

EVERY NEWBORN

AN ACTION PLAN TO END
PREVENTABLE DEATHS



EVERY
PREEMIE
SCALE

march of dimes THE MDG Health Alliance



PUBLIC-PRIVATE PARTNERSHIP TO PREVENT PRETERM BIRTH ROUNDTABLE DISCUSSION

Wednesday, February 18th, 2015
9:30am - 12:30pmEST

MDG Health Alliance
One Rockefeller Plaza
28th Floor
New York, NY, 10020

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- 9:30 **Welcome**
Leith Greenslade, *MDG Health Alliance*
Chris Howson, *March of Dimes*
Judith Robb McCord, *Every Premie-SCALE, Project Concern International*
- 10:00 **Context**
Every Woman, Every Child, Natalie Africa, UN Foundation
Every Newborn Action Plan/Every Mother, Every Newborn, Mary Kinney, Save the Children, and Lori McDougall, Partnership for Maternal, Newborn and Child Health
- 10:15 **Evidence**
"Preventing Preterm Birth: What Can Be Done with What We Know Now?", *Jim Litch, Every Premie-SCALE, Global Alliance to Prevent Prematurity and Stillbirth*
- 10:30 **Partnership Landscape**
Active multi-country partnerships with potential impact on preterm birth including maternal and newborn partnerships and those addressing lifestyle, infection, nutrition and contraception (LINC) factors, *Partnership Representatives*
- 11:00 **Public-Private Partnership to Prevent Preterm Birth**
Leith Greenslade, *MDG Health Alliance*
Chris Howson, *March of Dimes*
- 11:45 **Next Steps**
- 12:00 **Lunch**

PUBLIC-PRIVATE PARTNERSHIP TO PREVENT PRETERM BIRTH

DRAFT CONCEPT NOTE

February 2015

As the world approaches the 2015 deadline for the Millennium Development Goals (MDGs), there has been enormous progress in reducing child mortality from an estimated 12 million deaths in 1990 to just over 6 million in 2013. However, it is equally clear that much more remains to be done to achieve the new goal of ending preventable child deaths by 2030. 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% of all child deaths.¹ Further, preterm birth rates are rising in many low and middle-income countries and preterm birth complications are a significant cause of morbidity and life-long disability in babies who survive. Without an intense focus on reducing preterm births and resulting deaths, the world will struggle to achieve the Every Newborn Action Plan goal of driving newborn deaths to 12 per 1,000 live births by 2030.



PARTNERSHIP OVERVIEW

We are seeking to accelerate achievement of the Every Newborn goals by launching a Public-Private Partnership to Prevent Preterm Birth. The Partnership will set an ambitious 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% of all deaths from preterm birth complications. In these three countries, the partnership will focus on those sub-national 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.

Table 1: India, Nigeria and Pakistan account for 50% of all deaths from preterm birth...

Country	# Preterm Births (2010)	# Deaths from Preterm Complications (2013)
India	3,500,000	326,496
Nigeria	770,000	85,715
Pakistan	750,000	69,054
Total	5,020,000	481,265
World	15,000,000	965,102
% World	33	50

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. While prevention is challenging because of its population-based nature and often extended time between intervention and outcome, it offers many

¹ Liu, L., Oza, S., Hogan, D., Perin, J., Rudan, I., Lawn, J., Black, R. (2014). Global, regional, and national causes of child mortality in 2000-13, with projections to inform post-2015 priorities: An updated systematic analysis. *The Lancet*.

benefits, particularly with respect to the prevention of preterm birth. Preventive interventions have the potential to reach a broad population and be highly cost-effective, as experience with the provision of immunization, contraception and malaria prophylaxis has shown. Also, because of overlapping risk factors—for example, between preterm birth, maternal death, stillbirth and congenital disorders—preventive interventions for preterm birth have the potential to reduce multiple adverse pregnancy outcomes simultaneously.

In addition, increasing evidence suggests that prevention of preterm birth will have a cascade of beneficial health effects across the life span. Diabetes and hypertension before and during pregnancy are known to increase the risk of preterm birth and low birthweight, and growing evidence suggests that these adverse birth outcomes increase the risk of adult onset diabetes and hypertension in survivors. Intervening early in the life course of an individual not only decreases preterm birth risk in a single generation, it also has the potential to break an increasingly evident vicious intergenerational cycle of risk. Finally, effective prevention encourages communication and collaboration across medical specialties including adolescent, maternal and newborn health, and across public health categories including reproductive health, nutrition, infectious and chronic diseases.

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, non-government organizations, 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 programs where at-risk girls and women before, during and between pregnancy 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 behaviors.

Lifestyle services will focus on the prevention, diagnosis and treatment of risk factors including tobacco smoking, alcohol use, intimate partner violence and exposure to indoor air pollution. At the very minimum, the partnership will promote the delivery of quality prenatal care to pregnant women in the target populations including screening and treatment for syphilis, urinary-tract infections and maternal complications such as gestational diabetes and pre-eclampsia. In malaria endemic areas, the distribution and use of insecticide-treated bed nets for pregnant women will be promoted as will intermittent preventive treatment for malaria. Nutrition interventions will target underweight, overweight and anemia, addressing iron, calcium, protein and energy deficiencies. Modern contraception that is easily accessible, especially to adolescent girls to delay first pregnancy and to women who have recently delivered to delay subsequent pregnancies and improve birth spacing, will be provided.

Not all risk factors will apply equally to all populations. A recent [study](#) on risk factors for preterm birth in 22 countries found that the greatest risk factors in Asia were maternal malnutrition, preeclampsia, urinary tract infections and diabetes, while diabetes, malaria, preeclampsia and malnutrition played a more important role in increasing risk in sub-Saharan populations. The Partnership will tailor program interventions to address the leading preterm birth risk factors in the target populations.

To be effective, the Partnership will actively engage priority stakeholders from a number of key sectors, including (1) relevant government agencies whose policies and programs impact the target populations; (2) non-government organizations (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 behavior change, social media and telecommunications to design and deliver communication programs that inspire women and girls to take the actions necessary to reduce their risk of preterm birth.

Critically, research and development experts will work alongside the Partnership to improve knowledge and understanding of how to prevent preterm birth. The *Every Newborn Action Plan* argues strongly that *“much more knowledge is needed to address the solution and reach a point where preterm birth is prevented,”* and it 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. The Plan also calls for the development of new treatments, including tocolytics to delay preterm birth. By embracing the R&D priorities of the *Every Newborn Action Plan*, the Partnership will not only have an immediate impact on reducing preterm birth rates and associated mortality and disability in the target populations, but will also position these populations for more rapid access to new research advances, especially new diagnostics, medicines and other technologies, as they come on line.

PARTNERSHIP ACTIVITIES

The Partnership will seek to reduce rates of preterm birth in the target populations of India, Nigeria and Pakistan by pursuing three core activities:

1. Develop Integrated Preterm Birth Blueprints

The Partnership will convene a multi-disciplinary team of local stakeholders to develop integrated blueprints to show how the preterm birth rate could be halved within a specific time frame in each of the target populations. Each blueprint would provide rapid, population-specific assessments of: (a) the numbers and rates of preterm birth and death from preterm complications, (2) the numbers and rates of preterm birth-associated disability in survivors, (3) the major risk factors driving preterm births and deaths (e.g. maternal undernutrition), (4) the prevalence of major LINC factors (e.g. modern contraceptive usage), (5) the quality of public and private services affecting preterm birth outcomes (e.g. presence of skilled attendants at birth); and the effectiveness of current government policies and programs to prevent preterm birth and its attendant complications. Based on these assessments, the blueprint for each target population would propose strategies to halve the rate of preterm birth within a specific time-frame. The Partnership would then advocate for the endorsement and implementation of these blueprints with governments and other key stakeholders.

2. Issue Preterm Birth Report Cards

The Partnership will support multi-disciplinary team of local stakeholders to develop and implement *Preterm Birth Report Cards*, modeled on the U.S. Premature Birth Report Card issued annually by the March of Dimes. The March of Dimes Premature Birth Report Card measures progress by comparing each US state's rate to the national 2020 goal of 9.6% set by the March of Dimes in 2012 and identifies actions that must be taken by the states—e.g. decrease the rates of uninsured women, early elective deliveries before 39 weeks of completed gestation that are not medically necessary and reduce the number of women who smoke—in order to achieve the 2020 goal. The Premature Birth Report Card has been important for monitoring and accountability, drawing the widespread attention of elected officials and media in the U.S. and prompting state and federal officials to make or support needed changes. We anticipate that *Preterm Birth Report Cards* tailored to the health risks and health systems needs of the target populations will have similar benefits in the target countries, helping to raise awareness among policy makers and increase funding in support of prematurity prevention.

3. Execute Preterm Birth Communication Campaigns

The Partnership will develop and execute targeted communication campaigns, including mass media, interpersonal and mHealth, to educate women, their families and health professionals in the target populations about the dangers of preterm birth and how specific behaviors can reduce risk. Campaigns will build on global efforts such as World Prematurity Day (November 17th), and recruit key influencers in the target populations to disseminate campaign messages. In addition, the Partnership will convene meetings of the World Prematurity Network, a global coalition of parent groups, in India, Nigeria and Pakistan to strengthen the capacity of local parent groups and their influence on public policy. The campaigns will also be designed to increase care-seeking behavior for specific prenatal services that can reduce the risk of preterm birth (e.g. screening for infections).

CONCLUSION

We have described a prevention-focused, public-private partnership-based approach that can significantly reduce the rates of preterm birth and prematurity-related newborn death in high-burden populations in India, Nigeria and Pakistan by simultaneously focusing on four risk factors—Lifestyle, Infection, Nutrition and Contraception—which we call the *LINC* factors. To reduce the prevalence of these risk factors within the target populations, the proposed Partnership will engage multi-disciplinary teams of key stakeholders to develop Blueprints, Report Cards and Communication Campaigns that together create a powerful force with the potential to dramatically reduce preterm births and deaths in the target populations.

While care for any mother or baby struggling to survive and thrive is an imperative, prevention is the most critical tool in our arsenal to fight the leading threats to maternal and child health and development. With less than 400 days until we usher in the new era of the Sustainable Development Goals, it is more important than ever that we have a robust global strategy to fight the leading cause of child death - preterm birth. To do so, it is essential that the strategy includes a powerful prevention agenda. Prevention is an urgent priority for the mothers and families of the almost one million preterm babies who will lose their lives in 2015 and for the many millions more who will survive birth but who will continue to struggle with life-long disabilities as a result.

FOUNDING PARTNERS

ABOUT EVERY PREEMIE – SCALE

Every Premie—SCALE (Scaling, Catalyzing, Advocating, Learning, and Evidence-Driven), is a five-year \$9 million United States Agency for International Development (USAID) Cooperative Agreement designed to provide practical, catalytic, and scalable approaches for expanding uptake of preterm birth (PTB) and low birth weight (LBW) interventions in 24 USAID priority countries in Africa and Asia (Afghanistan, Bangladesh, DR Congo, Ethiopia, Ghana, Haiti, India, Indonesia, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nepal, Nigeria, Pakistan, Rwanda, Senegal, South Sudan, Tanzania, Uganda, Yemen, Zambia).

Every Premie—SCALE will work with partners to identify and overcome bottlenecks to implementation and significantly increase coverage of PTB and LBW evidence-based interventions in order to increase newborn survival.

The program will be implemented by a consortium comprised PCI, the Global Alliance to Prevent Prematurity and Stillbirth (GAPPS), and the American College of Nurse-Midwives (ACNM). PCI will lead community capacity building and mobilization activities, GAPPS will lead evidence and knowledge sharing, program learning, and implementation research (IR) activities, while ACNM will lead health provider capacity building and performance improvement activities.

The strategic objective of Every Premie—SCALE is to catalyze global uptake of preterm and low birth weight interventions, overcome obstacles to the delivery of interventions and services, and increase coverage and utilization of care services. Every Premie—SCALE will scale up evidence-based and underutilized PTB and LBW interventions by translating evidence into action at and below the national level, increasing capacity and performance for improved service delivery at facility and community levels, and increasing prioritization of PTB and LBW interventions within national and global policies, protocols, and initiatives. The program will combine critical evidence and learning from IR and country demonstration projects with targeted technical assistance to governments, USAID missions, and local organizations while leveraging newborn related advocacy and policy dialogue.

Every Premie—SCALE will implement one of three packages among the above mentioned priority countries:

1. A Core Package in all USAID priority countries will include an overall assessment, local partner and resource mapping to leverage scale-up, an Evidence Toolkit for adoption and rapid dissemination of evidence-based PTB and LBW interventions, and an Advocacy and Awareness Module to guide communication on key messages.
2. A Country Demonstration Package in four selected countries will include: a) stakeholder workshops focusing on advocacy, policy, and key evidence; b) IR to identify solutions to barriers that inhibit availability and uptake of PTB and LBW care; c) gender and barrier analyses to assist in addressing bottlenecks to care; d) learning projects that demonstrate how to implement rapid scale-up of PTB and LBW interventions at the community and health facility levels; and e) small grants to catalyze commitment and engagement among strategic country leaders from professional organizations, academia, and local NGOs.
3. A Targeted Technical Assistance (TTA) Package in countries with limited or no partner presence but who declare readiness to accelerate the implementation of PTB and LBW

interventions, or request specific inputs to an evolving country program. Examples of country specific TTA include the revision of policy, standards and protocols, curricula development, health provider training, essential evidence/implementation research, and/or support for health management information systems.

Every Preemie—SCALE will convene a Global Technical Working Group (TWG) on PTB and LBW Implementation Challenges and Solutions to refine IR priorities, develop PTB and LBW indicators, and provide focused support for PTB and LBW interventions and approaches.

In addition, the program will engage current positions on key global working groups, and will collaborate with leading global professional organizations. Program learning, knowledge, and collective experience will be shared through established global dissemination networks and through regional and global learning events.

Every Preemie—SCALE will work closely with USAID's Flagship Maternal and Child Survival Project (MCSP), Saving Newborn Lives (SNL) and other key partners working in maternal and newborn health.

ABOUT THE MARCH OF DIMES FOUNDATION

The March of Dimes has a long history of taking on bold prevention campaigns and succeeding, beginning with the development of March of Dimes funded research in the 1950s leading to both the Salk (IPV) and Sabin (OPV) vaccines to prevent polio. Subsequently, the March of Dimes led the way in preventing the potentially lethal and devastating effects of genetic, metabolic, and hormonal conditions that can be identified and treated at birth with newborn screening (NBS). At the start of the NBS campaign, the U.S. was a patchwork of varied and unequal NBS state programs; today, through engaging and effectively coordinating key stakeholders across all levels of government, the private sector and civil society, all states screen all newborns for a recommended core group of conditions and federal legislation was passed to assist the states with education, outreach, and coordinated follow-up care. This core strength of the March of Dimes foundation in creating national partnerships for prevention will be brought to bear in the PPP-INP. This success has accrued through 251 chapters located in all 50 U.S. states and Puerto Rico.

In 2003, the March of Dimes turned its attention to the rising rates of preterm birth in the U.S. by launching a national Prematurity Campaign. After rising steadily for three decades, the preterm birth rate began to decline in 2007. In 2013, the U.S. preterm birth rate fell for the seventh consecutive year to 11.4 percent of all births. We remain focused on reducing the U.S. preterm rate further, predicting 9.6% by 2020 and 5.5% by 2030. We will do so by greater implementation of proven interventions² and by research elucidating novel therapies based on contemporary technologies.

Internationally, March of Dimes has overseen a rapidly growing portfolio of cost-effective, transparent and accountable in-country partnerships and programs in over 35 low- and middle-income countries. These partnerships and programs have emphasized capacity building in RMNCAH and helped conduct surveillance and public advocacy/education programs to

² Chang, Hannah H., et al. "Preventing preterm births: analysis of trends and potential reductions with interventions in 39 countries with very high human development index." *The Lancet* 381.9862 (2013): 223-234.

strengthen prevention of adverse birth outcomes in target countries. In 2012, March of Dimes in collaboration with the World Health Organization (WHO), Partnership for Maternal, Newborn and Child Health and Save the Children published the first-ever estimates of preterm birth rates for 184 countries. The report, *Born Too Soon: The Global Action Report on Preterm Birth*, found that over 60% of preterm deaths occur in sub-Saharan Africa and Southeast Asia. The report recommended interventions that are among those that if implemented before, between and during pregnancy, have potential to reduce a woman's likelihood of having a preterm birth.

March of Dimes is a pivotal player in other international initiatives created to extend the breadth of activities to address preterm birth rates and accelerate progress toward MDG 4 and 5 goals, including the Global Coalition to Advance Preterm Birth Research (G-CAPR). Founding partners include the Bill and Melinda Gates Foundation, National Institute for Child Health and Development and MOD. A formal MOU was signed codifying G-CAPR in July 2013 and, since that time, over 20 international partners have joined, including India.

In 2013 MOD also finalized an MOU with the International Federation of Gynecology and Obstetrics (FIGO), again to address the global reduction in preterm birth rates, neonatal deaths and maternal mortality. Initial MOU activities include educational presence at all FIGO international meetings to enhance focus on the rising problem of preterm birth worldwide. The inaugural symposium occurred in Sri Lanka on 1-2 November, attended widely by delegates from India and Pakistan. The other major initiative is a collaborative network to identify best practices to lower preterm birth rates.

ABOUT THE MDG HEALTH ALLIANCE

The MDG Health Alliance is an initiative of the UN Special Envoy for Financing the Health Millennium Development Goals and for Malaria. The Alliance operates in support of [Every Woman Every Child](#), an unprecedented global movement spearheaded by the Secretary-General to mobilize and intensify global action to improve the health of women and children.

The MDG Health Alliance develops innovative and accelerative efforts to drive global progress towards achieving the health MDGs, typically working in partnership with governments, non-government organizations, academic institutions and corporations. The Alliance is led by a group of accomplished private sector leaders — referred to as Vice Chairs of the Special Envoy's Office — who have committed their time, energy and resources to projects that can make a difference in global health. Each of the Vice-Chairs brings a career's-worth of solid accomplishment, inspired leadership and proven results, and it is this private sector expertise that provides the energy and momentum of the Alliance.

This team working to achieve MDG 4 is championing programs that increase access to the most cost-effective interventions for preventing and treating the leading causes of child deaths: pre-term birth, pneumonia, diarrhea, birth complications, newborn infection, malaria and malnutrition. The Child Health team focuses on the countries where child deaths are most concentrated and has a special focus on increasing high-impact, co-ordinated public and private sector engagement with the potential to dramatically accelerate achievement of child survival efforts.