NEWBORN HEALTH INDICATORS WORKING GROUP

MEETING REPORT | DECEMBER 2012

SAVE THE CHILDREN’S SAVING NEWBORN LIVES PROGRAM

WASHINGTON, D.C.
The Newborn Health Indicators Technical Working Group (TWG) met on December 17th, 2012 at the Save the Children office in Washington DC. The purpose of the meeting was to: 1) Discuss new areas of focus for TWG (KMC, Newborn resuscitation, HMIS) and form small groups to move forward; 2) Provide updates on related research and meetings; and 3) Review progress since June 2012 meeting on reference sheets for newborn indicators and obtain feedback on next steps. The agenda is given in Appendix 1 and participants are listed in Appendix 2.

1. Welcome and introductions

Deborah Sitrin gave welcoming remarks and an overview of the objectives for the meeting. The focus of the meeting was to discuss new areas for the working group (Kangaroo Mother Care, newborn resuscitation and newborn data collected through routine systems), share updates on related research and meetings, review progress in promoting newborn indicators. Deborah also noted that a page on the Healthy Newborn Network (HNN) dedicated to the newborn indicators TWG has been launched (URL is http://www.healthynewbornnetwork.org/page/newborn-indicators).

2. Process and challenges for collecting KMC data through routine systems: findings from SNL/MCHIP 4 country review

Kate Kerber from Save the Children, Saving Newborn Lives (SNL) gave a presentation on KMC data collection through routine systems. The presentation outlined a set of core and supplemental indicators for KMC as specified in the MCHIP KMC Implementation Guide (2012) available on the HNN website\(^1\). Core indicators include 3 output indicators and 3 outcome indicators (see presentation for list). The indicators can be disaggregated by level of facility and type of KMC service. Two indicators were recommended for inclusion in HMIS (proportion of facilities with in-patient capacity where KMC is operational; proportion of LBW babies who received KMC and survived to discharge from facility). These indicators should be captured and used at the point of care for monitoring service quality. Recommended supplemental indicators are listed in the presentation. The tools currently being used to collect this information include individual patient records, KMC registers, maternity/admissions register (for denominator of LBW babies), monthly/quarterly summary forms for aggregated data. At the district level, there is also a list/database of health providers trained in KMC and the facilities offering KMC services.

Kate Kerber summarized the results of the SNL/MCHIP KMC implementation evaluation in five countries (Malawi, Mali, Rwanda, Uganda and Nigeria), which aimed to systematically measure the scope and institutionalization of KMC services and assess barriers and facilitators to sustainable implementation. As part of the evaluation, measurement and documentation of KMC was assessed. An overview brief of the evaluation findings is available on HNN\(^2\). Most facilities assessed were at the stage of implementation, and only some had progressed to the stage of integration into routine practice. Those facilities in the integration or sustainability phase were often the larger, more established teaching hospitals.

Findings related to documentation of KMC showed highly variable quality and completeness of record keeping and documentation. Few facilities had a mechanism for regular reporting on KMC-specific activities to higher levels. There was confusion regarding the denominator of LBW babies at the facility level and documentation of intermittent KMC and feeding was poor. The KMC register and patient records rarely connected through to follow-up, making it difficult to calculate the recommended core indicators. On the positive side, some facilities demonstrated self-motivated documentation, developing their own registers and reports for documenting KMC.

\(^1\) http://www.healthynewbornnetwork.org/resource/kangaroo-mother-care-implementation-guide
\(^2\) http://www.healthynewbornnetwork.org/resource/tracking-implementation-progress-kangaroo-mother-care
Recommendations include emphasizing M&E in KMC training and follow-up supervision, ensuring that appropriate indicators are being collected and used, using existing feedback channels (e.g. facility or district meetings) to report on KMC statistics and encouraging accountability by including KMC data capture in job descriptions and including KMC statistics in routine reports.

There is potential for integration of KMC indicators into MNCH data systems (necessary for local use, tracking and awareness) and two indicators were recommended for inclusion in routine HMIS. KMC elements are already included in Measure DHS’ Service Provision Assessment (SPA) and the rapid facility assessment tool developed by the TWG. Integration into household surveys is challenging, since sample size may be an issue given that only about 10-15% of babies would be eligible for KMC services.

Four questions were posed for the group to consider: 1) what can we do to get the two suggested KMC indicators into HMIS?; 2) how can we encourage districts to collect and use KMC information?; 3) how to improve the quality and completeness of information collection at the health facility level and how to link in the community denominator?; and 4) how can we ensure that monitoring remains after a project ends?. These questions were discussed following the second presentation on KMC (see below).

3. Overview of indicators from community KMC study in Ethiopia

Jennifer Callaghan-Koru from JHU IIP provided an overview of a community KMC feasibility study in Ethiopia, which promotes skin-to-skin, breastfeeding and monitoring by Health Extension Workers (HEWs) for all babies, implemented by MCHIP and Save the Children. The indicators for the study are informed by the step-wise evaluation approach, focusing on provision, utilization, and effective coverage. Data sources include household surveys (for coverage), routine program data for utilization, and routine data and HEW skills assessment for provision.

The advantages of collecting data on KMC through a household survey are that it represents a probability sample of the population in the program catchment area and generates an actual measure of coverage. Challenges include obtaining an adequate sample size, difficulties in screening procedures (not feasible to screen for only LBW babies) and that information is based on maternal recall.

Baseline data have been collected for the study implementation areas using an instrument adapted from SNL COMBINE trial survey instrument. Interviews were conducted with women who delivered a live birth in the last 1-7 months before the survey (6,881 households screened, sample of 218). The household survey captured exposure to intervention components, including home visits by HEWs and exposure to messages on KMC promotion and facility-based KMC promotion through antenatal care at health facilities. Information on coverage of behaviors related to thermal care and breastfeeding was captured for all newborns (skin-to-skin, delayed bathing, immediate breastfeeding, exclusive breastfeeding). Among 41 newborns perceived to be small by their mothers, only 8 babies were placed in KMC position and most not for very long.

Routine program data on KMC has the advantage of being regularly available and has the potential to provide feedback to the program on bottleneck areas that need attention. The HEW registers are designed to record data on the number of pregnancies, deliveries and LBW babies identified and the number of antenatal and postnatal home visits conducted as well as the number of LBW babies for whom KMC was initiated. These data points can be extracted and analyzed to estimate coverage (using expected numbers). However, establishing such routine systems can be difficult and the project has not been able to establish a functional process for extracting data from HEW registers.

Discussion points:
The Ethiopia study found low levels of ‘don’t know’ for the question on STS and participants inquired about the wording and placement of questions on immediate skin-to-skin and KMC. It was clarified that the question on STS was worded “was baby placed naked on your chest after delivery?” and that questions on KMC positioning were distinct (KMC questions only asked to mothers who perceived their newborn to be small). Questions on wrapping were also included, but findings have not yet been cross-tabulated to explore inconsistencies with responses on immediate STS. It was noted that immediate wrapping has been dropped from list of recommended indicators for household surveys since wrapping was highly correlated with wiping/drying and the potential inconsistencies with recommendations on immediate STS.

Group agreed that initial focus of the TWG for measurement and monitoring should be on facility-based KMC as community based KMC still not evidence-based.

The issue of how to define LBW for measuring KMC coverage was raised, specifically whether we keep 2500g as the denominator for the indicator on KMC coverage (as currently recommended in the KMC Implementation Guide) or push to modify to 2,000g to be consistent with the evidence on mortality and practice in most facilities (evidence for KMC at facility level is for babies less than 2000g and limited space in facilities in many settings means that usually only babies <2000g are admitted). The 2500g cut-off is easier to explain, but will underestimate the KMC coverage if service delivery is only provided for those <2000g. This requires more discussion and experience to resolve.

Participants discussed the KMC indicators proposed for HMIS in the KMC Implementation Guide, focusing on issues around defining and measuring through routine systems how ‘operational’ KMC services are. Participants discussed changing the recommended indicators for HMIS to: 1) proportion of LBW babies who received KMC and 2) proportion of LBW babies who received KMC and survived to discharge from facility. The group felt HMIS needed to capture KMC coverage, and district or program managers can monitor the number of facilities with KMC services outside the HMIS system. However, the first indicator faces some denominator issues that need to be resolved (how to determine the total number of LBW babies given home births, definition of LBW as 2000g or 2500g).

Reporting on these indicators through HMIS will require strengthening of routine systems and this extends beyond KMC alone. It was agreed that the focus of the TWG should be promoting inclusion of newborn indicators in general into HMIS and this will require awareness raising and advocacy. The upcoming Newborn health conference in Johannesburg in April 2013 could be an important forum and really help countries assess their information needs, what information they already have and what they are missing, and how they can use their data for decision-making. Sessions would need to be tailored to who is attending the meeting, and if possible organizers should try and include representatives from HMIS as part of the country team.

Next steps:

- SNL to take the lead to develop sessions for routine data collection of newborn data as part of April newborn conference
- Continue to explore other opportunities for including KMC indicators into household surveys and to document experiences using routine KMC indicators at health facility level

4. Report-out from WHO’s September PNC meeting

Allisyn Moran from USAID presented on the WHO PNC Guidelines meeting held in Geneva in September. The purpose of the meeting was to review available evidence and develop recommendations for postnatal care for mothers and newborns, covering the length of stay at facility and the number and content of PNC contacts. Draft recommendations included:
Timing of discharge after birth: After an uncomplicated vaginal birth in a facility, healthy mothers and newborns should receive care in facility for at least 24 hours after birth. “Healthy mothers and newborns” are defined in the safe childbirth checklist that should be used to assess mothers and newborns at the time of discharge.

Number and timing of PNC contacts: The meeting generated lots of discussion on what is intrapartum versus postnatal period, but consensus not reached on when the postnatal period starts; however, participants did agree that the term ‘postnatal’ should be used to refer to both mother and newborn (replacing ‘postpartum’ for mother). The draft recommendations stipulate that: i) there should be separate checks for mother and baby prior to discharge; ii) if the birth is at home, the first PNC contact should be as early as possible within 24 hours of birth; iii) at least two additional PNC contacts are recommended, on day 3 (48-72 hours) and between day 7-14 after birth and iv) final PNC contact is recommended at 6 weeks. They also agreed that if the birth in facility, both mother and newborn should receive PNC prior to discharge (separate from intrapartum check).

Home visits for PNC: home visits in the first week after birth are recommended for care of the mother and newborn. PNC visits are usually combined with pregnancy home visits and depending on the setting, home visits can be made by midwives, other skilled providers or well-trained and supervised community health workers. Further, PNC contacts may also occur at clinic visits.

Content of PNC for newborn: assessment of the newborn should cover an agreed on set of danger signs (not feeding well, history of convulsions, etc), promote exclusive breastfeeding, appropriate thermal care (delayed bathing, appropriate clothing including hat, same room as mother for 24hr/day), cord care (CHX applied to cord first week of life in high mortality settings NMR >30/1000; just home births), and other care (immunization, pre-term/LBW; communication/play).

Content of PNC for mother: assessment of mother should include: within 6 hours - urine voided, blood pressure checked; within 24 hours -vaginal bleeding, uterine contraction, fundal height, temperature and pulse (full details in guidance); at postnatal contacts -micturition and urinary incontinence, healing of any perineal wound, headaches, fatigue, etc. PNC content for the woman should also cover nutrition counseling and supplementation (iron and folic acid supplementation should be provided for at least 3 months – WHO guideline review in progress); breastfeeding, infection prevention; family planning and sexual health counseling; malaria prevention; mobilization, rest and exercise; and psychosocial support (debrief about birth experience, prevention of postpartum depression, etc). More details are given in the presentation and full detail will be provided with the WHO guidelines. It should be noted that the guidelines do not specify which cadres of health workers could do the assessment for the mother.

Next steps: As of December 2012, all participants have reviewed and given comments on draft guidelines. The guidelines will go through the formal WHO guideline process and finalization is expected in early 2013. There is ongoing discussion of including ‘signal functions’ in guidelines for newborn and woman.

Discussion points:
- Vitamin A for newborn was not mentioned at the WHO meeting; this could be due to the confusing evidence, showing effective in Asia if given within 24-48 hours but not in Africa. Skin-to-skin for thermal care also was not discussed.
- Despite slight variation in the recommended timing of PNC visits, no changes are recommended in the global indicator for PNC (PNC within 2 days after birth). One of the remarks accompanying the guidelines is that if possible, a second visit on day 2 is recommended, especially if mother and/or baby are sick.
- Debriefing on birthing experiences to prevent postpartum depression could be done earlier so could feedback into system; all evidence for the recommendation comes from developed countries and more experience is needed on how to deliver this aspect of PNC for mothers in developing countries

Next steps:
- Share the full recommendations once they are finalized in early 2013
5. Overview of HBB M&E TWG and Discussion of potential for links with the NBH Indicators TWG

Shivam Gupta from JHU-IIP presented on behalf of the Helping Babies Breath (HBB) TWG (for Abdullah Baqui and Steve Wall) about the current status and next steps. He noted that there is an HBB implementation guide available online. The goal of the TWG is to contribute to HBB program performance evaluation design and implementation in selected countries (Malawi, Zimbabwe, etc). The aim is to help to determine how well the HBB program is being implemented and help to measure performance outcomes. The TWG formed about six months ago and has met several times to discuss and agree on main tasks of the group, which include: refine M&E framework consistent with the implementation guide drawing on routinely collected data; develop a standard set of evaluation indicators for M&E of coverage and quality, share tools and consent forms that can be adapted by country programs; and disseminate information (tools, resources, manuals). The TWG has recruited a diverse range of members including implementers, evaluators, donors, and academic agencies. To date, the TWG has established a common evaluation framework and indicators are available in the implementation guide. Compilation of different country plans and tools is ongoing and discussions were held during their latest meeting in October to agree on a draft TOR and HBB evaluation matrix and to review a draft list of HBB indicators, logic frame with indicators and M&E section of implementation guide. Next steps for the HBB TWG include: obtaining written feedback from members on draft materials; connecting with WHO to involve them in discussions; exploring date and agenda for phone meetings and for a face-to-face meeting.

Discussion points:

- MCHIP has translated the implementation guide into Spanish and there is an opportunity to include Latin America in the roll-out
- Questions were raised as to whether the HBB TWG is considering integration of HBB into ENC, rather than a vertical program; the HBB TWG is aware that this is necessary for sustainability and feasibility, especially as countries move towards scale-up within existing systems.
- HBB working group has a list of 8-10 indicators and they would be interested in identifying a subset of these that could be integrated into HMIS. They are in the process of collecting data on these indicators in Bangladesh, Malawi, Tanzania and Ethiopia and could possibly share experiences at the next NB indicators TWG in 2013.

Next steps:

- Explore opportunity to link HBB programming in Latin America to the HBB TWG.
- Continue to identify opportunities for further testing of proposed indicators, particularly those for HMIS

6. Update on MCHIP work on maternal indicators for routine systems

Steve Hodgins from MCHIP gave a status update on maternal indicators for routine systems and an overview of what to expect in the coming months. For last two years, MCHIP has engaged in dialogue with WHO counterparts and other partner organizations in maternal health measurement to develop a list of indicators for maternal health within routine systems. The impetus for this work stems from limitations of using current indicators such as skilled birth attendance and ANC4 as proxies for maternal health program performance (relevant for newborn as well). While these indicators are used as proxy for overall program performance, they are essentially content free – just measure contacts. As a result, program managers make decisions to optimize performance against those indicators, resulting in sometimes ‘wrong’ choices. The intent was to make significant process at country level to broaden indicators to include content

3 http://www.helpingbabiesbreathe.org/implementationguide.html
and quality and to have WHO endorse the recommendations to MOH. The focus has been on maternal, but from beginning also considered capture of newborn indicators. Consensus has been reached on a set of indicators and the main challenge now is to move towards formal WHO endorsement. To date, only formal WHO endorsement is specifically for PPH prevention (formal recommendation is to track use of uterotonics in third stage of labor in HMIS). Under the accountability commission, the WHO maternal task force was asked to develop a rapid approach to assess quality of care; this took the group on a diversion from recommended indicators towards developing an assessment tool. This has created some delays from the WHO side for the original objective of recommending a set of indicators. Discussions are being held with WHO is determine what we can realistically expect and it is not clear now what the revised timeline might be.

The six proposed indicators are:
1. Use of uterotonics in the third stage of labor
2. Quality of intrapartum care. The optimal version is intrapartum deaths – deaths where fetal heart rate is documented on admission but the baby is dead at the time of delivery. Alternatives would be deaths within 6 hours of birth or could also take fresh still births (less optimal); ideal would be to collect all three to be in a better position to interpret the results.
3. Caesarean section delivery rate - this indicator has been recommended for quite some time, but not consistently collected
4. Assisted vaginal delivery – as above, not consistently collected
5. Stock-outs of key maternal newborn commodities (oxytocin, magnesium sulfate, gentamycin) where a functional Logistics Management System (LMIS) is available
6. Composite index of services during ANC (ITN distribution, syphilis screening, etc)

A draft assessment tool has been developed by WHO, who are hoping that partners will provide assistance to apply the tool in a number of countries. The initial goal is to complete assessments at least once to draw attention to quality of care issues and it is not clear whether efforts will be made to institutionalize the assessments. Steve Hodgins will be shifting to SNL in 2013 but will continue working with MCHIP on the development of routine metrics for maternal health going forward.

7. Update on review of newborn data and indicators within routine systems and discussion of next steps

Tanya Guenther presented findings from a preliminary review of newborn related data collected through routine systems. Recommendations for newborn indicators collected through routine systems were raised as a priority gap that the NB Indicators TWG could address. A small sub-group met in August 2012 and agreed there was a need to know what is currently collected and reported. The small group also connected to the Gates-funded IDEAS project, which is doing a similar content review in Ethiopia, Northern Nigeria, and UP in India (more than just newborn indicators) and a review of quality and completeness of data. Dialogue and collaboration with the IDEAS group will continue to avoid duplication of efforts and to share findings.

Four countries were selected for the initial review (Malawi, Uganda, Nepal, and Bangladesh) based on availability of forms and SNL presence in country for follow up and clarification. Tanya shared tables that summarize data elements collected in registers/forms, what is included in the facility reporting forms, and what is included in HMIS quarterly or annual reports (see presentation for full details on methods and findings).
The findings highlight:

- Substantial variability in data collection and reporting for newborns within routine systems across countries
- Only a small proportion of what is collected for the newborn is aggregated at facility level and even less is included in MOH reports
- Lack of guidance of recording and key terms not defined.
- Open format registers are likely to be more prone to lack of standardization and ambiguity
- Disconnects between what is recorded and reported
- Immediate newborn care practices are poorly captured and reporting is non-existent
- Data on newborn infection identification and management disjointed and poorly defined (except in Nepal and Bangladesh, likely exceptions)
- Limited data on postnatal care for newborns; where it is captured and reported, information on timing of the visits is missing and it is not clear whether the visit was for the mother or baby or both
- Capture of stillbirths and distinction between fresh macerated is unlikely valid and reliable without standard definitions
- Data quality and completeness not assessed – important to get results, possible from IDEAS

In terms of next steps, the small working group intends to review and confirm findings with country-based counterparts; complete Bangladesh (forms only available in Bangla); expand the review to include community forms and reports; and convene smaller working group meetings to review findings and to discuss with IDEAS.

Discussion points:

- The need to review out-patient registers was raised; in Malawi newborns would go to maternity ward and be entered in maternity register; Nepal and Uganda have postnatal registers. However, when data are reported, not always clear which registers data coming from.
- Opportunities to engage with other partners were identified:
  - Engage WHO and build on work of maternal indicators once it becomes clear how to move forward;
  - Leverage UNICEF DIVA, Commission on Commodities to build support for standardized data collection of relevant newborn data within routine systems
  - Continue to identify country level opportunities (e.g. a content review conducted in Tanzania)
- Group discussed areas of focus and agreed on the need to improve what is already collected with standard definitions
  - Give samples of registers/forms and guidance on how to complete
  - Need to advocate of including measurement/data collection in training and refresher training and on job supervision and mentoring to help health workers properly collect data
  - Need to discuss how data are used, including data already collected but now viewed as ‘newborn’ related
- Group also recommended that the sub-group focus its efforts on identifying a short-list of newborn indicators at the district and national level.
  - Frame indicators around major causes of death and recommend basic indicators for each cause, linking to groups that can recommend a longer list of indicators (such as HBB, KMC, etc)
  - For each cause of death, look at availability, coverage, quality, and impact
  - This process should involve discussing with countries what information they need, and the April newborn meeting is a good opportunity to initiate these discussions.
- It would be helpful to have information on when countries were planning to revise their HMIS systems to help direct efforts to influence these systems. The Health Metrics Network (HMN) has started to track opportunities for HMIS revisions and the small sub-group should reach out to them as well as to other HMIS-focused organizations such as RHINO (JSI)

Next steps:

- Small working group to meet early in 2013 to move forward on recommendations made during the meeting as outlined above; this should include linking up with the IDEAS group
- Explore opportunities to engage countries in discussions around routine monitoring at the April newborn meeting in Johannesburg

8. MCHIP validation study in Mozambique

Barbara Rawlins from MCHIP presented findings from a maternal and newborn indicator validation study in Mozambique. The study, implemented in collaboration with CHERG MA13 and the Ministry of Health in Mozambique, aimed to validate women’s self-report of indicators of maternal/newborn care during the intrapartum and immediate postpartum (up to 1 hour after birth) periods. Study findings will inform recommendations on indicators to measure the content and quality of care that could be captured by household surveys such as the DHS. Indicators for validation were selected through a document review and discussions with technical experts from the CHERG, MCHIP, and SNL. The validation study was nested within the MCHIP Quality of Care study and included direct observation of delivery and up to one hour postpartum in selected health facilities followed by face-to-face interviews with women 7-9 months after delivery. Study looked at both individual level and population level validity.

A total of 525 births were observed and follow-up interviews were completed with 304 women. Investigators decided on threshold levels for determining acceptable individual (Area under the curve >0.60) and population validity (inflation factor between 0.75 and 1.25) There was no consensus in the literature on acceptability criteria for any of the validity measures used in the study. A total of 34 indicators were tested: 3 in DHS and MICS, 13 ‘high demand’ indicators and potential candidates to add to DHS and MICS, and 18 of interest in special or in-depth studies. Of these 34 indicators, 7 did not have sufficient data to validate. The findings show that 14 of the high demand, evidence-based indicators met one or both criteria and are recommended. Some results are highlighted below:

- **Newborn related indicators that met both individual and population level validity criteria** (recommended for DHS and MICS):
  - Newborns placed skin to skin on mother’s chest

- **Newborn indicators that met population validity criterion** (recommended for population-based surveys but not for DHS and MICS):
  - Newborn dried and wrapped in a towel (among those not placed skin-to-skin)
  - Newborn immediately dried

- **Newborn indicators that did not meet either validity criterion** (Not recommended):
  - Newborn placed skin to skin and covered with cloth (composite)
  - Newborn wrapped in a towel/cloth
  - Newborn dried, placed STS and covered with a towel/cloth (composite indicator)
  - Newborn breastfed within 1 hour after birth (DHS/MICS indicator)
  - Newborn held upside down
  - Newborn bathed within one hour (e.g. bathing not delayed)
Study recommendations include conducting similar studies in other settings to confirm the results, conducting qualitative research to improve the formulation of questions, and that future studies should plan for high loss to follow-up (at least 35%) and if possible use a three-arm design to better distinguish whether accuracy is due to poor recall or inability to report and if recall worsens over time.

Discussion points:
- Group raised issues regarding the generalizability of the study findings beyond Mozambique; Barbara indicated that Mozambique is typical of low resource settings in sub-Saharan Africa where DHS/MICS are conducted but that similar studies in Asia and Latin America are needed to confirm these results in other settings.
- Concerns were raised about the cut-off value of 0.60 AUC for acceptable individual level validity; Barbara responded that the the recall period for DHS/MICS is long and some of the questions tested were long and complex and referred to very specific time intervals, which should be taken into consideration. The study refers to the an AUC score of .60 or above as ‘acceptable’ only. Studies/questions using short recall periods (e.g., two weeks) may establish a higher AUC acceptability standard.
- Encouraging that STS was shown to be an acceptable indicator; further testing in other settings is needed before it can be recommended

Next steps:
- Findings have been submitted for publication. Once the findings have been published, the full presentation will be circulated and further details on the study findings disseminated.
- Opportunities to confirm these results in other settings should be identified

9. Progress on reference sheets for household survey indicators recommended by NBH Indicators TWG

Deb Sitrin presented an update on progress to date in drafting reference sheets for a set of new indicators recommended for use in household surveys (drying after birth, delayed bathing, cord cut with clean instrument for home births) and another set of indicators recommended for further testing (STS, nothing harmful to cord and postnatal care signal functions). Further, newborn indicators and a draft tool for health facility assessments have been developed. The intended audience for the reference sheets would be those at country level who determine additional content for DHS and MICS surveys and others who are conducting household surveys to support newborn health programs (such as NGOs, etc). Deb Sitrin provided an overview of the proposed content and scope of the indicator reference sheets and posed some questions for the group to discuss.

In addition, she discussed how the TWG is promoting dissemination and further testing of the indicators - a manuscript on measurement has been submitted to PLOS medicine and a page on the HNN has been established. Household indicators recommended by the group are also being tested by USAID CSHGP grantees and experiences will be shared.

Discussion points:
- Group discussed if reference sheets are needed for indicators that are already standard in DHS/MICS agreed that it would be helpful to include reference sheets with the rationale for the indicator and measurement notes. This information is helpful to remind people of the strengths and limitations of each indicator, even if already standard and well-known. However, reference sheets for existing indicators do not need to include questions, interviewer guidelines, or tabulation plans and can refer to existing DHS/MICS tools.
- Indicator reference sheets are not needed at this time for the facility level indicators, but could be considered after the household survey indicators are completed. A table of the health facility indicators will be included with the reference sheets
Next steps:
- SNL will prepare a full draft of the indicator reference sheets and accompanying materials and share with the TWG members for feedback in early 2013.
- Continue to explore opportunities for further testing and dissemination in 2013.

10. Summary of Recommendations and Next Steps

Tanya Guenther from Saving Newborn Lives (SNL) facilitated a brief discussion on recommendations and next steps for the working group.

Summary of recommended next steps:
- SNL to coordinate the development of a session for routine collection and reporting of newborn data as part of the upcoming Newborn Health conference in Johannesburg in April 2013.
- Continue to explore other opportunities for including KMC indicators into household surveys and share experiences at upcoming TWG meeting as data become available.
- Continue discussions and testing on KMC indicators at the facility level with a focus on resolving the issues related to definition and capture of the denominator (number of LBW babies).
- Convene a small working group meeting on routine data collection and reporting for newborns in early 2013. Participants should include representatives from the IDEAS team as well as others engaged in HMIS, such as RHINO, WHO HMN, etc. This group would discuss indicators within routine systems for newborns in general, including KMC, HBB, and management of neonatal infections, rather than setting up separate working groups.
- Circulate the full recommendations from WHO on PNC once they are finalized.
- SNL to prepare a full draft of the indicator reference sheets and accompanying materials and share with the TWG members for feedback in early 2013.
- Continue to explore opportunities for further dissemination of newborn indicators and related resources in 2013 including: 1) Healthy Newborn Network (HNN); 2) Newborn meeting in April 2013; 3) Maternal Health Taskforce (MHTF) quality of care meeting in Tanzania in January 2013; 4) Women Deliver Spring 2013 and other as noted in previous meetings.

11. Next Indicators TWG meeting

The TWG will meet again in late spring/early summer 2013. Topics may include:

- Update on WHO PNC guidelines
- Update from working groups on newborn indicators within routine systems and presentations from the IDEAS group
- Update on April 2013 newborn meeting in Johannesburg South Africa
- Share experiences collecting indicators recommended by the TWG, especially those that need additional testing
Appendix 1: Agenda

AGENDA
Newborn Health Indicator Technical Working Group Meeting
Save the Children
2000 L Street, NW Suite 500
17 December 2012

Objectives of the Meeting:
1. Discuss new areas of focus for TWG (KMC, Newborn resuscitation, HMIS) and form small groups to move forward
2. Updates on related research and meetings
3. Review progress since June 2012 meeting on reference sheets for newborn indicators and obtain feedback on next steps

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<td>Breakfast</td>
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<td>9:30-9:45am</td>
<td>Welcome and Introductions</td>
<td>Deborah Sitrin</td>
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<td>9:30-9:45am</td>
<td>Objectives of Meeting</td>
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<td>9:45-10:15am</td>
<td>Process and challenges for collecting KMC data through routine systems: findings from SNL/MCHIP 4 country review</td>
<td>Kate Kerber</td>
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<td>10:15-10:45am</td>
<td>Overview of indicators from community KMC study in Ethiopia</td>
<td>Jennifer Callaghan (JHU)</td>
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<td>10:45-11:30am</td>
<td>Discussion of KMC presentations and next steps for the TWG</td>
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<td>11:30am-12:00pm</td>
<td>Report-out from WHO’s September PNC meeting</td>
<td>Allisyn Moran</td>
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<td>12:00-12:30pm</td>
<td>Overview of HBB M&amp;E TWG (presentation)</td>
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<td>12:00-12:30pm</td>
<td>Discussion of potential for links with the NBH Indicators TWG</td>
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<td>1:00-1:30pm</td>
<td>Update on MCHIP work on maternal indicators for routine systems</td>
<td>Steve Hodgins</td>
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<tr>
<td>1:30-2:00pm</td>
<td>Update on review of newborn data and indicators within routine systems and discussion of next steps</td>
<td>Tanya Guenther</td>
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<tr>
<td>2:00-2:30pm</td>
<td>MCHIP validation study in Mozambique</td>
<td>Barbara Rawlins</td>
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<tr>
<td>2:30-3:15pm</td>
<td>Progress on reference sheets for household survey indicators recommended by NBH Indicators TWG</td>
<td>Deborah Sitrin</td>
</tr>
<tr>
<td>3:15-3:30pm</td>
<td>Break</td>
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<tr>
<td>3:30-4:00</td>
<td>Summary of next steps for TWG</td>
<td>Tanya Guenther</td>
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Appendix 2: Meeting Participants
<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
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</thead>
<tbody>
<tr>
<td>Jennifer Luna</td>
<td>ICF Macro</td>
</tr>
<tr>
<td>Heather Rosen</td>
<td>JHSPH/MCHIP</td>
</tr>
<tr>
<td>Becky Ferguson*</td>
<td>BMGF</td>
</tr>
<tr>
<td>Joy Fishel*</td>
<td>Macro</td>
</tr>
<tr>
<td>Steve Hodgins*</td>
<td>MCHIP</td>
</tr>
<tr>
<td>Barbara Rawlins</td>
<td>MCHIP</td>
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<tr>
<td>Vikas Dwivedi</td>
<td>MCHIP</td>
</tr>
<tr>
<td>Kate Kerber*</td>
<td>SC</td>
</tr>
<tr>
<td>Allisyn Moran</td>
<td>USAID</td>
</tr>
<tr>
<td>Joseph de Graft Johnson</td>
<td>SC/MCHIP</td>
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<tr>
<td>Stella Abwao</td>
<td>SC/MCHIP</td>
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<tr>
<td>Jessica Hulse</td>
<td>SC</td>
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<tr>
<td>Tanya Guenther</td>
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<td>Deborah Sitrin</td>
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<tr>
<td>Leanne Dougherty</td>
<td>kmsg</td>
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<tr>
<td>Jennifer Callaghan</td>
<td>JHU-IIP</td>
</tr>
<tr>
<td>Shivam Gupta</td>
<td>JHU-IIP</td>
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<tr>
<td>Lindsay Morgan</td>
<td>Broad Branch Associates</td>
</tr>
<tr>
<td>Lyndsey Wilson-Williams*</td>
<td>SC/MCHIP</td>
</tr>
<tr>
<td>Sarah Williams*</td>
<td>SC-UK</td>
</tr>
<tr>
<td>Nikhil Patil</td>
<td>Consultant</td>
</tr>
</tbody>
</table>

*-via phone
Appendix 3: Presentations

*See separate attachment

1. Process and challenges for collecting KMC data through routine systems: findings from SNL/MCHIP 4 country review – Kate Kerber
2. Overview of indicators from community KMC study in Ethiopia – Jennifer Callaghan-Koru
3. Report-out from WHO’s September PNC meeting – Allisyn Moran
4. Overview of HBB M&E TWG – Shivam Gupta
5. Update on review of newborn data and indicators within routine systems and discussion of next steps (includes detailed tables provided as hand-out) – Tanya Guenther
6. Progress on reference sheets for household survey indicators recommended by NBH Indicators TWG – Deborah Sitrin