



Ministry of Health - Uganda

# **Newborn Component of the Child Survival Strategy in Uganda**

## **IMPLEMENTATION FRAMEWORK**

March 2010

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## FOREWORD

There is evidence that Uganda is making progress towards the Millennium Development Goals (MDG) 4 and 5 targets for child and maternal health but this progress needs to be accelerated. Uganda's under-five mortality rate declined from 152 per 1000 live births in 2000 to 137 in 2006 while the infant mortality rate declined to 76 from 88 per 1000 live births during the same period. Forty percent of infant deaths occur during the first month of life - the neonatal period - amounting to 45,000 each year. An equal number of babies are born with no signs of life. Risk factors for neonatal deaths are also the major risk factors for maternal deaths. Meeting the MDG 4 targets will therefore require a strong focus on reducing neonatal deaths. In the Health Sector Strategic Plan II (2005/6 - 2009/2010), the Government of Uganda prioritised newborn health care. Consequently the Road map for Accelerating Reduction in Maternal and Neonatal Morbidity and Mortality (2006-2015) and the Child Survival Strategy (2008-2015) were developed with specific interventions to address the constraints of newborn health.

This implementation framework is a result of collaboration between The Ministry of Health Child Health and Reproductive Health Divisions, Save the Children's Saving Newborn Lives programme, WHO, UNICEF and the Newborn Technical Working Group of the Maternal and Child Health Task Force. This framework has been refined through feedback from a number of stakeholders consulted in a series of meetings including the final meeting of January 2009 attended by over 50 participants representing implementers at district and regional level, policy makers from other departments of the Ministry of Health (MoH) and members of the professional health associations, which finalised and endorsed the framework

The overall goal of this document is to stimulate operationalisation and integration of the newborn health component of the Child Survival Strategy and the Road map of the Ministry of Health into existing maternal and child health programs. Thus the concept of Maternal, Newborn and Child Health (MNCH) enhances the integration of services as one component in the minimum health care package. It would not only help address gaps in newborn health service provision as identified in the recent Situation Analysis of Newborn Health in Uganda, but would also facilitate and catalyse the realisation of our goals For improving MNCH and the overall health system through improved coverage of evidence based interventions across the continuum of care.

The audience of this framework is wide and ranges from frontline health workers at the facility and the facility-community interface to sub-district and district level managers, programme officers at the national level, non-government organisations (NGOs) and other partners, both donor and technical assistance agencies.

We strongly encourage programs and partners to use this document to integrate newborn health in existing programs in order to enhance operationalisation of the Child Survival Strategy and the Road map.



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## ABBREVIATIONS

ADH	-	Adolescent Health
ANC	-	Antenatal Clinic
AOGU	-	Association of Obstetricians and Gynaecologists of Uganda
ARVs	-	Anti-retroviral drugs
CBOs	-	Community Based Organisations
CEA	-	Cost-effectiveness Analysis
CSOs	-	Civil Society Organisations
CSS	-	Child Survival Strategy
BCG	-	Bacillus Calmette-Guérin
EmOC	-	Emergency Obstetric Care
FANC	-	Focused Antenatal Care
FIGO	-	International Federation of Gynaecology and Obstetrics
FP	-	Family Planning
HIV	-	Human Immune Deficiency Virus
HUMC	-	Health Unit Management Committee
IBFAN	-	International Baby Food Action Network
IPH	-	Institute of Public Health
IPT	-	Intermittent Presumptive Treatment of Malaria
ITNs	-	Insecticide Treated Nets
KMC	-	Kangaroo Mother Care
MCH	-	Maternal and Child Health
MDG	-	Millennium Development Goal
MNCH	-	Maternal, Newborn and Child Health
MoH	-	Ministry of Health
MoLG	-	Ministry of Local Government
NBHC	-	Newborn Health Care
NBH	-	Newborn Health
NGOs	-	Non-Governmental Organisations
PEAP	-	Poverty Eradication Action Plan
PMTCT	-	Prevention of Mother-To-Child Transmission of HIV
PNC	-	Postnatal Care
SITAN	-	Situation Analysis of Newborn health
TBA	-	Traditional Birth Attendant
TT	-	Tetanus Toxoid
UDHS	-	Uganda Demographic Health Survey
UNDAF	-	United Nations Development Assistance Framework
UN	-	United Nations
UNEST	-	Uganda Newborn Study
UNHCO	-	Uganda National Health Consumers Organisation
UNICEF	-	United Nations International Children's Fund
UPA	-	Uganda Paediatric Association
USAID	-	United States Agency for International Development
SWAp	-	Sector-wide Approach
VHTs	-	Village Health Teams
WHO	-	World Health Organisation

## 1.0 INTRODUCTION AND BACKGROUND

### 1.1 *Introduction*

There is evidence that Uganda is making progress towards the MDG 4 &5 targets by 2015 but this progress needs to be accelerated. Under-five mortality rate declined from 152 per 1000 live births in 2000 to 137 in 2006 while the infant mortality rate declined 76 from 88 per 1000 live births during the same period. Forty percent of infant deaths occur during the neonatal period amounting to 45,000 each year. An equal number of babies are stillborn with no signs of life. Risk factors for neonatal deaths are also the major risk factors for maternal deaths. Meeting the MDG 4 targets will therefore require a strong focus on reducing neonatal deaths. The situation is made complex by the very high total fertility rate (which has not changed over the last two decades and is now one of the highest in the world at 6.7).

In the Health Sector Strategic Plan II (2005/6 – 2009/2010), the Government of Uganda prioritised New Born Health Care (NBHC). The purpose of this document is to establish a common vision and approach, as well as to identify the role of the national, district, facility and community, as well as other partners to improve newborn health. Part 1 of the document gives the background, situation and context of newborn health in Uganda and the evidence based intervention for reducing newborn deaths; Part 2 presents strategies, desired behaviour changes among the target population also known as the critical actors/boundary partners and priority areas of focus for implementation of NBH programmes. It also lists interventions for each of the areas of focus.; Part 3 is on how to introduce and implement newborn activities including monitoring and evaluation; and, finally, Part 4 considers the role and functions of the key players.

To develop this framework outcome mapping, which involves defining the desired behaviour changes for the target population (in this case referred to as boundary partners) to achieve the goals and targets set in the health sector strategic plan was used. Then priority areas of focus for implementation to bring about the desired change are proposed. The indicators for tracking progress towards the desired behavioural changes in the boundary partners are also outlined. The framework also identifies strategic partners who may assist the NBH programmes to achieve their desired outcomes.

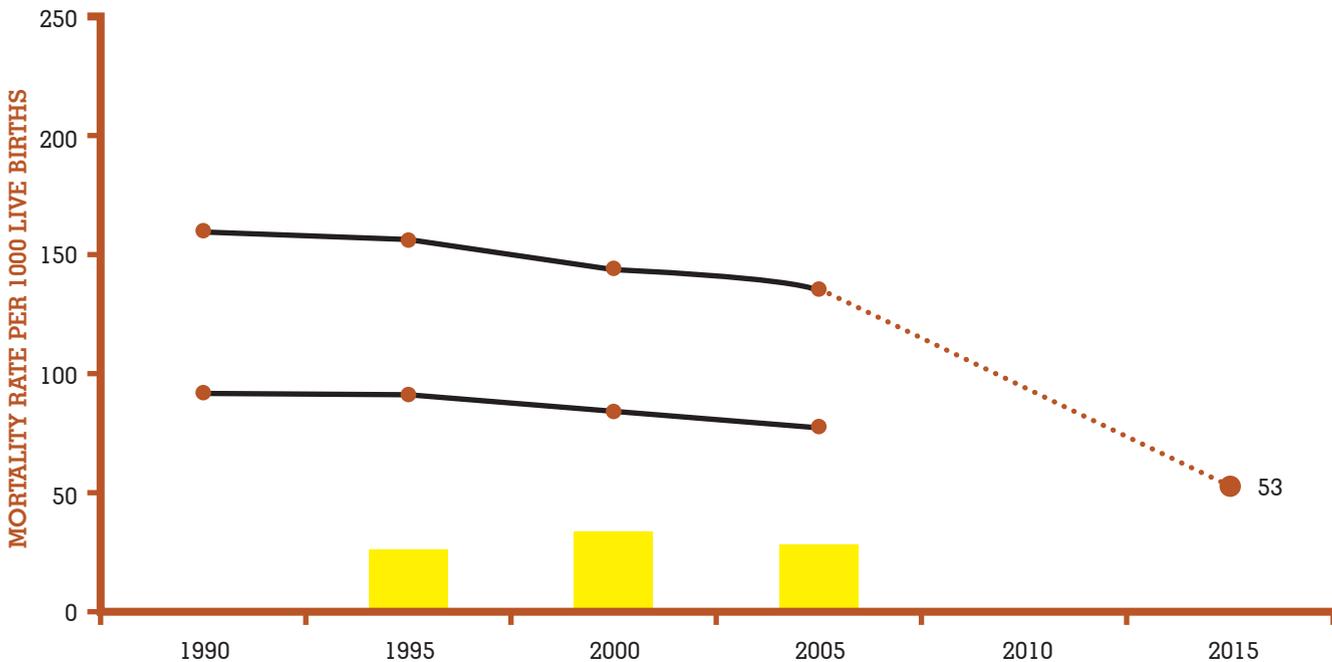
The primary audience of this framework are the frontline health workers at both facility and community interface, district and sub district level managers, program officers at the national level, Civil Society Organisations, Non - Government Organizations and other partners both donor and technical assistance agencies. This framework is the result of a consultative process, and collaboration between child and reproductive health divisions in the ministry of health, academia, civil society and development partners all represented on the national newborn technical steering committee.

### 1.2 *Situation Analysis*

The rationale for this framework is based on the Situation Analysis of New Born Health in Uganda (SITAN) of 2008. The SITAN report notes that 40% and 25% of deaths among infants and children under-five respectively are neonatal deaths (occurring within the first 28 days of life). Neonatal mortality rate for Uganda is 29/1000 live births. The first week of life poses the highest risk of deaths for newborns, with 75% of deaths occurring during this time and 50% occurring within just the first 24 hours of life, mostly births occur at home. Figure 1 illustrates Uganda's progress towards achievement of MDG 4 of reducing the under-five mortality rate to 53 in 2015. The SITAN identified three major causes of newborn deaths;

infections 33%, asphyxia 26%, complications of pre-term births 32%. Ironically, these leading causes are largely preventable or treatable. The SITAN report identifies four major risks associated with newborn deaths namely; (a) age of the mother being below 20 years; (b) the interval from previous birth being less than 24 months; (c) a birth weight of less than 2500 grams (being born smaller than normal sized babies), (d) being born to a mother in a rural area.

Figure 1: Uganda's progress towards progress to MDG 4 (Source: UDHS 2006)



The report also noted that while efforts and programs exist to provide services and care for newborns but serious gaps exist associated with weaknesses at facility level and community levels (where most births occur). Skilled birth workers assist in only 42% of births and out of every four mothers, only one receives postnatal care. Essential equipment for childbirth and immediate newborn care was lacking in the health centres especially at the lower level facilities. Most health workers have limited knowledge and skills to provide essential care for newborns. Consequently, the coverage of critical interventions for newborn health during pregnancy, childbirth and the postnatal period is far below the expected.

### 1.3 The Health Sector Strategic Plan

This framework is also based on the health sector renew, commitment to prioritize and accelerate newborn efforts through the road map for accelerating reduction in Maternal and Neonatal mortality and morbidity (2006-2015) and a Child Survival Strategy (2008-2015) to ensure high coverage of newborn interventions. Both CSS and Road map to maternal health target "a reduction in neonatal mortality from 29 per 1000 live births to 25 per 1000 live births in 2009/10 and to less than 20 per 1000 live birth in 2014/15 " at national level. Achieving the desired vision for newborn health in Uganda will require very high coverage of the priority interventions. Achieving high coverage of interventions will require developing capacities for health and making healthy choices using the three main delivery modes as identified in the Child Survival Strategy. First, given the personal and social nature of pregnancy and childbirth, the initiative considers it essential to develop capacities to assure supportive household and community environments. To be effective, the continuum of care should extend from the woman and her family to population based services, including access to essential neonatal care through outreaches or campaigns. Finally strategies for working with care-seekers and providers to improve healthcare at facility level are equally important.

## 1.4 Evidence based newborn interventions

This framework also builds on a wide array of experiences and lessons learned from other low-income countries. The Lancet series of papers (2008) describe a number of known affordable interventions for which, if implemented fully, could prevent 63% of current mortality. These interventions are distributed across a continuum of care, prenatal, delivery and early postnatal period as shown below.

### Prenatal period

- Information and counselling on self-care at home, nutrition, safer sex, breast feeding and post-partum family planning
- Tetanus toxoid immunisation
- Birth and emergency preparedness
- Detection and treatment of pre-eclampsia, syphilis and bacteriuria
- Use of insecticide treated bed nets
- Intermittent prophylactic treatment of malaria
- Prevention of mother to child transmission of HIV (PMTCT)

### Intrapartum and immediate Postnatal in the first 1-2 hours after birth

- Monitoring of labour and birth by a skilled attendant, using partograph
- Detection of problems and complications (e.g. prolonged or obstructed labour, hypertension, bleeding, infection)
- Social support (companion) during birth
- Emergency obstetric and Newborn care for complications
- Temperature maintenance
- Early initiation of breast feeding and exclusive breast feeding
- Hygienic code and eye care
- Neonatal resuscitation
- Use of antibiotics for pre-term premature rupture of membranes
- Use of Antenatal corticosteroids for pre-term labour
- Prevention of mother to child transmission of HIV (PMTCT)

### Early postnatal care (from 1-2 hours after birth to 1 week)

- Temperature maintenance
- Early initiation of breastfeeding and exclusive breastfeeding
- Hygienic cord care
- Prompt care seeking for illness
- Counselling on birth spacing (>24 months)
- Extra care of low-birth-weight infants

- Management of local infections and feeding problems
- Identification and emergency management of severe newborn illness – infections, asphyxia, pre-term birth (including KMC)
- Immunisation (BCG, polio)
- Prevention of mother to child transmission of HIV (PMTCT)

## 2.0 GOALS AND OBJECTIVES

### 2.1 Goal

To improve newborn health and survival by increasing equitable coverage of high impact evidence based interventions.

#### Objectives

- i. Increase proportion of newborns receiving timely and appropriate PNC checks at from 5% to 30%
- ii. Increase proportion of health facilities meeting the newborn health services standards to 25%
- iii. Reduce the proportion of neonates seen in health facilities with septicaemia/severe disease by 30%
- iv. Increase the proportion of health workers trained in essential newborn care to 60%

### 2.2 Guiding principles

Four principles will guide the improvement of newborn health in Uganda, namely:

1. Pursue high intervention coverage to address health inequities and Gender,
2. Facilitate the respect, protection, and fulfilment of the human rights of newborns,
3. Address cultural sensitivity,
4. Emphasize existing social and personal resources. These principles are designed from the Poverty Eradication Action Plan (PEAP) and National Development Plan which form the underlying basis for the implementation framework, presented below.

## 3.0 STRATEGIES, DESIRED BEHAVIOUR & PRIORITY AREAS

### 3.1 Strategies

The strategies to achieve the aim of working with individuals, families and communities for improved maternal and newborn health are outlined in this section of the document. These strategies have been identified because of their long-term perspective, their capacity to achieve the proposed aims, and their relationship with the priority areas of intervention set forth. These strategies are intended to interact and be mutually reinforcing.

#### *a. Creating enabling policies*

For newborn interventions, existing policies sometimes are lacking while others need to be reviewed on postnatal package, timing and where these services should be provided to reach the majority of births. Many studies have shown lack of skilled attendance during and soon after childbirth. To begin with, the staffing norms for midwives have not yet been met especially in lower level facilities where most deliveries occur. There is no specific provision for follow up mothers who deliver at home. Thus there is very low coverage of postnatal care; only one in every four mothers receives postnatal care. Even then mothers who deliver in public health facilities are discharged too early, most without having received any postpartum care and support. The routine postnatal visit at six weeks comes late after most newborn deaths have occurred. Besides the majority of health workers do not know the protocols for postnatal care for the newborn. The national policy in lower level facilities also does not allow antibiotics needed to treat infection in newborns. These policies should be created, reviewed and disseminated widely and capacities built for them.

#### *b. Communication to change behaviour*

Culturally sensitive education and counselling of parents and caregivers is one of the essential elements of improving behaviours and is considered as one of the important contributors to maternal and newborn health. The situation analysis identified several inappropriate and often harmful household practices, most of them rooted in culture. For example nearly 60% of mothers give birth at home, alone or with assistance of traditional birth attendant (TBA) or family member under unhygienic conditions. Although nearly all mothers practice breastfeeding, and 42% begin breastfeeding within one hour after delivery, 54% of mothers supplement their newborns with pre-lacteal feeds, including water, tea and cow's milk. Some cultures practice harmful home remedies such as applying ash or cow dung to the cord, bathe babies soon after delivery and first seek care from village elders and traditional birth attendants before going to the skilled health workers. Systematic approaches that build on culture and health literacy, and go further to provide women, men, families and communities with the knowledge and skills to act, maintain, preserve, promote and improve newborn health are needed. A broad perspective for communication is however required, that would include: intrapersonal, community factors and public policy.

### ***c. Partnership building***

Building partnerships is essential for scaling up and sustainability of newborn health. Collaborative relationship with other players within the sector and externally are foreseen during planning, development of capacities, monitoring etc. Close collaboration is needed within MoH departments. Partnerships with multilateral and bilateral development agencies, NGOs, civil society and communities are also essential. Partnerships at the district level are also essential to assure coordination and convergence of efforts, ensure quality and avoid duplication of activities. Also, formal coordination between public and private health facilities will ensure that minimum standards are followed. The fundamental premise is to build on existing knowledge and expertise of different partners and actors.

Deliberate mechanisms should be established to make these partnerships operational. The decentralization policy and sector-wide approach (SWAp), both promote integration and pooling available resources and allocating them to priority areas such as newborn. United Nations Development Assistance Framework (UNDAF) is also a useful approach at country level for the implementation of a coordinated programme with development partners. The MNCH cluster working group in the MoH, newborn steering committee, safe motherhood and prevention of infant and maternal mortality task force should be used to coordinate newborn health. Interventions in communities, workplaces, schools, and adult education and through multi-channel communication must be employed as interacting strategies.

### ***d. Strengthening health systems***

As decentralization occurs, efforts and planning must consider strengthening for district, health facilities and community organizations so that they can actively assume ownership and improved delivery of newborn health strategies. The situation analysis identifies awareness, financing and supervision as key factors for the strengthening of district health systems for newborn. Capacity building efforts are required for the planning and implementation. At the planning stage, a skills development strategy for planning, assessing status of newborn standards and prioritisation of interventions taking into account the existing gaps and available resources needs to be developed. Skills for building capacities among caregivers, behaviour change educational approaches, continuous quality improvement, procurement and supply management are also needed. These efforts should be incorporated into existing processes health system strengthening.

## ***3.2 Desired behaviours changes***

In this framework to achieve the goal of newborn health the target population represents the boundary partners who include individuals, groups, or organizations whose behaviour the program intends to influence to contribute to the intended desired behaviour improvement. A brief description of the specific desirable behavioural changes for each of the target population is provided on the next page.

## Household and family

Health outcomes of newborns be it positive or negative, are largely determined by decisions made by the mothers, fathers, and other significant caregivers within the household. Healthy behaviours among caregivers before, during and after delivery include:

1. Pregnant women attending ANC at least four (4) times
2. All pregnant women taking malaria prophylaxis & sleeping under ITNs
3. All mothers delivering at health facilities with skilled health worker in a clean environment
4. All newborns initiated on breastfeeding within the first hour of life
5. Mothers practicing proper hygiene, including cord care, skin care, eye care and hand washing
6. Mothers and caretakers recognizing maternal and newborn danger signs and seeking appropriate care as early as possible
7. Keeping the newborn baby warm by delaying the baby's first bath after birth for 24 hours and practicing Kangaroo mother care

## Community health service providers

The role of community health workers such as Village Health Teams (VHTs), NGOs, CSOs is to be considered when designing newborn health programs. Expected behaviours among community service providers include;

- i. Mobilizing and sensitizing communities to adopt best newborn care practices at household and community level
- ii. Identifying and immediately referring all mothers and newborn with danger signs to skilled health workers in the nearest health facilities
- iii. VHTs conducting at least three home visits for delivered mothers with a newborn in the first week of life and two extra visits for small babies after birth

## Facility based front line health workers [public and private]

All public and private health workers are expected to provide quality newborn care and services across the continuum of care during ANC, delivery, and postnatal period by doing the following;

- (i) Providing quality care and services for newborns across the continuum of care according to national service standards.
- (ii) Carrying out and maintaining complete and accurate documentation for each mother baby pair delivered at a health facility
- (iii) Conducting regular perinatal death audits to improve quality of care

## District health management teams/ committees

As articulated in the decentralization policy, districts are responsible for implementing programs. District capacities can be one of the critical factors in addressing newborn health issues. Moreover, ability to implement takes into consideration planning, management, training, supervision, monitoring and resource mobilization to support the health of newborns. Appropriate information and approaches for

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working with communities are critical. All district health management teams/ committees are expected to;

- i. Plan for and assure provision of the minimum package of newborn interventions and standards at all levels of care
- ii. Integrate NBH care activities into the district health plans and budgets
- iii. Procure equipment and materials for NBH care among other medical supplies for the district

### **3.3 Priority areas of focus**

To achieve the desired behaviours four priority areas of intervention have been defined. Given the complex nature of newborn health, a comprehensive strategy with interventions from each one of the priority areas is recommended. Actions from each of the areas should be implemented concurrently to contribute to improvements to newborn health. The priority areas of intervention are listed and each of these areas analysed further. These are:

- a. Mobilizing and developing CAPACITIES for households and families to keep newborns healthy, make healthy decisions and respond appropriately to illness;
- b. Improving QUALITY of health services at community and facility level and of their interactions with caregivers;
- c. Strengthening LINKAGES between communities, health system and programs or services to ensure continuum of care;
- d. Increasing AWARENESS of the rights, needs and potential problems related to the survival of newborn health

#### **3.3.1 Capacities of communities and caregivers**

In this framework, “household” is considered a setting equivalent to family. Family in the context of this document refers to “any group of persons that assumes responsibility for maternal and newborn health.”. Health outcomes of newborns be it positive or negative, are largely determined by decisions made by the mothers, fathers, and other significant caregivers within the household.

The underlying gaps to be addressed at the household level include:

- Lack of awareness of harmful practices.
- Delayed and inappropriate response to problems of the newborn.
- Poor access to right information and mothers relying more on information obtained from “significant others”.

These gaps can be addressed by developing healthy caring practices, care-seeking behaviour and compliance with care recommendations. Efforts will be aimed at increasing and improving those abilities, such as knowledge, cognitive abilities, and health competencies. This can be influenced by various interventions.

- I. **Behaviour change communication** targeting mothers, and the “significant others” on home care practices. Multi-channel communication and health education activities will be implemented. Formative research is an important part of the development of this area of action to strengthen the base of local evidence which link different behaviour change communication approaches to outcomes of increased knowledge, better caring practices and increased use of services. Also, an initial understanding of the reasons for use and non-use of the services is fundamental to developing appropriate strategies and messages. Newborn care practices are also closely linked to having resources needed for good caring practices such as mama kits, contraceptives, and ITNs to motivate behavioural change. These will be distributed by MoH and its partners.
- II. **Strengthening social networks and male involvement** in newborn and maternal health. Individual and collective awareness and capacities will be maximized through the establishment or strengthening of social networks, which are able to collaborate and interact with health service networks including mother peer support groups to provide peer support to mothers and care givers that will subsequently lead to behavioural change. Traditionally most health programs do not prepare men to participate in the crucial aspects of pregnancy, childbirth and postnatal care. Programmes need to broaden their understanding of men’s needs and perspectives related to care of mothers and newborns to achieve this. In addition health care workers need to be prepared and need the interpersonal skills to work with men to support them in their roles and to support women in developing capacities for decision-making.

### 3.3.2 Quality of health services

For newborn babies, health care services include essential newborn care at the community, primary and referral levels (village, dispensary, health centre, district hospital). At the community level the underlying gaps include failure to engage VHTs in providing information and screening for sick newborns. There is also little attention given to supporting mothers in avoiding harmful practices. Even where health workers are available, their skills are inadequate and they are not facilitated, supervised and motivated to provide quality services. High patient to health worker ratio overwhelms the existing staff. Basic tools such as equipment and supplies, standards and guidelines required for provision of newborn care at facility and community level are often lacking. These gaps can be addressed by various interventions.

- I. **Community based postnatal care services.** Based on community input, to make services more responsive, adequate, appropriate and culturally sensitive, a newborn health program will be designed around the VHT structure including home visits during pregnancy and after delivery. It is hoped that focus on the community will increase access to newborn interventions and subsequently the use of facility based services. Skills of VHTs will be built on education on Antenatal, skilled care during birth and postnatal care attendance; support women and disseminate health information on care practices compliance (infant feeding, care seeking, birth and emergency planning, family planning etc.); and serve as a link between communities and formal health services. In those sites where they play an important role in providing care, TBAs may be included as members of the VHTs.
- II. **Define and introduce minimum quality of care standards,** which include definition of basic supplies, equipment and treatment for newborn care. Relevant standards of other MNCH programme e.g. FANC, EmOC, FP, ADH, PMTCT, Malaria, nutrition, Paediatric HIV/AIDS, immunization need to be harmonized and mainstreamed in this process. Each district or facility will be expected to set performance targets given their situation. Periodic assessment of these standards will be accompanied by feedback and corrective action. Systematic approaches for improving the quality of care in the health facility that are feasible and effective will need to be designed. Existing approaches like the yellow star program will be used to build on these interventions. Capacities will

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then be built among health facility staff and district managers for improving standards through in-service and pre-service training in medical, paramedical and nursing schools. Essential equipment, drugs and supplies will need to be procured and supplied regularly to improve compliance with the standards

- III. **Build interpersonal/intercultural skills of health care providers.** Quality is often determined by the interaction between clients and providers. Most providers have poor attitudes and lack skills needed for individual interactions as well as skills for working with the larger community. To be able to communicate effectively, providers should have the ability to listen, actively engage mothers, demonstrate cultural sensitivity and give support, moving away from the customary sessions based on information giving. These skills are likely to improve quality of care and use of services.
- IV. **Audit health facility perinatal deaths** Information regarding newborn health is needed to improve quality of care. Death audit information can serve as the basis for dialogue within the health facility itself and also between the facility and managers to improve care. Death audit committees at national, district and facility levels will be established to carry out the identification and investigation of neonatal deaths and, subsequently, recommend corrective actions. Community involvement in audits will act alongside other educational initiatives. Communities can learn about the conditions which contribute to mortality and morbidity from cases within their communities and discuss what actions can be taken to prevent these.

### 3.3.3 Linkages and continuum of care

Continuation of care has been identified as one of the most critical health care delivery determinants for the survival of newborns. The continuum of care should extend from the woman, her family and the community level to the health provider and health services, including access to a skilled attendant when neonatal complications arise. Most traditional programmes lay little emphasis on continuum of care. Structures are lacking to enhance the interface between home care and professional care for the newborn. There are little working alliances for complementary and coordinated actions for newborn activities to strengthen the linkages between communities with health services. These gaps can be addressed by various interventions.

- i. **Community financing and transport schemes** One major factor in access to care is the ability to reach and use services. Lack of financing and transport schemes affects individual and household decision-making processes, can reduce access and, therefore, increase delays in receiving skilled care. Funds for emergency transportation (special funds or within-community financing schemes) may be made available to increase the use of transport facilities. Agreements can also be sought with local transport unions, with private drivers, and with motorcycle transporters, when available to carry patients who are referred. Communication for referrals is also an issue related to access and transport
- ii. **Maternal, newborn and child handbook.** Health Systems Strengthening must be at the centre stage of efforts for more drastic reduction of mortality. Many countries are re-energizing work on health system strengthening through improvement of health information. The Maternal and Child Health Handbook is a book that contains essential information, kept by the family, to promote and maintain the health of mothers and children. It is designed to promote continuity between maternal, neonatal and child health care and health records. Through use of this handbook integration of many health services is also fostered. The handbook is part of the national MCH program in strengthening the

country's healthcare system; improve the capacity, networking and collaborative activities on MCH programs.

- iii. **Partnerships for newborn health.** More ambitious increase in resources and effective partnerships at all levels are needed for more effective programs to reach the goals. A focused, coordinated effort and appropriate action by programs and partners is needed to provide newborns with the health care they need in a more efficient way. Operational partnerships should be organized with maternal and child health to take promising interventions to scale with government in the lead, and donors, NGOs, the private sector and other stakeholders engaged in joint programming, co-funding of activities and technical reviews.

### 3.3.4 Awareness of rights and situation of newborns

Awareness on newborns' right to survival, needs and barriers to reducing mortality is generally limited among caregivers, communities, health workers, policy makers and leaders. The lack of male involvement whereby women are viewed as the primary consumers of newborn health services contributes to failure of enhancing the roles of stakeholders in newborn health. These include:

- I. **The rights to survival and development.** Critical to improving newborn health outcomes is the recognition that birth and newborn survival is a human right. Therefore the provision of appropriate newborn service is a right that people are entitled to demand from their governments. Raising awareness of rights can "empower" communities to "demand" quality services that meet their needs. The approach should aim to facilitate women, men and communities to advocate and act at district level, to ensure that comprehensive neonatal care services and information are accessible and available to them, when they most need them. Stakeholders should support this area by disseminating information related to the clients' rights. To better protect, respect and fulfil their human rights obligation to safeguard newborns, the legal, policy and practice situation related to newborn health should be reviewed. Advocacy strategies should be developed to support this area.
- II. **Situation of newborn health.** Information from situation analysis of newborn health can be used to get official backing and buy-in for the proposed interventions, which is important for scaling up and integrating it with other initiatives. For example a situation analysis in 2008, shows each year in Uganda at least 45,000 newborns die with an equal number stillborn. Uganda has many good policies in place to protect newborns and provide integrated care but these do not address adequately early postnatal period, skills and knowledge on caring practices and poverty and culture. Uganda also has a strong network of health centres and hospitals and most women access the formal health system during pregnancy. The quality of care however is poor and links between facilities and communities are limited resulting in low use of services around the time of childbirth and the early postnatal period. The Situation Analysis has since been used to inform sectoral policies and guidelines.
- III. **Cost effectiveness analysis** There is a need to know which strategies are best for preventing newborn deaths and how services should be improved, and whether these are a good investment compared with other health care interventions. The available evidence provides some guidance to decision-makers. However, the potential to inform policy debates is limited by the gross lack

## IMPLEMENTATION FRAMEWORK

of information on the costs and effects of many newborn interventions, the very small number of cost effectiveness analyses available, and the problems in generalizing or comparing studies that relate to specific settings. Economic evaluation methods, and in particular cost-effectiveness analysis (CEA), focusing on sub Saharan Africa where a big burden occurs can provide important information for identifying the interventions that represent the best value for money.

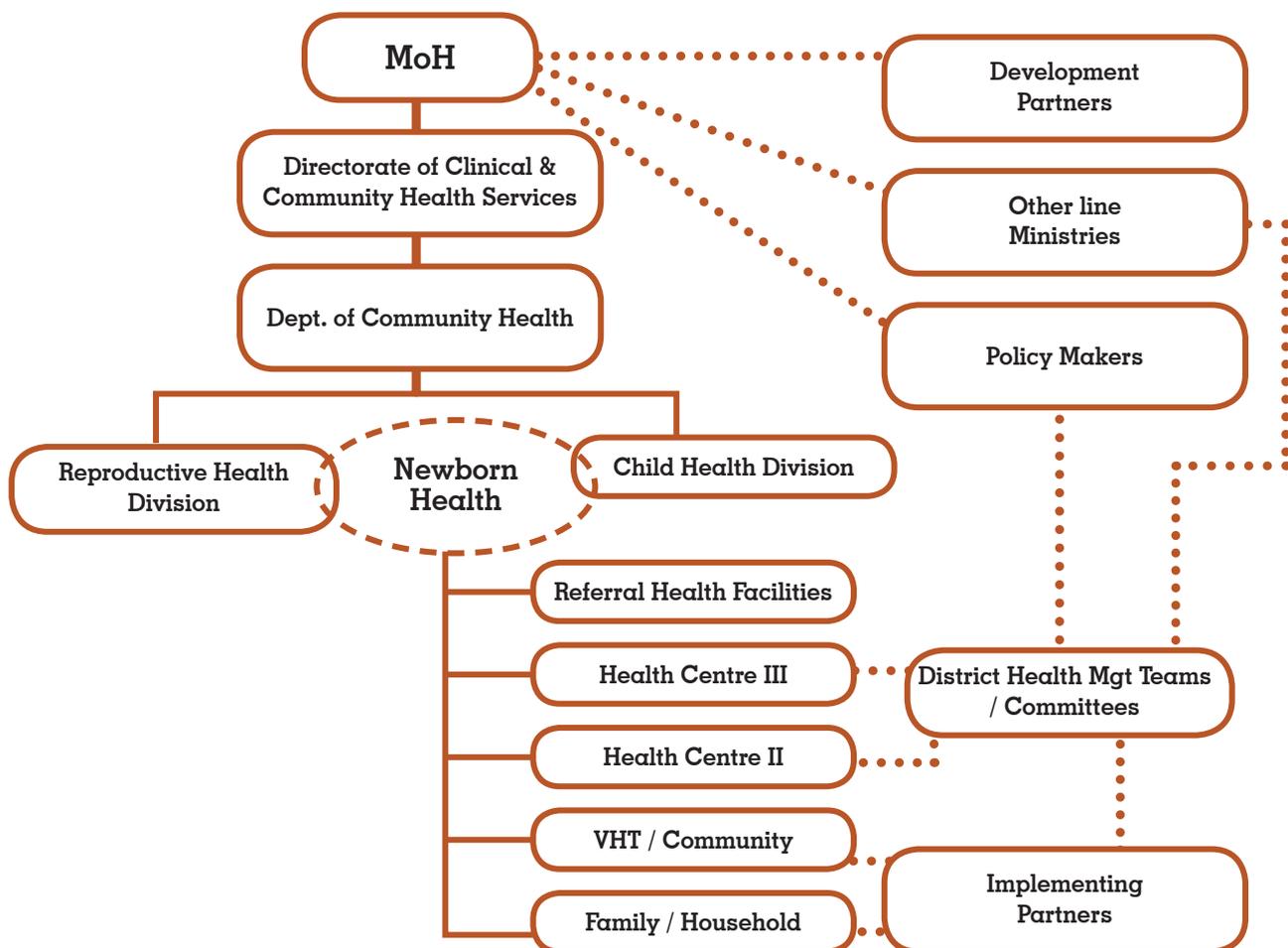
Table 1: Overview of interventions in the priority areas

Priority Areas	Developing caregiver CAPACITIES	Improving QUALITY	Strengthening LINKAGES	Increasing AWARENESS
Interventions	Behaviour change communication Social support networks Male involvement Essential commodities	Service standards Interpersonal & intercultural skills Death audits VHT training Essential drugs and equipment	Transport and financing schemes Hand book for MNCH Partnership for MNCH	Rights to newborn survival Health situation of newborns Cost effectiveness of interventions

## 4.0 OPERATIONALISING THE FRAMEWORK

Interventions for strengthening delivery of newborn care services will be implemented within the framework of the existing system. Figure 2 shows the health care structure at different levels of care and the links between other partners and sectors.

Figure 2: Organisational Framework for Implementation of Newborn



### 4.1 Develop and disseminate policies, guidelines and tools

At the national level the areas of focus in this framework seek to integrate programs and activities for the Road map for reduction of maternal and neonatal mortality and the child survival strategy, with specific regard to those relevant for newborns survival. The key gaps identified in the situation analysis include lack of policies to support implementation of postnatal newborn interventions; service provision standards and capacity to introduce the standards; data for planning and monitoring; commitment for scaling newborn interventions and poor coordination of newborn health activities currently implemented by reproductive health and child health units. At the national level the following broad activities and outputs are expected:

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- Establish a national multi-disciplinary advisory committee to advocate for, coordinate different efforts to implement newborn health and provide policy and technical guidance for implementation including monitoring, evaluation and research on newborn health.
- Formulate a specific national plan for providing district support for designing, introducing, implementing and evaluating newborn interventions at different levels.
- Review, develop and disseminate policies, guidelines, standards, information education and communication materials for implementing newborn health at all levels, including collaboration with the education sector to produce guidelines for pre-service training on newborn health.
- Design or adapt an integrated in-service health worker training package covering newborn examination, resuscitation, management of a low birth weight baby and sick newborn, death auditing, routine newborn care and how to organize the health facility to make it newborn friendly, including tools for evaluating trainings
- Support all hospitals to revitalize newborn nurseries through centrally coordinated assessment of capacity, action plan for revitalization, resource mobilization, supervision and monitoring

**4.2 Assessment, priority selection and planning**

The district is the most appropriate level for linking up local priorities with national health policy guidelines and resource allocations, and for coordination between health delivery services and communities, between government and private sector, and between health and other sectors. The key gaps identified in the situation analysis include limited capacity to plan for newborn health at different levels of care and patchy coverage of interventions falling short of getting the desired outcome. At the district level the following broad activities and outputs are expected;

- Establish district clinical audit teams consisting of hospital clinical specialists, district health teams, financial administrators and NGOs to champion and support lower level health facilities and communities in the catchment area to assess newborn health standard, introduce and maintain quality improvement approaches in these units.
- Conduct rapid assessment of the level of implementation of newborn standards at facility and community level, and use this as a basis for selecting priority areas for initial implementation to improve coverage and quality of services. A criterion based tool and guide for conducting the assessment will be developed based on the Yellow star program.
- Mobilize existing resources, including a number of “hidden resources” (local organizations, traditional structures, groups) to integrate or build on newborn activities such as reproductive health, child’s health, immunization, HIV, malaria and others. A number of actions could help to develop partnerships, such as undertaking an inventory and determining the kinds of support needed to enable them to be more effective in the promotion of newborn health.

**4.3 Implementation of newborn health**

This framework is focussed on working with individual families and health facilities to improve newborn health. The aim is to contribute to the empowerment of communities as well as to increase access and utilization of quality health services, particularly those provided by skilled attendant. At the implementation level the following broad activities and outputs are expected;

- Build capacity for implementation and monitoring of newborn activities through training needs assessment, training health workers and VHTs, supply of job aids, registers and other tools, procurement and distribution of medicines, supplies and equipment for newborn care; and regular supervision.
- Health facilities conduct monthly perinatal death audits and report to the district. Death audit committees at national, district and facility level will be established to carry out the identification and investigation of neonatal deaths and, subsequently, recommend corrective actions. Communities will be involved in the audits through Health Unit Management Committee (HUMC) alongside other educational initiatives.
- VHTs sensitise communities, register pregnant mothers in the community and conduct three (five for low birth weight babies) post natal home visits to assess babies for danger signs, refer babies to health facilities and support mothers to provide essential or routine home care for newborns. VHTs will attend quarterly review, reporting and refresher training meetings at the health facility.

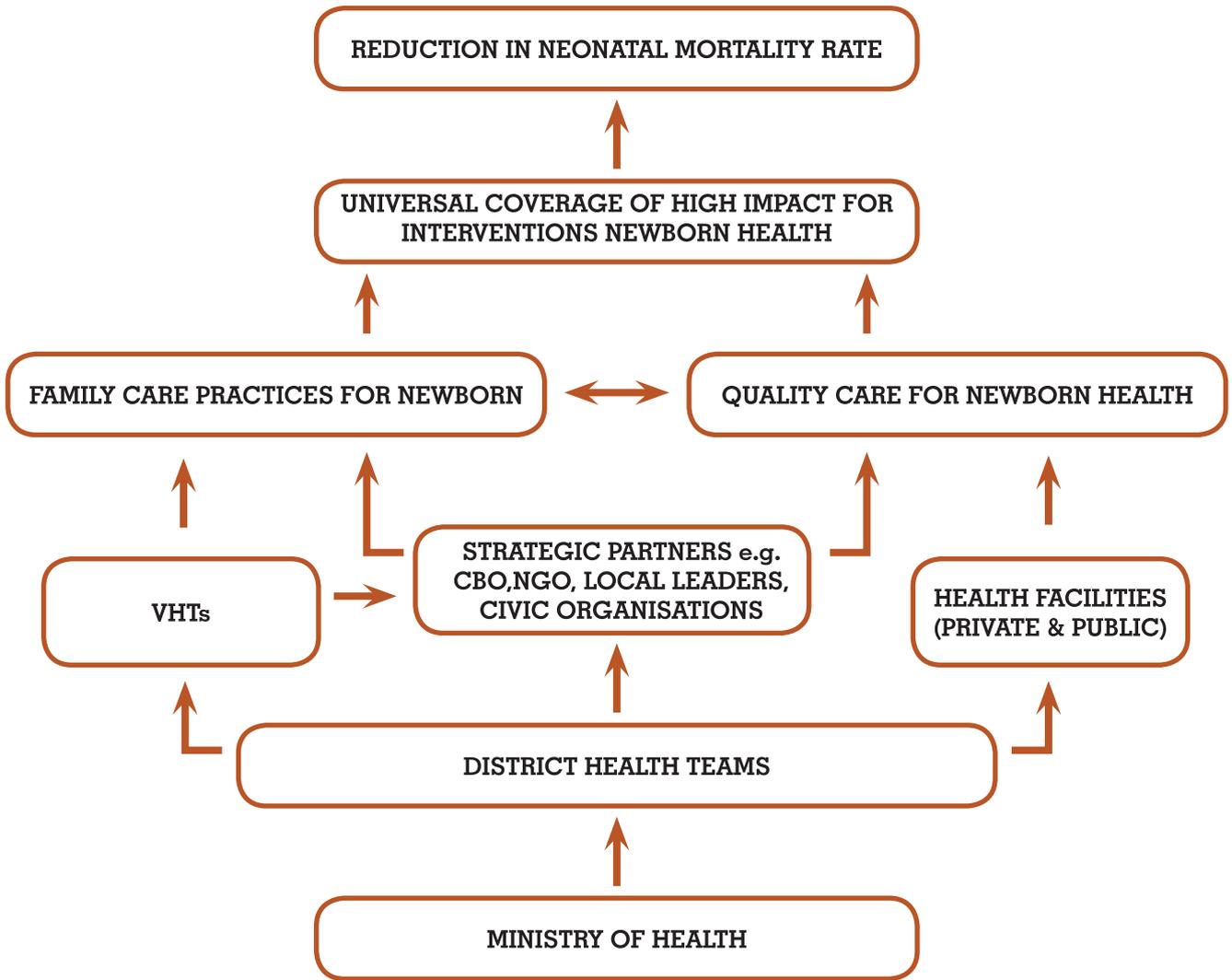
#### **4.4 Monitoring and evaluation**

The success of this framework depends not only on stepping up commitment to scale up activities in focus areas but also implement interventions in a way that delivers results and multiplies impact. Scaling up of newborn interventions will require generation and use of information on approaches that work, efficient and equitable distribution of resources and impact on the wellbeing and survival of babies. The basic principles underlying newborn monitoring are the following:

- i. Monitor inputs, outputs and outcomes in order to make adjustment over time in the strategic design and implementation of activities.
- ii. A core list of monitoring indicators that can be expanded as needs for additional information is clearly demonstrated in the future.
- iii. Indicators are aligned such that they are in harmony and feed into the HSSP, regional and global processes for newborn monitoring.
- iv. Routine systems for monitoring will be applied as much as possible including use of existing tools for monitoring maternal and child health. Where existing systems of reporting are functional partnerships will be built.
- v. Monitoring information should reach decision makers and actors in a timely way to ensure that it is transformed into decisions and actions
- vi. Adequate participation of programs, partners and sectors in monitoring and evaluation that extend from design to data gathering to analysis and sharing of results.

*Figure 3: The conceptual framework of the interplay of a variety of activities for newborn implementation at the different levels of care to achieve the desired health outcomes*

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Specific benchmarks particularly at intermediate outcome levels will be required to establish the performance and efforts of a number of different actors. A combination of process and output indicators (performance assessment) should permit the tracking of progress made in achieving the defined objectives and targets. Quality assurance mechanisms will be in-built in the system of monitoring at all levels.

Table 2 below shows the indicators for tracking Newborn Health service delivery.

Table 2: Indicators for tracking Newborn Health service delivery

<b>Health Outcomes</b>	<ul style="list-style-type: none"> <li>Newborn mortality</li> <li>Newborn avoidable mortality</li> <li>Prevalence of septicemia and pneumonia</li> <li>Prevalence of low birth weights</li> </ul>		
<b>Intermediate health services Outcomes</b>	<ul style="list-style-type: none"> <li>Coverage of life saving interventions including IPT2, TT, BCG, polio 0, antibiotics for pneumonia, vitamin A post delivery, ARVs</li> <li>Coverage of clean cord care, exclusive breast feeding, care seeking and treatment compliance practices</li> </ul>		
<b>Intermediate health services Outputs</b>	<b>Community care</b> 1 week old visited thrice, with danger signs referred, with no danger signs counselled on routine care	<b>Health facility care</b> Newborns examined, treated, resuscitated, vaccinated, mothers and caregivers counselled as required	<b>Enabling environments</b> Newborn drugs, equipment on credit line. Post natal policy and guidelines developed
<b>Intermediate health services processes</b>	<b>Village level</b> Coverage trained VHTs supervision	<b>Health facilities</b> Facilities implementing newborn standards Facilities supervised	
<b>Intermediate health promotion outputs</b>	<b>Community</b> Knowledge and skills on newborn health; care-seeking intentions; healthy decisions  Social norms; public opinion	<b>Health workers</b> Knowledge & skills of danger signs, pneumonia, septicaemia management	Measures include: regulation; resource allocation; organisational practices at district health system level; participatory planning processes
<b>Health Promotion Actions</b>	<b>Education</b> Training in interpersonal and intercultural skills; health talks; school, adult education; media & other communication channels	<b>Social mobilization</b> Community organization; group facilitation; men and family involvement; community dialogue	<b>Advocacy</b> Epidemiological surveillance; death audit; HUMC functional, lobbying for newborn

Data sources to measure the processes and outputs will be mainly service-based. This comprises information on service use and outcomes from health information systems (i.e. registers and case notes) client exit interviews, situation analysis, clinical audits and supervisions. Data for outcomes will be collected using population-based sources which will provide information on a target group and about newborn interventions. Non-indicator methods, such as perinatal death audits, will also be important for monitoring and evaluating newborn services. Audits of barriers and problems encountered by women can also be effective in measuring the impact of interventions. In addition, the process of gathering information to determine performance and “success” will be participatory.

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**IMPLEMENTATION FRAMEWORK**

Implementation of the monitoring process will require: (a) operationalising the above M&E framework and process, and (b) undertaking a number of strategic activities designed to deal with technical, methodological and institutional issues. These include:

- i. Identification of intermediate and end users of the information and their needs.
- ii. Facilitation of inter-institutional information sharing.
- iii. The need to establish a baseline to monitor progress over time, especially in groups vulnerable to mortality,
- iv. Problems that have been identified with information sources will supply part of the newborn monitoring process,

The current capacities of the programs or institutions responsible for different aspects of the monitoring process will need to be assessed and, where needed, their capacities strengthened. Implementing, monitoring and evaluation of newborn health will require a clearly defined costed work plan which will focus on the following components: (a) generation of information and synthesis of existing information, (b) information processing and management, (c) analysis and interpretation (guided by the conceptual framework), and (d) dissemination of information and analytical results in line with monitoring information needs.

## 5.0 ROLE OF STRATEGIC PARTNERS

Strategic partners are not the primary targets but they assist the NBH programme to achieve its goals/intentions. They are stakeholders with whom the program works to influence the outcomes. The program may have very limited influence over these strategic partners. The strategic partners are diverse in terms of scope, level of partnership and type of services they offer. In the Newborn health care program the strategic partners include

- Implementing partners e.g. CBOs, NGOs, CSOs and Faith Based Organisations
- Other line ministries e.g. MoLG, Finance, gender, education, agricultural extension workers, teachers and officers in other administrative units.
- Policy makers (parliamentarians )
- Development partners/donors such as UN Agencies

The desired actions and support of each of these categories are briefly described in Table 3 below.

*Table 3: Actions and support expected from strategic partners*

STRATEGIC PARTNER	ACTIONS AND SUPPORT EXPECTED FROM THE PARTNER
Implementing partners	<ol style="list-style-type: none"> <li>1) Mainstream new born health related services in their programmes and activities following established guidelines and standards</li> <li>2) Advocate for and promote transparency and accountability among new born health service providers</li> <li>3) Contribute to strengthening policies for new born health</li> <li>4) Mobilise resources to support new born health programmes and services</li> <li>5) Mobilise and sensitize communities to adopt recommended NBH practices</li> <li>6) Participate in monitoring and evaluation of new born health programmes</li> <li>7) Empower communities to demand for services and actively participate in monitoring and evaluation of new born health programmes and activities</li> </ol>
Ministry of Education and Sports	<ol style="list-style-type: none"> <li>1) Prioritise and integrate safe motherhood and newborn health care as part of the existing curricula for schools and pre-service training institutions of health workers at all levels.</li> </ol>
Policy Makers	<ol style="list-style-type: none"> <li>1) Formulate relevant policies that promote newborn health provision at all levels</li> <li>2) Advocate and lobby for increased investment in newborn health services</li> <li>3) Participate in dissemination of information and education of the public about NBH issues</li> <li>4) Monitor and ensure accountability of resources disbursed for Newborn Health</li> </ol>
Development partners	<ol style="list-style-type: none"> <li>1) Prioritise &amp; provide financial and other resources that support NBH programs</li> <li>2) Provide technical support for effective planning, implementation, monitoring and evaluation of NBH care programs</li> </ol>

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