebrities, donors and many other champions have worked together to increase the availability of and access to routine and emergency newborn care services and supplies, improve the quality of newborn care services and supplies, and increase knowledge of and demand for newborn care.

Saving Newborn Lives Champion toolkit

Based on its experience partnering with champions, Save the Children's Saving Newborn Lives programme developed the Saving Newborn Lives – Champions Toolkit, that provides guidance and tools to help help stakeholders to strategically partner with champions for maximum impact. Working with champions is one of many strategies, but an important one and critical for raising the profile of the issue of newborn health.

The toolkit may be accessed at www.healthynewbornnetwork.org/resource/saving-newborn-lives-champions-toolkit/.⁶⁴

Country spotlight: Ghana's Newborn Champions

"Identifying your stakeholders and involving them at each stage from conceptualization, planning, implementation and monitoring are very important. Taking time to build consensus before moving ahead is critical. This creates ownership and long-lasting partnerships. Equally important is opening your mind to new stakeholders and embracing them."

~ Dr. Isabella Sagoe-Moses, Child Health Coordinator, Ghana Health Service

Champions within Ghana's Ministry of Health and Ghana Health Service drive newborn health progress through their systematic engagement of a broad range of stakeholders.

Ghana provides a strong example of how government commitment and leadership with the engagement of key stakeholders and champions can lead to the prioritization of newborn health. The National Newborn Sub-committee provides a platform for engagement for a multitude of stakeholders across the public and private sectors, national and international partners, civil society and the media and key development stakeholders as well as Ghana Health Service staff from all regions, teaching hospital staff and other Ministry of Health agencies. This innovative partnership has raised public awareness of newborn survival issues and generated increased funding and support.

As part of the National Newborn Health Strategy and Action Plan 2014–2018, an advocacy group was formed to spearhead efforts at reducing neonatal mortality.

Known as the Newborn Champions, these champions have undergone a training session organized by the Ghana Health Service in collaboration with UNICEF and PATH Global Health, on how to engage the public, policy makers and corporate bodies on the need to ensure babies live beyond their first 28 days. There are both National and Regional Newborn Champions.

Champions for newborn health are in all walks of life. In Ghana, visible national champions include a paediatric surgeon, Professor Afua Hesse; the CEO of Premier Productions Group, Nanahemaa Adwoa Awindor; the host of Stand Point, Nanayere Gifty Anti Executive Director of Salt and Light Ministries, the Rev. Dr Joyce Aryee, banker Kobby Mannoh; the Chief Imam, Shiekh Dr Osmanu Nuhu Shaributu and freelance journalist Betty Kankam Boadu. Reverend Joyce Aryee has used her religious radio programme to discuss the importance of newborn care. Gifty Anti, a seasoned journalist and media personality, has devoted one of her weekly television shows to Ghana's newborn care issues. A rapper, Sarkodie, raps on the benefits of breastfeeding.

Newborn champions in the regions. Newborn champions in the regions are drawn from religious leadership, *traditional leadership and health and social partners, work closely together to encourage all persons to support newborn survival.* They reach people at community durbars, in the pulpit, in market places, at social events and on radio, television, Facebook and other social media with the message that newborns can and should be helped to survive. In April 2017, the newborn champions, led by Nanahemaa Adjoa Awindor, launched a national campaign in Dormaa in the Brong Ahafo Region to mobilize materials and funds to support health care institutions to improve newborn care. PATH and UNICEF support the identification, orientation and activity planning of the champions.

Country spotlight: Malawi's ban on child marriage

On 14 February 2017, the Malawi Parliament took a landmark decision towards advancing health and gender equality by banning child marriage in the country. The Parliament unanimously adopted a constitutional amendment that raises the minimum age of marriage from 15 to 18 years, for both girls and boys. The amendment aligns the Constitution with the 2015 Marriage, Divorce and Family Relations Act enacted by the Parliament.

Malawi has one of the world's highest rates of child marriage with 9 percent of girls married by 15 years and 46 percent married by age 18.⁶⁵ Teen pregnancies contribute to 20-30 percent of maternal deaths in the country⁶⁷ and this is a proven high risk factor for preterm birth.⁶⁶ Malawi has the highest preterm birth rate in the world with 18 out of 100 births taking place before 36 weeks' gestation.

Civil society came together to demand the harmonization of the constitutional and legal frameworks to address child marriage. Specifically, this included advocating with Parliament to adopt the definition of a child as a person below the age of 18 in the constitution in line with the relevant legal frameworks and the international commitments that the government has ratified. A number of national technical working groups presented the impact of child marriage on health outcomes and projects like Reducing Teenage Pregnancies have long championed the review of child marriage.

This amendment will change the lives of many girls and will provide advocates the platform with which to ensure the law is implemented. The amendment also provides an opportunity to empower girls, parents and traditional leaders to stand together for child rights.

World Prematurity Day: Amplifying parents' voices

World Prematurity Day is a key moment to focus global attention on the leading cause of child deaths under age 5 – complications from preterm birth – which account for over almost deaths each year. World Prematurity Day 2016 did so by drawing on the newly released cause of death estimates published in *The Lancet* and the year's theme was on innovations that show the most promise in transforming the prevention, diagnosis and management of preterm birth.

Celebrations for the 6th annual World Prematurity Day on 17 November 2016 were held in more than 120 countries with support from parent groups, researchers, governments, civil society and more. This annual advocacy day remains a pivotal moment across the globe to engage parents, health workers, partners, governments and media around issues of preterm birth to champion the survival and wellbeing of babies born too soon. More than 200 special events worldwide were recorded. Columbia, Egypt, Ethiopia, Saudi Arabia and Thailand were among the countries to hold major national events. Nigeria and Nepal had high level

events to launch their national Newborn Action Plans. The international health care professional associations launched the Kangaroo Mother Care Joint Statement in Washington, D.C.

Social media increased awareness and drove online conversations with more people than ever participating in a Thunderclap on Twitter and on Instagram. The World Prematurity Day Facebook page alone reached about 5.4 million people. The number of purple lightings, one of the symbols of this awareness day, increased by about 20 percent, with 225 buildings reportedly lit purple to mark the day. Celebrity champions also helped elevate awareness on social media and through media articles. The growth of World Prematurity Day has been due to the work of dedicated parent groups and partners around the world to ensure prevention of and care for preterm birth remains a global health priority. Efforts for this advocacy day support the Every Woman Every Child movement.

[65] The toolkit may be accessed at www.healthynewbornnetwork.org/resource/saving-newborn-lives-champions-toolkit/.

[66] UNICEF (2016). Available at <https://data.unicef.org/topic/child-protection/child-marriage/>.

[67] UNICEF (2013). Child Marriages: 39,000 Every Day. Available at https://www.unicef.org/media/media_68114.html.

7. Every Newborn Milestone: Data

Count every newborn by using and improving programmatic coverage data including equity and quality gap assessments. Institutionalize civil registration and vital statistics, adapt and use a minimum perinatal dataset, implement maternal and perinatal death surveillance and response

Audit and review of stillbirths and neonatal deaths

Nearly all babies who are stillborn and half of all newborn deaths are never recorded meaning that they do not receive a birth or death certificate, and thus have never been registered, reported or investigated by the health system. As a result, countries often do not know the true numbers of deaths or the causes of these deaths and are unable to understand the true magnitude of the problem will not know what effective and timely actions to take to prevent more babies and mothers from dying.

Mortality review is a key strategy for reducing preventable deaths among mothers and babies by

generating data for decision-making. Mortality audits and reviews help health system managers understand the causes of death, and the contributing factors, so they are able to take corrective actions to improve the quality of care. It is an important mechanism for holding countries accountable for meeting targets to reduce stillbirths and maternal and neonatal deaths. In order to understand and address newborn health-related conditions and emerging health problems such as Zika, the establishment of a minimum perinatal data set in every country is necessary. A minimum perinatal data set ensures that all births and outcomes are in the HMIS and collated at higher levels. For each birth and death, it is essential to collect information on maternal age, place of delivery, mode of delivery, birth weight, gestational age and birth outcome.

Table 18: Countries reporting to have a perinatal audit system in place

2016 (n=51)		
Yes	In process	No
Angola, Cameroon, Chad, China, Democratic Republic of Congo, Egypt, Gambia, Ghana, Indonesia, Islamic Republic of Iran, Kenya, Lebanon, Myanmar, Namibia, Nepal, Nigeria, Palestine, Sri Lanka, Togo, Tunisia, Uganda, United Republic of Tanzania, Zimbabwe (23)	India, Jordan, Lesotho (3)	Afghanistan, Benin, Bhutan, Burkina Faso, Côte d'Ivoire, Djibouti, Ethiopia, Guinea, Guinea-Bissau, Iraq, Liberia, Libya, Mali, Mauritania, Morocco, Niger, Pakistan, Senegal, Sierra Leone, Sudan, Syrian Arab Republic, Viet Nam, Yemen (23)

Source: Every Newborn Tracking Tool 2016, UNICEF and WHO.

Regional initiatives are helping to drive this work. For example, the WHO South East Asia Regional Office in partnership with the All India Institute of Medical Science has established an electronic integrated

perinatal database across a network of 200 hospitals in nine countries and to date more than one million births have been documented.

Country spotlight: Sri Lanka's implementation of the National Feto-infant Mortality Surveillance System

Sri Lanka has long experience with the maternal death surveillance and response (MDSR) system but continues to have a large proportion of infant deaths in the early neonatal period and a high rate of stillbirths. In January 2016, the Ministry of Health initiated the National Feto-infant Mortality Surveillance System with a focus on perinatal death surveillance and response.

Sri Lanka has implemented the feto-infant surveillance to identify both the technical as well as health care management deficiencies resulting in perinatal deaths, so as to implement corrective actions in institutions and the field. Sri Lanka is the first country in the world to use the International Classification of Diseases-Perinatal Mortality at a national level. Pathological post-mortems have been made compulsory and guidelines have been developed and issued. This will definitely help to focus on high-burden causes at the national, district and facility levels.

Making Every Baby Count: Audit and Review of Stillbirths and Neonatal Death Guidance and Tools

In 2016, WHO developed a new international guidance document and accompanying tools *'Making Every Baby Count: Audit and Review of Stillbirths and Neonatal Deaths'* to help countries review and investigate individual deaths so they can recommend and implement solutions to prevent similar incidents in the future. The guide explains the essential steps needed to complete at least a basic death review, which is an in-depth investigation into causes and circumstances surrounding the death. For those countries that would like to classify perinatal deaths as well, the guide has also incorporated the ICD-PM classification which uses the codes from the International Classification of Diseases version 10 (ICD-10) for consistent classification.

The tools have been piloted among health workers

representing varying types and levels of health facilities in Bhutan, Moldova, Nigeria, Uganda and South Africa. Results of these pilot tests and reviews show the tools to have excellent acceptability, completeness, ease of use, efficacy and effectiveness in guiding future perinatal death reviews at the health facility level. This work is ongoing with a series of dissemination webinars planned for 2017.

Maternal death surveillance and response mechanisms⁶⁸

Official reports underestimate the true magnitude of maternal mortality by up to 30 percent worldwide and 70 percent in some countries.⁶⁹ *Time to respond: a report on the global implementation of maternal death surveillance and response (WHO, 2016)*⁷⁰ summarizes progress in implementing the MDSR and demonstrating that while 86 percent of countries have adopted a policy on maternal deaths notification, only 46 percent of countries have a functional mechanism to systematically report, review and respond to maternal deaths.

Table 19: Countries reporting to have MDSR mechanisms in place

2016 (n=51)		
Yes	In process	No
Afghanistan, Angola, Benin, Bhutan, Burkina Faso, Cameroon, Chad, China, Côte d'Ivoire, Democratic Republic of Congo, Egypt, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, India, Indonesia, Islamic Republic of Iran, Iraq, Kenya, Lebanon, Lesotho, Liberia, Mali, Morocco, Myanmar, Namibia, Nepal, Niger, Nigeria, Pakistan, Palestine, the Philippines, Senegal, Sierra Leone, Sri Lanka, Sudan, Togo, Tunisia, Uganda, United Republic of Tanzania, Viet Nam, Zimbabwe (44)	Djibouti, Jordan (2)	Libya, Mauritania, Syrian Arab Republic, Yemen (4)

Source: Every Newborn Tracking Tool 2016

[68] Born Too Soon (2012). See http://www.who.int/maternal_child_adolescent/documents/born_too_soon/en/

[69] Making Every Baby Count: Audit and Review of Stillbirths and Neonatal Death Guidance and Tools, WHO (2016) at Making every baby count: audit and review of stillbirths and neonatal deaths

[70] WHO (2016). See http://www.who.int/maternal_child_adolescent/news_events/better-data-stillbirth-maternal-death/background/en/

Of the 51 countries, forty-four countries stated having an MDSR mechanism in place in 2016 (see Table 18). Although a high number reports having a maternal and perinatal death surveillance system in place, it is difficult to gauge the exact scope and functionality of MDSR systems since the reporting countries provide limited information.

- Sri Lanka reported implementing a maternal death audit in all 65 hospitals at the facility, district and national level as a no-fault-finding exercise whereas perinatal death reviews also take place in the same hospitals in monthly meetings.
- In Niger, all 44 district hospitals and three referral maternity units, the Centre for Mother and Children and the Regional Hospital of Niamey are covered under maternal audits.
- Gambia reported to have maternal as well as perinatal death reviews in place in all seven hospitals and six major health facilities.
- All the 38 hospitals are implementing maternal mortality audits in Guinea.
- MDSR committees have been set up in all 21 government hospitals in Liberia working with the six private hospitals to ensure the functionality of the committees.
- Sierra Leone reported positioning MDSR in all 25 government hospitals as well as all 1,200 Public Health Units.
- India has reported that the Operational Guidelines in facilities are under development.
- In Lesotho, all the 10 district hospitals have a maternal death review system.
- MDSR is reported being implemented in health centres in addition to district hospitals in Ethiopia.
- In Afghanistan, the Ministry of Public Health Policy on maternal death notification within 24 hours was signed in March 2017-10 maternity hospitals are reporting on maternal death and cause of death according to WHO ICD-10 coding.

Country spotlight: Presidential decree for Maternal and Newborn Death Surveillance and Response in Liberia

In Liberia, a presidential decree was issued to request notification of all maternal deaths to the Ministry of Health and ensure accurate registration of births and death. While the Ministry of Health implements the Integrated Disease Surveillance and Response Strategy for surveillance activities across all levels, this was seen to provide little guidance to maternal and new born death surveillance and response.

In March 2017, **National Technical Guidelines on Maternal and Newborn Death Surveillance and Response** was released.⁷¹ It stresses the need to respond to each maternal and newborn death with actions to prevent similar deaths in the future, and to collect data on all maternal and newborn deaths using clearly defined data sources and processes for identification and notification. Key facets:

- **Maternal and Newborn Death Surveillance is integrated** so that rather than using scarce resources to maintain separate vertical activities, resources are combined to collect information from a single focal point at each level.
- **The district level is the focus for integrating surveillance functions.** This is because the district is the first level in the health system and responsible for monitoring health events in the community, mobilizing community action, and encouraging national assistance. Surveillance focal points at the district, county and national levels collaborate with epidemic response committees at each level to plan relevant public health response actions and actively seek opportunities for combining resources. The focus is on the creation of an overall public health surveillance system with sufficient capacity for detecting, confirming, reporting and responding to diseases and events of public health importance.

In Liberia, SBAs conduct only a third of all deliveries and most births occur at home, assisted by traditional midwives. For deaths outside facilities, community health volunteers are responsible for identifying deaths of all women of reproductive age and newborns and to report the death to the head of the health facility immediately or within 48 hours. The District Health Officer visits the community to investigate and determine whether the death was pregnancy-related and reports to the county surveillance officer and the catchment health facility.

[71] A Time to Respond – A report on the global implementation of Maternal Death Surveillance and Response (WHO, 2016) at <http://apps.who.int/iris/bitstream/10665/249524/1/9789241511230-eng.pdf>

A Time to Respond – A report on the global implementation of Maternal Death Surveillance and Response⁷³

In 2013, WHO published the *Maternal Death Surveillance and Response Technical Guide*⁷² to help countries strengthen their maternal mortality review process in hospitals and clinics and also monitor the deaths and causes of deaths to improve quality of care at all levels of the health system by learning from previous deaths. The document also provides guidance for establishing a safe environment for health workers to improve quality of care within clinics and an approach to recording deaths occurring outside the

health system, such as when mothers deliver at home. MDSR is a relatively new approach to investigating maternal deaths in real time by a maternal death review committee (a group of experts) so that health facilities can then take corrective actions. In 2015, to monitor its implementation, WHO and UNFPA have conducted a baseline survey among Member States with the results published in a report in 2016. The report describes a high policy commitment by Member States; however, the number of countries implementing MDSR fully, with functional MDSR committees in place at national and subnational levels, is significantly fewer. By WHO standards, committees should meet at least twice a year, but currently only 46 per cent of countries meet this standard.

Urgent Need for More Data

Maternal and Newborn Information Tracking for Outcomes and Results (MoNITOR)

In 2016, WHO established MoNITOR (Maternal and Newborn Information Tracking for Outcomes and Results) which is an expert group set up to harmonize maternal and newborn measurement efforts and provide guidance for improving national data collection capacities, based on evidence.⁷⁴ The group convened in January 2017 to determine a work plan and will meet in June 2017 to take forward this work. The work plan is led by WHO's MCA Monitoring and Evaluation Team in collaboration with global partners. To compliment this work, the team is working to establish one data platform to collate national data on MNCAH combining WHO Policy Surveys and the Every Newborn Tracking Tool and work led by the Health Data Collaborative and with DHIS 2.

ENAP Measurement Improvement Roadmap (2015-2020)

The ENAP Measurement Improvement Roadmap⁷⁵ was developed at a WHO technical consultation on newborn health indicators in 2014.⁷⁶ This plan highlighted the urgent need to coordinate technical work to define and improve coverage and quality of care metrics, particularly for care at birth and care of small and sick newborns. The plan aims to further opportunities to scale-up perinatal audits linked to maternal death surveillance, and to increase coverage of birth and death registration. The implementation is being led by the London School of Hygiene & Tropical Medicine and WHO, working with MoNITOR.

[72] Ministry of Health, Liberia, (2017). National Technical Guidelines for Maternal & Newborn Death Surveillance and Response Liberia, Monrovia, Republic of Liberia.

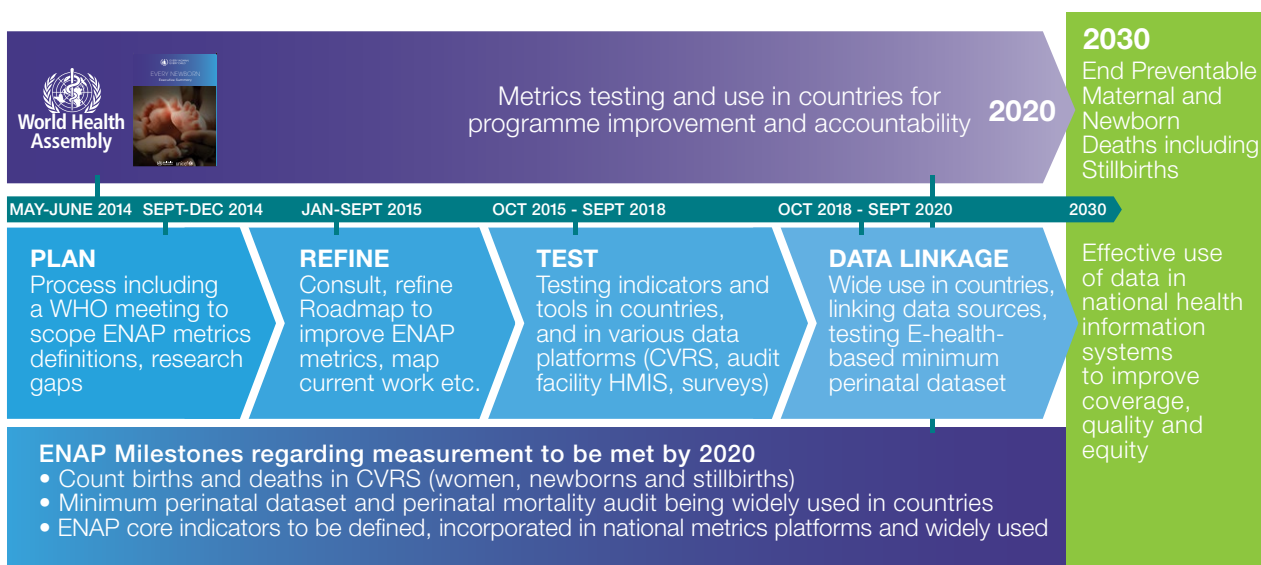
[73] Maternal Death Surveillance and Response Technical Guide, WHO (2016) at http://www.who.int/maternal_child_adolescent/documents/maternal_death_surveillance/en/

[74] A Time to Respond – A report on the global implementation of Maternal Death Surveillance and Response (WHO, 2016) at <http://apps.who.int/iris/bitstream/10665/249524/1/9789241511230-eng.pdf>

[75] http://www.who.int/maternal_child_adolescent/news_events/news/call-nominations-monitor/en/

[76] <https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-15-S2-S8>

Figure 11: ENAP Measurement Improvement Roadmap



1. Developing indicators of coverage and quality of care

One of the most frequent requests from countries is to have a short list of indicators that can be measured at all levels from facilities, districts and countries up to the global level, in order to drive coverage and quality of care.

There are indicators that can be used immediately in countries, notably those focussed on process for example the presence of a bag and mask. However,

for coverage and quality indicators research is greatly required to assess and prioritize a small number of coverage and quality indicators to ensure countries can accurately capture useful programmatic data.

Table 20 combines the ENAP and EPMM indicators that were selected based on wide expert consultation. These were chosen on the basis of the existing evidence available and they are currently being tested for their validity before further recommendation can be made national and global health facility monitoring activities.





Validating indicators for facility based coverage of quality care at birth in Bangladesh, Nepal, and Tanzania

Together, three sites aim to capture data on around 20,000 births and are comparing routine hospital register entries to observation data focused on the practise of prioritized ENAP and EPMM interventions. A range of denominator options will also be collected for assessment, in addition to data on routine practices for essential maternal and newborn care. Quantitative data will be collected using tablets with a software application developed specially for this purpose by the expert team at International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR, B). The aim is to assess the validity of these selected maternal and newborn health indicators to provide recommendations to national and global health facility monitoring systems. The indicators will subsequently be tested for feasibility of collection in routine HMISs. Some interventions – such as use of chlorhexidine cord cleansing or KMC – may also be measurable through household surveys and require separate work.

A pre-discharge maternal recall survey will assess which, if any, of these indicators may be feasible to measure in household surveys. These results are anticipated to have negative predictive value; if at the time of discharge women do not know if they (or their babies) had received a specific treatment, it is unlikely that they will be able to recall the same details 3-5 years later in a household survey (such as DHS or MICS).

Bangladesh: The ICDDR, B is coordinating the research in Bangladesh at a tertiary facility in Dhaka, the Maternal and Child Health Training Institute and two additional study sites in Kushtia: the District Hospital, a secondary facility, and Daulatpur Sub-district Hospital, a primary referral facility.

Nepal: UNICEF Nepal is funding and coordinating research at Paropakar Maternity and Women's Hospital. This is a government tertiary hospital in Kathmandu, with a strong track-record of research especially for newborn resuscitation and essential newborn care.

United Republic of Tanzania: Ifakara Health Institute in collaboration with Muhimbili University of Health and Allied Sciences are coordinating the research in Tanzania at two large hospitals, Muhimbili National Hospital and Temeke Municipal Hospital.

The Tanzanian team will lead a multi-country mixed methods assessment of barriers and enablers to routine data collection. This will include a time and motion study of how long health-workers spend recording data in registers, and how many times the same data point is recorded in various records. The aim is to improve data management systems, data quality, and to inform the design of electronic birth registers. Research undertaken in Bangladesh and Tanzania is funded by the Children's Investment Fund Foundation via the London School of Hygiene & Tropical Medicine.

Comparison of household survey methods to measure birth outcomes in INDEPTH sites in five countries

Led by INDEPTH Network, working with LSHTM and funded by ClIFF, Makerere University, Uganda is coordinating research with five sites; Matlab (Bangladesh), Dabat (Ethiopia), Kintampo (Ghana), Bandim (Guinea-Bissau) and Iganga (Uganda). These five sites have high quality pregnancy surveillance and are collaborating the following research.

There are four aims:

1. Improve Household Survey capture of stillbirths and neonatal deaths through a randomized assessment of whether the 'pregnancy history' approach produces a considerably better estimate of pregnancy outcomes than the current 'DHS-7 birth history' approach;
2. Improve Household Survey capture of birth weight and gestational age by assessing various methods for measuring these outcomes in surveys;
3. Optimize Household Survey data capture of pregnancy outcomes (stillbirths, neonatal deaths, birth weight and gestational age) to link and compare with survey data to examine what is missing and why.
4. Identify barriers and enablers of reporting of pregnancy losses in survey data and in the context of the Household Survey data collection.

Data collection, using tablets, is starting in mid-2017 and will involve surveying over 70,000 women. The results will inform the best approaches for measuring stillbirths, neonatal deaths and birth weight in large household survey platforms such as DHIS and MICS and how to optimise population based surveillance such as in INDEPTH.



Table 20: Every Newborn and EPMM core and additional indicators to track impact, coverage and equity^[77]

	EPMM Phase I Indicators	ENAP Indicators
Impact	1. Maternal mortality ratio	1. Maternal mortality ration
	2. Maternal cause of death (direct/indirect) based on ICD-MM	
	3. Adolescent birth rate	
		2. Stillbirth rate <i>Additional Indicator: intrapartum stillbirth rate</i>
		3. Neonatal mortality rate <i>Additional Indicators:</i> <ul style="list-style-type: none"> • Preterm birth rate • Small for gestational age • Neonatal morbidity rates • Disability after neonatal conditions
Coverage	4. Four or more antenatal care visits <i>Additional Indicator: Content of antenatal care</i>	<i>Additional Indicator: Content of antenatal care</i>
	5. Skilled attendant at birth	4. Skilled attendant at birth
	6. Institutional delivery <i>Additional Indicator: Respectful maternity care</i>	
	7. Early postnatal/postpartum care for woman and baby (within 2 days of birth)	5. Early postnatal care for mothers and babies
	8. Met need for family planning	
	9. Uterotonic immediately after birth for prevention of postpartum hemorrhage (among facility births)	
		6. Essential newborn care (tracer is early breastfeeding) <i>Additional Indicator: Exclusive breastfeeding up to 6 months</i>
		7. Antenatal corticosteroid use
		8. Newborn resuscitation
		9. Kangaroo mother care, feeding support
		10. Treatment of severe neonatal sepsis <i>Additional Indicator: Chlorhexidine cord cleansing</i>
	10. Caesarean section rate <i>Additional Indicator: Met need for emergency obstetric and newborn care (EmONC)</i>	<i>Additional Indicator: Caesarean section rate</i>
Inputs	11. Maternal death registration	Birth registration <i>Additional Indicator: Death Registration, cause of death</i>
	12. Availability of functional EmONC facilities	<ul style="list-style-type: none"> • Emergency Obstetric Care • Care of small and sick newborns • Every Mother Every Newborn Quality Initiative with measurable norms and standards

Note: Blue means the newborn and maternal health indicators overlap.

2. Supporting countries in institutionalizing civil registration and vital statistics: health collaborations to promote birth registration

Counting every newborn is one of the strategic objectives of Every Newborn Action Plan. Birth registration varies from 96 per cent in Viet Nam to 3 per cent in Somalia^[78]. According to the most recent data, 57 million births were not registered with civil authorities, equaling 4 out of 10 babies born worldwide. Nearly 230 million children under five have never been registered^[79]. This challenge in numbers highlights the need for national and global efforts to close this gap.

UNICEF has longstanding leadership in supporting countries in increasing birth registration. In 2016, a total of more than 12 million children across 70 countries were registered with the assistance of UNICEF and 42 countries reported activities for integration of birth registration and health and nutrition systems. In addition, in 2016, UNICEF hosted a GAVI sponsored workshop of global partners in civil registration and vital statistics (CRVS), Health and Immunization to examine best practices and challenges and to make recommendations to improve CRVS and health interoperability. The goal is to include a focus on improved birth registration in RMNCH programming as a robust and preferred data source on child births (and deaths). UNICEF is launching a landscape analysis to determine birth notification/health and CRVS interoperability in 157 programme countries.

As part of Every Newborn metrics, in close collaboration with WHO and UNICEF, London School of Hygiene and Tropical Medicine and partners are exploring ways to close the birth notification and registration gap in both facility-based research and population-based work as follows:

Population-based research in five INDEPTH-ENAP sites: Currently DHS and Multiple Indicator Cluster Surveys (MICS) collect birth registration information regarding the percentage of children under age five whose births are registered at the time of the survey; however, these surveys do not ask about the notification process and often there are errors and confusion regarding the wording of the questions. UNICEF has recommended improving questions to refer to the authority in charge, but this requires more assessment. The draft UNICEF CRVS module will be assessed in the household survey of >70,000 births in the 5 INDEPTH-ENAP sites.

Facility-based research in Bangladesh, Nepal and United Republic of Tanzania: The maternal pre-discharge recall survey includes six birth notification and registration questions to assess what mothers remember before discharge. A qualitative study will identify barriers and enablers of birth notification and registration.

Birth Registration as part of Country Plans: Two regional meetings in 2016 (Middle-East & North Africa Region and West & Central Africa Region) were held with countries to support the strengthening of the newborn component of national policies and plans. In both workshops training on Birth Registration and CRVS as a component of plans were included.



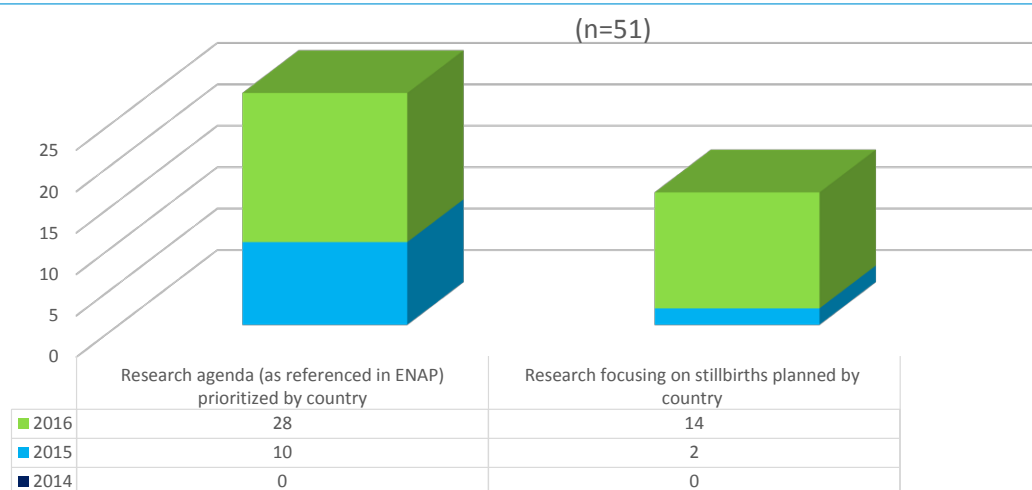
8. Every Newborn Milestone: Research and innovation

Develop, adapt and promote access to devices and commodities to improve care for mothers and newborn babies around the time of birth, and agree on, disseminate and invest in a prioritized and coordinated research agenda for improving preterm and newborn health outcomes. Particular focus is required for stillbirths, who have been left out and left behind

A research agenda for maternal and newborn health has been prioritized in 28 out of 51 countries. However, the issue of stillbirths needs to gain greater traction as only 14 countries out of these 28 indicated that they have planned research on this

issue. Nonetheless, it is very encouraging to see the large increase in prioritizing maternal and newborn health research over the course 2015 and 2016 as no country reported this activity when tracking was first initiated in 2014.

Figure 12: Number of countries with an increased focus on a maternal and newborn research agenda



Source: Every Newborn Tracking Tool.

All countries are required to develop an implementation research agenda relevant to their national newborn plans to understand how to bring life-saving interventions to scale in their context and require technical assistance to materialize the issues. Some highlights:

- In India, the Ministry of Health and Family Welfare in collaboration of Medical Research and International Clinical Epidemiology Network is developing a research agenda on maternal, newborn and child health at the national level using the Child Health and Nutrition Initiative process.
- Ghana reported implementation research on Quality of Care-Standards and Criteria in the Upper East Region where baseline research has been completed. The project Bandim Health Program focuses on neonatal and perinatal mortality and there are three active projects on these issues as part of ongoing quality improvement activity.
- In Afghanistan, UNICEF along with JHPIEGO, in coordination with the Ministry of Public Health is carrying out the Obstetric and Newborn Quality of Care Need Assessment and plans to disseminate the results in 2017.
- Often countries require technical support to materialise an effective research agenda. Democratic Republic of Congo reports a significant list of barriers such as a lack of financial resources and technical capacity, low collaboration or lack of coordination with research institutions, difficulties monitoring pregnant women and deliveries due to the low use of health centres as more than half of home deliveries at home, and fewer opportunities for facility based research due existing demands on the health facilities.

Country spotlight: Indonesia's Evidence Summit on Reducing Maternal and Neonatal Mortality

In 2016, the Indonesia Academy of Science and USAID announced the 2017 Evidence Summit on Reducing Maternal and Neonatal Mortality to help inform the efforts of the Government of Indonesia and its development partners. A multi-stakeholder committee was formed to review and synthesize all available evidence to formulate recommendations for dissemination at the summit in 2017. The outcomes from the summit will guide the country in shaping policies, plans and programmes. The Ministry of Health also committed to adopt Maternal and Perinatal Death Surveillance and Response and formed a committee to improve the quality of services at all levels.



Catalysing innovation

Developing, adapting and promoting access to devices and commodities to improve care for mothers and newborn babies around the time of birth is an important focus area to accelerate progress for mothers and their babies. A range of global initiatives have been supporting such innovation including the Every Woman Every Child Innovation Marketplace^[80], Born on Time^[81], Saving Lives at Birth^[82], Helping Babies Survive and Grow^[83] and the Pre-term Birth Initiative^[84].

Apps for continuing education for the management of care for sick newborns based on standard treatment protocols developed by All India Institute (AIIMS)

AIIMS has developed multiple smartphone Apps for continuing education for the management of sick newborn based on standard treatment protocols prepared by WHO South Asia Regional Office. These include:

- WHO CC STPS for Android
- Sick Newborn for iOS
- Refresher training tool for Helping Babies Survive programme (HBSECEB and HBSECSB for iOS & Android).

Mobile-based interventions allow for a relatively low-cost way of scaling-up health information dissemination that can help improve neonatal care. The ubiquity of mobile phone access now offers a platform that can be leveraged for a variety of interventions, including enhancing knowledge for best neonatal practices. 'WHO CC STP App' has been tested for content reliability and validity. Its efficacy in sick newborn care has been reported among the nursing students^[85], and among the physicians involved in the direct management of sick newborns at district hospital level^[86]. In light of these studies, and increasing usage of mobile devices, this may serve as a simple, bed side useful tool for improving clinical practices, and also as a refresher tool for continuing education of health care professionals for evidence-based management of sick neonates.

Innovation of Helping Babies Breathe, Helping Babies Survive and Helping Babies Grow

Reduce deaths from asphyxia, sepsis and preterm birth: Helping Babies Breathe (HBB) is an evidence-based simplified training programme using low-cost innovative simulation mannequins that changed the global landscape for newborn resuscitation by mainstreaming it as part of national programs; raising political commitment for tackling asphyxia; influencing evidence based policy recommendations; and increasing global demand, supply, and use of resuscitation equipment. HBB has been introduced in over 80 countries. Studies from Tanzania and Nepal shows a reduction in early neonatal deaths by 50 per cent and fresh stillbirth by 25 per cent when implemented within a quality improvement programme. Building on the principles of HBB, two new training new modules with low-cost training tools and videos have been developed under the Helping Babies Survive umbrella to reduce deaths from infections and preterm birth. Global Media Strategies have prepared the videos in collaboration with WHO^[87].

[80] United Nations Children's Fund, Every Child's Birth Right: Inequities and trends in birth registration, UNICEF, New York, 2013.

[81] Every Woman Every Child Innovations Marketplace www.everywomaneverychild.org/networks/innovation-marketplace.

[82] Born on Time. See bornontime.org.

[83] Saving Lives at Birth. See <https://savinglivesatbirth.net/>

[84] Laerdal Global Health. See laerdalglobalhealth.com.

[85] Preterm Birth Initiative. See ucsf.edu

[86] Thukral A, Joshi M, Joshi P, Prakash V, Adkoli BV, Deorari AK. Apps for management of sick newborn: evaluation of impact on health care professionals. J Trop Pediatr. 2014;60:370-6

[87] Prakash V, Thukral A, Sankar MJ, Agarwal R, Paul VK, Deorari AK. Efficacy and acceptability of an "App on sick newborn care" in physicians from newborn units. BMC Med Educ. 2016;16:84.

Regional and Global support to countries to accelerate progress to the Every Newborn 2020 Milestones

Regional drives to improve maternal and newborn health

World Health Organization Regional Offices have established maternal and newborn health Strategies:

- WHO South East Asia Regional Office established newborn health as a Regional flagship priority in 2014. Regional strategies developed to address specific issues across the continuum of care include the framework for implementing the Strategic Framework for improving Neonatal and Child Health and Development 2013–2017. In support of this priority a large volume of work in the region includes a Regional Framework to improve the Quality of Care for RMNCAH with an assessment tool for Hospital Care and effort to strengthen country capacity for MPDSR. In 2016, the region established a H6 Regional Working Group to ensure coordinated country support by UN agencies towards implementation of the Global Strategy with a focus on accelerating the reduction of neonatal mortality in the region.
- In the Western Pacific Region, an Action Plan for Health Newborn Infants (2014 -2020) is being implemented in the region. Steady progress has been made to scale up early essential newborn care in eight priority countries, reaching 27,727 health workers in 2,258 health facilities with skills building through coaching^[88].
- In the European Region, key activities for newborn are part of the 'Action plan for Sexual and Reproductive Health: towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind' adopted by the 66th session of the Regional Committee for Europe in September 2016.
- In the East Mediterranean Region, an UN interagency meeting for National MCH programme managers of 16 Member States was held on newborn health in 2016, to support country effort to update their RMNCAH plans with focus on identifying key actions for each ENAP strategic objectives at country level. EMRO developed neonatal and child health country profiles for each country covering neonatal mortality, causes of neonatal deaths and coverage of essential newborn interventions to support the planning, monitoring and evaluation. Particular effort is placed on adding stillbirth to country profiles. There are focussed efforts on quality of care with a workshop for 10 countries held in Morocco in November 2016, as well as Regional training of trainers course on “caring for the newborn at home” conducted in Islamabad, Pakistan.
- In the Africa Region, key activities for newborn health are set out in the 'Global Strategy for Women's, Children's and Adolescents' Health 2016-2030: Implications for the African Region, 2016-2020' adopted by the 66th Regional Committee for Africa in August 2016. In 2016, country capacity building focussed on inter- country meetings on improving quality of care Quality of Care, implementing guidance on antenatal care, MPDSR, PBSI and a focus on strengthening the maternal and newborn components of RMNCAH plans.
- In the Latin American and the Caribbean Region, the final evaluation of the Regional Strategy and Plan of Action for Neonatal Health within the continuum of maternal, newborn and child care, was presented and approved by the 55th Directing Council 68th Session of the Regional Committee of WHO for the Americas in 2016. The final recommendations involve continuing in the region supporting the actions in neonatal health in the framework of ENAP and EWEC.

[88] Global Health Media. See <https://globalhealthmedia.org/videos/smallbaby/>

Every Newborn 2020 Global Milestones and Results Framework 2017-2018

Since the endorsement of the Every Newborn Action Plan, regional and global support for its implementation has been led by WHO and UNICEF, who chair the Every Newborn Management Team. Support to coordinated in accordance with the identified needs and technical assistance requests from countries. This support is aligned to the Every Newborn Global Milestones for 2020 for which the path to progress is agreed in the Every Newborn Results Framework 2017-2018^[89]. The Results Framework which was endorsed by the Every Newborn Management Team in December 2016.

The Results Framework articulates work at the global level to support countries to accelerate their progress toward the National Milestones for 2020, and sets out activities to be undertaken in 2017 and 2018 to reach specific outputs by December 2018. Working groups have been formed for activities or groups of activities and report every month to the Every Newborn Management Team. In endorsing the Results Framework and driving action to realise these outputs, newborn health partners; UN, donors, academics, non-governmental, health professional associations and the private sector, can collectively ensure effective coordinated effort by partners in support of country action.

Table 21 sets out the Global Milestones. Column A lists Global Milestones that mirror National Milestones. Column B lists the three additional Global Milestones which are presented as a scorecard, with green for those milestones that are achieved and orange for those in progress.

[89] Every Newborn Results Framework (2017-2018) at Healthy Newborn Network <http://www.healthynewbornnetwork.org/>

Table 21: Every Newborn Global Milestones for 2020

A	Milestones	B	Milestones
Data	1. Design and test a minimum perinatal dataset	Accountability	Ensure SDG development framework includes specific targets in newborn mortality and stillbirth reduction.
	2. Create a monitoring plan, improve programmatic coverage data including equity and quality gap assessments and improve indicators and investment to ensure that these are being tracked at scale.		
	3. Count every birth and death for women and babies including stillbirths - invest in civil registration and vital statistics, and innovate to improve and ensure the poorest are counted.	Investment	Ensure that investment in maternal and newborn health is continued in 2015 and sustained in the SDG period.
Quality	Develop standards of quality and a core set of indicators to access quality of maternal and newborn care at all levels of the health system.	Coordination	Ensure coordinated support among UN partners, donors, academic, non-governmental organizations and the private sector, and intensify efforts in the 20 countries that account for 80 per cent of all newborn deaths.
Research and innovation	Develop, adapt and promote access to devices and commodities to improve care for mothers and newborn babies around the time of birth, and agree on, disseminate and invest in a prioritized and coordinated research agenda to improve preterm and newborn health outcomes. Particular focus is required for stillbirths, who have been left out and left behind.		
Champions	Develop newborn champions and engage champions in RMNCAH to integrate newborn messaging.		

Human Rights Council Resolution 33/11 in relation to newborn health

The Human Rights Council is an inter-governmental body within the United Nations system responsible for strengthening the promotion and protection of human rights around the globe and for addressing situations of human rights violations and make recommendations on them. The Council is made up of 47 United Nations Member States which are elected by the UN General Assembly.

In September 2016, the Human Rights Council resolution 33/11 states that the Council is 'Deeply concerned that, despite progress made in the reduction of child mortality, Millennium Development Goal 4, on reducing child mortality by two thirds from 1990 to 2015, was not achieved, and that deaths of newborn babies are falling more slowly, with a projected increase, if current trends continue, in the share of neonatal deaths by 2030.'

In June 2017, the Council is convening a workshop 'to discuss experiences in preventing mortality and morbidity of children under 5 years of age, with a particular focus on the implementation of the technical guidance, including challenges, best practices and lessons learned, and including consideration of the particular challenges in respect of the newborn child'.

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For more information: Healthy Newborn Network: www.healthynewbornnetwork.org

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