

EVERY NEWBORN

AN ACTION PLAN TO END
PREVENTABLE DEATHS



EVERY NEWBORN PROGRESS REPORT

May 2015

Supplementary materials

The supplementary materials in this document contain the additional information on the content of the Every Newborn Progress Report: May 2015, available at www.everynewborn.org/progress2015

Contents

I. Every Newborn: action with a plan.....	2
II. Placing mothers and newborns at the heart of the post-2015 framework.....	2
III. Country progress.....	4
Spotlight on countries.....	7
IV. Regional activities.....	8
V. Every Newborn coordination.....	10
Every Newborn Country Implementation Group.....	10
Stakeholder commitments to support action.....	11
New partnerships towards country implementation.....	13
Additional content received from NORAD.....	14
Content received from Core Group.....	15
Advocacy.....	15
Improving data and metrics and monitoring progress.....	16
VI. Looking ahead.....	19
Quality improvement for maternal and newborn health – a new initiative.....	19
New guidelines and tools.....	19

www.everynewborn.org



I. Every Newborn: action with a plan

The action plan and all activities directly linking to the implementation of this plan are available at www.everynewborn.org.

II. Placing mothers and newborns at the heart of the post-2015 framework

Full content received on the Sustainable Development Goals, the Global Strategy for Women's and Children's Health, and the Global Financing Facility:

The Global Strategy for Women's and Children's Health was launched by the United Nations Secretary-General (UNSG) Ban Ki-moon in September 2010. Almost five years since the strategy and subsequent Every Woman Every Child movement launched, a recent Progress Report provided the Secretary-General with an opportunity to report back to Member States and other stakeholders on the progress made and lessons learned under the Global Strategy for Women's and Children's Health.

In addition to the Progress Report, the fourth annual accountability report released last year found that coordinated efforts to ensure that resources are being directed towards improving the health of women, adolescents and children are paying off. Commitment-makers are delivering on their financial commitments and are well on their way to disbursing the almost US\$60 billion pledged to the Global Strategy for the period 2011–2015. The number of commitment-makers has tripled, from about 100 in 2010 to over 300 in 2014.

Following an extensive consultative process, the Every Newborn Action Plan (ENAP) was officially launched in June 2014 to take forward the Global Strategy by focusing specific attention on newborn health. Endorsed by the 194 member-states of the World Health Assembly in May 2014, the Every Newborn Action Plan aims to enhance and support coordinated and comprehensive planning and implementation of newborn-specific actions within the context of national reproductive, maternal, newborn, child, and adolescent health (RMNCAH) strategies and an action plan.

Accompanying the launch of the ENAP was a package of approximately 40 financing, policy and service delivery commitments showcasing multi-stakeholder interest and recognition of the need to invest in newborn health. These commitments represent a significant contribution to the Every Woman Every Child movement and underscore the sustained determination by the global community to ensure accelerated progress towards the Millennium Development Goals (MDGs), and women's and children's health in particular.

Multilateral institutions played their part with a US\$90 million commitment coming from the Islamic Development Bank focusing on, among other activities, building midwifery schools, training health workers in maternal and neonatal care, and establishing well-functioning health information systems, including for birth registration. For example, the Islamic Development Bank launched the "Save the Mothers" initiative, which will provide financing in the tune of US\$90 Million to improve maternal and newborn health in 56 member countries in Sub-Saharan Africa.

The governments of Bolivia, Cameroon, Malawi, the United States and Oman also made commitments. Oman has adopted and translated the ENAP into its 2050 health vision and strategic plan and will seek to strengthen the health system to improve the quality of care for mothers and newborns. Under the Family Health at the Community and Intercultural Levels (SAFI), Bolivia has committed to strengthen primary health care and reduce morbidity and mortality for women and children.

Preventing newborn deaths and stillbirths is a priority area for many NGOs, as well as academic and research institutions. Save the Children will invest a total of at least US\$100 million in maternal and newborn health annually, and through the launch of the Helping Babies Survive suite of newborn related curricula aimed at strengthening the skills of birth attendants and caregivers, the American Academy of Pediatrics has committed to reaching more than 60 countries and 1.5 million children, their mothers and families.

In addition, the private sector embraced the launch of the Every Newborn Action Plan by contributing 17 new commitments valued at over US\$100 million, representing over 40% of all new commitments and the single largest private sector contribution recorded for the launch of a new global health initiative.

Commitment-makers included multinational pharmaceutical, medical device and communications companies Johnson & Johnson, Merck, GSK, Sandoz, Pfizer, Novo Nordisk, Becton Dickinson, Masimo and Medtronic, Laerdal and McCann Health, alongside national corporate leaders Reliance Industries in India and Premier Medical Systems in Nigeria. Industry associations including the International Pharmaceutical Federation, the International Federation of Pharmaceutical Wholesalers and GSMA, also made commitments alongside new players like ayzh, an innovative social business based in India with markets across South Asia sub-Saharan Africa. In addition to these new commitments, at least 40 other companies have investments that are contributing to improvements in the health and development of newborns all over the world. A new report by GBCHealth and MDG Health Alliance, “The Ultimate Investment in the Future: Corporate Engagement in Newborn Health and Development,” will be launched in 2015 to strengthen and further align private sector engagement with the goals of ENAP. Given the ambition of the ENAP goals it is vital that governments, non-government organizations and academic institutions increase their collaboration with the private sector and focus new efforts on the populations in South Asia and sub-Saharan Africa where newborn deaths are concentrated.

Also in September, innovators from both the public and private sectors announced additional commitments to advance the Global Strategy. These included announcements from: Philips, Medtronic Foundation, Medela, General Electric, Reliance Foundation, Novo Nordisk, BSR-GAIN, Royal DSM, GSK, GSMA, International Federation of Pharmaceutical Wholesalers Foundation and Nike Foundation totaling more than \$69 million in value. A number of commitments focused on newborn health – a key gap – in line with the vision of the Every Newborn Action Plan.

Another key Every Woman Every Child pledge was made last September when the World Bank Group and Governments of Canada, Norway, and the United States announced that they will jumpstart the creation of an innovative Global Financing Facility (GFF). The GFF seeks to mobilize support for developing countries’ plans to accelerate progress on the health-related Millennium Development Goals (MDGs) and bring an end to preventable maternal and child deaths by 2030.

The GFF is being developed in close collaboration with a broad range of stakeholders, including partner countries; the H4+ agencies (UNICEF, UNFPA, WHO, UNAIDS, UN Women and the World Bank Group); civil society organizations; bilateral and multilateral development partners; foundations; private sector and others working in the areas of reproductive, maternal, newborn, child and adolescent health. The GFF will support countries in their efforts to mobilize additional domestic and international resources required to scale up and sustain essential health services for women, children and adolescents.

The GFF resources will be provided to countries in conjunction with low-interest loans and grants from the International Development Association (IDA), the World Bank Group’s fund for the poorest countries. Based on strong country demand for health results-based financing programs, these bilateral contributions could leverage up to an estimated \$3.2 billion from IDA, for a total of up to \$4 billion in financing to support MDG acceleration and improve reproductive, maternal, newborn, child and adolescent health.

An updated Global Strategy for Women’s, Children’s, and Adolescents’ Health will build on new evidence, including the need to focus on critical population groups such as newborns, and continue the momentum from the ENAP launch. It will align with the targets and indicators developed for the Sustainable Development Goals framework and outline opportunities for means of implementation, including innovative financing and the Global Financing Facility.

Several sub-streams are informing the updated framework. The one relevant to newborns is “health interventions, strong workforce & resilient health systems”. This sub stream is evaluating the main challenges and gaps for the health workforce and health systems to provide quality care and to fully implement the updated Global Strategy.

Several consultations, including a face-to-face meeting that took place in Delhi in February and an upcoming meeting in Johannesburg will further help to define how newborns and stillbirths should be embedded in the updated Global Strategy. The ENAP/EPMM joint paper for the Global Strategy consultation process has been finalized and a strong

submission for the consultation process is in development from the partners representing ENAP. Other key elements include how ENAP goals/objectives could be incorporated for example: human rights, health system strengthening, and the investment case as well as better integrated into and aligned with the forthcoming Sustainable Development Goals Framework.

III. Country progress

Twenty eight countries have been prioritized by ENAP Country Implementation Group for ENAP progress tracking in countries with top ten with highest Neonatal Mortality Rate and ten with highest burden of neonatal deaths and another eight based on strong interest and pledges by governments at WHA 2014. Out of 28 priority ENAP countries, 18 (almost two third) are in Africa and remaining 10 (one third) are in Asia. While the ENAP progress tracking tool is being revised in light of the pilot testing in ten countries, a short questionnaire was sent to all countries to provide a report for WHA 2015 and ENAP progress report. The questionnaire included the following questions:

- Country action plan (Yes, No, In process)
- Sharpened RMNCAH strategies/plans (Yes, No, In process)
- NMR and SBR targets set for country strategies/plans (If yes, Source/document)

The data shows that advocacy and country implementation support has been successfully mobilized eight countries to have National ENAP plans, four have completed costing while two (Afghanistan, Indonesia) are in process. All of these countries have set NMR reduction targets but Still Birth reduction targets are available for only half of these. Afghanistan, Ghana, Kenya and Zambia lack specific SBR reduction target. Another ten countries are either in process to complete or development of national newborn plan or it has been developed awaiting approval or launch. Malawi has planned to launch in June 2015.

A total of seven countries have sharpened their existing RMNCH strategies and plans in light of ENAP and two countries (Ethiopia and Lesotho) are in process. Costing for the plan has been done by seven countries while Ethiopia is still in process and Lesotho has not yet started the process. Angola, CAR and Somalia do not have yet started the development of the national plan and would need more support.

The ENAP Progress Report only provided data on the 18 countries with the greatest burden of newborn mortality or deaths.

Categories	Countries
Countries with specific action plans to improving newborn health since January 2013 (those with * indicate since formal endorsement)	Afghanistan, Bangladesh, Ghana, India, Indonesia, Kenya, Philippines, Zambia
Countries with strengthened newborn components within existing plans since January 2013 (those with * indicate since formal endorsement)	Chad, DRC, Kenya, Mali, Tanzania, Uganda, Zambia
Countries with national plans including a newborn mortality target since January 2013	Afghanistan, Bangladesh, DRC, Ghana, India, Indonesia, Kenya, Lesotho, Myanmar, Nepal, Philippines, Tanzania, Uganda, Vietnam, Zambia, Zimbabwe
Countries with national plans including a stillbirth target since January 2013	Bangladesh, India, Indonesia, Nepal, Philippines, Tanzania
Countries developing specific action plans to improving newborn health	China, Guinea Bissau, Malawi, Myanmar, Nepal, Nigeria, Pakistan, Sierra Leone, Vietnam, Zimbabwe
Countries revising existing RMNCH strategies and plans to strengthen newborn components	Ethiopia, Lesotho

Table 1: Countries with stand-alone National Newborn Action Plan

Region	Country	Date	Costing status	NMR			SBR		
				Current	Target	Target Year	*Current	Target	Target Year
ESARO	*Kenya	Aug-13	Costed	26	15	...	22	...	...
	*Zambia	2013	Costed	29	20	2016	26	...	...
WCARO	Ghana	Jul-14	Costed	29	21	2018	22	...	...
EAPRO	Indonesia	Oct-14	In process	14	9	2030	15	7	2030
	Philippines	Nov-13	Costed	14	<10	2016 (national) 2035 (sub national)	16	12	...
ROSA	Afghanistan	Dec-14	In process	36	10	2035	29	...	...
	Bangladesh	Dec-14	Not costed	24	10	2035	36	10	2035
	India	Sep-14	Not costed	29	<10	2030	22	<10	2030

* Kenya and Zambia also have integrated RMNCH Framework.

Table 2: Countries with Newborn Action Plan as part of Integrated RMNCH Plan

Region	Country	Costing status	NMR		SBR	
			Current	Target	*Current	Target
ESARO	Tanzania	Costed	21	16	26	20
	Uganda	Costed	22	10	25	...
WCARO	Chad	Costed	40	...	29	...
	DRC	Costed	38	20	26	Data not even collected as cultural beliefs do not consider still birth
	Mali	Costed	40	...	23	...

Table 3: Countries with Newborn Action Plan in progress

Region	Country	Comments	NMR			SBR	
			Current	Target	Comments	*Current	Target
ESARO	Malawi	Planned to be launched in June 2015	23	...		24	...
	Zimbabwe	Child Survival Strategy 2010-2015 under revision to incorporate ENAP.	39	20	by 2020 (Health Development Fund Program Document, 2016-2020)	20	...
WCARO	Guinea-Bissau	In process (a roadmap this year)	44	...	...	30	...
	Nigeria	In process	37	In process		42	In process
	Sierra Leone	In process	44	...		30	...
EAPRO	China	National child survival strategy – draft Dec 2013.	8	...		10	...
	Myanmar	Not launched yet, draft available as of 2014	26	<16	by 2020 (both national and sub national)	20	...
	Vietnam	Detailed implementation plan developed for 2015, but medium term plan in process.	13	7	by 2020	13	...
ROSA	Nepal	No comments available	23	10	...	23	10
	Pakistan	In Punjab, ENAP already incorporated into Integrated RMNCH PC-1. All components of ENAP are being integrated into other Provincial Newborn Survival strategies (Sindh, Baluchistan and KP/FATA) being developed with support of UNICEF in 2015.	42	12	as per SDGs	47	...

Table 4: Countries with Newborn Action Plan in process of integration in RMNCH Plan

Region	Country	Costing status	NMR		SBR	
			*Current	Target	**Current	Target
ESARO	Ethiopia	In process	28	...	26	...
	Lesotho	Not costed	44	27	25	...

Table 5: Countries with no Newborn Action Plan

Region	Country	**NMR		***SBR	
		Current	Target	Current	Target
ESARO	Angola	47	...	25	...
	Somalia	46	...	30	...
WCARO	CAR	43	...	24	...

**Committing to Child Survival : A Promise renewed Progress Report (Sep 2014) UNICEF

Spotlight on countries

The 14 country summaries were provided by WHO or UNICEF offices with approval from the Ministries of Health. More countries have made progress and due to limitations in space, not all could be included. Additional information for the following countries are available:

- **India:** More details available at <http://www.healthynewbornnetwork.org/resource/india-newborn-action-plan>.
- **Ghana:** More details available at <http://www.everynewborn.org/ghana-launches-national-newborn-health-strategy-action-plan-speed-reduction-new-born-deaths/>.
- **South Africa** (Full text received and approved by MOH): To support implementation of the national Strategic Plan for Maternal, Newborn, Child and Women's Health (MNCWH) and Nutrition, the National Department of Health has strengthened all levels of newborn care by appointing a national neonatal care improvement advisor, establishing a National Neonatal Coordinating Committee and developing a national neonatal implementation and monitoring plan. Provincial NBC teams and plans with District Clinical Specialist Teams in every district to function as implementers, master trainers of targeted intervention packages and to play a district clinical governance role. At the facility level, the seven-step implementation plan for maternal and neonatal care allows facilities to plan on their own data. All these have the specific goal of improving the quality of care throughout South Africa. In one such intervention package, Essential Steps to Manage Obstetric Emergencies (ESMOE), over 9000 health care workers have been trained with an estimated 35 per cent reduction in neonatal mortality rates in six pilot sites.
- **Cameroon** (Full content received and approved by MOH): Following strong commitment to endorse the adoption and implementation of ENAP, Cameroon has prioritized newborn care within a national context characterized by stagnating unsatisfactory newborn health indicators. Neonatal mortality stands at 31 per 1,000 live births, representing 50 per cent of infant mortality. Taking into consideration results of a recent bottleneck analysis regarding implementation of newborn care, a 2015–2016 operational action plan for improving newborn health has been developed for rapid rollout in priority health districts. The plan highlights five of the nine recommended high impact newborn health interventions that will be scaled up in order to address the leading causes of neonatal mortality. Guidelines for newborn care have been developed and capacity-building of health care providers is ongoing. The government of Cameroon and its partners are committed to implement newborn care within the multisector approach as endorsed by the national multisectoral programme to combat maternal, newborn and child mortality, with the intention of raising awareness at all levels of the importance of rallying efforts in favour of the newborn and also creating synergies for fast-tracking action that will result in significant reduction of avoidable neonatal deaths in the country. The overall objective is to reduce newborn mortality to 24 per 1,000 live births by 2020.
- **Myanmar** completed a bottleneck analysis in early 2014 and subsequently developed the draft National Newborn action plan in May 2014 which is now part of the National Newborn and Child Health and Development Strategic Plan (2015-2018) awaiting endorsement. Chlorhexidine was introduced for cord care in early 2015, the role of auxiliary midwives is being expanded and scale-up of community based newborn care for strengthening postnatal care is ongoing.

- **Nepal:** (full summary) In Nepal, a core team of national actors has developed the draft of ENAP. The team is led by Program planning and international cooperation division from the MOHP and has representatives from Child Health Division, Family Health Division, UNICEF, WHO, Save the Children, USAID, NHSSP/DFID, UNFPA and Chlorhexidine Navicare Program/JSI. Individual team members were assigned to work on various sections include setting targets for key maternal and newborn impact and coverage indicators, and to include specific actions on demand generation and on maternal and adolescent nutrition.
- **Philippines** conducted a comprehensive newborn care needs assessment (2012) followed by national consultation (2013) to provide feedback for the global ENAP process and developed a Newborn Action Plan in November 2013. Government of Philippines launched A Promise Renewed plan on 23rd April 2014 with emphasis on achieving universal health care. PhilHealth - the largest national health insurance provider in the country) and MoH are currently designing a separate coverage package for premature newborns.
Link for Philippines: http://www.unicef.org/philippines/media_22447.html
- **Tanzania:** Full summary available <http://www.everynewborn.org/tanzania-newborns-stakeholders-roundtable-meeting/>.
- **Vietnam:** (text received from country office) Vietnam undertook a Bottleneck Analysis in August 2013. By the end of 2014, the Ministry of Health finalized national guidelines to implement four early essential new-born care (EENC) practices – immediate and thorough drying, delay cord clamping, immediate skin to skin contact, and early initiation of breastfeeding. National guidelines on EENC have been approved by MOH, the EENC Clinical Pocket book was adapted; three Centres of Excellence initiated complete with EENC support team, health staff coached, and a Health Facility Strengthening approach introduced. Additionally, a national guideline to implement Kangaroo Mother Care supporting preterm and low birth weight newborns is being developed.

IV. Regional activities

Additional information on regional activities includes:

Africa

An inter-country workshop on improving the quality of midwifery education in French speaking countries was held in Abidjan from 3 to 5 February 2015 with the participation of 80 participants from 12 countries (Benin, Burkina Faso, Cameroon, Côte d'Ivoire, Guinea, Mali, Mauritania, Niger, Senegal, Democratic Republic of Congo, Togo and Chad). It was co-organized by WHO, UNFPA, World Bank and Western African Health Organization, with the financial support from the Muskoka French Fund. The workshop built on findings from assessment in the participating countries that showed that quality of midwifery education needs strengthening, in spite of recent progress in regulation, school infrastructure, the level of students at enrolment, and practical training. Encouragingly, a new World Bank initiative on demographic dividends and women's empowerment will bring financial and technical resources to improve the training of teachers for midwifery training institutions in the twelve countries, with particular attention to rural areas. The initiative will provide a systematic solution to strengthening midwifery education, with a clear objective of improving the quality of maternal and newborn health care in health facilities and saving women's and newborns' lives.

Improving Quality Of Care In Health Facilities

WHO recently hosted two multi-country workshops on quality of maternal, newborn and child care, in Burkina Faso and in Congo. The workshops brought together participants from 12 French-speaking countries (Benin, Burkina Faso, Burundi, Cameroun, Côte d'Ivoire, Guinea, Mali, Niger, DRC, Senegal, Chad and Togo). The aim was orient participants on practical approaches for improving the quality of care, with a specific attention to the WHO *Integrated maternal, neonatal and child quality of care assessment and improvement tool*. This tool is based on standards derived from the WHO Pocket book of Hospital Care for Children and the WHO Integrated Management of

Pregnancy and Childbirth (IMPAC) guidance. It can be used in a modular form and enables health professionals to assess the quality of care in health facilities, identify the most important constraints and plan for appropriate actions. Participants returned to their respective countries with a specific work plan to carry out assessments of the quality of maternal, newborn and child care in their own settings.

Europe

50% of U5 children deaths in WHO European Region happen during the first month of life. However, EURO was not included as a priority region in the ENAP activities by WHO. UNICEF supported development of a national neonatal care road map using ENAP in Tajikistan. We consider contribution in this process by WHO as important, as well as advocating for inclusion of the ENAP's actions to the new MNCH program. We will need to move in this area in Central Asia and the Caucasus, in particular, but will need to find resources for activities and staff to where WHO has an advantage to address this regional priority area .

Latin American and the Caribbean

The Americas have a Regional Strategy and Plan of Action on Neonatal Health, within the continuum of maternal, newborn, and child care. The Plan was approved in 2008 and ends on 2015. A mid-term evaluation was performed and submitted for approval in 2013. The final evaluation is being prepared in 2015 and strategies and goals will be updated, aligned with ENAP strategies and goals. This final evaluation of the Regional Strategy and Plan of Action for Neonatal Health within the continuum of maternal, newborn and child care, will simultaneously become a baseline analysis for ENAP.

Since the adoption of ENAP, different activities have been developed in Latin America and the Caribbean Region, at both regional and national level, but also involving key actors and partners, to disseminate and implement ENAP's strategies and specific actions.

ENAP has been widely disseminated and discussed with technical focal points at country level, involving key actors from the MOH. Priority countries – Bolivia and Haiti- were defined. Complementary, other priority countries are defined in PAHO's Strategic Plan. ENAP was reviewed and discussed with all national teams and representatives from MOH in different forum, including the Annual Meeting of Regional Neonatal Alliance. A process of adapting surveillance and monitoring tools and systems is being implemented in LAC in order to provide the data required for monitoring and evaluation of ENAP.

South East Asia

A Regional Meeting on ENAP and Postnatal care for Mother and Newborn was organized in Colombo, Sri Lanka in November 2014 to review country progress and to disseminate recently released WHO technical guidelines on postnatal care for mothers and newborn, and develop common understanding for universal implementation of these in member countries of the region. Countries agreed to finalize costed national ENAPs and adopt/adapt WHO PNC guidelines for implementation by December 2015. To this end, a Regional Capacity Building Workshop on One Health Tool for costing of newborn action plan has been conducted in Kathmandu, Nepal from 20-24 April 2015.

WHO-SEARO and UNICEF will provide joint country support to high priority countries in the Region in taking forward the ENAP process. Joint SEARO-ROSA mission was undertaken in Bangladesh to review the progress and consider the next steps as well as the needs for technical assistance.

South East Asia Regional Meetings on Every Newborn and Postnatal Care: More details available at <http://www.everynewborn.org/regional-meeting-every-newborn-postnatal-care/>.

In response to WHA resolution 2010, and in recognition of increasing proportional contribution of birth defects to neonatal mortality, SEARO has developed Regional strategic framework for prevention and control of birth defects. The goal is to reduce the burden of birth defects in order to contribute to reduction in newborn and child mortality and long term morbidity associate with birth defects. The framework recommends establishment of surveillance of birth defects and integration of evidence-based preventive interventions in the existing RMNCAH, immunization and nutrition programme. Member States have developed national plans for prevention and control of birth defects that have been linked with national newborn action plans. SEARO has also initiated an online (web-based) regional hospital-based integrated Newborn-Birth defects database to study the pattern and trends of newborn morbidity and mortality and at birth prevalence of birth defects. National networks of hospitals have been established in

Bangladesh, Bhutan, India, Indonesia, Myanmar, Nepal, Sri Lanka and Thailand and identified hospitals have started collecting data in a standard manner based on the online system developed by SEARO.

Western Pacific

As part of the Action Plan for Healthy Newborn Infants in the Western Pacific Region (2014–2020), in March 2015, WHO Region for the Western Pacific launched First Embrace, a campaign highlighting simple steps that will save more than 50,000 newborn lives and prevent hundreds of thousands of complications each year from unsafe practices in newborn care in the region.

First Embrace highlights early essential newborn care (EENC) – a package of actions and interventions that address the most common causes of newborn death or disease, such as prematurity (being born too early), low birth weight and severe infection. First Embrace addresses this challenge by urging women and health care providers to take simple steps to protect babies during the crucial time immediately after birth. Skin-to-skin contact should be followed by proper clamping and cutting of the umbilical cord with sterile instruments. Early initiation of breastfeeding is especially important because colostrum, the first milk, contains essential nutrients, antibodies and immune cells.

The plan calls for improved political and social support to secure an enabling environment for EENC and mobilization of families and communities to increase demand for these approaches. The First Embrace campaign seeks to engage the general public, health workers, policy makers and civil society to champion EENC.

Health workers may be unaware of these relatively simple steps to protect newborns. In addition, customs and beliefs among some communities and health care providers may act as a barrier to full implementation of the EENC. Changing practices requires a supportive environment and informed families and individuals that insist on best practices from health-care providers. More details at <http://thefirstembrace.org>.

V. Every Newborn coordination

Every Newborn Country Implementation Group

Tracking tool

The ENAP Country Implementation Group (CIG)¹ monitored progress of ENAP implementation in countries and led the design and data collection with UNICEF playing a lead role in the design, data collection and analysis with support and review by all members of the CIG. The tool intended to assess status of progress, identify barriers to implementation and map specific technical assistance needs in each country. The tool was shared for pilot testing with 20 countries out of which 10 (Bangladesh, Ethiopia, Indonesia, Kenya, Malawi, Myanmar, Nigeria, The Philippines, Tanzania and Viet Nam) returned the filled template. The information received in the table below showed significant progress on action plan development and inclusion of commodities in the essential medicines list. The presence of multiple partners working on maternal and newborn health and numerous advocacy events was noted. The areas with least progress were maternal death surveillance and response for which the countries' affirmative response showed limited geographic coverage, perinatal auditing, prioritization of research and development/adaptation of local MNH devices. The technical assistance needs were mostly around support required for costing/budgeting of the action plans and guidance on perinatal audits.

The lessons learnt from the pilot testing are being used to develop a revised tracking tool with key epidemiological indicators, simplified questions, pre-coded responses and the inclusion of all priority CIG countries on the basis of high NMR and or high burden of neonatal deaths.

Mapping

The Every Newborn country implementation group also undertook a mapping exercise to create a repository of the technical support to countries currently available for maternal and newborn care at the time around birth, including where the activity is taking place and what capacities and resources, both human and financial, are available to

¹

support countries to deliver quality maternal and newborn care at the time around birth. The questionnaire design and draft repository development took place between September and November 2014. The draft repository frames the categories of technical support with the WHO Health Systems Building Blocks. Semi-structured interviews began in October 2014 with partner organizations. Through a snowball approach, further partners were identified and in total 47 semi-structured interviews were undertaken with core partners. The information collected was reviewed and supplemented by the WHO country offices to ensure validity.

Stakeholder commitments to support action

The Global Strategy for Women's and Children's Health was launched by the United Nations Secretary-General Ban Ki-moon in September 2010. Almost five years later, and the subsequent launch of Every Woman Every Child, a recent *Progress Report* provided the Secretary-General with an opportunity to report back to Member States and other stakeholders on the progress made and lessons learned under the Global Strategy for Women's and Children's Health.

In addition to the *Progress Report*, the fourth annual accountability report released last year found that coordinated efforts to ensure that resources are being directed towards improving the health of women, adolescents and children are paying off. Those who made financial commitments are delivering on them and are well on their way to disbursing the almost \$60 billion pledged to the Global Strategy for the period 2011–2015. The number of commitment-makers has tripled, from about 100 in 2010 to over 300 in 2014.

Following an extensive consultative process, ENAP was officially launched in June 2014 to take forward the Global Strategy by focusing specific attention on newborn health. Endorsed by the 194 Member States of the World Health Assembly in May 2014, ENAP aims to enhance and support coordinated and comprehensive planning and implementation of newborn-specific actions within the context of national reproductive, maternal, newborn, child, and adolescent health (RMNCAH) strategies and an action plan.

Accompanying the launch of ENAP was a package of approximately 40 financing, policy and service delivery commitments showcasing multi-stakeholder interest and recognition of the need to invest in newborn health. These commitments represent a significant contribution to the Every Woman Every Child movement and underscore the sustained determination by the global community to ensure accelerated progress towards the MDGs, and women's and children's health in particular.

Multilateral institutions played their part with a \$90 million commitment coming from the Islamic Development Bank focusing on, among other activities, building midwifery schools, training health workers in maternal and neonatal care and establishing well-functioning health information systems, including for birth registration. For example, the Islamic Development Bank launched the Save the Mothers initiative, which will provide financing to the tune of \$90 million to improve maternal and newborn health in 56 member countries in sub-Saharan Africa.

The governments of Bolivia, Cameroon, Malawi, Oman and the United States also made commitments. Oman has adopted and translated ENAP into its 2050 health vision and strategic plan and will seek to strengthen the health system to improve the quality of care for mothers and newborns. Under its Family Health at the Community and Intercultural Levels programme (SAFI), Bolivia has committed to strengthen primary health care and reduce morbidity and mortality for women and children.

Preventing newborn deaths and stillbirths is a priority area for many NGOs, as well as academic and research institutions. Save the Children will invest a total of at least \$100 million in maternal and newborn health annually, and through the launch of the Helping Babies Survive suite of newborn-related curricula aimed at strengthening the skills of birth attendants and caregivers, the American Academy of Pediatrics has committed to reaching more than 60 countries and 1.5 million children, their mothers and families.

In addition, the private sector embraced the launch of ENAP by contributing 17 new commitments valued at over \$100 million, representing over 40 per cent of all new commitments and the single largest private sector contribution recorded for the launch of a new global health initiative.

Commitment-makers included multinational pharmaceutical, medical device and communications companies Johnson & Johnson, Merck, GSK, Sandoz, Pfizer, Novo Nordisk, Becton Dickinson, Masimo and Medtronic, Laerdal and McCann Health, alongside national corporate leaders Reliance Industries in India and Premier Medical Systems in Nigeria. Industry associations including the International Pharmaceutical Federation, the International Federation of Pharmaceutical Wholesalers, and GSMA, also made commitments alongside new players like ayzh, an innovative social business based in India with markets across South Asia and sub-Saharan Africa. In addition to these new commitments, at least 40 other companies have investments that are contributing to improvements in the health and development of newborns all over the world. A new report by GBHealth and MDG Health Alliance, *The Ultimate Investment in the Future: Corporate Engagement in Newborn Health and Development*, will be launched in 2015 to strengthen and further align private sector engagement with the goals of ENAP. Given the ambition of the ENAP goals it is vital that governments, NGOs and academic institutions increase their collaboration with the private sector and focus new efforts on the populations in South Asia and sub-Saharan Africa where newborn deaths are concentrated.

Also in September, innovators from both the public and private sectors announced additional commitments to advance the Global Strategy. These included announcements from Philips, Medtronic Foundation, Medela, General Electric, Reliance Foundation, Novo Nordisk, BSR-GAIN, Royal DSM, GSK, GSMA, International Federation of Pharmaceutical Wholesalers Foundation and Nike Foundation totalling more than \$69 million in value. A number of commitments focused on newborn health – a key gap – in line with the vision of ENAP.

Another key Every Woman Every Child pledge was made last September when the World Bank Group and Governments of Canada, Norway, and the United States announced that they would jumpstart the creation of an innovative Global Financing Facility (GFF). The GFF seeks to mobilize support for developing countries' plans to accelerate progress on the health-related MDGs and bring an end to preventable maternal and child deaths by 2030.

The GFF is being developed in close collaboration with a broad range of stakeholders, including partner countries; the H4+ agencies (UNICEF, UNFPA, WHO, UNAIDS, UN Women and the World Bank Group); civil society organizations; bilateral and multilateral development partners; foundations; private sector and others working in the areas of reproductive, maternal, newborn, child and adolescent health. The GFF will support countries in their efforts to mobilize additional domestic and international resources required to scale up and sustain essential health services for women, children and adolescents.

The GFF resources will be provided to countries in conjunction with low-interest loans and grants from the International Development Association (IDA), the World Bank Group's fund for the poorest countries. Based on strong country demand for health-results-based financing programmes, these bilateral contributions could leverage up to an estimated \$3.2 billion from IDA, for a total of up to \$4 billion in financing to support MDG acceleration and improve reproductive, maternal, newborn, child and adolescent health.

Private sector commitment

The private sector embraced the launch of ENAP in June 2014 contributing 17 new commitments valued at over \$100 million, representing over 40 per cent of all new commitments and the single largest private sector contribution recorded for the launch of a new global health initiative. Commitment-makers included multinational pharmaceutical, medical device and communications companies Johnson & Johnson, Merck, GSK, Sandoz, Pfizer, Novo Nordisk, Becton Dickinson, Masimo and Medtronic, Laerdal and McCann Health, alongside national corporate leaders Reliance Industries in India and Premier Medical Systems in Nigeria.

Industry associations including the International Pharmaceutical Federation, the International Federation of Pharmaceutical Wholesalers and GSMA, also made commitments alongside new players like ayzh, an innovative social business based in India with markets across South Asia sub-Saharan Africa. In addition to these new commitments, at least 40 other companies have investments that are contributing to improvements in the health and development of newborns all over the world. A new report by GBHealth and MDG Health Alliance, *The Ultimate Investment in the Future: Corporate Engagement in Newborn Health and Development*, will be launched in 2015 to strengthen and further align private sector engagement with the goals of ENAP. Access the report at <http://www.gbchealth.org/the-ultimate-investment-profiles-of-corporate-engagement-in-the-health-and-development-of-newborns/>

Given the ambition of ENAP goals it is vital that governments, NGOs and academic institutions increase their collaboration with the private sector and focus new efforts on the populations in South Asia and sub-Saharan Africa where newborn deaths are concentrated. A full description of each commitment can be found on the Every Woman, Every Child website.

Commitments made to date by the RMNCH Fund

Programmatic focus	Approved Budget	%
Maternal Health	\$ 25,367,666	27
New born Health	\$ 24,253,349	26
Family Planning/RH	\$ 25,294,790	27
Child Health	\$ 18,807,103	20
Grand Total	\$ 93,722,908	100

New partnerships towards country implementation

Additional content on these partnerships.

Helping Babies Survive

Helping Babies Survive: an Educational Programme Supported by the Survive and Thrive Global Development Alliance to Accelerate Newborn Mortality Reduction

Survive and Thrive is a public-private partnership that engages U.S. paediatric, Ob/Gyn and midwifery membership organizations with the private sector and USAID to collaborate with national and international professional associations and global health scholars to help newborns, children and women survive and thrive. Founding partners include USAID, NICHD, American Academy of Pediatrics, American College of Nurse Midwives, American College of Obstetrics and Gynecologists, Johnson and Johnson, Laerdal Global Health, Jhpiego and Save the Children.

The Survive and Thrive partners have been actively involved in contributing to ENAP from its very inception and, moving forward, supporting countries to achieve their ambitious newborn mortality targets. An important contribution of the alliance is the development of a suite of training modules called Helping Babies Survive (HBS) which aims to improve clinical skills of health providers to prevent and manage the major causes of newborn death. The content and skills training of these modules were created with guidance from WHO as well as extensive assistance from medical professionals in Africa, Asia and South America. The training methodology replicates the simplicity and practical hands-on approach of the successful Helping Babies Breathe training programme that has now been introduced in over 70 countries. In addition, quality improvement skills are an integral part of the HBS training programme. During 2014 and 2015, master trainers from over 20 African and Asian countries were trained in regional workshops convened in Ethiopia and Bangladesh respectively. Several country teams have developed plans to adapt and integrate the HBS modules into their existing newborn programmes.

Also in support of ENAP, Survive and Thrive and the professional associations of Ethiopia, India and Nigeria have entered into a partnership to support Help 100,000 Babies Survive and Thrive national efforts. In addition to resources contributed by the above partners, the initiative has received support from NORAD and the Bill and Melinda Gates Foundation.

Public-Private Partnership to Prevent Preterm Birth

Chief among the causes of child mortality is prematurity, which caused an estimated 965,000 deaths in 2013, more than any other single cause and 15 per cent of all child deaths.

The Public-Private Partnership to Prevent Preterm Birth seeks to accelerate achievement of the Every Newborn goal to halve preterm birth rates over a five-year period, with an initial strategic geographic focus on the three countries with the largest numbers of newborn deaths from preterm complications: India, Nigeria and Pakistan. Together, these countries account for an estimated five million or one-third of all preterm births globally and an astounding 480,000 or 50 per cent of all deaths from preterm birth complications. In these three countries, the partnership will focus on those subnational populations with the highest numbers of newborn deaths, specifically in the Indian states of Uttar Pradesh and Bihar in India, the Nigerian states of Kano, Kaduna and Katsina and in the Pakistani provinces of Punjab and Sindh.

The Public-Private Partnership to Prevent Preterm Birth will specifically target four areas we call the LINC factors (a) lifestyle, (b) infection, (c) nutrition and (d) contraception, and work in close partnership with governments, NGOs, parent groups, the private sector and the research community to reduce related risk factors among the target populations in India, Pakistan and Nigeria. Through working alliances, the Partnership will improve access to preterm prevention programmes where at-risk girls and women before, during and between pregnancies can receive lifestyle education, testing and treatment for infections and non-communicable diseases; nutrition services; and access to modern contraception. Interventions will preferably be provided at the same location and be fully integrated into mainstream maternal and child health services. Media, mobile and social technologies will be used to transmit health messages to the target population and incentivize healthy behaviours.

The Partnership will target the leading risk factors for spontaneous preterm birth identified in the landmark *2012 Born Too Soon* report, including age of pregnancy, pregnancy spacing, multiple pregnancy, infection, underlying maternal conditions (e.g., non-communicable diseases like high blood pressure and pre-gestational and gestational diabetes) and poor nutrition, lifestyle, occupation and psychosocial factors. Priority stakeholders from a number of key sectors will be actively engaged, including (1) relevant government agencies whose policies and programmes impact the target populations; (2) NGOs with a major track record in maternal and newborn health and development and parent groups; (3) major manufacturers of relevant services and products, including diagnostic tests and medicines for diabetes, high blood pressure, urinary tract infections, syphilis, malaria and HIV-AIDS; macro- and micronutrient supplements and fortified foods and contraception; and (4) leading private sector experts in behaviour change, social media and telecommunications to design and deliver communication programmes that inspire women and girls to take the actions necessary to reduce their risk of preterm birth. Additionally, research and development experts will work alongside the Partnership to improve knowledge and understanding of how to prevent preterm birth. ENAP argues strongly that “much more knowledge is needed to address the solution and reach a point where preterm birth is prevented,” and calls for more research to discover new ways of preventing preterm birth by providing a better understanding of the biological bases and causal pathways of preterm labour.

Additional content received from NORAD

Increased access to CHX to avoid umbilical cord infection

RMNCH Trust Fund aims to increase access to critical health products and quality services among women and children by supporting countries’ RMNCH-related plans. Among newborn health activities in the RMNCH plans and progress of EWEC countries were the pilot programmes to increase access to CHX in DRC, Liberia, Madagascar, Nigeria, Pakistan and Uganda.

Increased access to zink/ORS to treat diarrhoea

“Local market shaping for zink and ORS in Nigeria” (CHAI) aims to reduce diarrhea related deaths among newborns and children under five years in Nigeria by increasing access to ORS and zink treatment in Lagos, Rivers and Kano. Availability in outlets has on average increased from 11 per cent to 62 per cent, and prices have reduced up to 80 per cent.

Improved quality of newborn care services through training

In “Accelerating progress to achieve health-related MDGs in Nigeria” (CHAI), newborn health has been improved by supporting the government in developing the Essential Newborn Care Course Curriculum for health workers, and expanding access to quality newborn care services by training mentors. Other efforts include improving referral

systems to increase the number of women giving birth in health facilities and equipping mothers with CHX to avoid umbilical cord infections.

Content received from Core Group

In Ethiopia, the CORE Group is working with its in-country affiliate, the CORE Group Polio Project, and member NGOs to develop a package of harmonized newborn messages and actions targeted to pregnant women and new mothers in pastoralist areas, using health volunteers and a pregnancy registry. A workshop supported by the Maternal and Child Survival Program (MCSP) was held in Addis Ababa (March 3–6, 2015) to develop the parameters of the activity, and a pilot study of the messages and strategy will begin in April 2015. These activities are aligned with the Ministry of Health's Family Health Card guidance, and lessons learned from full implementation may inform community based newborn practices nationally.

Advocacy

World Prematurity Day

Celebrations for the fourth annual World Prematurity Day on 17 November 2014 were held in over 70 countries with support from parent groups, researchers, governments, civil society and more. Bhutan, Ethiopia, Kenya and Tanzania held their first-ever national events to commemorate World Prematurity Day and more than 13 national governments engaged in activities. Also, more than 150 landmarks around the globe were lit purple in support of World Prematurity Day, including the Niagara Falls, The Empire State Building in New York City, Mexico's Federal Congress and Ministry of Health, and the Bosphorus Strait Bridge in Istanbul. The media coverage alone reached almost 2 billion people worldwide. A 24-hour global Twitter relay on November 14 and 15 highlighted the social media campaign that reached over 171 million people that month. These impressive results came after new research published by *The Lancet* medical journal in September that announced preterm birth as the new leading cause of under-five mortality worldwide. Research is critical to finding out the causes of preterm birth and \$250 million in new research programmes were announced on World Prematurity Day. The growth of World Prematurity Day has been due in part to the work of dedicated parent groups around the world and a renewed interest for and action around ENAP and the United Nation's Secretary-General's Every Woman Every Child initiative.

More details can be found at <http://www.everynewborn.org/world-prematurity-day-global-events-honour-babies-born-too-soon>.

World Breastfeeding Week – to be broadened to Breastfeeding Advocacy Initiative

World Breastfeeding Week is celebrated every year from 1 to 7 August in more than 170 countries to encourage breastfeeding and improve the health of babies around the world. It commemorates the Innocenti Declaration signed in August 1990 by government policy makers, WHO, UNICEF and other organizations to protect, promote and support breastfeeding. In 2014, UNICEF and WHO together with 18 partners produced an effective advocacy brief on the importance of early initiation of breastfeeding. Prioritizing the teaching and emphasis of healthy breastfeeding practices starts on the first day, in the first hour of life and is a key, low-cost intervention that saves newborns and improves development outcomes for children. The brief is part of a larger global breastfeeding advocacy initiative, spearheaded by UNICEF and WHO, and involving a range of partners, to raise the visibility of breastfeeding as a cornerstone of child survival, health and development. One of the central aims of the initiative is to cultivate alliances and integrate advocacy and programming for breastfeeding across related sectors, particularly MNCH. The ultimate purpose of the advocacy initiative is to raise political commitment and financial resources for breastfeeding and contribute to building a social movement in which mothers and families are empowered and supported to breastfeed. See the global breastfeeding advocacy strategy:

http://www.unicef.org/nutrition/files/Breastfeeding_Advocacy_Strategy-2015.pdf.

Nigeria National Newborn Health Conference

The Nigerian Federal Ministry of Health, with partners, convened the country's first-ever national conference on newborn health from 23-24 October 2014.² The conference was preceded by a two-day stakeholder consultation for

² Partners included Save the Children, UNICEF, WHO, CHAI, TSHIP, Jhpiego, Wellbeing Foundation Africa, MamaYe Nigeria and others.

the Helping 100,000 Babies Survive and Thrive. The conference offered the opportunity to build synergy among maternal, newborn and child health stakeholders in the delivery of high-impact interventions. It also featured the Nigeria launch of *The Lancet* Every Newborn series and [Nigeria State Data Profiles](#)³ as an accountability tool for MNCH. Importantly, the Government of Nigeria also reaffirmed its commitment towards ending preventable newborn deaths with [A Call to Action to Save Newborn Lives](#)⁴ emphasizing state-level implementation of MNCH interventions. The government also committed to developing the Nigeria Every Newborn Action Plan, which will build on post-2015 goals and link with previous government commitments including the Saving One Million Lives Initiative. More details can be found at <http://www.everynewborn.org/nigeria-launches-call-to-action-to-save-newborn-lives/>.

The Commemoration of World Birth Defects Day

The Neonatal Alliance for Latin America and the Caribbean contributed to the celebration of the first World Birth Defects Day, promoted by a network the Alliance shares with 12 other leading global health organizations. The aim is to raise awareness about the prevalence of birth defects, to develop and implement primary prevention programs and to expand services for the referral and care of those born with congenital malformations.

Birth defects are a frequent and costly problem and a major public health challenge, affecting in 1 in 33 babies worldwide. Congenital disorders are the leading cause of death in infants and young children, as well as the second cause of mortality among newborns and children under five years in the Americas region. Along with prematurity, asphyxia and sepsis, birth defects account for over 44% of child deaths in the region. Likewise, they bear a significant burden of disease and have a major impact on people’s health and quality of life, with medium and long term deleterious effects. For babies who survive and live with these conditions, birth defects increase their risk of long-term disabilities.

1000+OBGYNS Project

Led by [Professor Frank Anderson](#), Director of Global Initiatives at the University of Michigan’s Department of Obstetrics and Gynecology, the [1000+OBGYNS](#) Project is a response to the call by African representatives from academic obstetrics and gynecology programs and Ministries of Health and Education in 14 sub-Saharan African countries for stronger university-based programs to train physicians to become obstetricians and for African-based certification systems that embed stature and community into such systems. At a BMGF-funded gathering Professor Anderson convened in Accra in February 2014 these stakeholders made it clear that their ability to deliver high impact interventions to reduce maternal and newborn mortality and stillbirth is severely limited by the underdeveloped obgyn capacity in many countries across the continent.

Improving data and metrics and monitoring progress

Original text received

Tracking progress to ending preventable maternal, newborn deaths and stillbirths

Count every newborn is the fifth strategic objective in the Action Plan, and data are crucial for informing and accelerating change. In accordance with the Plan and accompanying *Lancet* series, table 1 illustrates the 10 priority metrics that were agreed in order to track *impact* (3 indicators), *coverage of care for every mother and newborn* (3) and *specific interventions* (4), along with the need to better measure quality of care at birth and care for small and sick newborns. All of these metrics link to ongoing work, especially with maternal healthcare tracking and can also be analysed to inform equity of care.

Table 1: Core and additional indicators to track progress of Every Newborn Action Plan

Current status		Core ENAP Indicators	Additional indicators
Definitions clear – but quantity and	<i>Impact</i>	1. Maternal mortality ratio 2. Stillbirth rate	Intrapartum stillbirth rate

³ Nigeria State Data Profiles. Nigeria Federal Ministry of Health and Save the Children’s Saving Newborn Lives program. 2014. Available at <http://www.healthynetwork.org/sites/default/files/resources/Nigeria%20State%20Profiles%20-%20Complete%20Booklet.pdf>.

⁴ Nigeria’s Call to Action: To Save Newborn Lives. Nigeria Federal Ministry of Health. October 2014. Available at <http://www.healthynetwork.org/sites/default/files/resources/Nigeria%20Call%20to%20Action%20Final%20Oct%202014.pdf>.

consistency of data lacking		3. Neonatal mortality rate	Low birth weight rate Preterm birth rate Small for gestational age Neonatal morbidity rates Disability after neonatal conditions
Contact point definitions clear but data on content of care are lacking	Coverage: Care for All Mothers and Newborns	4. Skilled attendant at birth 5. Early postnatal care for mothers and babies 6. Essential newborn care (tracer is early breastfeeding)	Exclusive breastfeeding up to 6 months
Gaps in coverage definitions, and requiring validation and feasibility testing for HMIS use	Coverage: Complications and Extra Care	7. Antenatal corticosteroid use 8. Neonatal resuscitation 9. Kangaroo mother care 10. Treatment of severe neonatal infections	Caesarean section rate Chlorhexidine cord cleansing
	Input: Service Delivery Packages for Quality of Care	Emergency Obstetric Care Care of Small and Sick Newborns Every Mother Every Newborn Quality Initiative with measurable norms and standards	
	Input: Counting	Birth Registration	Death registration, cause of death

Shaded= Not currently routinely tracked at global level

Bold red= Indicator requiring additional testing to inform consistent measurement

Indicators to be disaggregated by equity such as urban/rural, income, and education

Adapted from WHO and UNICEF, Every Newborn Action Plan. WHO, 2014. www.everynewborn.org and Mason et al Lancet 2014

Major gaps in metrics especially to track programmatic advances

The ENAP metrics work is co-chaired by WHO and the London School of Hygiene & Tropical Medicine with a wide network of partner. Over the last year substantial progress has been made in aligning indicator definitions that can be used in countries now and work is underway to develop a multi-partner ENAP measurement improvement roadmap (Figure 1).

Table 1 provides an overview of the current status of indicator definitions and data availability with the indicators requiring most improvement identified in red. Several high impact interventions for newborn health lack standardised indicator definitions and are not routinely monitored at a national or global level, especially in low and middle-income countries (LMIC). These interventions (core indicators 7-10), are targeted on specific needs yet identifying a precise denominator is challenging, since this may require subjective (often clinical) judgement such as need for resuscitation or infection case management and is usually unavailable (particularly from household survey respondents). Most of these specific interventions are currently predominantly implemented at facility level and hence the initial focus will be on facility-based testing of validity and utility of coverage indicators, and potential denominators. Some, such as use of chlorhexidine (CHX) cord cleansing or kangaroo mother care are more likely to be trackable through household surveys.

Hence, given the need for research on the population coverage metrics, recommendations are being made with respect to process indicators for indicators 7-10 and CHX which are immediately useable.

Figure 1. ENAP Measurement Improvement Roadmap



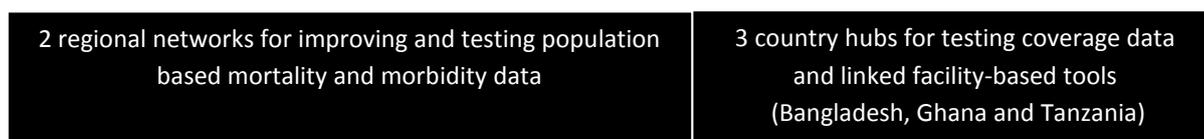
Ambitious plan to improve and use the data to accelerate change in countries

The five-year *ENAP Measurement Improvement Roadmap* details ongoing steps for refining and rigorously testing these indicators, to ensure they can be validly and feasibly collected at scale in routine systems (CVRS, HMIS, and where appropriate, household surveys). In addition, the *Roadmap* outlines the process to deliver on ENAP milestones related to metrics notably for the improvement of birth and death registration, the development and testing of a Minimum Perinatal Dataset to link CVRS birth outcomes and facility HMIS, and also perinatal audit tools to link to Maternal Death Surveillance and Response, as a fulfilment of recommendations in COIA.

This *Metrics Improvement Roadmap* is being developed with wide consultation including a WHO meeting of 50 experts held in December 2014, and a series of consultation sessions throughout 2015. Peer reviewed papers will provide the technical background, initially for the coverage indicators with the greatest gaps and then for the other indicators.

Importantly, to maximise the opportunity for strengthening technical capacity for data collection and use, the improvement work towards these indicators, especially the coverage metrics testing, will be nested in 3 identified Centres of Excellence from high burden countries, with other partners also working on similar questions in other sites (Figure 2). Furthermore the INDEPTH network Maternal Newborn Interest Group, coordinated from Makerere University, Uganda, and involving over a dozen sites of the total of over 40 INDEPTH sites, will lead the testing of questions and improved tools for counting births and deaths around the time of birth, including improved cause of death and birth weight/gestational age assessments. The WHO Collaborating Centre at the All India Institute of Medical Sciences will lead on defining databases and feasible approaches for follow up of at risk newborns, to track and minimise disabilities for example Retinopathy of Prematurity.

Figure 2. Leadership from the highest burden regions to improve and use the data



Mortality data etc	"Beyond newborn survival" data	
 INDEPTH Network <i>Better Health Information for Better Health Policy</i>	 WHO COLLABORATING CENTER FOR TRAINING AND RESEARCH IN NEWBORN CARE <small>Department of Pediatrics, All India Institute of Medical Sciences, New Delhi, India</small>	
INDEPTH Maternal & Newborn Interest Group 20+ sites in Africa and Asia <ul style="list-style-type: none"> ▪ Population-based pregnancy surveillance of births, stillbirths, neonatal deaths. ▪ Opportunities to advance validation of pregnancy history modules, verbal autopsy, improved LBW assessment etc. 	With UNICEF and others partners in India and beyond <ul style="list-style-type: none"> ▪ Follow up at risk newborns by varying levels of health care ▪ Opportunities to validate and test feasibility of follow up, screening for disability, ROP and models to improve care 	

Validation and feasibility testing for facility-based coverage data
 Also tools such as audit, min perinatal dataset, simplified gest age assessment etc

VI. Looking ahead

Quality improvement for maternal and newborn health – a new initiative

Despite the increasing coverage of skilled birth attended deliveries in health facilities, a high proportion of avoidable maternal and perinatal mortality and morbidity are still occurring. Poor quality of care is an important reason for not ending preventable women and newborn mortality and morbidity. Quality of care is defined as the extent to which health services provided to mothers and newborns improve desired health outcomes. The comprehensive characteristics of quality can be grouped under three key components of quality - clinical (safe and effective), interpersonal (people-centred) and contextual (timely, efficient and equitable). In response to the Every Newborn Action Plan and Strategies for Ending Preventable Maternal Mortality, WHO and UNICEF are spearheading an initiative for quality improvement in maternal and newborn health services that is based on standards. WHO hosted a consultation in April 2014 to discuss domains of quality of care and develop a scope of work for standards. Based on the outcomes of this consultation and a review of the literature, a framework for quality of care has been developed that considers eight domains related to provision as well as experience of care. Standards and verifiable criteria for each domain will form the basis of self- assessments which in turn will catalyse the quality improvement process in health facilities. The approach and draft tools will be subject to expert review in June 2015.

New guidelines and tools

Compilations of WHO recommendations for maternal and perinatal health and for newborn health are made available on the WHO website since 2013 and are annually updated^[1]. They are meant to serve as a 'one-stop shop' that can be used for easy reference on evidence-based guidelines.

In 2014, systematic evidence reviews and expert consultation led to the formulation of updated guidelines for improving preterm birth outcomes. The guidelines, expected to be released by WHO in the first half of 2015, address care during pregnancy including the use of antenatal corticosteroids and care of the preterm infant including kangaroo mother care. The recommendations will be a useful complement to those published in 2011 on optimal feeding of low birth weight infants.

Recently, three studies were completed on management of newborns and young infants with possible serious bacterial infection whose caregivers could not or did not accept hospitalization^[2]. WHO is synthesizing the evidence

^[1] http://www.who.int/maternal_child_adolescent/documents/mnca-recommendations/en/

and developing guidelines on simplified antibiotic treatment that will have the potential to increase access and coverage of effective care for sick newborns who would otherwise would not be reached. Their implementation will strengthen the interplay between community health workers who can be effective agents in identifying and ensuring timely referral of infants aged 0 – 59 days with signs of severe illness, and primary level health care workers who will be able to provide treatment when referral is not possible. The release of the new guidelines is expected in the first half of 2015.

A Promise Renewed: Acting on the Call to End Preventable Child and Maternal Death, India, 2015

More information available at <http://www.usaid.gov/ActingOnTheCall>

Every Newborn webinars are available at the following links:

- Overview <http://www.everynewborn.org/webinardec2014/>.
- Country Implementation update <http://www.everynewborn.org/webinarfeb2015/>.
- Metrics update <http://www.everynewborn.org/webinarmarch2015/>.

^[2] AFRINEST study group. Oral amoxicillin compared with injectable procaine benzylpenicillin plus gentamicin for treatment of neonates and young infants with fast breathing when referral is not possible: a randomised, open-label, equivalence trial. *Lancet*. 2015; (published online April 2.)[http://dx.doi.org/10.1016/S0140-6736\(14\)62285-6](http://dx.doi.org/10.1016/S0140-6736(14)62285-6). AFRINEST study group. Simplified antibiotic regimens compared with injectable procaine benzylpenicillin plus gentamicin for treatment of neonates and young infants with clinical signs of possible serious bacterial infection when referral is not possible: a randomised, open-label, equivalence trial. *Lancet*. 2015; (published online April 2.)[http://dx.doi.org/10.1016/S0140-6736\(14\)62284-4](http://dx.doi.org/10.1016/S0140-6736(14)62284-4). Baqui A et al Safety and efficacy of alternative antibiotic regimens compared with 7 day injectable procaine benzylpenicillin and gentamicin for outpatient treatment of neonates and young infants with clinical signs of severe infection when referral is not possible: a randomised, open-label, equivalence trial [http://dx.doi.org/10.1016/S2214-109X\(14\)70347-X](http://dx.doi.org/10.1016/S2214-109X(14)70347-X)