Progress in south Asia after the launch of the Global Every Newborn Action Plan

Since the launch of the Every Newborn Action Plan (ENAP) at the World Health Assembly in 2014,[1] and, in 2015, the launch of the UN Secretary General's second Global Strategy for Women's, Children's and Adolescents' Health, there has been a renewed focus on improving newborn health globally.[2]

South Asia has reduced neonatal mortality since 1990, when more than 2 million newborn babies died in the first 28 days of life every year. By 2015 this number had halved.[3] Although progress has been impressive, neonatal mortality in south Asia is among the highest in the world, and considerable acceleration is needed to achieve the sustainable development goal (SDG) target of at least as low as 12 deaths per 1000 livebirths by 2030.

The figure shows the projected progress based on current trends and the progress required to achieve the SDG target. Acceleration in progress is clearly needed to address the wide disparity between the direction the region is headed to and the SDG target.

Specific countries in south Asia face steep challenges. In Pakistan, the current annual rate of reduction in neonatal mortality is 1·9%. This rate needs to increase to 8·9% to meet the SDG target. Similarly, Afghanistan needs to increase the rate of reduction from 1·6% to 7·2% to align with global efforts. Although India has made solid progress, needing to move from 3·2% to 5·6%, the challenge is still high given the extensive population size.[4]

The leading causes of newborn deaths are pre-term birth complications, intrapartum complications (including asphyxia), and infections. The evidence-based interventions for reducing neonatal mortality are well known. Yet uptake of simple interventions, such as kangaroo mother care, are not widespread because of factors such as professional resistance, lack of priority for low-birthweight care, and cultural and social norms.[5] Other interventions for newborn babies including administration of antenatal corticosteroids for the management of mothers at risk of preterm birth, neonatal resuscitation, and special care for very small and sick babies, have similarly not achieved coverage at scale.[6]

Provision of high-quality emergency obstetric care is critical for saving lives. It is, however, still a major challenge—bottlenecks in the health system include problems with health financing and skilled health-care workforce within many countries.[6]

Skilled birth attendance and institutional delivery are closely related to newborn survival. However, the proportions of deliveries with skilled birth attendance are less than 50% in Afghanistan and Bangladesh, with proportions between 50% and 60% in India, Nepal, and Pakistan. Inequities are also commonplace. Skilled birth attendance in the wealthiest quintiles are three-to-four times higher than those of the poorest quintiles.[7]

Progress on early initiation of breastfeeding, an effective intervention to reduce neonatal mortality, is limited. There is a clear disparity between institutional deliveries and breastfeeding initiated within 1 h of birth in some countries.[7] This disparity is enigmatic, and more needs to be done to make sure that women who come to the right place for birth receive the care and attention they deserve.

The provision of obstetric and newborn services requires skilled staff across the whole population. The number of health-care professionals per 10 000 population is eight in Afghanistan, seven in Nepal, six in Bangladesh, 12 in Bhutan, and 14 in Pakistan.[8] WHO recommends 23 per 10 000 population to achieve adequate coverage of skilled health personnel
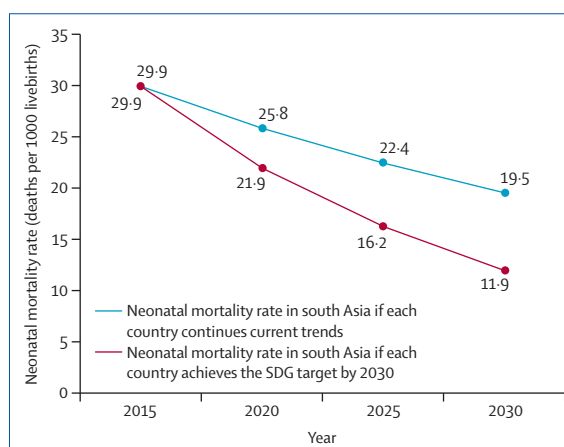

Figure: Neonatal mortality in south Asia: current trend and trend if all countries in the region reach the SDG target, 2015–30
SDG=Sustainable Development Goal.

at delivery.[9] Shortages of skilled health-care workers arise from many factors, including underinvestment in institutions, training and recruitment, and poor incentives for health-care workers.

Among the eight south Asian countries, all, with the exception of Bhutan and the Maldives, have high out-of-pocket expenditures.[10] Paying for health-care deters families from seeking care and depletes poor households of already scarce resources.

High-quality administrative datasets are essential for public health decision making and resource allocation, and form a basis of accountability for governments' commitments to their citizens. The ENAP has identified ten core indicators and ten additional indicators to determine whether targets have been met. Integrating new indicators into already weak data systems is problematic, and countries should consider establishing independent data validation bodies. The absence of reliable vital registration data—neonatal mortality rate is based on household survey data or statistical models in most of south Asia—leads to a lack of information needed for targeted and timely responses.

The momentum generated by the ENAP 2 years ago, and other recent global initiatives, needs to continue in the SDG period to drastically reduce neonatal mortality. Solutions are generally neither complex nor expensive. A high degree of organisational readiness using a health system strengthening approach with a specific emphasis on building human resources for health is needed to deliver better outcomes for newborn babies and their mothers. Although investment including child health subaccounts is crucial, there are many quick wins through improving quality of simple interventions, such as early initiation of breastfeeding for babies born in facilities when skilled birth attendants are already on hand. Monitoring change over time with the right indicators and associated targeted performance improvement measures are steps that will help to reduce neonatal mortality in south Asia.

Sufang Guo, Nuzhat Rafique, Danzhen You,
*Douglas J Noble
UNICEF Regional Office for South Asia, Lekhnath Marg, Kathmandu, Nepal (SG, NR, DJN); and UNICEF HQ, New York, NY, USA (DY)
djnoble@unicef.org

1   WHO. Every Newborn: An action plan to end preventable deaths. Geneva: World Health Organization, 2014. https://www.everynewborn. org/every-newborn-action-plan/ (accessed July 8, 2016).

2   Every Women Every Child. The Global Strategy for Women's, Children's and Adolescents' Health (2016–2030). Every Women Every Child, 2015. http:// globalstrategy.everywomaneverychild.org/ (accessed July 8, 2016).

3   UN Inter-agency Group for Child Mortality Estimation (UNIGME). Levels and trends in child mortality: Report 2015. New York: UNICEF, 2015. http://www.data.unicef.org/corecode/uploads/document6/uploaded_ pdfs/corecode/IGME-report-2015-child-mortality-final_236.pdf (accessed July 8, 2016).

4   UNICEF Analysis based on UNIGME 2015 data. http://www.data.unicef.org/ child-mortality/neonatal.html (accessed July 8, 2016).

5   Bergh A-M, de Graft-Johnson J, Khadka N, et al. The three waves in implementation of facility-based kangaroo mother care: a multi-country case study from Asia. *Int Health Hum Rights* 2016; **16:** 1.

6   Dickson KE, Kinney MV, Moxon SG, et al. Scaling up quality care for mothers and newborns around the time of birth: an overview of methods and analyses of intervention-specific bottlenecks and solutions. *BMC Pregnancy Childbirth* 2015; **15** (suppl 2)**:** S1.

7   UNICEF global database. UNICEF, 2016. http://data.unicef.org/ (accessed July 8, 2016).

8   Database: Global and National Newborn Health Data and Indicators. Healthy Newborn Network, 2015. http://www.healthynewbornnetwork. org/numbers/ (accessed July 8, 2016).

9   Bhutta ZA, Chopra M, Axelson H, et al. Countdown to 2015 decade report (2000–10): taking stock of maternal, newborn, and child survival. *Lancet* 2010; **375:** 2032–44.

10 Scammell K, Noble DJ, Rasanathan K, et al. A landscape analysis of universal health coverage for mothers and children in South Asia. *BMJ Glob Health* 2016; **1:** e000017.