First Embrace

Second biennial progress report (2016–2017)

World Health Organization
Western Pacific Region

unicef
unite for children

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The views expressed in this report are those of the participants in the Second Biennial Meeting on Accelerating Progress in Early Essential Newborn Care (EENC) held in Da Nang, Viet Nam from 14 to 17 August 2017, and do not necessarily reflect the policies of the World Health Organization.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific to document the status of Early Essential Newborn Care in the Western Pacific Region and country plans for accelerating progress in the next biennium, based on the outcome of discussions in Da Nang, Viet Nam.

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ABBREVIATIONS

AIR	annual implementation review
CHERG	Child Health Epidemiology Reference Group
CPAP	continuous positive airway pressure
CRVS	civil registration and vital statistics
DHS	Demographic and Health Survey
EENC	Early Essential Newborn Care
HMIS	health management information system
IGME	United Nations Inter-agency Group for Child Mortality Estimation
KMC	Kangaroo Mother Care
LBW	low birthweight
MCH	maternal and child health
MICS	Multiple Indicator Cluster Survey
NCU	neonatal care unit
PPH	postpartum haemorrhage
SDGs	Sustainable Development Goals
STS	skin-to-skin
UHC	universal health coverage
UNICEF	United Nations Children's Fund
WHO	World Health Organization

FOREWORD

The World Health Organization (WHO), United Nations Children's Fund (UNICEF), Member States and stakeholders in the Western Pacific Region share a vision for mothers and their children: that every newborn infant has the right to a healthy start in life. But one newborn infant dies every two minutes – often needlessly – in the Region. Together, we have taken bold steps to address this grim statistic, with Member States endorsing the *Action Plan for Healthy Newborn Infants in the Western Pacific Region (2014–2020)*. The plan aims to improve the quality of childbirth and newborn care in health facilities, where the vast majority of births occur in the Region.

Member States reported important accomplishments in improving care in the two years following the launch of the action plan, as outlined in the *First biennial progress report* of the action plan. This *Second biennial progress report* shows further impressive results achieved in 2016 and 2017, thanks to the dedication of Member States, health providers and development partners. Early Essential Newborn Care (EENC) has been introduced in more than 3360 health facilities with 30 251 health facility staff coached. Cambodia and the Philippines have achieved the action plan target of 80% of facilities introducing EENC. Coverage of life-saving interventions for term babies has also increased significantly: 75% of term babies are placed in immediate skin-to-skin contact with their mothers after birth, and 85% are exclusively breastfed in the immediate newborn period.

Still, we cannot rest on these successes. Assessments of care reveal that evidence-based practices are often not applied during antenatal care and childbirth. Unnecessary caesarean sections are common, and only one in four babies born by caesarean section benefit from skin-to-skin contact. Preterm babies, who account for half of all newborn deaths, are unnecessarily separated from their mothers before receiving EENC – increasing their risk of poor health. We need to accelerate our efforts to leave no mother and child behind.

Together, we, the governments, WHO and UNICEF, must push to meet the Sustainable Development Goal target of a global maternal mortality ratio of fewer than 70 deaths per 100 000 live births with no country above 140; and the regional neonatal mortality rate target of 10 or fewer deaths per 1000 live births in countries. To reach these ambitious targets, we will work with Member States and partners to ensure universal coverage of high-quality EENC.

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HIGHLIGHTS

Early Essential Newborn Care (EENC) since 2015

Eight priority countries with the highest burden of newborn deaths[a] met in August 2017 to review progress in implementing the *Action Plan for Healthy Newborn Infants in the Western Pacific Region (2014–2020)*.

By August 2017, 3366 facilities had introduced Early Essential Newborn Care (EENC) and 30 251 staff had been coached, with Cambodia and the Philippines achieving the regional Action Plan target of 80% of facilities adopting EENC. Term babies had improving rates of immediate skin-to-skin (STS) contact (75%), sustained STS contact until the first breastfeed (57%) and exclusive breastfeeding (85%). EENC teams had been formed by 55% of hospitals, a dramatic improvement from 2015, but only 19% conducted the routine quality of care assessments essential for sustaining practice.[b] Most countries had appointed EENC coordinators, adapted the clinical practice pocket guide, formed national EENC working groups and conducted regular data reviews. However, incorporation of EENC into pre-service curricula has lagged.

BETTER ANTENATAL AND DELIVERY CARE IS NEEDED

EENC assessments have revealed low rates of syphilis (32%) and HIV testing (55%), use of the partograph (59%), non-supine position during the second stage of labour (50%), companion of choice during childbirth (24%) and early postnatal use of oxytocin to prevent bleeding (79%). Unnecessary and potentially harmful procedures such as enema (25%) persist.

a. Cambodia, China, the Lao People's Democratic Republic, Mongolia, Papua New Guinea, the Philippines, Solomon Islands and Viet Nam.

b. Estimated from a random sample of EENC-implementing hospitals across eight countries (n = 178).

BABIES BORN PRETERM OR BY CAESAREAN SECTION ARE NOT RECEIVING SUFFICIENT EENC

Preterm babies account for half of all newborn deaths but are less likely than term babies to receive immediate STS contact (56%), breastfeeding before separation (29%) and exclusive breastfeeding (69%). Kangaroo Mother Care (KMC) was received by 35% of preterm babies, an increase from 7% in 2015, but only 15% received it for at least 18 of the previous 24 hours. Overuse of caesarean section remains common in many countries but only 26% babies born by caesarean section receive EENC. High rates of separation of stable preterm babies and babies born by caesarean section for observation increases risk of hypothermia, infection and death.

THE WESTERN PACIFIC HIGH-LEVEL FORUM ON ACCELERATING PROGRESS IN EENC

On 16–17 August 2017, high-level representatives from priority countries met to identify steps towards universal adoption of EENC. The group committed to continue support for EENC, particularly for preterm and low-birthweight (LBW) babies and those born by caesarean section, and noted that improved collaboration and coordination will be central to further progress (Box 1) *(1)*.

BOX 1. High-level Forum on Accelerating Progress in Early Essential Newborn Care

At this landmark forum on 16–17 August 2017, vice-ministers of health, undersecretaries and assistant secretaries of health, and representatives from the eight priority countries outlined their approach to ensuring that EENC is adopted and sustained.

Continued advocacy is essential for sustaining resources. Although most countries are financing many aspects of EENC scale-up using local resources, continued advocacy is needed to ensure increased allocation of government resources for EENC.

Quality-of-care approaches need continued support. Mechanisms to improve and sustain quality are essential, including upgrading pre-service training curricula, an area that has not yet received enough attention; formation of hospital EENC teams to conduct self-monitoring of quality of childbirth and newborn care; facility accreditation systems that include EENC practice standards; and maternal and child health (MCH) insurance policies that reimburse providers for practising EENC.

Over-medicalization is a major problem in most countries in the Region, causing preventable morbidity, mortality and expenditure. Overuse of caesarean section and over-admission of stable neonates to neonatal care units remain very common. This trend results from many factors including rapid economic growth, aggressive efforts by commercial interests to promote the use of medical products and devices, and policies that allow institutions or staff to receive additional reimbursement for unnecessary procedures (conflicts of interest). While it is recognized that adoption and use of technology can have many benefits, it is also essential that ineffective, harmful and cost-ineffective practices be limited by strong regulation and policy guidance.

Marketing of breast-milk substitutes remains rampant and is a challenge to increasing breastfeeding rates. Combating this problem will require enforcement of marketing laws, strict application of facility breastfeeding standards through accreditation and other methods, improved maternity leave and workplace legislation to support longer and exclusive breastfeeding.

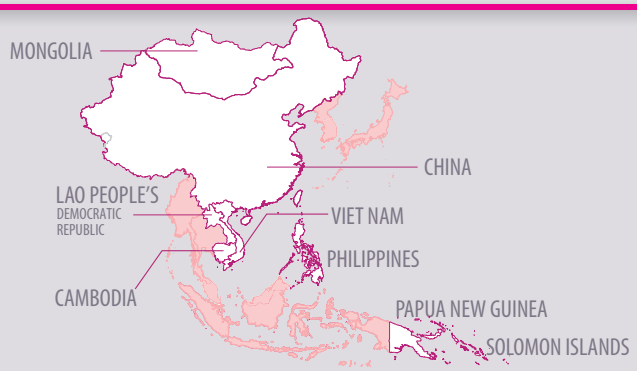
Engaging professional associations and civil society organizations will be important for further scale-up. Engagement of professional associations and civil partners is essential for building community acceptance. Demand for EENC will be an important area to emphasize in the next phase.

1

Introduction

REALITY CHECK

8 PRIORITY COUNTRIES
account for
96% of neonatal deaths
IN THE WESTERN PACIFIC REGION



Regional vision: a healthy start for every newborn

A newborn dies every two minutes in the World Health Organization (WHO) Western Pacific Region *(2).* In response, the *Action Plan for Healthy Newborn Infants in the Western Pacific Region (2014–2020)* was developed by the WHO Regional Office for the Western Pacific, the United Nations Children's Fund (UNICEF) Regional Office for East Asia and the Pacific, Member States and experts, and endorsed in October 2013 by the WHO Regional Committee for the Western Pacific *(3,4).*

Eight priority countries with the highest burdens of maternal and neonatal mortality – Cambodia, China, the Lao People's Democratic Republic, Mongolia, Papua New Guinea, the Philippines, Solomon Islands and Viet Nam – are implementing the Action Plan by scaling up Early Essential Newborn Care (EENC) (Annex 1). Fundamental to EENC is improving the quality of skilled delivery and post-delivery care, while also improving access to facility-based services for mothers and newborns.

Introducing, sustaining and scaling up EENC: a regional approach

Based on extensive country experience, an approach evolved to introduce, sustain and scale up EENC.

First, facility health providers are coached on routine delivery and newborn care using Early Essential Newborn Care Module 2 – *Coaching for the First Embrace for breathing and non-breathing babies (5)*. Once established, multidisciplinary hospital EENC teams use Early Essential Newborn Care Module 3 – *Introducing and sustaining EENC in hospitals: routine childbirth and newborn care* to: (1) assess their own hospital practices, policies, supplies and environmental hygiene to identify strengths and areas for improvement; (2) develop short-term action plans based on findings; and (3) monitor plan implementation and re-assess periodically *(6)*.

When coaching and quality improvement for routine childbirth and immediate newborn care are established, Early Essential Newborn Care Module 4 – *Introducing and sustaining EENC in hospitals: Kangaroo Mother Care for preterm and low-birthweight infants* is added to assess facility readiness and the development of an action plan *(7)*. Following this is clinical coaching on KMC. KMC has historically been difficult to establish in the past because of lack of adequate staff, space and beds, and reluctance by decision-makers. Thus, hospital staff members use data to prepare and secure essential support from senior hospital decision-makers prior to KMC clinical coaching. Finally, Early Essential Newborn Care Module 5 – *Introducing and sustaining EENC in hospitals: Managing childbirth and postnatal complications* is added to address maternal complications.

Quality of care in health facilities is further assessed using Early Essential Newborn Care Module 1 – *Annual implementation review and planning guide (8)*. Ministries of Health lead an external team to assess quality of childbirth and newborn care in health facilities that have introduced EENC. These assessments inform programme planning (Box 2).

Moving towards evidence-based practice: data driving change

The *Early Essential Newborn Care Monitoring and Evaluation Framework (2015–2020)* was developed to help countries measure progress in EENC (Annex 2). At the first biennial review of regional progress in 2015, priority countries had shown impressive progress, with over 25 000 health workers in about 2000 health facilities coached in EENC *(9)*. Policy-makers and programme managers acknowledged the power of data to understand and change practices and to mobilize political support and resources. Data became central to development of country biennial road maps for scaling up EENC *(10)*.

For the second biennial EENC progress meeting, the eight priority countries reported data on indicators in the framework in April and May 2017. The EENC Independent Review Group (IRG), comprised of experts in midwifery, neonatology, and obstetrics and gynaecology, validated the data (Annexes 3, 4). Final data were used to develop country profiles (Annex 5).

Participants from priority countries discussed progress at the Second Biennial Meeting on Accelerating Progress in EENC, in Da Nang, Viet Nam, on 14–17 August 2017, which is summarized in this report (Annex 6).

BOX 2. Regional approach to introducing, sustaining and scaling up EENC in hospitals

ACTION	Programme approach	Policy support
Clinical coaching to strengthen staff practices (EENC Modules 2, 4 and 5)		
	Two-day clinical coaching in a delivery room setting to improve practices using accredited facilitators focused initially on routine management of breathing and non-breathing babies *(5)*. Coaching on Kangaroo Mother Care (KMC) *(7)* and the management of maternal complications is added when the facility is ready.	*Early Essential Newborn Care Clinical Practice Pocket Guide (11)* adapted for local use ensures policies and protocols are consistent with evidence-based standards.
Multidisciplinary EENC hospital teams to improve collaboration (EENC Module 3)		
	Hospital teams formed to ensure close collaboration between obstetrics/midwifery and paediatrics and to oversee quality improvement and scale-up *(6)*.	Ministry of Health issues a formal directive on composition and roles of the team. Hospital directors establish and endorse teams and require regular meetings.
Hospital self-monitoring to improve quality of care (EENC Modules 3, 4 and 5)		
	Teams are oriented in the EENC quality improvement approach and conduct regular assessments to identify gaps and develop solutions tailored to local situations and resources *(6)*.	Hospital directors and senior clinical staff adapt or modify hospital protocols, change environments and organization, and make essential supplies or equipment available.
Annual implementation reviews to inform programming (EENC Module 1)		
	Six-day national annual (or biennial) implementation reviews (AIRs) of facilities collect data on practices and facility medicines, supplies and environments so that action can be taken quickly to address gaps *(8)*.	Staff at national, subnational and hospital levels use data to identify changes required in policies, protocols, standards and other systems support needed to accelerate scale-up, address gaps and secure funding from national, subnational or hospital budgets.

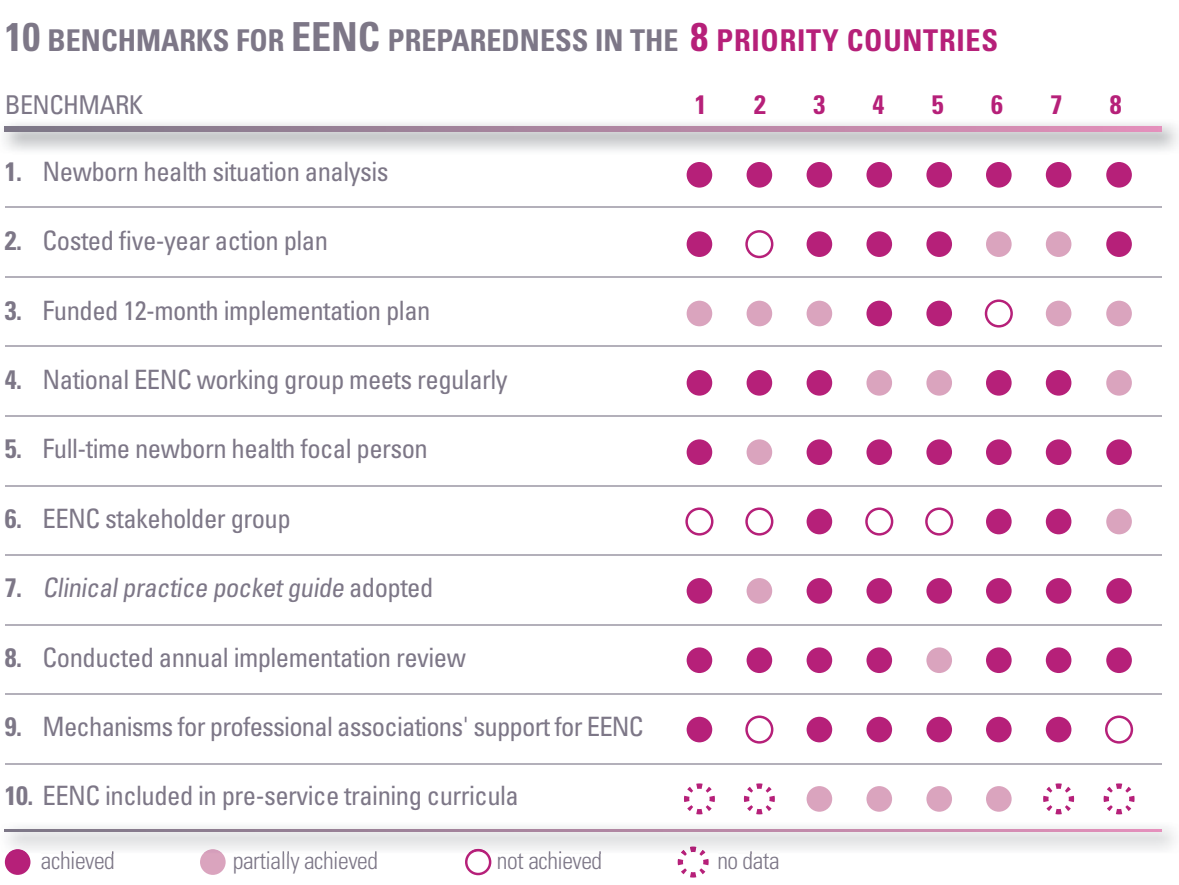
2

Benchmarks of EENC scale-up readiness

Ten benchmarks are used to assess the status of policy and planning measures that are important for introducing and supporting EENC. Four priority countries provided data for all 10 benchmarks and the others for nine benchmarks, with data available for 95% of benchmarks overall. Eighty-nine per cent of benchmarks achieved or partially achieved were validated (Table A3.1 in Annex 3).

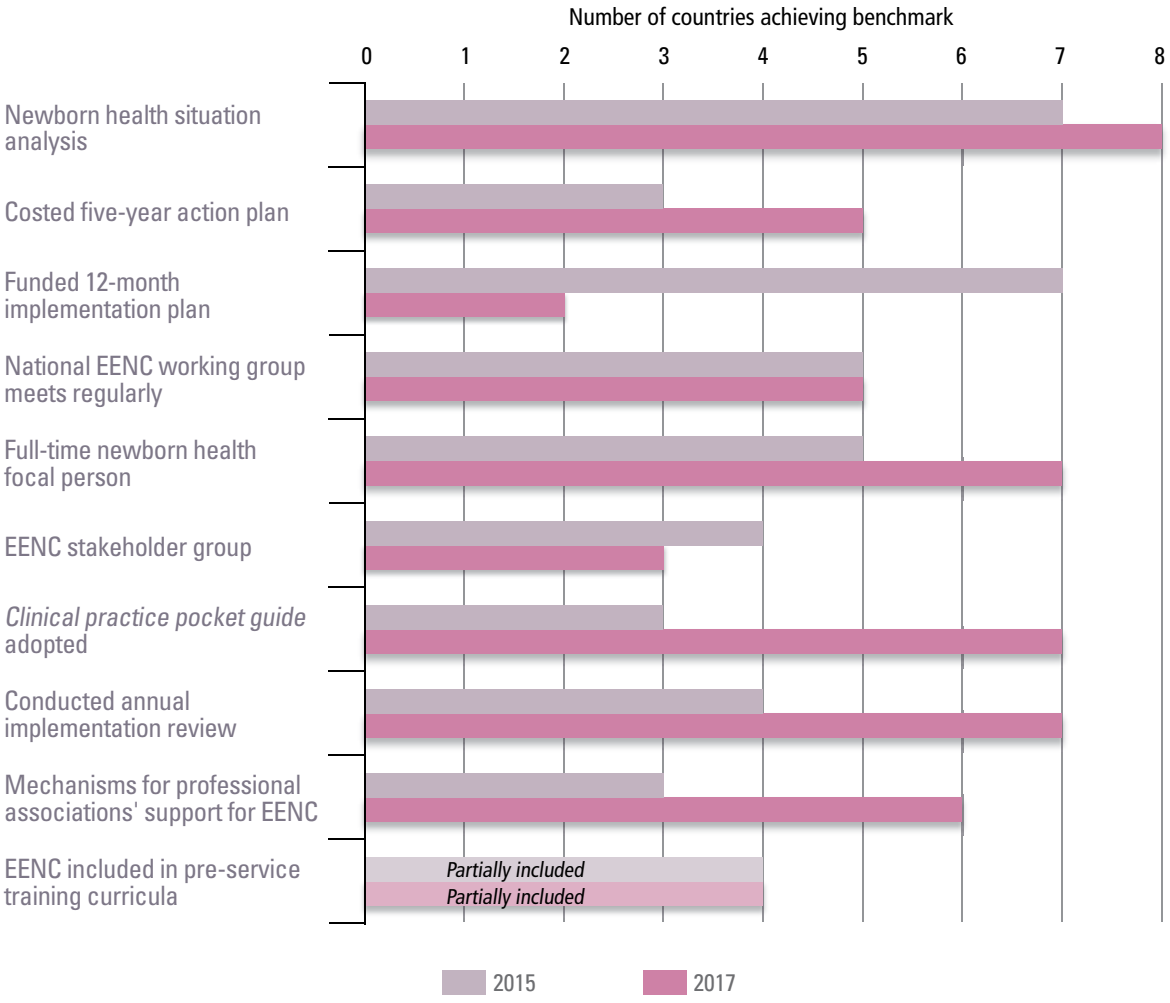
Five countries have achieved seven or more benchmarks, one achieved six, one five and one three. Six countries have completed a newborn health situation analysis, appointed a newborn health focal person in the ministry of health, adapted the *Early Essential Newborn Care Clinical Practice Pocket Guide (11)* and conducted AIRs for EENC (Fig. 1). The least-achieved benchmarks remain establishment of an EENC stakeholder group and incorporation of EENC interventions into pre-service curricula.

FIGURE 1. Status of the EENC scale-up readiness benchmarks by country, October 2017



Improvements in benchmark status between 2015 and 2017 were most significant for adaptation of the *EENC Clinical Practice Pocket Guide* (four countries), AIRs and professional associations' support for EENC (three countries each) (Fig. 2). A decline in benchmark status was noted for development of a fully funded 12-month EENC action plan and establishment of a stakeholder group, while regular meetings of the national EENC working group showed no change. In 2015, four countries reported that the proportion of EENC interventions incorporated into pre-service curricula was in the 62–92% range for medical curricula, 39–62% for nursing and 39–96% for midwifery. However, in 2017 no country reported updated data on incorporation of EENC into pre-service curricula.

FIGURE 2. Number of eight priority countries achieving EENC scale-up readiness benchmarks, 2015 and 2017



3

Health facility EENC standards

There continues to be significant progress in scale-up of **EENC**

3366 HEALTH FACILITIES
have introduced **EENC:**
a **17%** increase from 2016

30 251 HEALTH FACILITY STAFF
have been coached in **EENC:**
a **9%** increase from 2016

Implementation of EENC is defined by 13 health facility standards (Annex 2). Standards have been updated since 2015 to add practice measures for preterm and LBW babies and routine delivery care.

Across the eight countries, data were fully available for 65% of heath facility standard indicators, with an additional 31% partially available. Ninety-five per cent of the indicators were validated (Table A3.2 in Annex 3).

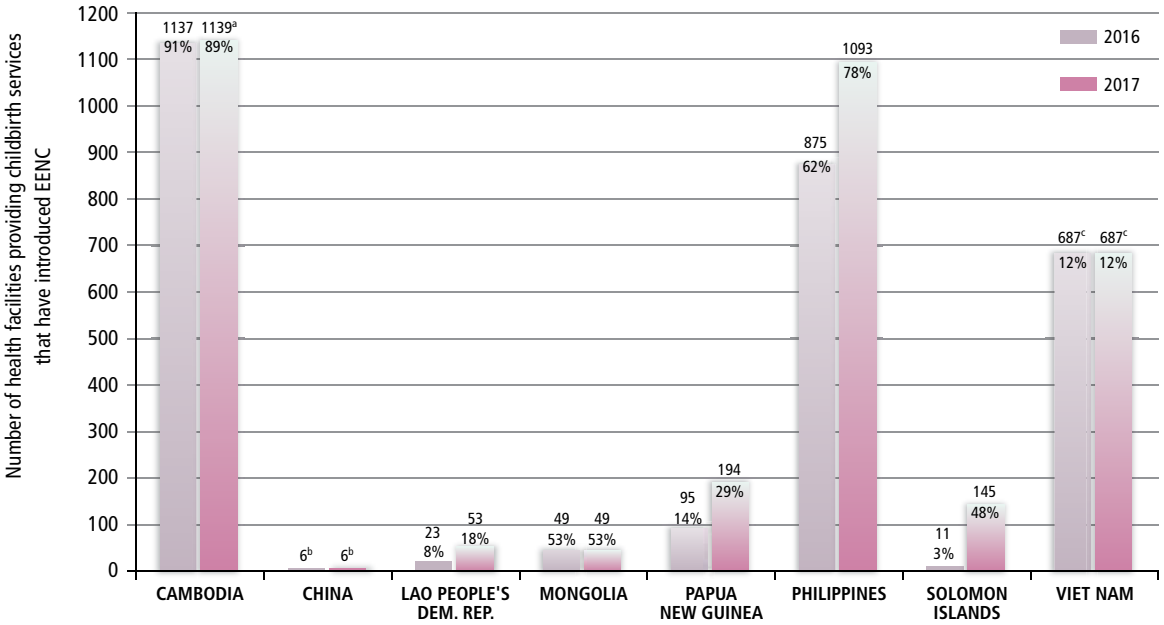
Progress with facility standards is summarized in five areas: (1) EENC clinical coaching and hospital teams; (2) routine antenatal and delivery practices; (3) immediate newborn care for term, preterm and LBW babies; (4) environmental hygiene practices; and (5) essential medicines and commodities.

EENC clinical coaching and hospital teams

Across the Western Pacific Region, 3366 facilities have introduced EENC, including 7% of national and regional hospitals, 13% of first-level referral hospitals and 14% of first-level facilities[1] (Fig. 3). Excluding China, where EENC has been launched in

1. National- and regional-level facilities offer services of first-level referral plus advanced neonatal care including continuous positive airway pressure (CPAP), serve as teaching hospitals and provide support to lower-level facilities. First-level referral facilities offer services of first- level plus management of preterm labour and common complications of prematurity (e.g. oxygen), complications of delivery including assisted delivery and caesarean sections. First-level facilities where deliveries take place should have the capacity for care of breathing and non-breathing babies.

FIGURE 3. Total number of health facilities providing childbirth services that have introduced EENC, by country, 2016–2017



a. The total number of health facilities providing childbirth services increased from 1246 in 2016 to 1272 in 2017.

b. The total number of health facilities in China is 25 860. Data are not available on the number of these facilities offering childbirth services. Six hospitals in China began EENC coaching in 2016.

c. Number is an underestimate as EENC has been introduced in first-level facilities in Viet Nam; however, data on the exact number are not available.

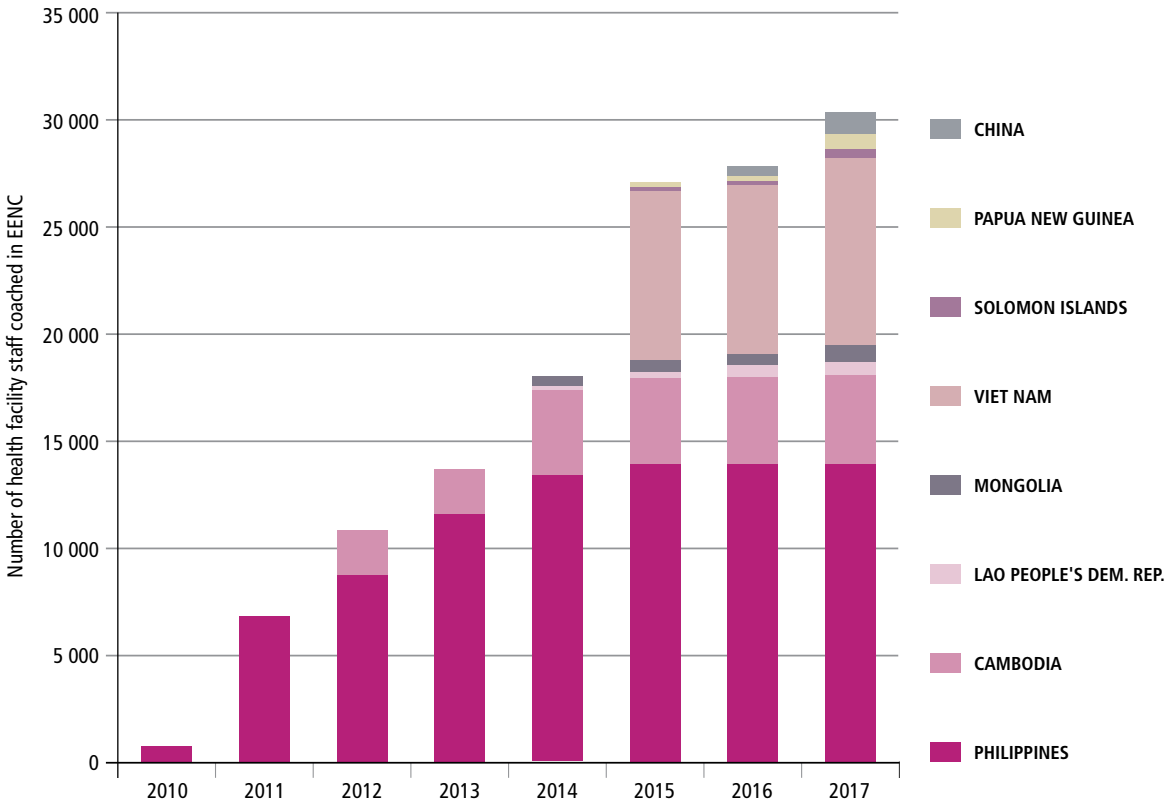
six hospitals, EENC has reached 84% (134/159) of national and regional hospitals, 58% (1190/2060) of first-level referral and 27% (2036/7628) of first-level facilities in the other seven priority countries.

Cambodia and the Philippines have reached the regional Action Plan target of 80% of all facilities introducing EENC (Table 1). However, quality of care continues to need improvement.

The total number of staff coached across the Region has also shown rapid progress since 2012 (Table 1, Fig. 4). In facilities implementing EENC, 30 251 providers responsible for childbirth, newborn and postnatal care have been coached, a 9% increase from 2016, including 62% at the national and regional levels, 58% in first-level referral and 63% of providers in first-level facilities (data by facility level

are not available for some countries). Coaching coverage of target staff in facilities implementing EENC is over 80% in China. Fifty-five per cent of hospitals have established an EENC team, a dramatic increase from 22% in 2016.[2] However, 19% of established teams met standards for implementing a quality-improvement approach.[3]

FIGURE 4. Total number of health facility staff coached in EENC by year and by country, 2010–2017



2. Estimated from a random sample of EENC-implementing hospitals across eight countries, *n* = 153 in 2016 and *n* = 178 in 2017.
3. Quality-improvement approach consists of: (1) regular and documented meetings of the EENC team; (2) at least two EENC assessments per year; and (3) developing and updating an EENC hospital action plan at least quarterly.

Maintaining the quality of **EENC** coaching is critical to changing practice

Accredited facilitator

6:1 participants-to-facilitator ratio

Two days full-time practice in delivery rooms

Pre- and post-coaching assessments to document practice change

Scale-up has occurred most rapidly in countries with a cadre of strong hospital facilitators who lead coaching roll-out (see Box 3 for an overview of the scale-up approach in Viet Nam). Because an emphasis has been placed on ensuring coaching quality for practice change, EENC facilitators must be nationally accredited before coaching on their own. Accreditation requires staff to complete basic EENC coaching, an additional day of facilitator instruction and then at least one coaching session under supervision. For this reason, increasing scale-up requires investments in building a cadre of facilitators at the national and subnational levels. Since coaching is conducted in hospitals by local staff over two days, it does not incur costs associated with traditional off-site training.

TABLE 1. Proportion of health facilities that have introduced EENC and of staff coached, by country, June 2017

COUNTRY	Proportion of health facilities providing childbirth services that have introduced EENC				Proportion of staff coached in health facilities that have introduced EENC			
	System level				System level			
	National/ Regional	First-level referral	First-level	TOTAL	National/ Regional	First-level referral	First-level	TOTAL
CAMBODIA	**83.0%** 5/6	**97.1%** 99/102	**88.9%** 1 035/1 164	**89.5%** 1 139/1 272	254/ND	**79.8%** 877/1 099	**68.9%** 2 926/4 248	**75.9%** 4 057/5 347[a]
CHINA	**0.2%** 3/1 954[b]	**0.04%** 3/6 850[b]	**0%** 0/7 009[b]	**0.02%** 6/25 860	**81.6%** 692/848	**90.6%** 289/319	0	**84.1%** 981/1 167
LAO PEOPLE'S DEM. REP.	**57.1%** 4/7	**32.0%** 49/153	**0%** 0/139	**17.7%** 53/299	**69.3%** 194/280	**76.5%** 374/489	0	**73.9%** 568/769
MONGOLIA	**75.0%** 9/12	**70.8%** 17/24	**40.4%** 23/57	**52.6%** 49/93	**77.8%** 396/509	**83.1%** 364/438	**25.6%** 140/546	**60.3%** 900/1 493
PAPUA NEW GUINEA	**100%** 1/1	**58.1%** 18/31	**27.4%** 175/639	**28.9%** 194/671	**70.3%** 135/192	579/ND	ND	714/ND
PHILIPPINES	**87.4%** 104/119	**84.2%** 324/385	**74.1%** 665/897	**78.0%** 1 093/1 401	**41.7%** 890/2 133	**43.6%** 786/1 801	ND	**42.6%** 1 676[c,d]/3 934
SOLOMON ISLANDS	**100%** 1/1	**66.7%** 6/9	**47.3%** 138/292	**48.0%** 145/302	**100%** 122/122	**41.3%** 100/242	**53.8%** 186/346	**57.5%** 408/710
VIET NAM	**76.9%** 10/13	**49.9%** 677/1 356	ND/4 440[e]	**50.2%** 687/1 369[c]	**55.9%** 1 187/2 125	**52.2%** 7 426/14 229	ND	**52.7%** 8 613/16 354
TOTAL	**6.5%** 137/2 113	**13.4%** 1 193/8 910	**13.9%** 2 036/14 637	**10.8%**[f] 3 366/31 267	**62.3%** 3 870/6 209	**58.0%** 10 795/18 617	**63.3%** 3 252/5 140	30 251[g]

ND: no data

a. Denominator is an underestimation as there are no data available on total number of staff providing childbirth and newborn care in national/regional hospitals.

b. There is a total of 25 860 health facilities in China, many of which do not provide childbirth services. Denominator for first-level referral facilities may include regional facilities; 10 045 facilities in China do not have a classification for level.

c. Total for national, regional and first-level referral hospitals only.

d. A total of 14 006 health workers have been coached in the Philippines; however, a breakdown of coaching data by health facility is not available from all facilities. Data shown here by level are only for selected facilities.

e. Denominator is based on the estimate that 40% of community health centres (n = 11 101) provide childbirth services in Viet Nam.

f. Does not include first-level facilities in Viet Nam, as data on the number of facilities where EENC has been introduced are not available.

g. The total of 14 006 health workers coached in the Philippines was included here to reflect that a total of 30 251 staff have been coached in the Region. Proportion of staff was not calculated due to incomplete data from some countries.

BOX 3. Rapid scale-up of EENC in Viet Nam

Viet Nam has made dramatic progress in introducing EENC. In three years, half of all national and first-level referral hospitals in the country have adopted EENC and over 8000 staff have received coaching. The expansion of EENC has been achieved by using centres of excellence, which have supported provincial coaching.

"I've conducted training for 20 years, but the sessions were never as successful as EENC."
– Staff member, Ministry of Health, Viet Nam

- **Selection of Centres of Excellence and coaching of facilitators, July 2014**

Before launching the EENC initiative, the Ministry of Health selected three hospitals to become Centres of Excellence: the National Hospital for Obstetrics and Gynaecology in the northern zone; Da Nang Hospital for Women and Children in the central zone; and Tu Du Hospital in the southern zone. With support from the WHO Regional Office for the Western Pacific, each hospital coached 10–12 of its own staff as facilitators. The facilitators received two days of coaching, attended a one-day orientation on facilitation, and then conducted at least one coaching session under supervision. A group of accredited facilitators was established at each of the three hospitals to lead implementation.

- **National policy directives, November 2014**

The *Early Essential Newborn Care Clinical Practice Pocket Guide*, published by the WHO Regional Office for the Western Pacific, was reviewed and adapted for Viet Nam as an evidence-based national clinical protocol after extensive stakeholder consultations. In November 2014, the Ministry of Health released Decision No. 4673 that required all facility-based staff to follow the EENC protocol and EENC-related policies. This was followed by an official letter from the Ministry of Health requesting Provincial People's Committees to ensure that departments of health guide and monitor health facilities in the implementation of Decision No. 4673. EENC implementation was also included in the criteria for evaluating the quality of hospital care (Decision No. 6858 in November 2016), which is conducted annually in Viet Nam.

- **Coaching of staff at Centres of Excellence by facilitators, July–December 2014**

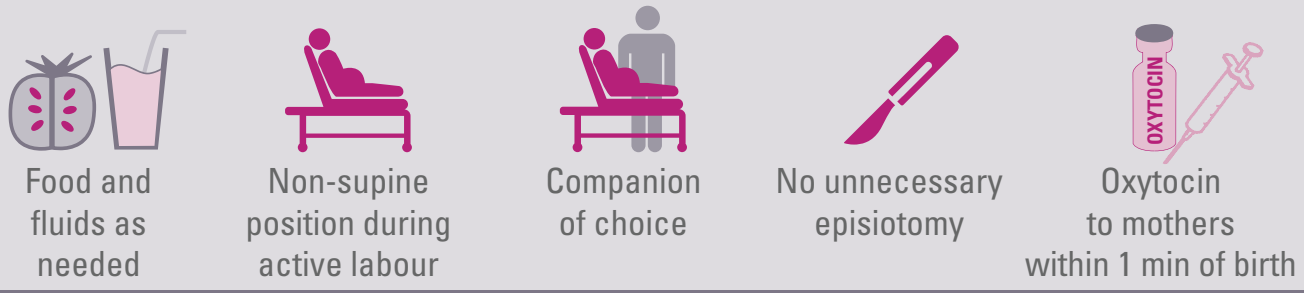
National facilitators coached staff in their own hospitals and established EENC hospital teams. They supervised teams to conduct quarterly self-assessments of the quality of routine childbirth and newborn care and to use data to take action to improve and support EENC practices.

- **Provincial EENC expansion plans – Centres of Excellence, Ministry of Health, provincial health departments, December 2014–onwards**

EENC facilitators at the Centres of Excellence developed an EENC coaching plan for provincial health staff in their own zones in collaboration with the Ministry of Health maternal and child health department. Funds to support coaching and oversight visits were provided by the Ministry of Health. Provincial health departments coordinated with hospitals and helped with arrangements. Successive rounds of EENC coaching reached the majority of provincial hospitals by the end of 2017. There are 500 coaching facilitators covering all 63 provinces of the country, in addition to 160 facilitators in 80 medical schools and training facilities.

- **Further development of the national EENC programme, 2016 and 2017**

As EENC became institutionalized across hospitals in Viet Nam, the Ministry of Health introduced EENC for caesarean section deliveries and Kangaroo Mother Care (KMC) for preterm and low-birthweight babies in the Centres of Excellence and other selected hospitals. Policy Directive No. 6734 (November 2016) introduced guidelines on EENC for caesarean section deliveries. With support from WHO, KMC readiness assessments and KMC staff coaching were conducted in 2016. Since then, Centres of Excellence have supported this process in hospitals in their zones.



Routine antenatal and delivery practices

Evidence-based practices before and during delivery are often not applied. Harmful or unnecessary practices such as fundal pressure and forced pushing remain common, with care often provided to suit the schedules and preferences of staff rather than needs of mothers and babies. Core antenatal and childbirth practices are now incorporated into health facility EENC standards to ensure they are monitored and that action is taken to improve them.

Testing for syphilis and HIV is recommended for all pregnant women as early as possible in pregnancy. Only 32% were tested for syphilis and 55% for HIV. Syphilis testing was generally lower for babies born at subnational as opposed to national facilities (Fig. 5). A partograph is a useful tool to assess the well-being of a woman and her baby and to reduce the risk of adverse birth outcomes. However, it was completed correctly for 59% of term deliveries, with higher completion rates at subnational facilities (Fig. 5).

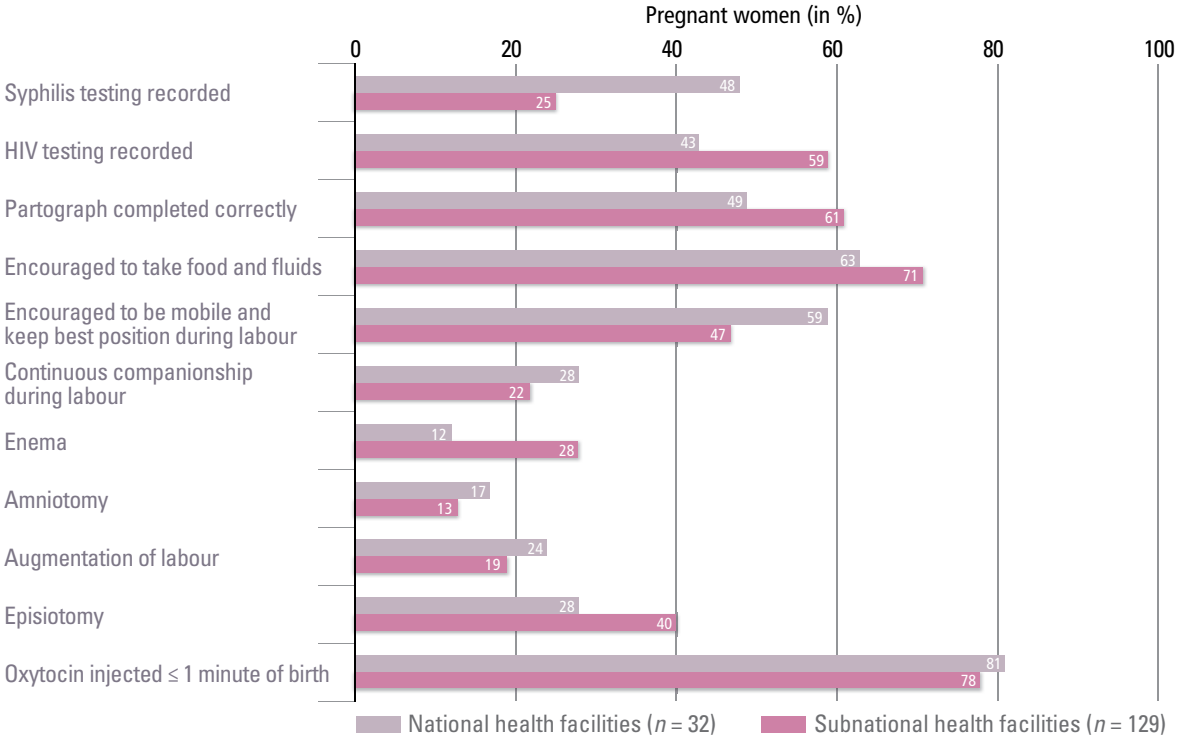
During all stages of labour, food and fluids, mobility, assuming a position of choice, and having continuous companionship are highly recommended for women. Adoption of an upright position during the second stage of labour may reduce episiotomy and instrumental vaginal births. Similarly, companionship improves the birth experience and may reduce the length of labour, need for caesarean section, instrument deliveries, use of pain relief and low Apgar scores among newborns at five minutes. Sixty-nine per cent of women delivering term babies were encouraged to take food and fluids during labour, 50% were offered mobility and encouraged to find the most comfortable position, and 24% had a companion of choice continuously during labour and in the delivery room. More women at national facilities were offered mobility and allowed companionship (Fig. 5).

WHO currently recommends episiotomies only for strict clinical indications because it increases rates of posterior perineal trauma, suturing and healing complications *(12)*. Episiotomy was performed for 37% of term deliveries and was prevalent at all levels (Fig. 5). Between countries, episiotomy rates varied from 6% to 71%. The high rate of episiotomies suggests many are done for inappropriate reasons.

Postpartum haemorrhage (PPH) is the leading cause of maternal mortality in low-income countries and accounts for one quarter of all maternal deaths globally. The majority of these could be avoided through the use of prophylactic oxytocin during the third stage of labour and by timely and appropriate management *(13)*. Oxytocin was given within one minute of birth to 79% of mothers.

Routine enema (25%), amniotomy (14%) and augmentation of labour (20%) remain common and are often not based on evidence-based criteria. Detailed reviews of these procedures are not included here but will be reviewed in detail as a part of Early Essential Newborn Care Module 5 – *Introducing and Sustaining EENC in Hospitals: Managing Childbirth and Postnatal Complications*.

FIGURE 5. Antenatal care and delivery practices by facility level, eight countries, June 2017



Source of data: 161 randomly selected health facilities implementing EENC across 8 countries (32 national/regional, 121 first-level referral and 8 first-level). Delivery practices (eating and drinking, position, companion) from interviews of 1344 postnatal mothers. Syphilis testing, HIV testing, episiotomy, enema, amniotomy and augmentation of labour from chart reviews of 1366 postnatal mothers. Timing of oxytocin injection from observations of 385 deliveries.

Immediate newborn care for term, preterm and LBW babies

EENC is effective for reducing risks of illness and preventable mortality for term, preterm and LBW babies. Skin-to-skin (STS) contact and breastfeeding prevent hypothermia, infection and death. In contrast, separation from mothers exposes newborns to these problems.

Eighty-seven per cent of term babies received STS contact, 75% within one minute of birth, and 57% remained in sustained STS contact until completion of the first breastfeed; however, only 36% remained in uninterrupted STS contact for 90 minutes (Fig. 6). Rates of early STS contact are high across all levels of facilities, with subnational facilities generally having higher rates. Of term babies, 95% received any breastfeeding, 62% were breastfed early (within 15–90 minutes of birth) and 85% were exclusively breastfed, with 56% receiving both early and exclusive breastfeeding (Fig. 7). Ten per cent of all term babies were bottle-fed. Ninety per cent of all term babies received dry cord care and 74% were bathed 24 hours after birth. Eighty-six per cent of term babies received the hepatitis B birth dose vaccine within 24 hours of birth.

Preterm and LBW babies are 19% less likely to receive immediate STS contact than term babies and 16% less likely to be exclusively breastfed.

Preterm and LBW babies do not receive the same care as term babies: 67% received any STS contact, 56% within one minute of birth and 29% remained in sustained STS contact until completion of the first breastfeed; 17% remained in uninterrupted STS contact for at least 90 minutes (Fig. 6). Of all preterm and LBW babies, 72% received any breastfeeding, 22% were breastfed early, 69% were exclusively breastfed, with 17% receiving both early and exclusive breastfeeding. Twenty-four per cent of all preterm and LBW babies were bottle-fed (Fig. 7). Observations and discussions with health staff reveal early separation of stable preterm and LBW babies is done for several reasons, which are incorrect, such as routine observation in a neonatal care unit (NCU) (Box 4). The longer babies are maintained in STS contact, the higher the rates of exclusive breastfeeding for both term and preterm and LBW babies (Fig. 8).

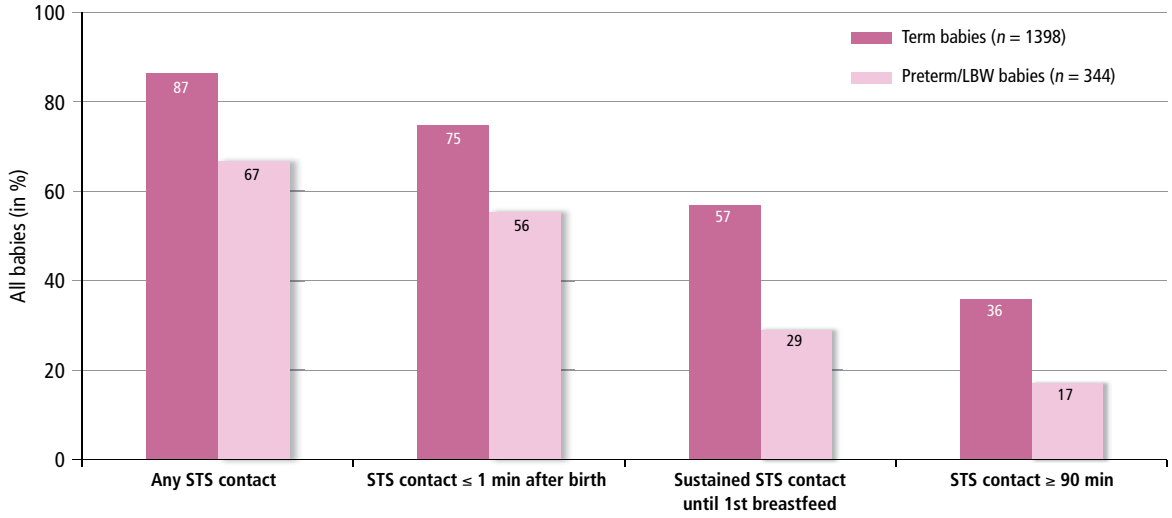
Antenatal steroids, provided they are administered to the mother according to guidelines, are associated with reduced neonatal deaths from respiratory distress syndrome. Magnesium sulfate reduces rates of cerebral palsy *(14)*. Only 61% of women at 24–34 weeks of gestation received corticosteroids and 35% of women

less than 32 weeks of gestation received magnesium sulfate (Fig. 9). In many countries, related policies are not in place.

Uninterrupted KMC for at least 20 hours each day prevents up to half of all deaths of preterm and LBW babies, reduces morbidity from infection, increases breastfeeding rates, provides effective thermal control and improves developmental outcomes *(15)*. KMC was practised for 35% of preterm and LBW babies, a significant improvement from 7% in 2016. Only 15% received KMC for at least 18 of the previous 24 hours (Fig. 9).

Of 161 health facilities assessed for childbirth and newborn care, babies born by caesarean section were sampled in 83 hospitals. In these hospitals, 99/380 (26%) of births by caesarean section received any STS contact (Fig. 10). National caesarean section rates in the eight priority countries range from 6% to 34%. Using these estimates, 4.6 million babies each year do not receive the benefits of EENC.[4]

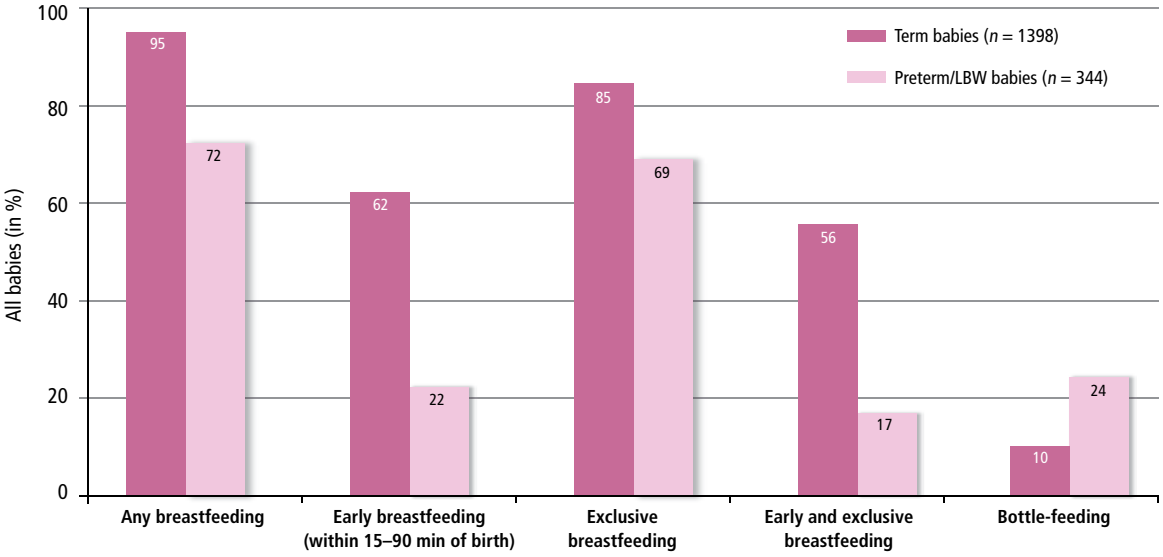
FIGURE 6. Skin-to-skin (STS) practices – term, preterm and LBW babies, eight countries, June 2017



Source of data: Interviews with postnatal mothers in 161 randomly selected health facilities implementing EENC (32 national/regional, 121 first-level referral and 8 first-level) for term babies, and 85/161 health facilities (28 national/regional, 57 first-level referral) for preterm/LBW babies.

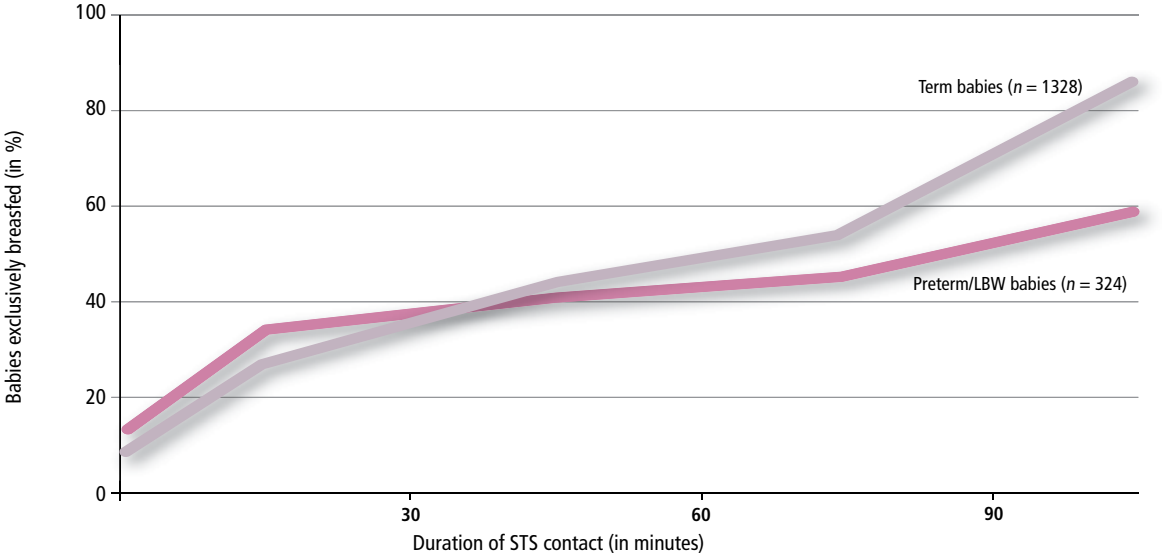
4. Estimate calculated from applying national caesarean section and facility delivery rates (sources: Country Demographic and Health Surveys and Multiple Indicator Cluster Surveys, 2006–2015, National Health Statistics Annual Report of China, 2016, Mongolia Health Indicators, 2015) to 2015 birth cohorts (The State of the World's Children, UNICEF, 2016). Estimated rates of STS contact with caesarean section were then applied to the regional estimate for total caesarean section births in health facilities.

FIGURE 7. Breastfeeding practices – term, preterm and LBW babies, eight countries, June 2017



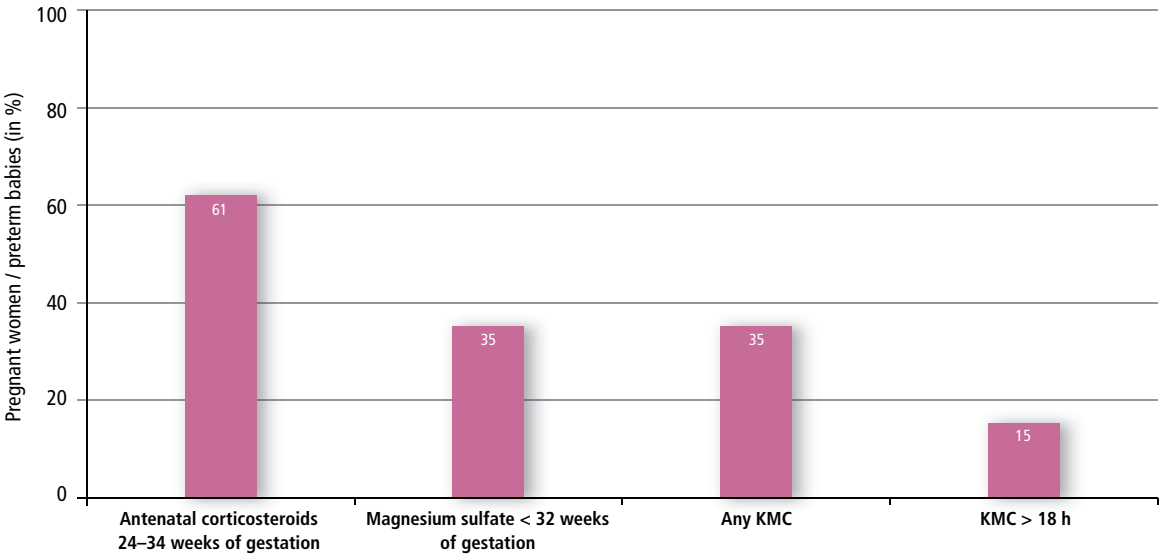
Source of data: Interviews with postnatal mothers in 161 randomly selected health facilities implementing EENC (32 national/regional, 121 first-level referral and eight first-level) for term babies, and 85/161 health facilities (28 national/regional, 57 first-level referral) for preterm/LBW babies.

FIGURE 8. Percentage of babies exclusively breasfed prior to discharge by duration of skin-to-skin (STS) contact – term, preterm and LBW babies, seven countries, June 2017



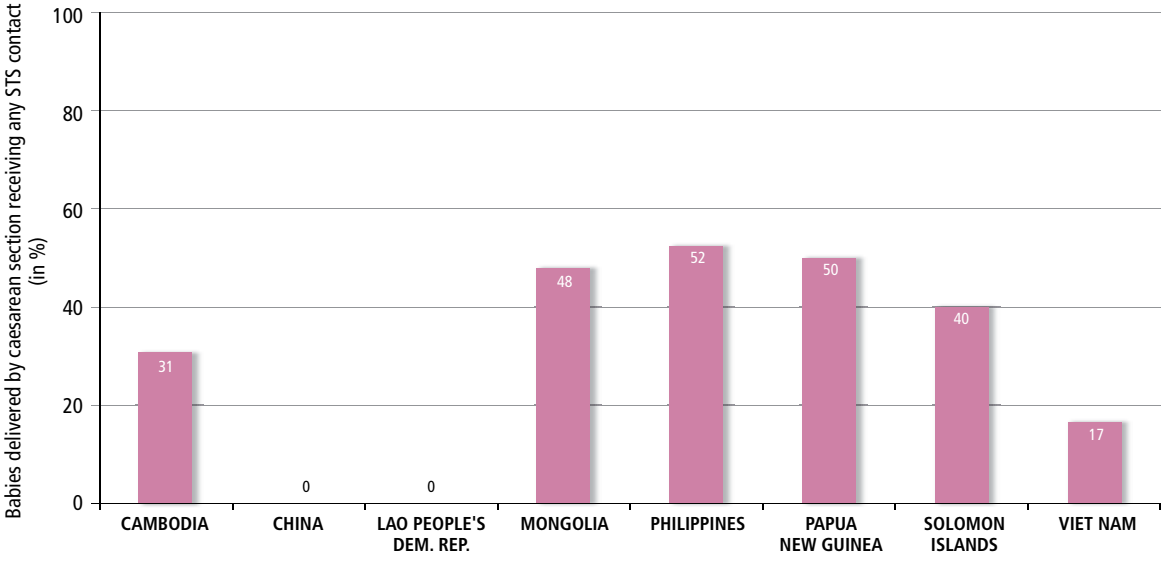
Source of data: Interviews with postnatal mothers in 155 randomly selected health facilities implementing EENC (29 national/regional, 118 first-level referral and eight first-level) for term babies, and 80/161 health facilities (26 national/regional, 54 first-level referral) for preterm/LBW babies. Does not include data from China.

FIGURE 9. Management of preterm and LBW babies, eight countries, June 2017



Source of data: 85 randomly selected hospitals implementing EENC across eight countries. KMC practices from interviews of 344 postnatal mothers, antenatal corticosteroids for 24–34 weeks of gestation from chart reviews of 227 postnatal mothers, magnesium sulfate for < 32 weeks of gestation from chart reviews of 75 postnatal mothers.

FIGURE 10. Term babies born by caesarean section receiving any skin-to-skin (STS) contact, eight countries, June 2017

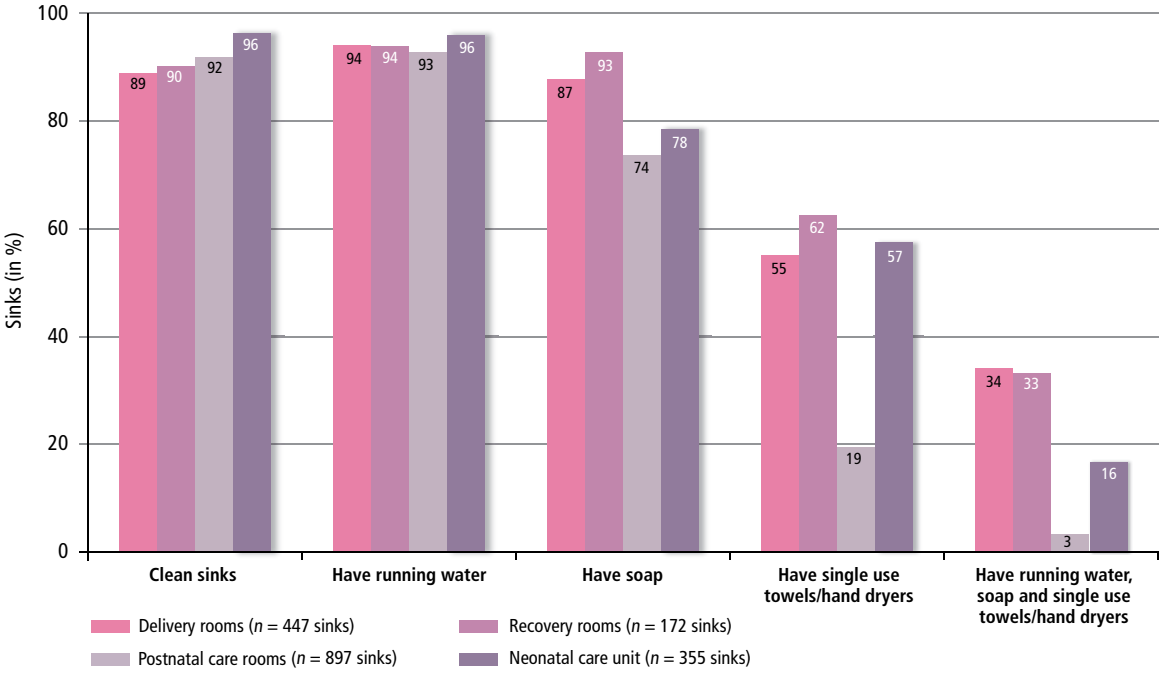


Source of data: Interviews with postnatal mothers of term babies in 83 randomly selected health facilities implementing EENC (25 national/regional, 58 first-level referral).

Environmental hygiene practices

Only 39% (933/2378) of delivery, operating, NCU and postnatal care rooms across 161 health facilities had sinks with soap, running water and disposable towels (or hand dryer), and 59% (1398/2378) of all rooms had alcohol hand gel available. Only 3% of sinks (31/897) in postnatal care rooms have all supplies needed for effective handwashing, because hospitals often require patients to bring their own supplies (Fig. 11). Observations of delivery practice found that adequate hand hygiene was practised in only 66% of cases.[5] Although not formally measured, hospital observations and reports from staff members indicate that use of cell phones by both staff and patients in facilities is common, with limited washing of hands after using phones and touching newborns. Hand hygiene is a major problem in the Region.

FIGURE 11. Handwashing facilities by room type in 155 health facilities, seven countries, June 2017



Source of data: Observations of environmental hygiene in 155 randomly selected health facilities implementing EENC (29 national/regional, 118 first-level referral and eight first-level). Does not include data from China.

5. Adequate hand hygiene comprises washing hands twice, the first before setting up the delivery area and the second before putting on sterile gloves for delivery, and then using sterile gloves prior to cutting the umbilical cord.

Essential medicines and commodities

Essential medicines and commodities were generally available in facilities, with stock-outs rarely a problem for most medicines (Annex 5). Stock-outs were reported most commonly for antenatal corticosteroids. Oxytocin was generally available, but in several facilities was stored at room temperature, not at 2–8 °C as recommended. Continuous positive airway pressure (CPAP) machines were often not available at first-level referral hospitals. Ambu bags and masks were available and functional in 81% (438/541) of resuscitation areas across 161 health facilities, and newborn resuscitation areas were within two metres of delivery beds – as recommended by EENC standards – in 81% (131/161) of facilities.

BOX 4. Separation of mothers and babies: a habit that must be broken

Early separation of mothers and their babies remains common, especially for preterm and LBW babies and those born by caesarean section.

- **Why is early separation harmful?**

Early separation increases the risks of hypothermia, infection and death and limits other benefits of STS contact including early and exclusive breastfeeding. Admission to neonatal care units compounds these risks. Approximately 85% of preterm infants are 32–36 weeks of age and do not require highly specialized care.

- **Why are preterm and LBW babies who are otherwise stable separated?**

» Incorrect policies and patient management protocols that require all preterm and LBW babies and those born by caesarean section to be routinely admitted to NCUs for observation and procedures.

» Incorrect staff perceptions that routine tasks must be done immediately, that small babies need specialized care in a NCU, and that the mother is not capable of supporting her baby.

» Financial incentives to provide highly specialized care (conflicts of interest)

» Lack of staff to support and monitor babies kept with their mothers

- **What can be done to reduce early separation?**

» *All babies* – Modify delivery room protocols, better educate staff and reorganize work environments to allow delayed routine tasks, with commitment of delivery room managers and senior staff.

» *Preterm and LBW babies* – Restrict NCU admission policies, reorganize postnatal care rooms to allow prolonged STS contact, coach staff and allocate space and resources for KMC, and monitor progress.

» *Caesarean section deliveries* – Develop a clear protocol for EENC with caesarean section, and coach all operative and recovery room staff, including anaesthesiologists, obstetricians and nurses. Allocate additional staff to assist with positioning and support of the baby in the STS position.

4

Tracking hospital impact

While hospital impact data should be able to help in clinical decision-making, help identify outbreaks and track long-term trends, only 6% of national/regional and first-level referral hospitals that have introduced EENC (*n* = 80) reported any of the nine hospital impact indicators. Of those reporting hospitals, complete data were available for 71% and partial data for 12% of indicators. Ninety-eight per cent of hospital impact indicators for which data were available, or partially available, were validated (Table A3.3 in Annex 3).

Large-scale collection of hospital data has not been possible in any country except Mongolia, which has integrated hospital impact data into the routine MCH surveillance system. Cambodia has integrated five EENC indicators into a web-based health management information system (HMIS), although data quality issues remain.

Hospital data reviews and anecdotal reports from staff reveal that problems with hospital data collection are common in all countries. Case definitions for live births, neonatal deaths and stillbirths may not match international standards; case definitions of neonatal sepsis and asphyxia are often different within and between countries. In some settings, babies in the NCU are discharged when very sick or likely to die and therefore are never registered as deaths. Case registers are often incomplete and inaccurate. For this reason, assessments of hospital routine reporting systems to identify gaps and problems are recommended so that action can be tailored to local needs.

A rapid assessment method, using simple tools to identify data gaps and actions to address these gaps, has been developed and used in Cambodia and Mongolia. This method validates reported EENC hospital indicators by conducting a register review and interviewing staff who collect and use data. The assessment in Mongolia found high accuracy in transfer of EENC hospital impact indicators from patient charts to an electronic database. Only for indicators of preterm births and deaths was under- or over-reporting noted due to incorrect definitions of preterms.

In Cambodia, consistent under- or over-reporting of several EENC indicators was found. This was attributed to several factors, namely paper-based systems that are prone to errors in data transfer, incomplete recording in registers, and incorrect

indicator definitions. Neonatal deaths were undercounted by 95% in the HMIS for the period assessed because deaths in paediatric wards were not counted in the database. Other factors likely to influence data quality are the use of multiple recording sources, lack of formal tally sheets, and insufficient feedback to hospitals on data reported that would help identify strengths and areas for improvement on data quality. Findings were discussed by staff at all levels of the system and feasible solutions to problems developed.

This approach has value for all countries collecting EENC hospital data to help improve data quality and completeness.

5

EENC intervention coverage and population impact

Population coverage

Improving population coverage of EENC interventions is the primary outcome of the EENC programme and a result of effective policy and systems inputs. No new data were available since 2015 for four countries, with three countries (China, Mongolia and Viet Nam) adding updates from routine HMIS data, and Solomon Islands from a Demographic and Health Survey (DHS) (Annex 4).

Thirteen indicators are reported to track population-based coverage. All eight countries reported on the coverage indicators, with data available for 67% of indicators. Ninety-one per cent of available data were validated (Table A 3.4 in Annex 3). Coverage data were least often available from countries that have not conducted large-sample, population-based surveys regularly. Indicators most frequently reported were skilled birth attendance, facility delivery rates, caesarean section rates, and mothers receiving postnatal care within two days of birth. Indicators least frequently reported were newborn care practices.

The review highlighted three main points about population coverage. First, reliable measures of immediate newborn care practice, important for validating national progress, have not been included in population-based surveys, such as DHS or Multiple Indicator Cluster Survey (MICS) with the exception of the 2013 Philippines DHS that included an indicator on early STS contact. Incorporating these indicators into such surveys will require programme managers and planners to actively participate in the development of survey questionnaires.

Second, the review again noted the high rates of deliveries by skilled attendants and at facilities in most priority countries. High coverage levels (Fig. A 4.1 in Annex 4) mean that improving the quality of care remains a key priority for further reductions in maternal and newborn deaths and illness. In particular, increasing rates of facility delivery mean that caesarean section deliveries are likely to further increase. Population coverage data show very high national caesarean section rates in three priority countries (Fig. A 4.1 in Annex 4), particularly in urban areas. While data

are not available on the proportion of unnecessary caesarean sections in countries with high rates, caesarean section rates higher than 10% are not associated with reductions in maternal and newborn mortality *(16)*. Eliminating procedures conducted for non-medical reasons and ensuring babies born by caesarean section also benefit from EENC are critical in the next two years.

Third, national coverage rates mask important inequities associated with wealth and educational status, urban/rural residence and other factors that remain common in most countries *(17)*. For example, although caesarean section rates in Cambodia are 6.3% nationally, rates among provinces range from 2% to 14% *(18)*. Similarly, in the Lao People's Democratic Republic, with a national caesarean section rate of 4%, rates among provinces range from 0.5% to 15% *(19)*. Location of high-risk populations may influence areas to target for early implementation and scale-up of EENC. Unnecessary procedures, a growing problem with increased facility delivery rates, will need to be better understood and evidence-based criteria more widely adopted.

Impact indicators for newborn health

Five indicators tracking newborn health impact were reported by all eight countries. Data on preterm birth rates using modelled estimates were added where data were not reported in 2015 *(20)*. China, Mongolia and Viet Nam updated impact data using routine health information statistics and Solomon Islands did so using 2015 DHS data. Sources of impact data included the United Nations Inter-agency Group for Child Mortality Estimation (IGME) (for neonatal mortality estimates and causes of death), population-based surveys, and routine surveillance data in countries with relatively high system coverage and reporting (China and Mongolia). Eighty-five per cent of impact indicators for newborn health were reported by countries. Data were most frequently unavailable for perinatal mortality (Table 2). Ninety-four per cent of available data were validated (Table A 3.5 in Annex 3).

All countries collect mortality and birthweight data and use these data for tracking progress. Findings were similar to those in 2015. The review re-emphasized three important conclusions based on findings. First, preterm birth rates should be included in population-based surveys or routine data systems. Second, countries should prioritize improving the collection of newborn data using routine HMIS. Current challenges with routine information systems include under-registration and under-reporting of live births, neonatal deaths and stillbirths (number and

causes), no routine reporting of neonatal deaths separate from child deaths, and non-application of globally recommended standard case definitions for many indicators. HMIS data are currently used for tracking newborn health impact data in two countries (China, Mongolia), although the accuracy and precision of these data have not been validated.

TABLE 2. Population impact indicators, eight countries, February 2018

	CAMBODIA	CHINA	LAO PEOPLE'S DEM. REP.	MONGOLIA	PAPUA NEW GUINEA	PHILIPPINES	SOLOMON ISLANDS	VIET NAM
Neonatal mortality rate (per 1000 live births)	18.0	5.4	29.0	10.2	24.0	13.0	9.0	12.0
Perinatal mortality rate (per 1000 live births)	20.0	4.9	No data	14.6	No data	22.0	14.0	No data
Proportional causes of neonatal death								
– sepsis	16.7%	2.6%	16.3%	2.8%	16.0%	13.4%	14.8%	8.6%
– tetanus	0.3%	0.0%	1.2%	0.0%	0.9%	0.3%	0.3%	0.6%
– birth asphyxia	23.1%	25.5%	28.7%	7.5%	27.5%	23.9%	23.1%	13.5%
– preterm birth	31.1%	30.8%	28.2%	No data	30.0%	31.0%	31.2%	40.4%
– congenital anomalies	15.5%	15.2%	9.7%	9.6%	11.0%	16.8%	18.0%	22.7%
Low-birthweight rate (< 2500 g)	7.9%	2.6%	14.8%	No data	No data	21.4%	10.2%	6.8%
Preterm-birth rate (< 37 weeks)	10.5%	7.8%	10.8%	13.5%	6.5%	14.9%	12.4%	9.4%

Source of data: Data from country Demographic and Health Surveys and Multiple Indicator Cluster Surveys, 2006–2015. For China and Mongolia, data are from routine health information systems. Neonatal mortality estimates are from IGME for countries where surveys were not conducted in the past three years. Data on proportional causes of death are from 2018 WHO-Maternal Child Epidemiology Estimations for the year 2016. Estimates on preterm birth rates are from national, regional, and worldwide estimates of preterm birth rates in the year 2010 with time trends since 1990 for selected countries: a systematic analysis and implications (Blencowe et al., 2012). For Viet Nam, the preterm birth rate estimate is from the 2016 National Reproductive Health Annual Report.

6

Accelerating progress towards universal adoption of EENC

At the Western Pacific High-level Forum on Accelerating Progress in Early Essential Newborn Care, held in Da Nang, Viet Nam (16–17 August 2017), high-level representatives agreed on areas for improvement that must be further addressed to accelerate progress towards adoption of EENC *(1)* (Annex 6).

Continued high-level support and advocacy is needed to consolidate gains

All country representatives reiterated their readiness to continue to promote EENC through improved laws, regulations, decrees and updated clinical protocols. They agreed on the urgent need to improve use of EENC for preterm and LBW babies and those born by caesarean section. They committed to reducing unnecessary over-medicalization of care for women and babies and to reducing conflicts of interest that are often behind these practices.

Communication will accelerate demand and supply

There was widespread recognition that improved communication is essential for both improving the demand for EENC from mothers and families, and for providing information to health workers and policy-makers. At the meeting, two new videos – an EENC documentary and another on the use of EENC with caesarean section were released. Within a few days, more than 230 000 people viewed and 2200 shared the EENC documentary on Facebook, highlighting intense demand for information and visual material. A rich dialogue emerged in which respondents answered each other's concerns, shared WHO information and called on their physicians to ensure the First Embrace is practised at every birth. The press conference held on the final day of the high-level forum attracted considerable interest, and resulted in 35 articles and four television broadcast stories, with journalists also attending the Da Nang Hospital for Women and Children tour and seeing KMC practised up close.

"KMC is so simple, it is revolutionary. I'm taking this back to my country." – Undersecretary, Ministry of Health and Medical Services, Solomon Islands.

Improved collaboration between obstetrics, midwifery and paediatrics remains important

Bridging traditional divisions between obstetric and newborn care around delivery remains critical for extending care to all babies. This is particularly important for extending EENC to caesarean section deliveries and the management of preterm babies. Study tours to various countries demonstrating successful approaches, the production and use of educational videos and documentaries, and the publication of papers on scaling up EENC in peer-reviewed journals may all be useful for engaging various stakeholders – in addition to ongoing policy and programme activities in countries.

7

Priority actions to consolidate gains and further scale up EENC in the next biennium

During the Second Biennial Meeting on Accelerating Progress in Early Essential Newborn Care in Da Nang, Viet Nam, on 14–17 August 2017, representatives from the eight priority countries discussed the status of EENC implementation, and identified challenges and priority actions for the next two years (see country road maps in the full report of the meeting) *(21)*. There was consensus across all countries that priority actions need to focus on six main areas (Table 3). The emphasis placed on each action will vary according to the current status of EENC implementation and systems capacity in the next two years.

TABLE 3. Priority actions developed by eight countries: consolidating gains and further scaling up EENC in the next biennium

	Strengthen laws, regulations, policies, guidelines and advocacy
	PURPOSE: *Ensure evidence-based standards are applied widely and sustained*
PRIORITIES	– Evidence-based routine delivery practices and respectful care – EENC with caesarean sections – Elimination of unnecessary caesarean sections – National KMC guidelines – EENC practices incorporated into pre-service curricula for medicine, nursing, midwifery – EENC/KMC practices included in service packages reimbursed by health insurance
	Continue to scale up EENC coaching
	PURPOSE: *Complete coaching for all obstetrics, midwifery and paediatric staff*
PRIORITIES	– Develop plans to expand and maintain quality of EENC clinical coaching – Ensure coaching meets standards – 6:1 participant-to-facilitator ratio; two days full-time – Train more accredited facilitators to support expansion – Consider establishing centres of excellence to coordinate and support EENC coaching

	Introduce KMC for preterm and LBW babies and EENC for caesarean section deliveries
	PURPOSE: *Improve care of babies who currently do not receive the benefits of EENC*
PRIORITIES	– Coach facilitators in KMC and EENC with caesarean section – Develop scale-up plan for phased introduction at provincial hospitals or higher – Begin KMC in hospitals where most staff have been coached and are practicing EENC

	Improve systems to maintain quality of EENC clinical practices
	PURPOSE: *Modify systems to support and encourage EENC evidence-based practices at all deliveries*
PRIORITIES	– Establish EENC teams to oversee EENC implementation and monitor quality of care – Ensure regular self-assessments of quality of care and planning by EENC hospital teams – Prioritize organization of work to allow 90 minutes of skin-to-skin contact, early and exclusive breastfeeding – Address barriers to improve hand hygiene urgently – Include EENC/KMC practices in hospital accreditation standards – Ensure regular collection of data for tracking progress using the EENC Monitoring and Evaluation Framework

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Annexes

ANNEX 1

Early Essential Newborn Care (EENC)

Early Essential Newborn Care (EENC) is the central pillar of the regional approach to preventing neonatal mortality. It is a package of evidence-based interventions demonstrated to reduce mortality from the three most important causes: prematurity, birth asphyxia and sepsis.

The EENC approach consists of:

- The First Embrace
- Prevention and care of preterm (< 37 weeks) and low-birthweight (< 2500 g) babies
- Prevention and care of sick newborn infants

Because the greatest risk of death and adverse outcomes comes during childbirth and in the first 24 hours of life, EENC emphasizes improving the quality of childbirth and the quality of newborn and postnatal care in the first 24 hours after birth. EENC focuses on eliminating harmful and outdated practices, including unnecessary procedures and admissions to neonatal care units, and replacing them with evidence-based practices. Improving practices during delivery and the immediate postpartum period improves outcomes for both mothers and babies. EENC is implemented through existing services and helps to identify health systems gaps that need to be strengthened.

Core interventions of Early Essential Newborn Care

		INTRAPARTUM CARE	NEWBORN CARE
All mothers and newborn infants	1. The First Embrace	Labour monitoring (partograph)	• Immediate drying • Immediate skin-to-skin contact • Appropriately timed clamping and cutting of the cord • Exclusive breastfeeding • Routine care – eye care, vitamin K, immunizations, weighing and examination
At-risk mothers and newborn infants	2. Preterm and low-birthweight infants	• Preterm labour – Elimination of unnecessary inductions and caesarean sections – Antenatal steroids – Antibiotics for preterm PROM	• Kangaroo Mother Care • Breastfeeding support • Immediate treatment of suspected infection
	3. Sick newborn infants	• Obstructed/prolonged labour • Fetal distress: – Assisted delivery – Caesarean section	• Not breathing at birth: resuscitation • Suspected sepsis: antibiotic treatment

EENC interventions

TABLE A 1.1 Detailed EENC interventions for all and high-risk mothers and newborn infants

ALL MOTHERS AND NEWBORN INFANTS
1. THE FIRST EMBRACE
All mothers
– Maintain a supportive environment (e.g. companion and position of choice, elimination of unnecessary/harmful procedures)
– Avoid environmental exposure to cold, draughts and infection
– Maternal and fetal monitoring during labour including use of the partograph
– Improved recognition of labour signs, care and referral of woman with risk factors (e.g. hypertension, diabetes, preterm labour) and management of obstetric complications, especially pre-eclampsia/eclampsia
– Set up newborn resuscitation area, including checking equipment for functionality
– Organize delivery space
– Postnatal care visits to include counselling for routine newborn care and danger signs
– HIV and syphilis point-of-care rapid testing
All newborn infants
– Immediate and thorough drying
– Delayed bathing
– Immediate skin-to-skin contact
All newborn infants, if breathing
– Appropriately timed cord clamping, cut once
– Exclusive breastfeeding when feeding cues occur
– Rooming in/keeping warm
– Routine care (e.g. eye care, vitamin K, immunizations and examinations) delayed until after a full breastfeed
– Elimination of harmful practices including routine suctioning, placing substances on the cord stump, and prelacteal feeds
– Postnatal care visits
All mothers and newborn infants
– Avoidance of exposure to nosocomial pathogens through: » hand hygiene and other infection prevention measures » non-separation unless urgent care required

TABLE A 1.1 Detailed EENC interventions for all and high-risk mothers and newborn infants *(continued)*

HIGH-RISK MOTHERS AND NEWBORN INFANTS

2. PREVENTION AND CARE OF PRETERM AND LBW NEWBORN INFANTS

High-risk mothers and newborn infants

- Elimination of unnecessary induction of labour and caesarean sections
- Antenatal steroids (and tocolytics [1])
- Antibiotics [2] for preterm pre-labour rupture of membranes
- Kangaroo Mother Care
- Feeding with breast milk
- Monitoring for complications

3. PREVENTION AND CARE OF SICK NEWBORN INFANTS

Newborn infants who are not breathing despite thorough drying (asphyxia)

- Bag and mask ventilation
- Post-resuscitation care (including aseptic cord trimming), monitoring and referral of cases with incomplete recovery/severe conditions

Sick newborn infants and newborn infants with complications of birth

- Standard case management of newborn sepsis and other newborn problems (e.g. pneumonia, meningitis, other infections, jaundice, malformations)
- Identification of at-risk newborn infants
- Stabilization (including prevention of hypothermia, hypoglycaemia, hypoxaemia, apnoea and infection) prior to timely referral
- Oxygen and/or continuous positive airway pressure (CPAP) for those with respiratory distress
- Care of seriously ill newborn infants
- Antiretrovirals for infants exposed to HIV and penicillin for those exposed to syphilis
- Referral between levels of care and wards

1. As of 2015, tocolytics for inhibiting preterm labour are no longer recommended by WHO. Corticosteroids and magnesium sulfate are now recommended.
2. Erythromycin is recommended as the antibiotic of choice, use of a combination of amoxicillin and clavulanic is not recommended (WHO 2015 recommendations on interventions to improve preterm birth outcomes).

ANNEX 2

EENC Monitoring and Evaluation Framework (2015–2020)

TABLE A 2.1 Benchmarks of EENC scale-up readiness

Review benchmarks annually to track progress with benchmarks scoring "No" or "Partial" and to ensure that benchmarks that previously scored "Yes" have not changed.

Benchmarks Yes, No, Partial or No Data	Status by year						Target
	2015	2016	2017	2018	2019	2020	
1. Newborn health situation analysis conducted in the previous five years used for strategic planning[1]							YES
2. Five-year EENC action plan developed based on *Regional Action Plan for Healthy Newborns,*[2] costed and adopted by the Ministry of Health							YES
3. EENC annual implementation review conducted at least biennially to inform development of annual implementation plans[3]							YES
4. Detailed annual EENC Implementation Plan funded							YES
5. EENC technical working/coordination group meets regularly[4]							YES
6. Full-time EENC/newborn health focal person appointed in the Ministry of Health							YES
7. EENC stakeholder group meets regularly[5]							YES
8. Clinical Intra-Partum and Newborn Care Protocol endorsed[6]							YES
9. Mechanisms established to ensure that professional associations are supporting implementation of EENC							YES
10. Proportion of EENC interventions (normal and high-risk deliveries) included in pre-service training curricula: a) medical; b) nursing; c) midwifery[7]							100% for all

1. Situation analysis includes: review of trends in newborn, child and maternal morbidity and mortality and intervention coverage along the continuum of care; an analysis of newborn health equity for different populations and groups; and status of key systems inputs to support delivery of newborn health interventions.
2. World Health Organization Regional Office for the Western Pacific, UNICEF. Action Plan for Healthy Newborn Infants in the Western Pacific Region (2014–2020). Manila, World Health Organization; 2014.
3. World Health Organization Regional Office for the Western Pacific. Annual implementation review and planning guide. Early Essential Newborn Care Module 1. Manila, World Health Organization; 2018.
4. Membership may include: ministry of health public health divisions, obstetric and paediatric decision-makers, professional associations, civil society organizations and development partners. Quarterly meetings are recommended.
5. Membership may include: policy-makers, legislators, health providers, hospital administrators, civil society leaders, development partners, media practitioners, academia and health professional associations. Quarterly meetings are recommended.
6. Most countries adapt and use the *Early Essential Newborn Care: Clinical Practice Pocket Guide* developed by the WHO Regional Office for the Western Pacific, 2014.
7. Technical content consistent with international EENC standards – curricula include clinical EENC coaching as part of the teaching method. EENC core interventions are described in Annex 1.

TABLE A 2.2 Health facility EENC standards

Use hospital summary forms to complete one table for all facilities of each level: (a) national and regional hospitals; (b) first-level referral hospitals; and (c) first-level where deliveries take place.[1] Note indicators where findings differ between different levels of facilities. Combine summary data for term and preterm babies for all practice measures.

Level of facility: _____

	Indicator	Data by year						Target
		2015	2016	2017	2018	2019	2020	
1.	**Proportion of staff providing childbirth, newborn and postpartum care services that are coached in EENC**							90%
2.	**Proportion of facilities using a quality improvement approach to support implementation of EENC**							90%
3.	**Pregnant women of 24–34 weeks of gestation at risk of imminent preterm birth and with no clinical evidence of infection administered the full course of intramuscular dexamethasone or betamethasone prior to childbirth**							90%
4.	**Proportion of women receiving all key delivery care tasks:**							4.a–4.d all 90%
	a. Companion of choice							90%
	b. Non-supine position during second stage							90%
	c. Food and fluids							90%
	d. No fundal pressure							90%
5.	**Proportion of mothers with a correctly completed partograph**							90%
6.	**Proportion of breathing newborns that receive:**							
	a. Immediate skin-to-skin contact							90%
	b. Early and exclusive breastfeeding in the immediate newborn period							90%
	c. Immediate and sustained skin-to-skin contact for at least 90 min and a complete breastfeed							80%
7.	**Proportion of newborns with a birthweight ≤ 2000 g who in the previous 24 hours received:**							
	a. Any Kangaroo Mother Care							80%
	b. Continuous Kangaroo Mother Care for at least 20 h							50%
8.	**Proportion of women who receive breastfeeding counselling in the immediate newborn period**							100%
9.	**Proportion of delivery room(s), operation room(s), neonatal care unit(s) (NCUs), and postnatal care room(s) that have adequate handwashing resources**							100%

TABLE A 2.2 Health facility EENC standards *(continued)*

Indicator	Data by year						Target
	2015	2016	2017	2018	2019	2020	
10. Proportion of health facilities with no stock-outs of key life-saving medicines required to provide EENC							100% (10.a–10.d all 100%)
a. Magnesium sulfate for severe pre-eclampsia and eclampsia, and fetal neuroprotection if gestational age < 32 weeks							100%
b. Oxytocin for the prevention and control of postpartum haemorrhage for all births							100%
c. Corticosteroids for women at 24–34 weeks of gestation at risk of preterm delivery							100%
d. Injectable antibiotics for management of newborn sepsis							100%
11. Proportion of health facilities with functional key life-saving commodities required to provide EENC							100% (11.a–11.c all 100%)
a. Functional newborn ambu bag and preterm and term masks (sizes 0 and 1) within 2 m of each delivery bed							100%
b. Continuous supply of oxygen for newborn use (national, regional and first-level referral hospitals)							100%
c. Continuous positive airway pressure (CPAP) (national, regional and first-level referral hospitals)							100%
12. Proportion of health facilities that have eliminated baby-food industry conflicts of interest							100% (12.a–12.c all 100%)
a. Health facilities where no mother has products or gifts from baby-food companies							100%
b. Health facilities with a written policy to prohibit use of infant formula and other baby-food company activities							100%
c. Health facilities with no promotional baby-food materials including posters, brochures, pamphlets or items with logos on their premises							100%
13. Proportion of EENC health facility standards (1–12) achieved							70%

1. a) National- and regional-level facilities: offer services of first-level referral plus advanced neonatal care including CPAP; serve as teaching hospitals and provide support to lower-level facilities.

   b) First-level referral facilities: offer services of first level plus management of preterm labour and common complications of prematurity (e.g. oxygen), advanced resuscitation, complications of delivery including assisted delivery and caesarean sections.

   c) First-level facilities: where deliveries take place, should have the capacity for care of breathing and non-breathing babies.

TABLE A 2.3 Hospital impact indicators

Use routine health management information system (HMIS) data or register reviews from hospitals that have begun implementing EENC to complete one table for each level of facility: a) national and regional hospitals; and b) first-level referral hospitals [1] for national estimates.

Level of facility: _____

	Indicator	Data by year						Target
		2015	2016	2017	2018	2019	2020	
3.1	Neonatal care unit/nursery admission rate							
3.2	Proportion of newborns by weight:							
	3.2.1 < 1000 g							
	3.2.2 1000–1499 g							
	3.2.3 1500–1999 g							
	3.2.4 2000–2499 g							
	3.2.5 ≥ 2500 g							
3.3	Proportion of newborns born at the facility classified with newborn sepsis [2]							
3.4	Proportion of newborns born at the facility classified with birth asphyxia [3]							
3.5	Newborn mortality rate stratified by weight:							
	3.5.1 < 1000 g							
	3.5.2 1000–1499 g							
	3.5.3 1500–1999 g							
	3.5.4 2000–2499 g							
	3.5.5 ≥ 2500 g							
3.6	Case-fatality rate (% registered cases dying):							
	3.6.1 Preterm [4] newborns							
	3.6.2 Low-birthweight newborns [5]							
	3.6.3 Newborn sepsis							
	3.6.4 Newborn asphyxia							

1. a) National and regional facilities: offer services of first-level referral plus advanced neonatal care including CPAP; serve as a teaching hospitals and provide support to lower-level facilities.

   b) First-level referral facilities: offer services of first level plus management of preterm labour and common complications of prematurity (e.g. oxygen), advanced resuscitation, complications of delivery including assisted delivery and caesarean sections.
2. Bacterial sepsis of the newborn: ICD-10 P36 (codes P36.0–P36.9, sepsis of known cause or unknown cause).
3. Birth asphyxia is defined as newborns who are gasping or not breathing at one minute of age.
4. Preterm newborns are live births less than 37 completed weeks gestation (ICD-10 P07.2 and ICD-10 P07.3).
5. Low birthweight is defined as a birthweight of < 2500 g.

TABLE A 2.4 Coverage indicators for EENC interventions

Use representative population-based surveys – Demographic and Health Survey (DHS) and Multiple Indicator Cluster Survey (MICS) or other population-based surveys – to periodically measure coverage, and HMIS and health-facility assessment data to track trends in coverage between surveys. Data are disaggregated by administrative or geographic divisions for subnational tracking and programme planning.[1]

National or subnational area: _____

	Coverage measure	Data by year (specify source)						Target
		2015	2016	2017	2018	2019	2020	
4.1	% of live births attended by skilled health personnel							90%
4.2	% of live births that take place at health facilities							90%
4.3	% of live births delivered by caesarean section							
4.4	% of live rural births delivered by caesarean section							
4.5	% of newborns dried after birth							100%
4.6	% of newborns with delayed bath after birth [2]							100%
4.7	% of newborns placed on the mother's bare abdomen or chest immediately after delivery (skin-to-skin)							100%
4.8	% of newborns breastfed within one hour of birth [3]							100%
4.9	% of newborns receiving a prelacteal feed							0%
4.10	% of live births with a reported birth weight							100%
4.11	% of women receiving postnatal care within two days of birth							100%
4.12	% of newborns receiving postnatal care within two days of birth							100%
4.13	% of newborns 0–1 month who are exclusively breastfed							100%

1. For survey methods and standard definitions of coverage indicators, see: http://www.dhsprogram.com/data/ Data-Tools-and-Manuals.cfm and http://mics.unicef.org.
2. Delayed bathing: at least 24 hours after birth.
3. The standard population-based survey indicator currently measures breastfeeding within 1 hour of birth and not the wider 90-minute window during which breastfeeding can occur.

TABLE A 2.5 Impact indicators for newborn health

Use large sample population-based surveys (DHS, MICS, or other large sample surveys) in most settings and civil registration and vital statistics (CRVS) data where available, valid and reliable. Modelled mortality data [United Nations Inter-agency Group for Child Mortality Estimation (IGME) and Child Health Epidemiology Reference Group (CHERG)] may be used to track trends. Data are disaggregated by country administrative or geographic divisions for subnational tracking and programme planning.[1]

National or subnational area: _____

	Population impact indicators	Data by year (specify source)						Target
		2015	2016	2017	2018	2019	2020	
5.1	Neonatal mortality rate (per 1000 live births)							10
5.2	Stillbirth rate [2] (per 1000 births)							
5.3	Perinatal mortality rate [3] (per 1000 live births)							
5.4	Proportional causes of neonatal death:							
	5.4.1 Sepsis							
	5.4.2 Tetanus							
	5.4.3 Birth asphyxia							
	5.4.4 Preterm birth							
	5.4.5 Congenital anomalies							
5.5	Low-birthweight rate (< 2500 g)							
5.6	Preterm birth rate (< 37 weeks)							

1. For survey methods and standard definitions of impact indicators, see: http://www.dhsprogram.com/data/Data-Tools-and-Manuals.cfm and http://mics.unicef.org.
2. For international comparisons and reporting, WHO/ICD defines stillbirths as the death of a fetus that has reached a birthweight of ≥ 1000 g, or if birthweight is unavailable, gestational age of ≥ 28 weeks or crown-to-heel length of ≥ 35 cm. It is expressed as the number of stillbirths per 1000 births. A stillbirth is defined as "death prior to the complete expulsion or extraction from its mother of a product of conception; the death is indicated by the fact that after such separation the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles without specification of the duration of pregnancy".
3. Perinatal mortality rate: The sum of the number of stillbirths and early neonatal deaths divided by the number of pregnancies of seven or more months' duration, expressed per 1000.

ANNEX 3

Validation of EENC monitoring and evaluation data from eight priority countries

EENC scale-up readiness benchmarks

Ten benchmarks are used to track scale-up readiness for EENC. All eight priority countries provided data for at least nine benchmarks, with data available for 95% of benchmarks overall. Eighty-nine per cent of available data were validated. Data were least often validated for the benchmarks "EENC stakeholder group formed" and "mechanisms established to ensure that professional associations are supporting implementation of EENC".

TABLE A3.1 Summary of the availability of data on EENC scale-up readiness benchmarks and validation status by country, June 2017

Indicator	CAMBODIA	CHINA	LAO PEOPLE'S DEM. REPUBLIC	MONGOLIA	PAPUA NEW GUINEA	PHILIPPINES	SOLOMON ISLANDS	VIET NAM	*n*/N (%)
Scale-up readiness benchmarks (N = 80 [1])									
Data available	9	9	10	10	10	10	9	9	76/80 (95%)
Data partially available	0	0	0	0	0	0	0	0	0/80 (0%)
Data not available	1	1	0	0	0	0	1	1	4/80 (5%)
Validated [2]	7	5	9	6	8	8	9	7	59/66 (89%)
Not validated [2]	1	0	1	2	1	1	0	1	7/66 (11%)

1. Number of benchmarks per country is 10; across eight countries data were collected for 10 × 8 = 80 indicators.
2. Validation of data applies only to those benchmarks for which data were available, and for benchmarks that had been achieved or partially achieved.

EENC facility standards

Twenty-three indicators are reported for EENC facility standards. Data were available for 65% of indicators across all countries (a doubling of availability from 2015), partially available for 31% and not available for 4%. A total of 95% of all indicators were validated. Data validation was not possible for a few indicators where supporting data were not provided or were not adequate for validation.

TABLE A3.2 Summary of the availability of data on EENC facility standards and validation status by country, June 2017

Indicator	CAMBODIA	CHINA	LAO PEOPLE'S DEM. REPUBLIC	MONGOLIA	PAPUA NEW GUINEA	PHILIPPINES	SOLOMON ISLANDS	VIET NAM	*n*/N (%)
Implementation indicators – Roll-out of EENC (N = 184 [1])									
Data available	23	23	22	3	2	3	22	22	120/184 (65%)
Data partially available	0	0	0	19	18	19	0	0	56/184 (31%)
Data not available	0	0	1	1	3	1	1	1	8/184 (4%)
Validated [2]	23	22	22	22	19	20	18	22	168/176 (95%)
Not validated [2]	0	1	0	0	1	2	4	0	8/176 (5%)

1. Number of indicators per country is 23; across eight countries data were collected for 23 × 8 = 184 indicators.
2. Validation was conducted for indicators with data available or partially available.

EENC hospital impact indicators

Nine indicators are reported on hospital impact. Of reporting hospitals, complete data were available for 71% of indicators, and data partially available for 12% of indicators. Ninety-eight percent of indicators with complete or partial data were validated.

TABLE A3.3 Summary of the availability of data on EENC hospital impact indicators and validation status by country, June 2017

Indicator	CAMBODIA	CHINA	LAO PEOPLE'S DEM. REPUBLIC	MONGOLIA	PAPUA NEW GUINEA	PHILIPPINES	SOLOMON ISLANDS	VIET NAM	*n*/N (%)
Hospital impact indicators – Roll-out of EENC (N = 72 [1])									
Proportion of hospitals that have introduced EENC reporting data [2]	3/ 104	0/ 6	17/ 53	25/ 26	3/ 19	24/ 428	6/ 7	2/ 687	80/ 1330 (6%)
Data available	9	0	6	9	9	9	9	0	51/72 (71%)
Data partially available	0	0	0	0	0	0	0	9	9/72 (12%)
Data not available	0	9	3	0	0	0	0	0	12/72 (17%)
Validated [3]	9	0	6	9	8	9	9	9	59/60 (98%)
Not validated [3]	0	0	0	0	1	0	0	0	1/60 (2%)

1. Number of indicators per country is 9; across eight countries data were collected for 9 × 8 = 72 indicators.
2. Number of national and regional, and first-level referral hospitals that have introduced EENC at the time of data collection.
3. Validation was conducted for indicators with data available or partially available.

EENC population coverage indicators

Thirteen indicators are reported to track population-based coverage. Coverage indicators were reported by eight countries and were available for 67% of all indicators, with 91% of indicators validated.

TABLE A3.4 Summary of the availability of data on population coverage indicators and validation status by country, June 2017

Indicator	CAMBODIA	CHINA	LAO PEOPLE'S DEM. REPUBLIC	MONGOLIA	PAPUA NEW GUINEA	PHILIPPINES	SOLOMON ISLANDS	VIET NAM	*n*/N (%)
Coverage indicators for EENC (N = 104 [1])									
Data available	10	7	9	9	3	11	10	11	70/104 (67%)
Data not available	3	6	4	4	10	2	3	2	34/104 (33%)
Validated [2]	10	7	9	9	0	11	10	8	64/70 (91%)
Not validated [2]	0	0	0	0	3	0	0	3	6/70 (9%)

1. Number of indicators per country is 13; across eight countries, data were collected for 13 × 8 = 104 indicators.
2. Validation was conducted for indicators with data available.

EENC impact indicators

Five indicators tracking newborn health impact were reported by all eight countries. Eighty-five per cent of impact indicators were reported by countries; no data were available for 13% of indicators; and 94% of all indicators were validated.

TABLE A3.5 Summary of the availability of data on impact indicators and validation status by country, June 2017

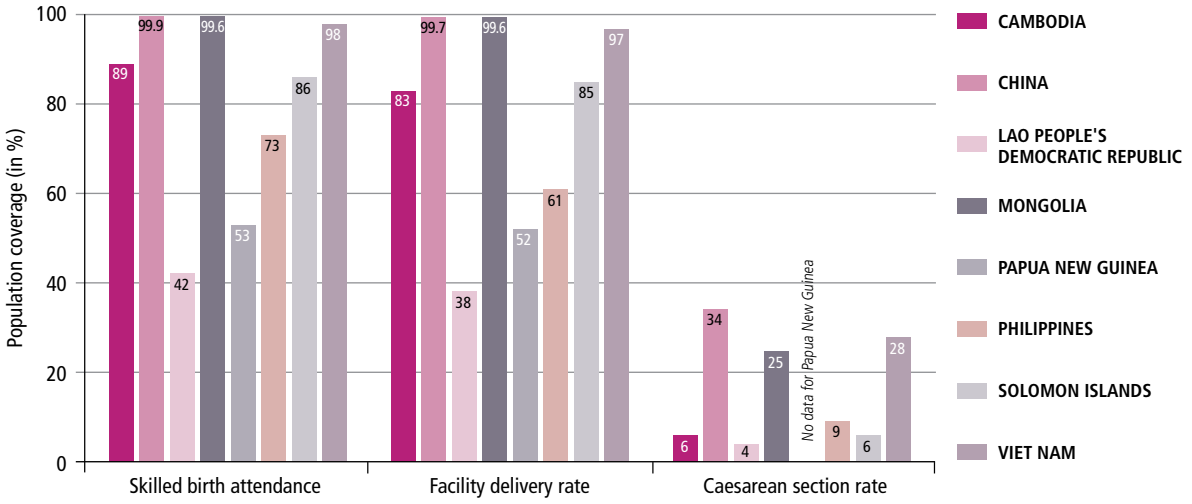
Indicators	CAMBODIA	CHINA	LAO PEOPLE'S DEM. REPUBLIC	MONGOLIA	PAPUA NEW GUINEA	PHILIPPINES	SOLOMON ISLANDS	VIET NAM	*n*/N (%)
Impact indicators for EENC (N = 40 [1])									
Data available	5	5	4	3	3	5	5	4	34/40 (85%)
Data partially available	0	0	0	1	0	0	0	0	1/40 (2%)
Data not available	0	0	1	1	2	0	0	1	5/40 (13%)
Validated [2]	5	3	4	4	3	5	5	4	33/35 (94%)
Not validated [2]	0	2	0	0	0	0	0	0	2/35 (6%)

1. Number of indicators per country is 5; across 8 countries, data were collected for 5 × 8 = 40 indicators.
2. Validation was conducted for indicators with data available or partially available.

ANNEX 4

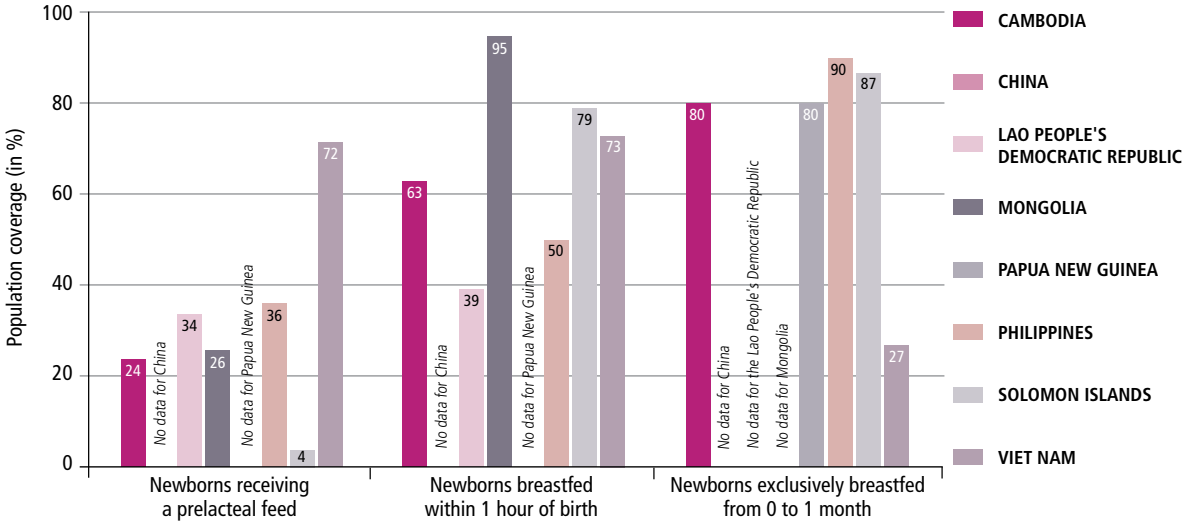
EENC population coverage indicators

FIGURE A4.1 Population coverage for skilled birth attendance, facility delivery and caesarean section, eight countries, 2006–2016



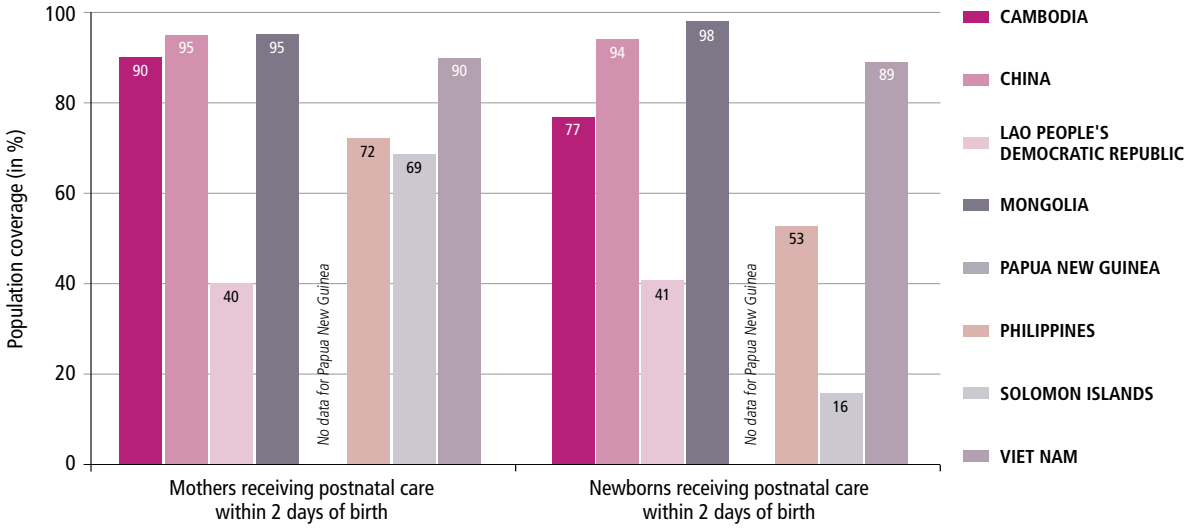
Source of data: Country Demographic and Health Surveys and Multiple Indicator Cluster Surveys, 2006–2015. National Health Statistics Annual Report of China, 2016. Mongolia Health Indicators, 2015. Viet Nam National Reproductive Health Annual Report, 2016.

FIGURE A4.2 Population coverage for prelacteal feeding, early breastfeeding and exclusive breastfeeding from 0 to 1 month, eight countries, 2006–2016



Source of data: Country Demographic and Health Surveys and Multiple Indicator Cluster Surveys, 2006–2015. National Health Statistics Annual Report of China, 2016. Mongolia Health Indicators, 2015. Viet Nam National Reproductive Health Annual Report, 2016 (for indicator on newborns breastfed within 1 hour of birth).

FIGURE A 4.3 Population coverage for maternal and newborn postnatal care, eight countries, 2006–2016



Source of data: Country Demographic and Health Surveys and Multiple Indicator Cluster Surveys, 2006–2015. National Health Statistics Annual Report of China, 2016. Mongolia Health Indicators, 2015.

ANNEX 5

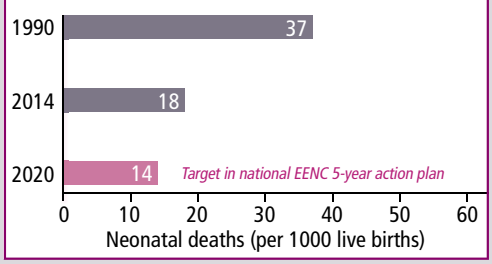
EENC country profiles

For all the above countries, the country profiles break into:

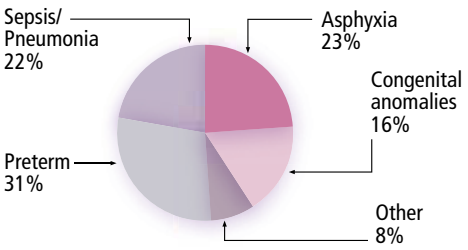
- Neonatal mortality rate
- Causes of neonatal death
- Programme readiness for EENC scale-up
- Stock-outs of key medicines and commodities for EENC in the past 12 months
- Coverage of key interventions
- EENC implementation
- Antenatal care and delivery practices
- Newborn care practices:
  - » Preterm
  - » Term babies
- Environmental hygiene
- Key Points

EARLY ESSENTIAL NEWBORN CARE
CAMBODIA (1)

NEONATAL MORTALITY RATE[1]



CAUSES OF NEONATAL DEATH, 2016[2]



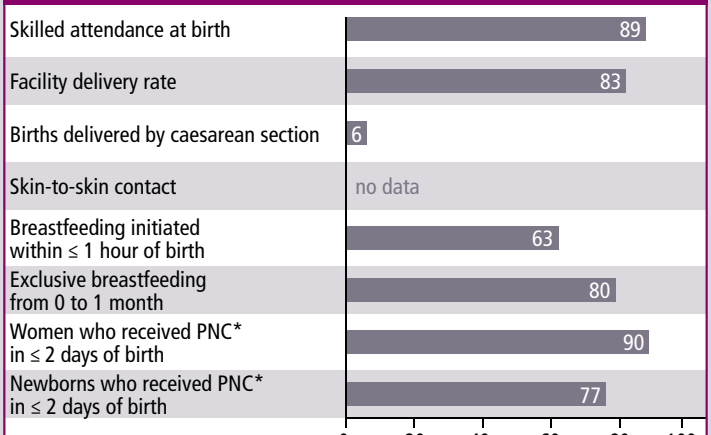
PROGRAMME READINESS FOR EENC SCALE-UP

2017[3]	YES	PARTIAL	NO
EENC 5-year action plan developed, costed and adopted	●		
Detailed 12-month EENC implementation plan developed and funded		●	
Clinical intra-partum and newborn care protocol adapted, reviewed and endorsed	●		
EENC technical working group formed	●		
EENC included in pre-service curricula (medical, midwifery and nursing)	no data		

STOCK-OUTS OF KEY MEDICINES AND COMMODITIES FOR EENC IN THE PAST 12 MONTHS, 2017[4]

Number of stock-outs across 20 health facilities (3 national hospitals and 17 subnational health facilities)	0	1	2–4	>4
Antibiotics for sepsis				●
Corticosteroids				●
Functional bag and mask within 2 m of delivery beds		●		
Hepatitis B vaccine			●	
Magnesium sulfate			●	
Oxytocin	●			
Vitamin K				●

COVERAGE OF KEY INTERVENTIONS, 2014[1]



* *postnatal care*

EENC IMPLEMENTATION, 2017[3]

EENC

introduced in **90%** of health facilities (1139/1272)

Of the facilities that have introduced EENC:

71%

71% of staff coached[7] (3803/5347)

27%

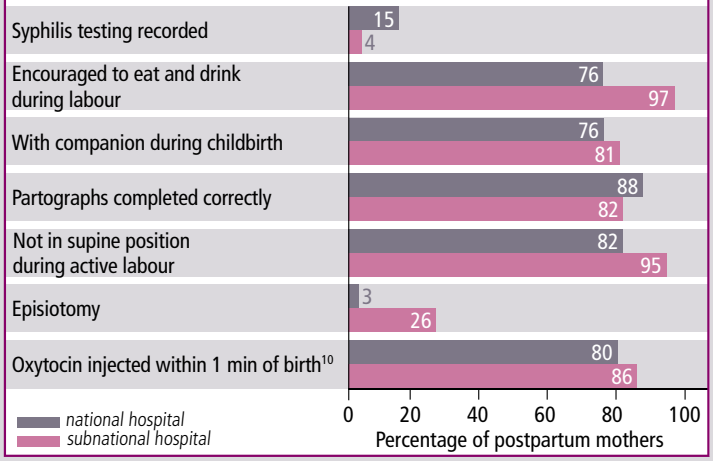
27% have EENC teams[8]

13%

13% have established a quality improvement approach[8,9]

ANTENATAL CARE AND DELIVERY PRACTICES, 2017[4]

Data from interviews and chart reviews of postpartum mothers:
– 38 at national hospitals ($n = 3$), and
– 126 at subnational health facilities ($n = 17$)

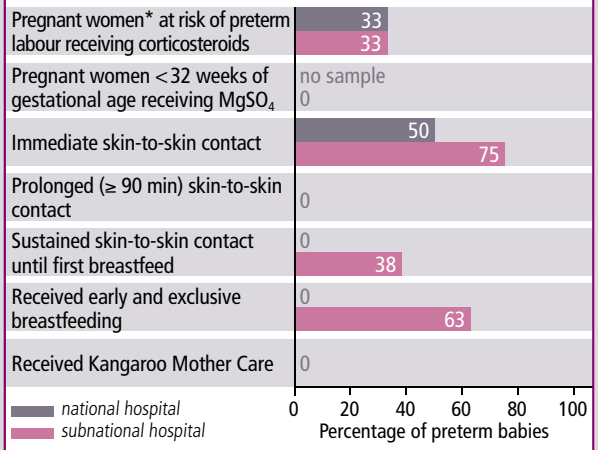


EARLY ESSENTIAL NEWBORN CARE
CAMBODIA (2)

NEWBORN CARE PRACTICES

PRETERM BABIES, 2017[4]

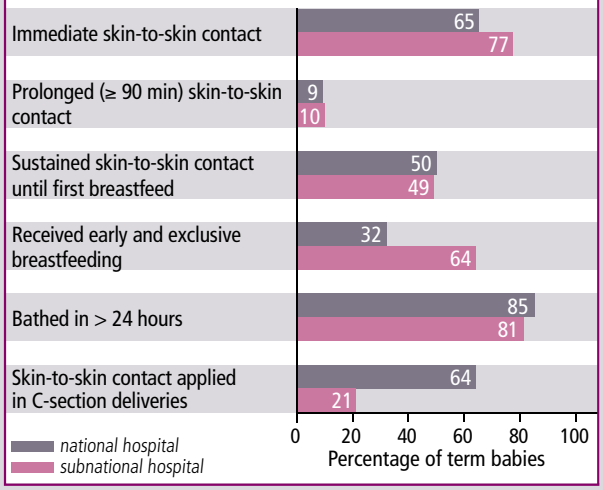
Data from interviews and chart reviews of postpartum mothers:
– 4 at national hospitals ($n = 3$), and
– 8 at subnational health facilities ($n = 7$)



* Women of 24–34 weeks of gestational age

TERM BABIES, 2017[4]

Data from interviews with postpartum mothers:
– 34 at national hospitals ($n = 3$), and
– 118 at subnational health facilities ($n = 17$)



ENVIRONMENTAL HYGIENE, 2017[4]

Data from observations in 20 health facilities
(3 national hospitals and 17 subnational health facilities)

0% of health facilities have adequate sink handwashing facilities[5] in all delivery, recovery, postnatal and neonatal care rooms

35% of health facilities have alcohol gel/hand rub available in all delivery, recovery, postnatal and neonatal care rooms

Adequate hand hygiene[6] practised in 73% of deliveries

75% of health facilities have clean and dry newborn resuscitation areas

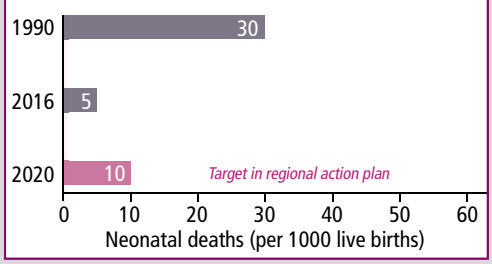
KEY POINTS

- 51% of all under-5 deaths in Cambodia occur in the newborn period.
- Immediate newborn care (INC) is implemented in Cambodia. INC coaching has been done in 5/6 national hospitals – all provincial hospitals – and over 90% operational district hospitals and first-level health facilities.
- A high proportion of maternity and paediatric staff have been coached in EENC, including 80% in provincial hospitals and close to 70% in operational district hospitals.
- Around 80% of pregnant women have a correctly completed partograph in their patient chart, are encouraged to assume a position of choice and have a companion during childbirth.
- Preterm newborns are less likely to receive EENC, which puts them at higher risk of poor health outcomes.
- Stock-outs of essential medicines and commodities are experienced mostly in subnational health facilities.
- No health facilities assessed have adequate sink handwashing facilities, while 1 in 3 have alcohol gel/hand rub available in all maternity and neonatal care rooms.

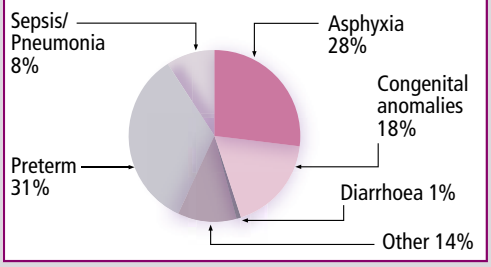
1. Cambodia Demographic and Health Surveys, 2000 and 2014.
2. WHO Global Health Observatory Data, 2018.
3. Ministry of Health, Cambodia, 2017.
4. Assessments of 20 selected health facilities that have introduced immediate newborn care (INC), 2017.
5. Adequate handwashing facilities defined as having at least one sink in the room, and all sinks in the room having running water, soap, and single-use towels/re-usable sterile towels/hand dryers available.
6. Adequate hand hygiene comprises washing hands twice before gloving and using sterile gloves to cut the umbilical cord.
7. Does not include staff coached at national hospitals, $n = 254$. Data on denominator not available from national hospitals.
8. Data from assessments of 15 randomly selected hospitals that have introduced INC, 2017.
9. Quality improvement approach consists of: (1) regular and documented meetings of the EENC team, (2) at least two EENC assessments per year, and (3) developing and updating an EENC hospital action plan at least quarterly. Data from 15 national, regional, and first-level referral hospitals.
10. Data from observations of 5 deliveries at 2 national hospitals and 7 deliveries at 6 subnational health facilities.

EARLY ESSENTIAL NEWBORN CARE
CHINA (1)

NEONATAL MORTALITY RATE[1]



CAUSES OF NEONATAL DEATH, 2016[2]



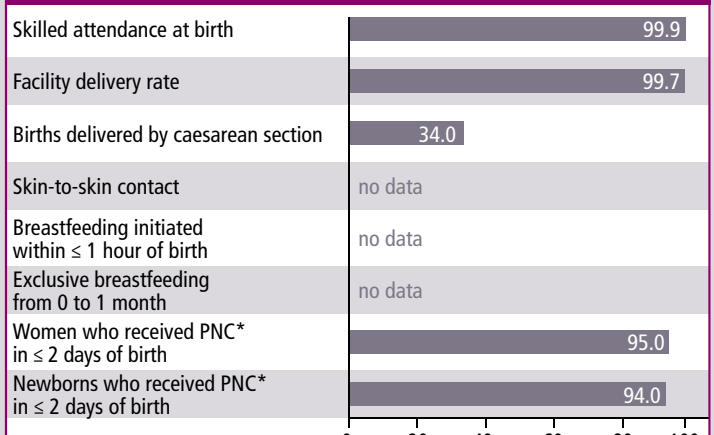
PROGRAMME READINESS FOR EENC SCALE-UP

2017[3]	YES	PARTIAL	NO
EENC 5-year action plan developed, costed and adopted			●
Detailed 12-month EENC implementation plan developed and funded		●	
Clinical intra-partum and newborn care protocol adapted, reviewed and endorsed		●	
EENC technical working group formed	●		
EENC included in pre-service curricula (medical, midwifery and nursing)	no data		

STOCK-OUTS OF KEY MEDICINES AND COMMODITIES FOR EENC IN THE PAST 12 MONTHS, 2016[4]

Number of stock-outs across 6 hospitals (3 national hospitals and 3 subnational hospitals)	0	1	2–4	>4
Antibiotics for sepsis	●			
Corticosteroids	●			
Functional bag and mask within 2 m of delivery beds	●			
Hepatitis B vaccine	●			
Magnesium sulfate	●			
Oxytocin	●			
Vitamin K	●			

COVERAGE OF KEY INTERVENTIONS, 2015[7]



EENC IMPLEMENTATION, 2017[3]

EENC

introduced in **0.02%** of health facilities (6/25 860)

Of the facilities that have introduced EENC:

84%

84% of staff coached (981/1167)

100%

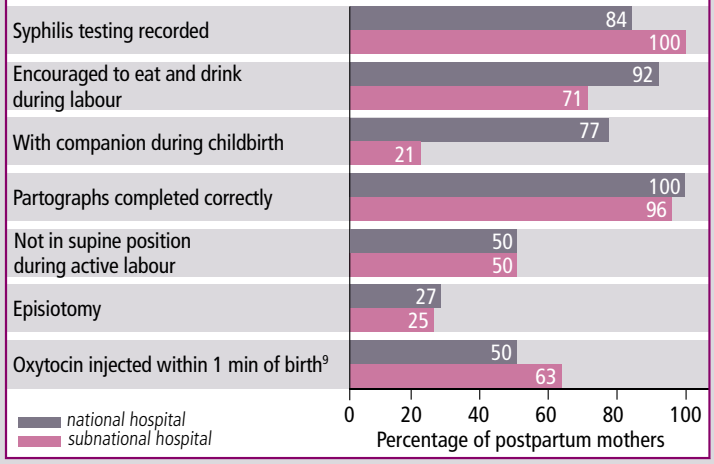
100% have EENC teams

50%

50% have established a quality improvement approach[8]

ANTENATAL CARE AND DELIVERY PRACTICES, 2016[4]

Data from interviews and chart reviews of postpartum mothers:
– 26 at national hospitals ($n = 3$) and
– 28 at subnational hospitals ($n = 3$)

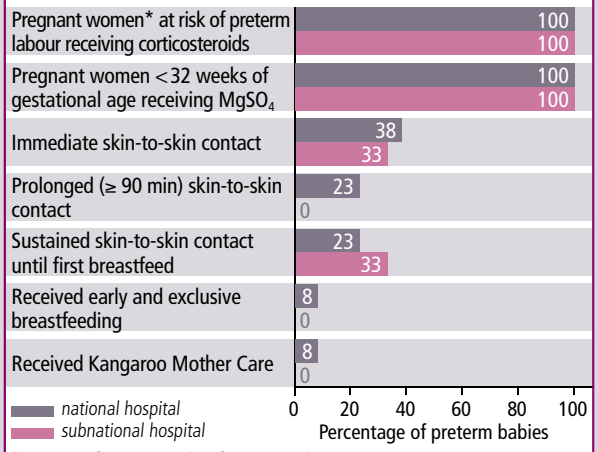


EARLY ESSENTIAL NEWBORN CARE
CHINA (2)

NEWBORN CARE PRACTICES

PRETERM BABIES, 2016[4]

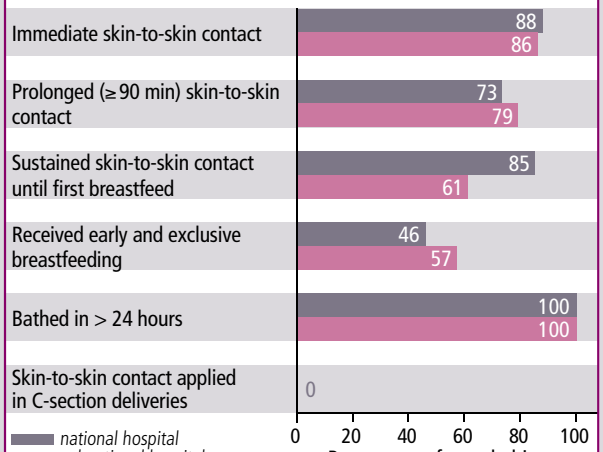
Data from interviews and chart reviews of postpartum mothers:
– 13 at national hospitals ($n = 3$), and
– 3 at subnational hospitals ($n = 3$)



* Women of 24–34 weeks of gestational age

TERM BABIES, 2016[4]

Data from interviews with postpartum mothers:
– 26 at national hospitals ($n = 3$), and
– 28 at subnational hospitals ($n = 3$)



ENVIRONMENTAL HYGIENE, 2016[4]

Data from observations in 6 hospitals
(3 national hospitals and 3 subnational hospitals)

33% of hospitals have adequate sink handwashing facilities[5] in all delivery, recovery, postnatal and neonatal care rooms

17% of hospitals have alcohol gel/hand rub available in all delivery, recovery, postnatal and neonatal care rooms

Adequate hand hygiene[6] practised in 94% of deliveries

100% of hospitals have clean and dry newborn resuscitation areas

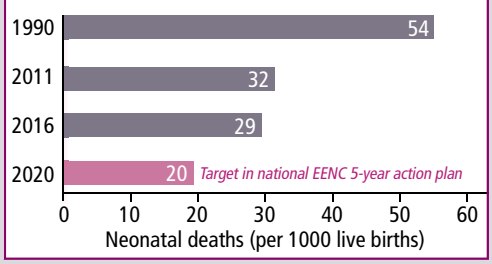
KEY POINTS

- 51% of all under-5 deaths in China now occur in the newborn period.
- A national EENC technical working group has been formed, while work on funding an annual implementation plan and endorsing a clinical protocol is on-going.
- Six health facilities introduced EENC in 2016, and 84% of staff providing childbirth and newborn care have been coached.
- The majority of women have syphilis testing recorded in their patient charts, are encouraged to eat and drink during labour, and have correctly completed partographs. However, few women assume a non-supine position during the active stage of labour or have a companion during childbirth.
- Preterm newborns are less likely to receive EENC, which puts them at higher risk of poor health outcomes.
- All key medicines and commodities for EENC are available in hospitals. One in three hospitals have adequate hand sink handwashing facilities in all maternal and neonatal care rooms.

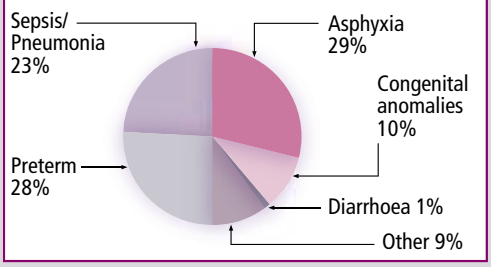
1. Level and Trends in Child Mortality: Report 2017. UNICEF, 2017. China Maternal and Child Mortality Surveillance Report, 2016.
2. WHO Global Health Observatory, 2018.
3. Ministry of Health, 2017.
4. Assessments of the 6 hospitals that have introduced EENC, 2016.
5. Adequate handwashing facilities defined as having at least one sink in the room, and all sinks in the room having running water, soap, and single-use towels/re-usable sterile towels/hand dryers available.
6. Adequate hand hygiene comprises washing hands twice before gloving and using sterile gloves to cut the umbilical cord.
7. China National Health Statistics Annual Report, 2016. China Maternal and Child Surveillance Report, 2016.
8. Quality improvement approach consists of: (1) regular and documented meetings of the EENC team, (2) at least two EENC assessments per year, and (3) developing and updating an EENC hospital action plan at least quarterly.
9. Data from observations of 8 deliveries at 3 national hospitals and 8 deliveries at 3 subnational hospitals.

EARLY ESSENTIAL NEWBORN CARE
LAO PEOPLE'S DEMOCRATIC REPUBLIC (1)

NEONATAL MORTALITY RATE[1]



CAUSES OF NEONATAL DEATH, 2015[2]



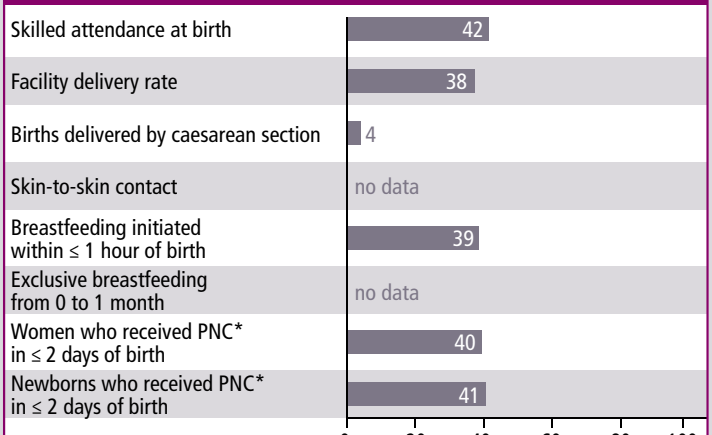
PROGRAMME READINESS FOR EENC SCALE-UP

2017[3]	YES	PARTIAL	NO
EENC 5-year action plan developed, costed and adopted	●		
Detailed 12-month EENC implementation plan developed and funded		●	
Clinical intra-partum and newborn care protocol adapted, reviewed and endorsed	●		
EENC technical working group formed	●		
EENC included in pre-service curricula (medical, midwifery and nursing)		●	

STOCK-OUTS OF KEY MEDICINES AND COMMODITIES FOR EENC IN THE PAST 12 MONTHS, 2016[4]

Number of stock-outs across 18 hospitals (4 national hospitals and 14 subnational hospitals)	0	1	2–4	>4
Antibiotics for sepsis		●		
Corticosteroids	●			
Functional bag and mask within 2 m of delivery beds				●
Hepatitis B vaccine	●			
Magnesium sulfate	●			
Oxytocin	●			
Vitamin K	●			

COVERAGE OF KEY INTERVENTIONS, 2012[7]



* *postnatal care*

EENC IMPLEMENTATION, 2017[3]

EENC

introduced in **18%** of health facilities (53/299)

Of the facilities that have introduced EENC[4]:

74%

74% of staff coached (568/769)

94%

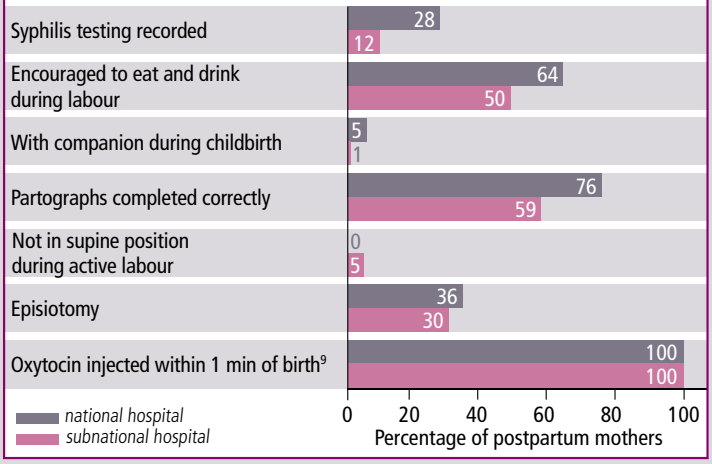
94% have EENC teams

6%

6% have established a quality improvement approach[8]

ANTENATAL CARE AND DELIVERY PRACTICES, 2016[4]

Data from interviews and chart reviews of postpartum mothers:
– 42 at national hospitals ($n = 4$) and
– 146 at subnational hospitals ($n = 14$)

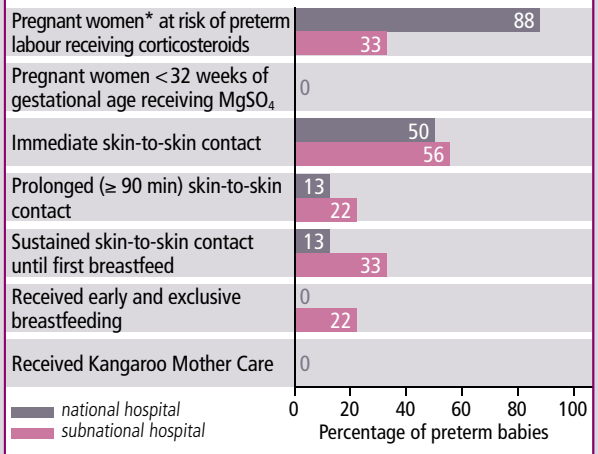


EARLY ESSENTIAL NEWBORN CARE
LAO PEOPLE'S DEMOCRATIC REPUBLIC (2)

NEWBORN CARE PRACTICES

PRETERM BABIES, 2016[4]

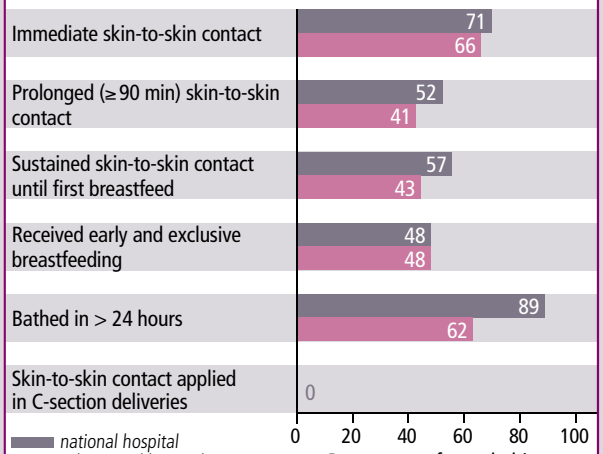
Data from interviews and chart reviews of postpartum mothers:
– 8 at national hospitals ($n = 2$), and
– 9 at subnational hospitals ($n = 7$)



* Women of 24–34 weeks of gestational age

TERM BABIES, 2016[4]

Data from interviews with postpartum mothers:
– 42 at national hospitals ($n = 4$), and
– 147 at subnational hospitals ($n = 14$)



ENVIRONMENTAL HYGIENE, 2016[4]

Data from observations in 18 hospitals
(4 national hospitals and 14 subnational hospitals)

6% of hospitals have adequate sink handwashing facilities[5] in all delivery, recovery, postnatal and neonatal care rooms

17% of hospitals have alcohol gel/hand rub available in all delivery, recovery, postnatal and neonatal care rooms

Adequate hand hygiene[6] practised in 70% of deliveries

67% of hospitals have clean and dry newborn resuscitation areas

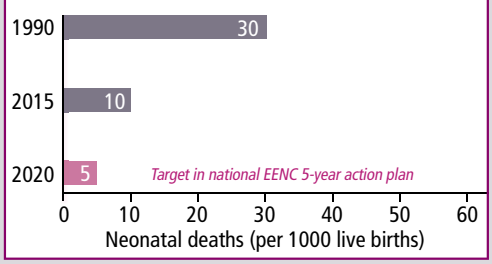
KEY POINTS

- 50% of all under-5 deaths in the Lao PDR occur in the newborn period.
- EENC coaching has been done in 4/7 (57%) of national hospitals, 17/17 (100%) of provincial hospitals, and 32/137 (23%) of district, military and police hospitals.
- A high proportion of maternity and paediatric staff have been coached in EENC, including 69% of staff in national hospitals and 76% of staff in provincial hospitals.
- Syphilis testing is recorded for a low proportion of pregnant women.
- Seventy per cent of partographs are completed correctly.
- Preterm newborns are less likely to receive EENC, which puts them at higher risk of poor health outcomes.
- The majority of essential medicines and commodities are available in national and provincial hospitals.
- A low proportion of hospitals has adequate sink handwashing facilities and alcohol gel/hand rub available in all maternity and neonatal care rooms.

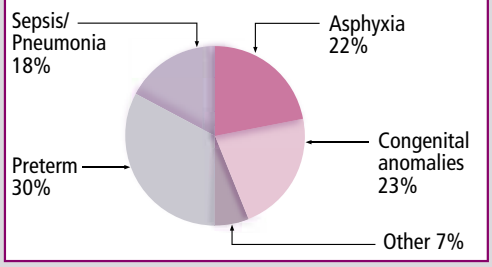
1. Level and Trends in Child Mortality: Report 2017. UNICEF, 2017. Lao Social Indicator Survey (LSIS) 2011–2012.
2. WHO Global Health Observatory Data, 2018.
3. Ministry of Health, Lao People's Democratic Republic, 2017.
4. Assessment of 18 randomly selected hospitals that have introduced EENC, 2016.
5. Adequate handwashing facilities defined as having at least one sink in the room, and all sinks in the room having running water, soap, and single-use towels/re-usable sterile towels/hand dryers available.
6. Adequate hand hygiene comprises washing hands twice before gloving and using sterile gloves to cut the umbilical cord.
7. LSIS 2011–2012.
8. Quality improvement approach consists of: (1) regular and documented meetings of the EENC team, (2) at least two EENC assessments per year, and (3) developing and updating an EENC hospital action plan at least quarterly.
9. Data from observations of 13 deliveries at 3 national hospitals and 8 deliveries at 6 subnational hospitals.

EARLY ESSENTIAL NEWBORN CARE
MONGOLIA (1)

NEONATAL MORTALITY RATE[1]



CAUSES OF NEONATAL DEATH, 2016[2]



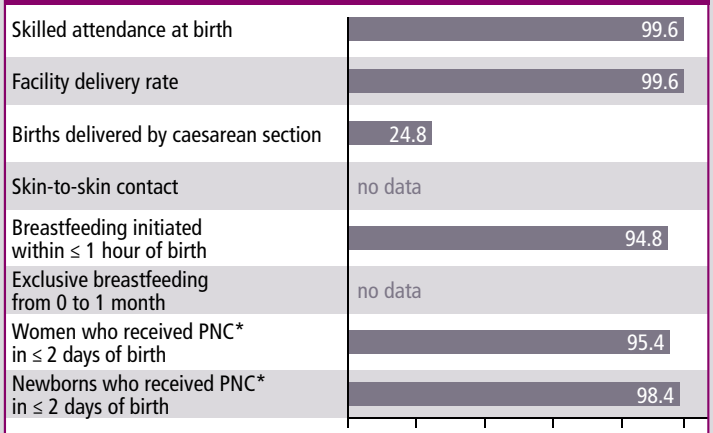
PROGRAMME READINESS FOR EENC SCALE-UP

2017[3]	YES	PARTIAL	NO
EENC 5-year action plan developed, costed and adopted	●		
Detailed 12-month EENC implementation plan developed and funded	●		
Clinical intra-partum and newborn care protocol adapted, reviewed and endorsed	●		
EENC technical working group formed		●	
EENC included in pre-service curricula (medical, midwifery and nursing)		●	

STOCK-OUTS OF KEY MEDICINES AND COMMODITIES FOR EENC IN THE PAST 12 MONTHS, 2016[4]

Number of stock-outs across 25 hospitals (4 national hospitals and 21 subnational hospitals)	0	1	2–4	>4
Antibiotics for sepsis			●	
Corticosteroids	●			
Functional bag and mask within 2 m of delivery beds	●			
Hepatitis B vaccine	●			
Magnesium sulfate		●		
Oxytocin	●			
Vitamin K	●			

COVERAGE OF KEY INTERVENTIONS, 2015[7]



* *postnatal care*

EENC IMPLEMENTATION, 2017[3]

EENC

introduced in **53%** of health facilities[3] (49/93)

Of the facilities that have introduced EENC:

80%

60% of staff coached (900/1493)

92%

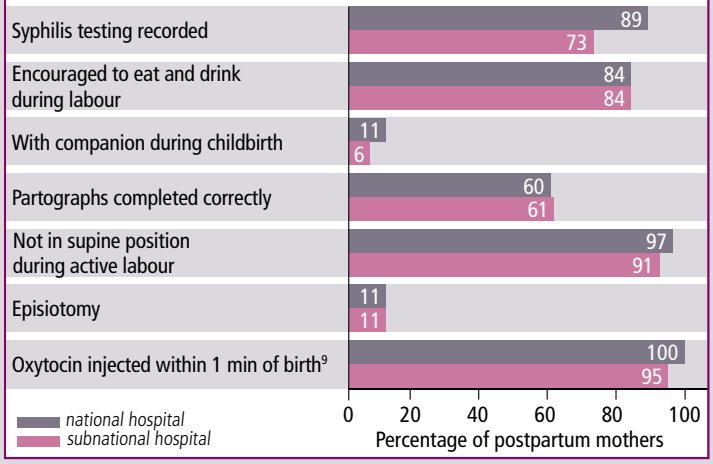
92% have EENC teams[4]

36%

36% have established a quality improvement approach[4,8]

ANTENATAL CARE AND DELIVERY PRACTICES, 2016[4]

Data from interviews and chart reviews of postpartum mothers:
– 38 at national hospitals ($n = 4$) and
– 173 at subnational hospitals ($n = 21$)

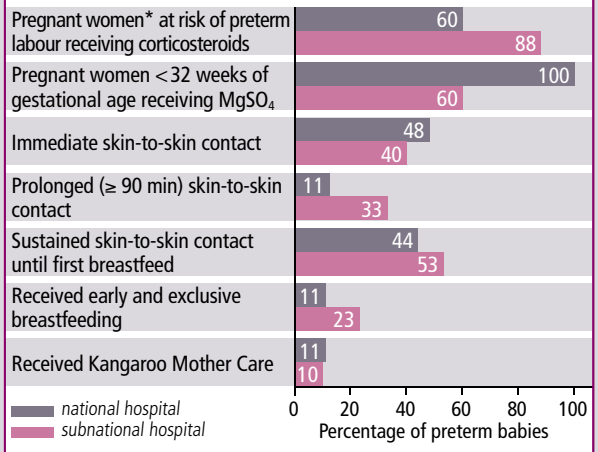


EARLY ESSENTIAL NEWBORN CARE
MONGOLIA (2)

NEWBORN CARE PRACTICES

PRETERM BABIES, 2016[4]

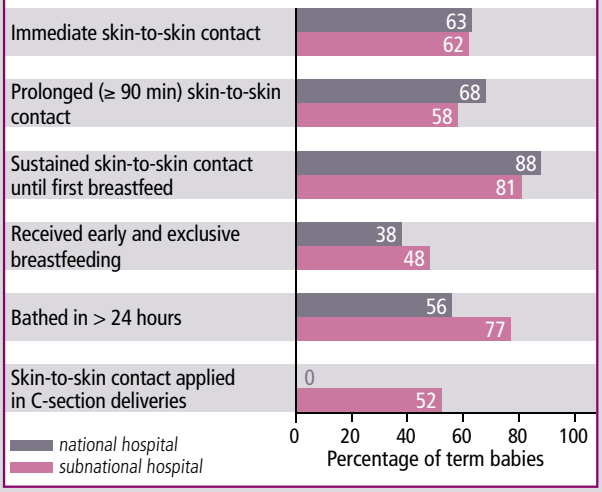
Data from interviews and chart reviews of postpartum mothers:
– 27 at national hospitals ($n = 4$), and
– 45 at subnational hospitals ($n = 19$)



* Women of 24–34 weeks of gestational age

TERM BABIES, 2016[4]

Data from interviews with postpartum mothers:
– 40 at national hospitals ($n = 4$), and
– 173 at subnational hospitals ($n = 21$)



ENVIRONMENTAL HYGIENE, 2016[4]

Data from observations in 25 hospitals
(4 national hospitals and 21 subnational hospitals)

20% of hospitals have adequate sink handwashing facilities[5] in all delivery, recovery, postnatal and neonatal care rooms

48% of hospitals have alcohol gel/hand rub available in all delivery, recovery, postnatal and neonatal care rooms

Adequate hand hygiene[6] practised in 82% of deliveries

72% of hospitals have clean and dry newborn resuscitation areas

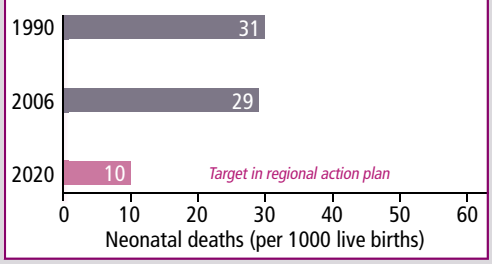
KEY POINTS

- 50% of all under-5 deaths in Mongolia now occur in the newborn period.
- EENC coaching has begun in 4/4 national and 21/21 first-level referral government hospitals and in 23/113 first-level facilities.
- Seventy-four per cent of staff at national and 84% at first-level referral hospitals have been coached in EENC.
- The majority of pregnant women have syphilis testing recorded, are encouraged to eat and drink, assume a non-supine position during the active stage of labour, and are injected with oxytocin within 1 minute of birth. However, less than 10% have a companion at childbirth.
- Preterm newborns are less likely to receive EENC, which puts them at higher risk of poor health outcomes.
- Most key medicines and commodities for EENC are available in hospitals. Only one in five hospitals has adequate sink handwashing facilities.

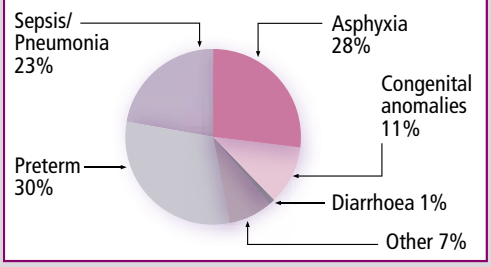
1. Level and Trends in Child Mortality: Report 2017. UNICEF, 2017. Mongolia Health Indicators, 2015.
2. WHO Global Health Observatory Data, 2018.
3. Ministry of Health of Mongolia, 2017.
4. Based on data from assessments of the 25 national and first-level referral hospitals that have introduced EENC.
5. Adequate handwashing facilities defined as having at least one sink in the room, and all sinks in the room having running water, soap, and single-use towels available.
6. Adequate hand hygiene comprises washing hands twice before gloving and using sterile gloves to cut the umbilical cord.
7. Mongolia Health Indicators, 2015. Social Indicator Sample Survey. National Statistics Office of Mongolia, UNFPA, UNICEF, 2013.
8. Quality improvement approach consists of: (1) regular and documented meetings of the EENC team, (2) at least two EENC assessments per year, and (3) developing and updating an EENC hospital action plan at least quarterly.
9. Data from observations of 24 deliveries in 4 national hospitals and 85 deliveries in 18 subnational hospitals.

EARLY ESSENTIAL NEWBORN CARE
PAPUA NEW GUINEA (1)

NEONATAL MORTALITY RATE[1]



CAUSES OF NEONATAL DEATH, 2016[2]



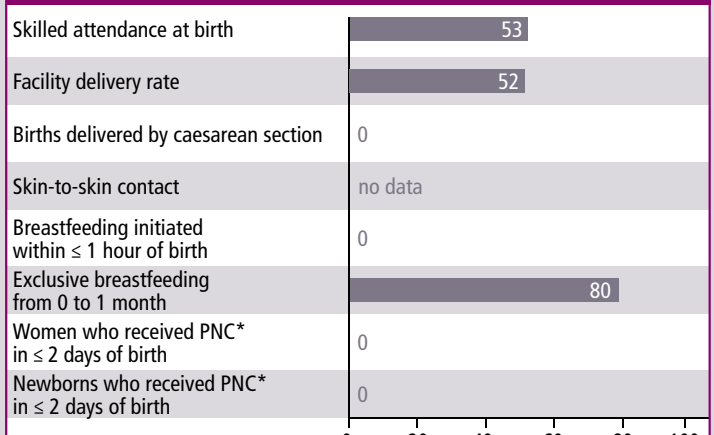
PROGRAMME READINESS FOR EENC SCALE-UP

2017[3]	YES	PARTIAL	NO
EENC 5-year action plan developed, costed and adopted	●		
Detailed 12-month EENC implementation plan developed and funded	●		
Clinical intra-partum and newborn care protocol adapted, reviewed and endorsed	●		
EENC technical working group formed		●	
EENC included in pre-service curricula (medical, midwifery and nursing)		●	

STOCK-OUTS OF KEY MEDICINES AND COMMODITIES FOR EENC IN THE PAST 12 MONTHS, 2016[4]

Number of stock-outs across 6 hospitals (1 national hospital and 5 subnational hospitals)	0	1	2–4	>4
Antibiotics for sepsis	●			
Corticosteroids				●
Functional bag and mask within 2 m of delivery beds			●	
Hepatitis B vaccine			●	
Magnesium sulfate	●			
Oxytocin	●			
Vitamin K	●			

COVERAGE OF KEY INTERVENTIONS, 2014[7]



* *postnatal care*

EENC IMPLEMENTATION, 2017[3]

EENC

introduced in **29%** of health facilities (194/671)

Of the facilities that have introduced EENC:

70%

70% of staff coached[8] (135/192)

3%

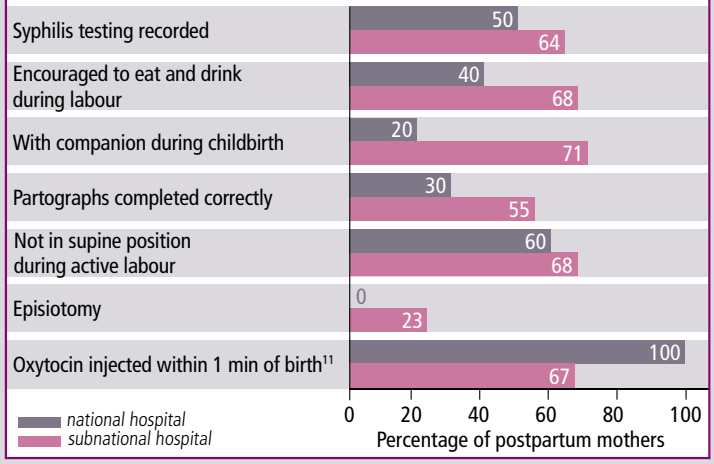
3% have EENC teams[9]

3%

3% have established a quality improvement approach[9,10]

ANTENATAL CARE AND DELIVERY PRACTICES, 2016[4]

Data from interviews and chart reviews of postpartum mothers:
– 10 at national hospital ($n = 1$) and
– 39 at subnational hospitals ($n = 5$)



EARLY ESSENTIAL NEWBORN CARE
PAPUA NEW GUINEA (2)

NEWBORN CARE PRACTICES

PRETERM BABIES, 2016[4]

No data from interviews and chart reviews of postpartum mothers

Pregnant women* at risk of preterm labour receiving corticosteroids	no data
Pregnant women < 32 weeks of gestational age receiving $MgSO_4$	no data
Immediate skin-to-skin contact	no data
Prolonged (≥ 90 min) skin-to-skin contact	no data
Sustained skin-to-skin contact until first breastfeed	no data
Received early and exclusive breastfeeding	no data
Received Kangaroo Mother Care	no data

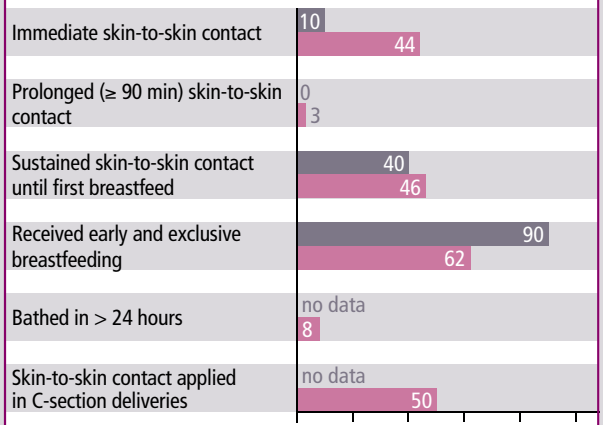
national hospital
subnational hospital

0 20 40 60 80 100
Percentage of preterm babies

* Women of 24–34 weeks of gestational age

TERM BABIES, 2016[4]

Data from interviews with postpartum mothers:
– 10 at national hospital ($n = 1$), and
– 39 at subnational hospitals ($n = 5$)



ENVIRONMENTAL HYGIENE, 2016[4]

Data from observations in 6 hospitals
(1 national hospital and 5 subnational hospitals)

0% of hospitals have adequate sink handwashing facilities[5] in all delivery, recovery, postnatal and neonatal care rooms

Hospitals have alcohol gel/hand rub available in all delivery, recovery, postnatal and neonatal care rooms: no data

Adequate hand hygiene[6] practised in 7% of deliveries

100% of hospitals have clean and dry newborn resuscitation areas

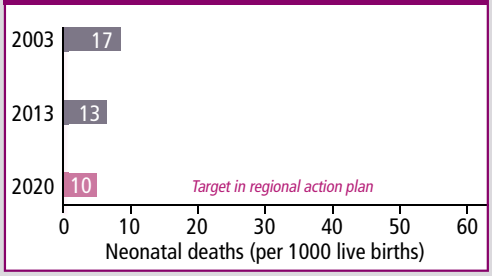
KEY POINTS

- 42% of all under-5 deaths in PNG now occur in the newborn period.
- EENC has been introduced in the national hospital, 18/31 (58%) first level referral hospitals and 173/717 (24%) first-level facilities.
- Seventy per cent of staff at the national hospital have been coached in EENC.
- All women receive oxytocin within 1 minute of birth at the national hospital, where episiotomies are also not routinely performed. Subnational hospitals perform relatively higher than the national hospital for other antenatal and delivery practices.
- Data on care for preterm babies are not available.
- Most key medicines and commodities for EENC are available at national and subnational hospitals. However, no hospital has adequate sink handwashing facilities.

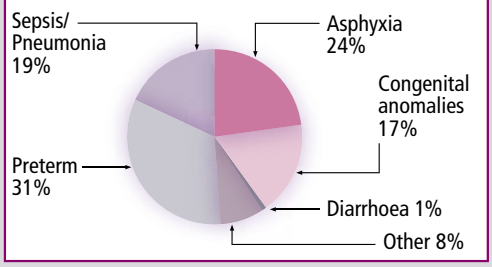
1. Level and Trends in Child Mortality: Report 2017. UNICEF, 2017. Papua New Guinea Demographic and Health Survey, 2006.
2. WHO Global Health Observatory Data, 2018.
3. National Department of Health, 2017.
4. Assessments of 6 hospitals that have introduced EENC, 2016.
5. Adequate handwashing facilities defined as having at least one sink in the room, and all sinks in the room having running water, soap, and single-use towels/re-usable sterile towels/hand dryers available.
6. Adequate hand hygiene comprises washing hands twice before gloving and using sterile gloves to cut the umbilical cord.
7. Papua New Guinea Demographic and Health Survey, 2006.
8. Data from the national hospital. An additional 579 staff have been coached in subnational health facilities.
9. Applies to national and first-level referral hospitals only.
10. Quality improvement approach consists of: (1) regular and documented meetings of the EENC team, (2) at least two EENC assessments per year, and (3) developing and updating an EENC hospital action plan at least quarterly.
11. Data from observations of 5 deliveries at the national hospital and 9 deliveries at 4 subnational hospitals.

EARLY ESSENTIAL NEWBORN CARE
PHILIPPINES (1)

NEONATAL MORTALITY RATE[1]



CAUSES OF NEONATAL DEATH, 2016[2]



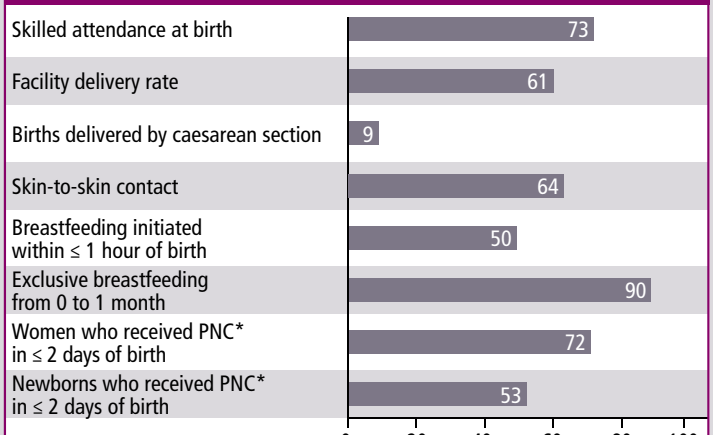
PROGRAMME READINESS FOR EENC SCALE-UP

2017[3]	YES	PARTIAL	NO
EENC 5-year action plan developed, costed and adopted		●	
Detailed 12-month EENC implementation plan developed and funded			●
Clinical intra-partum and newborn care protocol adapted, reviewed and endorsed	●		
EENC technical working group formed	●		
EENC included in pre-service curricula (medical, midwifery and nursing)		●	

STOCK-OUTS OF KEY MEDICINES AND COMMODITIES FOR EENC IN THE PAST 12 MONTHS, 2017[4]

Number of stock-outs across 28 hospitals (13 national hospitals and 15 subnational hospitals)	0	1	2–4	>4
Antibiotics for sepsis			●	
Corticosteroids				●
Functional bag and mask within 2 m of delivery beds				●
Hepatitis B vaccine				●
Magnesium sulfate				●
Oxytocin				●
Vitamin K		●		

COVERAGE OF KEY INTERVENTIONS, 2013[7]



* *postnatal care*

EENC IMPLEMENTATION, 2017[3]

EENC

introduced in **78%** of health facilities (1093/1401)

Of the facilities that have introduced EENC[4]:

43%

43% of staff coached (1676/3934)

75%

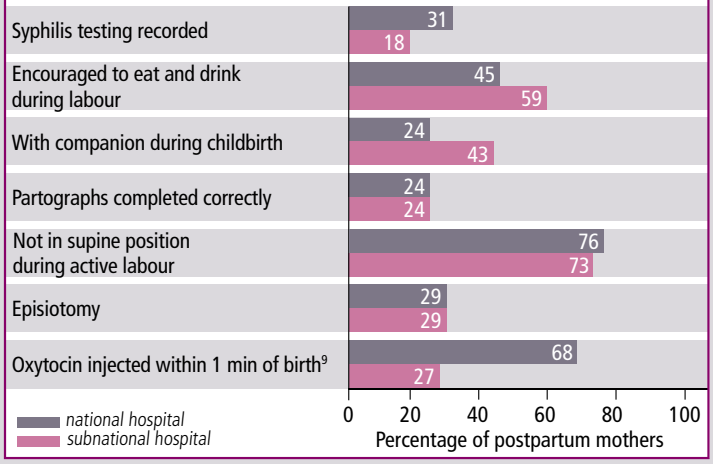
75% have EENC teams[4]

36%

36% have established a quality improvement approach[8]

ANTENATAL CARE AND DELIVERY PRACTICES, 2017[4]

Data from interviews and chart reviews of postpartum mothers:
– 113 at national hospitals ($n = 13$) and
– 141 at subnational hospitals ($n = 15$)

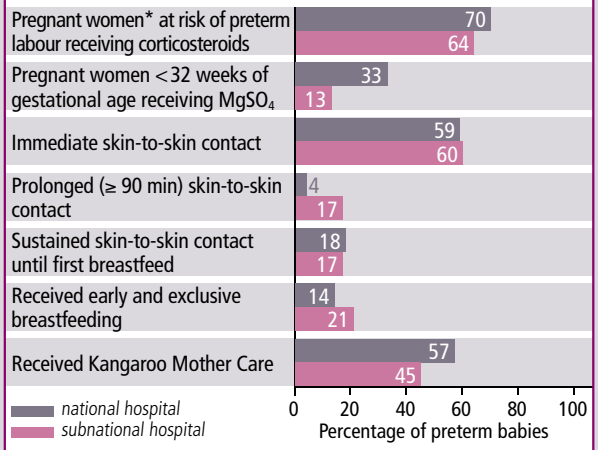


EARLY ESSENTIAL NEWBORN CARE
PHILIPPINES (2)

NEWBORN CARE PRACTICES

PRETERM BABIES, 2017[4]

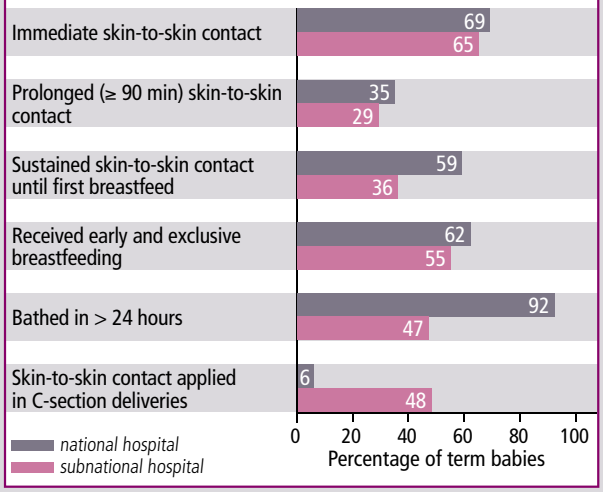
Data from interviews and chart reviews of postpartum mothers:
– 102 at national hospitals ($n = 13$), and
– 42 at subnational hospitals ($n = 12$)



* Women of 24–34 weeks of gestational age

TERM BABIES, 2017[4]

Data from interviews with postpartum mothers:
– 131 at national hospitals ($n = 13$), and
– 141 at subnational hospitals ($n = 15$)



ENVIRONMENTAL HYGIENE, 2017[4]

Data from observations in 28 hospitals
(13 national hospitals and 15 subnational hospitals)

7% of hospitals have adequate sink handwashing facilities[5] in all delivery, recovery, postnatal and neonatal care rooms

21% of hospitals have alcohol gel/hand rub available in all delivery, recovery, postnatal and neonatal care rooms

Adequate hand hygiene[6] practised in 48% of deliveries

93% of hospitals have clean and dry newborn resuscitation areas

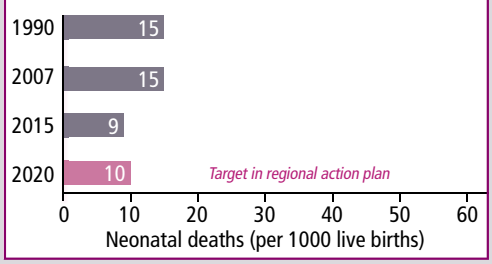
KEY POINTS

- 42% of all under-5 deaths in Philippines now occur in the newborn period.
- Essential intrapartum and newborn care (EINC) was rolled out in 2010. Since, at least 104 national and regional and 324 first-level referral hospitals have introduced EINC.
- The majority of pregnant women are encouraged to assume a non-supine position during active labour. Other globally recommended intrapartum care practices are practised for around half or less of pregnant women.
- Preterms are less likely to receive EENC, which puts them at higher risk of poor health outcomes.
- Stock-outs of key medicines and commodities are observed more frequently in national and regional hospitals.
- A low proportion of hospitals has adequate sink handwashing facilities in all maternal and neonatal care rooms. Appropriate hand hygiene is practised in one out of two deliveries.

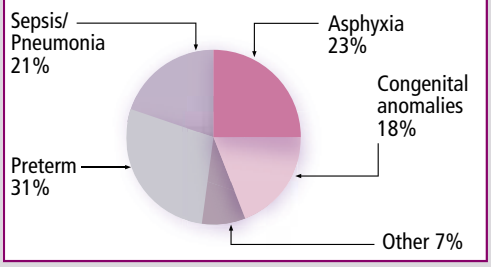
1. National Demographic and Health Survey Philippines, 2003 and 2013.
2. WHO Global Health Observatory, 2018.
3. Department of Health of the Philippines, 2017.
4. Based on data from assessments of 28 randomly selected hospitals that have introduced EINC, 2017.
5. Adequate handwashing facilities defined as having at least one sink in the room, and all sinks in the room having running water, soap, and single-use towels/re-usable sterile towels/hand dryers available.
6. Adequate hand hygiene comprises washing hands twice before gloving and using sterile gloves to cut the umbilical cord.
7. National Demographic and Health Survey Philippines, 2013.
8. Quality improvement approach consists of: (1) regular and documented meetings of the EENC team, (2) at least two EENC assessments per year, and (3) developing and updating an EENC hospital action plan at least quarterly.
9. Data from observations of 78 deliveries at 13 national hospitals and 52 deliveries at 14 subnational hospitals.

EARLY ESSENTIAL NEWBORN CARE
SOLOMON ISLANDS (1)

NEONATAL MORTALITY RATE[1]



CAUSES OF NEONATAL DEATH, 2016[2]



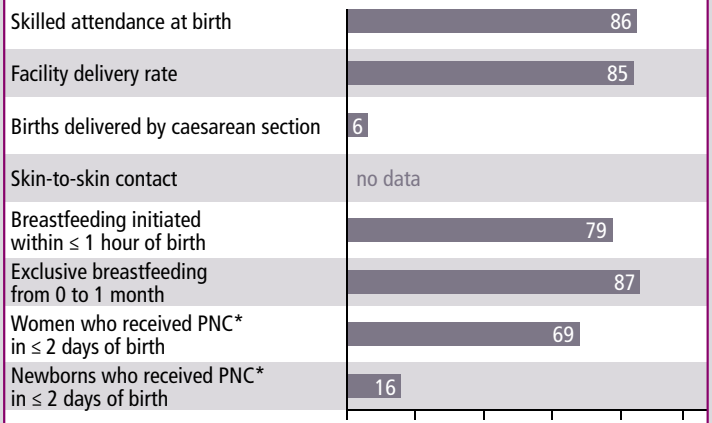
PROGRAMME READINESS FOR EENC SCALE-UP

2017[3]	YES	PARTIAL	NO
EENC 5-year action plan developed, costed and adopted		●	
Detailed 12-month EENC implementation plan developed and funded		●	
Clinical intra-partum and newborn care protocol adapted, reviewed and endorsed	●		
EENC technical working group formed	●		
EENC included in pre-service curricula (medical, midwifery and nursing)	no data		

STOCK-OUTS OF KEY MEDICINES AND COMMODITIES FOR EENC IN THE PAST 12 MONTHS, 2017[4]

Number of stock-outs across 10 health facilities (1 national hospital and 9 subnational health facilities)	0	1	2–4	>4
Antibiotics for sepsis			●	
Corticosteroids				●
Functional bag and mask within 2 m of delivery beds			●	
Hepatitis B vaccine	●			
Magnesium sulfate				●
Oxytocin				●
Vitamin K				●

COVERAGE OF KEY INTERVENTIONS, 2015[7]



* *postnatal care*

EENC IMPLEMENTATION, 2017[3]

EENC

introduced in **48%** of health facilities (145/302)

Of the facilities that have introduced EENC:

58%

58% of staff coached (408/710)

13%

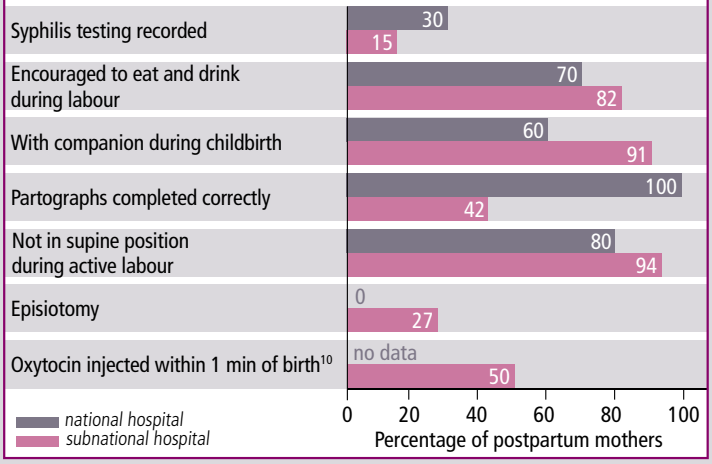
13% have EENC teams[8]

0%

0% have established a quality improvement approach[8,9]

ANTENATAL CARE AND DELIVERY PRACTICES, 2017[4]

Data from interviews and chart reviews of postpartum mothers:
– 10 at national hospitals ($n = 1$) and
– 33 at subnational health facilities ($n = 9$)

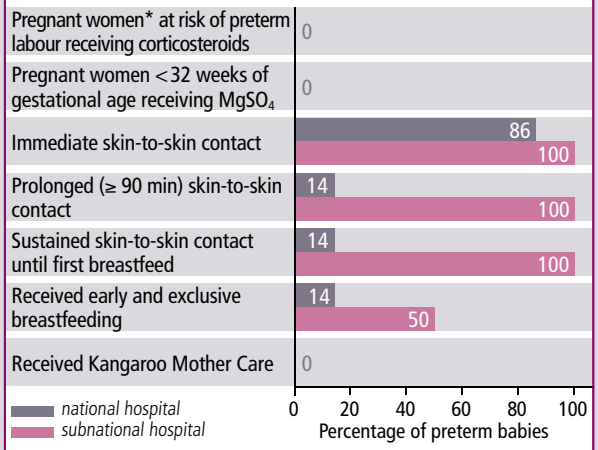


EARLY ESSENTIAL NEWBORN CARE
SOLOMON ISLANDS (2)

NEWBORN CARE PRACTICES

PRETERM BABIES, 2017[4]

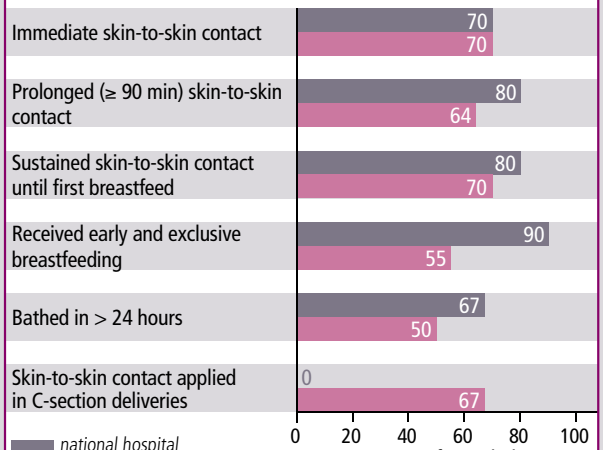
Data from interviews and chart reviews of postpartum mothers:
– 7 at national hospitals ($n = 1$), and
– 2 at subnational hospitals ($n = 2$)



* Women of 24–34 weeks of gestational age

TERM BABIES, 2017[4]

Data from interviews with postpartum mothers:
– 10 at national hospital ($n = 1$), and
– 33 at subnational health facilities ($n = 9$)



ENVIRONMENTAL HYGIENE, 2017[4]

Data from observations in 10 health facilities
(1 national hospital and 9 subnational health facilities)

0% of health facilities have adequate sink handwashing facilities[5] in all delivery, recovery, postnatal and neonatal care rooms

20% of health facilities have alcohol gel/hand rub available in all delivery, recovery, postnatal and neonatal care rooms

Adequate hand hygiene[6] practised in deliveries: no data

100% of health facilities have clean and dry newborn resuscitation areas

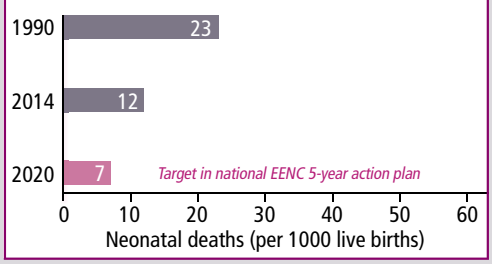
KEY POINTS

- 43% of all under-5 deaths in Solomon Islands now occur in the newborn period.
- EENC has been introduced in the national hospital, 6/9 (67%) provincial hospitals, and 138/292 (47%) first-level health facilities. Almost all staff providing childbirth and newborn at the national hospital have been coached in EENC. Coaching coverage at provincial hospitals is 41% and in first level facilities, 54%.
- Most mothers are encouraged to eat and drink and assume a non-supine position during active labour, and have a companion at the time of childbirth. Injection of oxytocin within 1 minute of birth however, is only done for half of the mothers in subnational health facilities.
- Preterm babies are less likely to receive EENC, which places them at higher risk of poor health outcomes.
- Stock-outs of key medicines and commodities for EENC are more frequently experienced in subnational health facilities.
- No health facility has adequate sink handwashing facilities in maternal and neonatal care rooms.

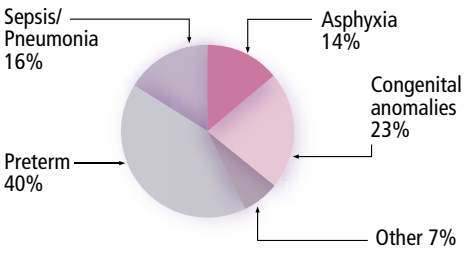
1. Level and Trends in Child Mortality: Report 2017. UNICEF, 2017. Solomon Islands Demographic and Health Surveys, 2007 and 2015.
2. WHO Global Health Observatory Data, 2015.
3. Ministry of Health and Medical Services, 2017.
4. Assessments of 10 health facilities that have introduced EENC, 2017.
5. Adequate handwashing facilities defined as having at least one sink in the room, and all sinks in the room having running water, soap, and single-use towels/re-usable sterile towels/hand dryers available.
6. Adequate hand hygiene comprises washing hands twice before gloving and using sterile gloves to cut the umbilical cord.
7. Solomon Islands Demographic and Health Survey, 2015.
8. Applies to national and first-level referral hospitals only.
9. Quality improvement approach consists of: regular and documented meetings of the EENC team, (2) at least two EENC assessments per year, and (3) developing and updating an EENC hospital action plan at least quarterly.
10. Data from observations of 2 deliveries at 2 subnational hospitals.

EARLY ESSENTIAL NEWBORN CARE
VIET NAM (1)

NEONATAL MORTALITY RATE[1]



CAUSES OF NEONATAL DEATH, 2016[2]



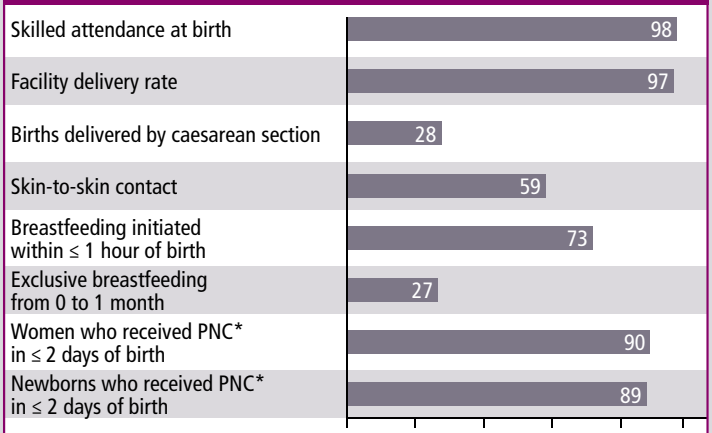
PROGRAMME READINESS FOR EENC SCALE-UP

2017[3]	YES	PARTIAL	NO
EENC 5-year action plan developed, costed and adopted	●		
Detailed 12-month EENC implementation plan developed and funded		●	
Clinical intra-partum and newborn care protocol adapted, reviewed and endorsed	●		
EENC technical working group formed		●	
EENC included in pre-service curricula (medical, midwifery and nursing)	no data		

STOCK-OUTS OF KEY MEDICINES AND COMMODITIES FOR EENC IN THE PAST 12 MONTHS, 2017[4]

Number of stock-outs across 48 hospitals (3 national hospitals and 45 subnational hospitals)	0	1	2–4	>4
Antibiotics for sepsis			●	
Corticosteroids				●
Functional bag and mask within 2 m of delivery beds				●
Hepatitis B vaccine			●	
Magnesium sulfate	●			
Oxytocin	●			
Vitamin K			●	

COVERAGE OF KEY INTERVENTIONS, 2016[7]



* *postnatal care*

EENC IMPLEMENTATION, 2017[4]

EENC

introduced in **88%** of hospitals (687/784)

Of the facilities that have introduced EENC[4]:

61%

53% of staff coached (8613/16 354)

63%

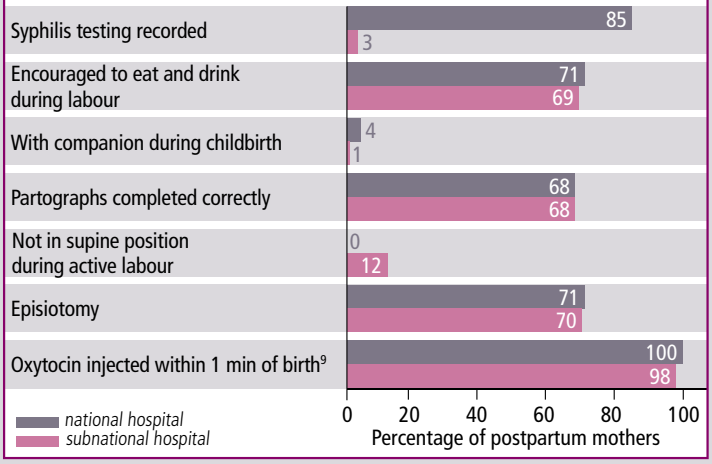
63% have EENC teams[4]

13%

13% have established a quality improvement approach[4,8]

ANTENATAL CARE AND DELIVERY PRACTICES, 2017[4]

Data from interviews and chart reviews of postpartum mothers:
– 38 at national hospitals ($n = 3$) and
– 389 at subnational hospitals ($n = 45$)

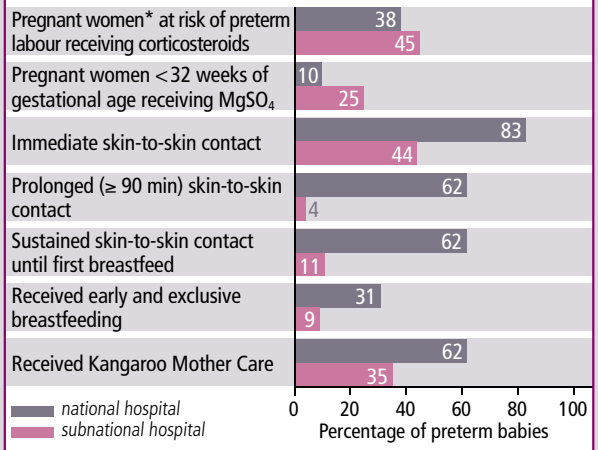


EARLY ESSENTIAL NEWBORN CARE
VIET NAM (2)

NEWBORN CARE PRACTICES

PRETERM BABIES, 2017[4]

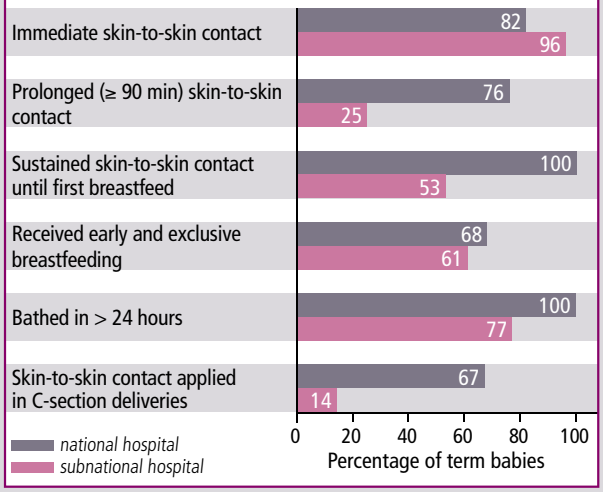
Data from interviews and chart reviews of postpartum mothers:
– 29 at national hospitals ($n = 3$), and
– 45 at subnational hospitals ($n = 15$)



* Women of 24–34 weeks of gestational age

TERM BABIES, 2017[4]

Data from interviews with postpartum mothers:
– 38 at national hospitals ($n = 3$), and
– 389 at subnational hospitals ($n = 45$)



ENVIRONMENTAL HYGIENE, 2017[4]

Data from observations in 48 hospitals
(3 national hospitals and 45 subnational hospitals)

0% of hospitals have adequate sink handwashing facilities[5] in all delivery, recovery, postnatal and neonatal care rooms

19% of hospitals have alcohol gel/hand rub available in all delivery, recovery, postnatal and neonatal care rooms

Adequate hand hygiene[6] practised in 79% of deliveries

90% of hospitals have clean and dry newborn resuscitation areas

KEY POINTS

- 53% of all under-5 deaths in Viet Nam now occur in the newborn period.
- Around 60% of hospital staff providing chidlbirth and newborn care have been coached in EENC at each level.
- Almost all women are injected with oxytocin within 1 minute of child-birth. However, very few pregnant women have a companion during childbirth and encouraged to assume a non-supine positive during active labour.
- Preterm newborns are less likely to receive EENC, which places them at higher risk of poor health outcomes.
- Stock-outs of key medicines and commodities are more frequently reported in district hospitals than in provincial and national hospitals.
- No hospital has adequate sink handwashing facilities in all maternal and neonatal care rooms. Adequate hand hygiene is practised in 4 out of 5 deliveries.

1. Level and Trends in Child Mortality: Report 2017. UNICEF, 2017. Multiple Indicator Cluster Survey Viet Nam, 2014.
2. WHO Global Health Observatory, 2018.
3. Ministry of Health, 2007.
4. Based on data from assessments of 48 randomly selected hospitals that have introduced EENC, 2017.
5. Adequate handwashing facilities defined as having at least one sink in the room, and all sinks in the room having running water, soap, and single-use towels/re-usable sterile towels/hand dryers available.
6. Adequate hand hygiene comprises washing hands twice before gloving and using sterile gloves to cut the umbilical cord.
7. Viet Nam Reproductive Health Annual Report, 2016. Multiple Indicator Cluster Surveys Viet Nam, 2014 (births delivered by caesarean section, and indicators on postnatal care) and 2011 (exclusive breastfeeding 0–1 month).
8. Quality improvement approach consists of: (1) regular and documented meetings of the EENC team, (2) at least two EENC assessments per year, and (3) developing and updating an EENC hospital action plan at least quarterly.
9. Data from observations of 21 deliveries at 3 national hospitals and 55 deliveries at 24 subnational hospitals.

Chair's Statement of the High-level Forum on Accelerating Progress in Early Essential Newborn Care

World Health Organization
Western Pacific Region

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Chair's statement of the High-level Forum on Accelerating Progress in Early Essential Newborn Care, 17 August 2017, Da Nang, Socialist Republic of Viet Nam

1. The Western Pacific Region High-level Forum on Accelerating Early Essential Newborn Care was held on 16–17 August 2017 in Da Nang, Viet Nam. The Forum was chaired by H.E. Professor Nguyen Viet Tien, Vice Minister of Health Viet Nam, supported by Honourable Herminigildo V. Valle Undersecretary of Health of the Philippines, as a Vice-Chair. The meeting was attended by Vice-Ministers of Health, Undersecretaries, Assistant Secretaries and representatives from Cambodia, China, the Lao People's Democratic Republic, Mongolia, Papua New Guinea, the Philippines, Solomon Islands and Viet Nam.

2. We, the Vice-Ministers, Undersecretaries, Assistant Secretaries and representatives (of the eight countries), had a positive and productive discussion through exchanging experiences with accelerating Early Essential Newborn Care (EENC) since the last biennial meeting in 2015.

3. We reaffirm that ensuring an enabling sociopolitical economic environment is required for a healthy start for every newborn and a safe motherhood, and to make progress towards achieving universal health coverage (UHC) and the Sustainable Development Goals (SDGs) principle of leaving no one behind.

4. We recognize the health, economic and social consequences of illness and death of pregnant and post-partum women in their prime of life and their babies. Their mortality and morbidity constitute a large burden, particularly in low-income and low-middle-income countries, and require urgent unified action at national, regional and global levels. We underscore that prominent investments in EENC will have a strong impact on the health and well-being of women, newborns and society.

5. We reiterate the need for accelerated action emphasized in the United Nations Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) and by the Every Newborn Action Plan (2014), the World Health Assembly Resolution 64.R13 Working towards the reduction of perinatal and neonatal mortality (2011) and the Action Plan for Healthy Newborn Infants in the Western Pacific Region (2014–2020).

6. We are proud of the significant progress made by the countries in our Region, with over 30 000 health workers from over 2500 health facilities now participating, and the vast improvements in the quality of care provided by them. However, we recognize the need to expand coverage of EENC to reach approximately five times more mothers and newborns.

7. We note with satisfaction the implementation of the recommended actions of the First Biennial Meeting on Accelerating Early Essential Newborn Care held in Tokyo in 2015.

8. We highlight the challenges of scaling up EENC posed by outdated health provider practices; weak accreditation standards and quality improvement mechanisms; weak and/or unenforced regulation of conflicts of interest; lack of quality information generated from national and regional health information systems to guide policy development and clinical decision-making; and, insufficient resources.

9. We also note with grave concern that marketing of breastmilk substitutes remains rampant and is a challenge to increasing exclusive breastfeeding prevalence. We reaffirm our strong commitment to the International Code of Marketing of Breastmilk Substitutes, the Mother–Baby Friendly Hospital Initiative and the related World Health Assembly Resolutions.

10. We emphasize the importance of identifying and eliminating conflicts of interest at all levels of the health system that result in suboptimal feeding; unnecessary admissions; medical procedures; and harmful practices.

11. We further note that harmful practices such as unnecessary admissions into neonatal care units and unnecessary medical procedures expose newborns and mothers to unnecessary risk of health facility acquired infections, long-term disability and death.

12. We pledge to continue our efforts to provide quality care to all mothers and newborns by; increasing awareness and understanding of standards of appropriate care; increasing multi-sectoral collaboration to identify underlying problems and implement sustainable actions and system changes to benefit women and newborns, in accordance with national EENC action plans and policies; enforcing laws and regulations to prevent conflicts of interest and harmful and unnecessary medical practices; and, actively and effectively supporting and monitoring progress of national EENC action plans.

13. We reiterate our commitment to build a resilient health system, in line with national strategies for the attainment of SDGs, especially universal health coverage; and, to strengthen national capacities to scale up EENC by intensifying ongoing multisectoral efforts to support national EENC action plans.

14. We reaffirm our commitment to work together to promote international and regional collaboration and partnerships to strengthen country and regional surveillance, response, and research and development capacity to make EENC available at every delivery toward UHC in the Region.

15. We request the WHO and UNICEF, through the Secretariat, to support an EENC network to share lessons learned and enable other exchanges such as study tours.

16. We acknowledge continued support from the WHO, UNICEF and other development partners and request ongoing support to countries in the Region to accelerate adoption and scale-up of EENC interventions.

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