



## CHIFA Discussion on Newborn Care #1

What is the size of the problem? What do we know about quality of care at different levels?

16 October to 25 November 2017

FULL TEXT

3 January 2018

With thanks to Every Newborn Action Plan and London School of Hygiene and Tropical Medicine for financial support for this discussion, and to the members of the HIFA working group on Newborn Care:

<http://www.hifa.org/projects/newborn-care>

Background to the discussion: <http://www.hifa.org/news/join-chifa-global-discussion-newborn-care-low-and-middle-income-countries>

See also our blog on the Healthy Newborn Network:

<https://www.healthynewbornnetwork.org/blog/join-3000-child-health-professionals-140-countries-global-discussion-care-small-sick-newborns-low-middle-income-countries/>

Metrics: 128 contributions from 41 contributors in 12 countries (Bangladesh, Canada, Ethiopia, Ghana, India, Kenya, Malawi, Nigeria, Rwanda, South Africa, UK, USA). (For full list, see Long Edit)

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>

To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>

Subject: [chifa] Newborn care (1) Blog on Healthy Newborn Network

Dear CHIFA colleagues,

Tomorrow Monday 16 October we start our 4-week thematic discussion on newborn care! We have just published a blog on the Healthy Newborn Network about this. I reproduce the text below and you can read online here: <https://www.healthynewbornnetwork.org/blog/join-3000-child-health-professionals-140-countries-global-discussion-care-small-sick-newborns-low-middle-income-countries/>

We welcome the many newborn care professionals who are now joining CHIFA for this discussion...

--

Join CHIFA - more than 3000 child health professionals in 140 countries for a global discussion on the care of small and sick newborns in low- and middle-income countries

Each year 2.7 million newborns die; 98% of these deaths in low and middle income countries and more than 80% are small, with preterm infants being most at risk. High levels of facility deliveries globally means that more newborn deaths are occurring within hospitals. Yet over two-thirds of these deaths could be prevented with effective hospital care of small and sick newborns.

To explore and address how we can improve the quality of care of newborns, particularly those born small and sick in LMICs, a series of global discussions in conjunction with CHIFA (Child Healthcare Information for All) and the ENAP metrics group[1] starts October 16th and will run through mid-2018. CHIFA is a growing global child health community with more than 3,300 members in 140 countries, whom interact daily on an online discussion platform on the CHIFA website. You can find the discussion page here.

<http://www.hifa.org/news/join-chifa-global-discussion-newborn-care-low-and-middle-income-countries>

Part of this discussion will address how to tackle the major challenge of defining and measuring the content, coverage and quality of care. For years, emergency obstetric care has used clear indicators or "essential functions" (a core list of life saving interventions) to measure the provision of basic and comprehensive care, which has improved programme standardisation, monitoring, and accountability. Yet for different levels of newborn care, "essential functions" have not been consistently defined or routinely tracked. ENAP Metrics has developed an online survey (available in English, French and Spanish), and are inviting healthcare professionals in newborn care from all backgrounds to contribute their opinions to help decide which interventions we should measure for small and sick newborns, and at which level of the health system. Learn more and complete the survey here.

<https://www.healthynewbornnetwork.org/blog/launch-enap-inpatient-care-small-sick-newborns-online-survey-world-prematurity-day/>

In any country, how we care for our small and sick newborns is one of the most sensitive indicators of health systems functioning. Major mortality reduction is possible even with basic newborn care, however to reach the SDG target of a neonatal mortality of fewer than 12 per 1000 live births, every country will need to aim to provide more comprehensive newborn care as outlined in The Lancet Every Newborn series and the Every Newborn Action Plan (ENAP), endorsed by all countries in 2014.

We hope that the CHIFA newborn care project will give a voice to those of you working on the ground to care for small and sick newborns whether parents, health workers or scientists to have your say in defining the components of service delivery inputs and "essential functions" for newborn care.

This work is being coordinated by a team at London School of Hygiene & Tropical Medicine on behalf of the Every Newborn metrics group, and CHIFA, with involvement from representatives at WHO, UNFPA, UNICEF, Averting Maternal Death and Disability (AMDD), Saving Newborn Lives/Save the Children, and USAID.

--

Best wishes, Neil

From: "Mike English, Kenya" <MEEnglish@kemri-wellcome.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (2) Essential Hospital Services

Although it is likely that essential services for sick newborns with problems such as prematurity, low weight for age, sepsis, respiratory distress and hypoxia-ischaemia delivered

at the level of small and larger "district" hospitals could save many newborn lives work to understand the coverage and quality of such services is uncommon. A team in Kenya working with collaborators from Oxford is trying to understand what gaps exist in the coverage and quality of care in Nairobi City County, Kenya, where neonatal mortality is estimated to be the highest of any county at 39/1000 livebirths. This high NMR is occurring in a setting where over 80% of births are estimated to be in health facilities. The work being conducted is using multiple methods from epidemiology to ethnography and ergonomics. A major issue is the difficulty of providing sustained, high quality nursing care. Something we believe is a largely neglected issue.

To find out more about the studies to assess coverage and quality you can find information here:

<http://bmjopen.bmj.com/content/6/12/e012448>

If anyone wants to examine the tools being used and use them for themselves then they have all been made available here:

<https://globalresearchmethods.tghn.org/methodology-projects/estimating-gaps-provision-and-quality-inpatient-newborn-care/>

We hope to share more results from large set of studies over the coming months.

Mike

HIFA profile: Mike English is a paediatrician with the Child and Newborn Health Group, Kenya Medical Research Institute-Wellcome Trust Research Programme, Centre for Geographic Medicine Research, Nairobi, Kenya. [menglish AT nairobi.kemri-wellcome.org](mailto:menglish@nairobi.kemri-wellcome.org)

From: "Sue Prullage, Rwanda" <[sue.prullage@gmail.com](mailto:sue.prullage@gmail.com)>  
To: "CHIFA - Child Health and Rights" <[CHIFA@dggroups.org](mailto:CHIFA@dggroups.org)>  
Subject: [chifa] Newborn Care (3) Essential Hospital Services (2) Newborn care in Rwanda

This is such a timely article. We just met with the ethical review board in Rwanda yesterday to receive approval to survey the nurses that work in the 50 neonatal units across Rwanda. Our approach is slightly different. We are asking about the orientation they received to the neo unit, what equipment they had and was it working. Had they received education surrounding common neo issues. We asked them to identify how comfortable they were in caring for neonatal patient with certain disease entity using a likert scale. Our approach is to identify the gaps in education and to help them develop a workable education program. We also will use the information to develop neonatal nursing competencies for Rwanda. Our team consist of the Council of International Neonatal Nurses (COINN) and the Chiesi Foundation. The MoH is very supportive as well as the nursing council.

I was happy to see your survey was 18 pages long for that was one of the things they were concerned about with ours that it was too long at 9 pages.

Very excited to see these things happening I have worked in Rwanda for 9 years in neo units and have observed that the staffing is terrible and training is minimal. Equipment doesn't make a neo unit

Sincerely  
Sue Prullage

CHIFA profile: Geralyn Sue Prullage is a member of the board of the Council of International Neonatal Nurses (COINN). She has worked in Rwanda since 2008 and has helped establish a neonatal unit in a district hospitals. She has a doctorate in Nursing Practice (DNP) and is a certified neonatal/pediatric nurse practitioner. sue.prullage AT gmail.com

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn care (4) Q1: What is the size of the problem? How many newborns die every day, where, and what are the causes?

Welcome to our global thematic discussion on newborn care! Our discussion will run from 16 October until 24 November 2017 (including World Prematurity Day, 17 November) and is supported by the Every Newborn Action Plan (ENAP Metrics) and technical support from a team of leading newborn health professionals from the London School of Hygiene and Tropical Medicine, Makerere University, Save the Children, USAID, and others.

Our aim is to support the global child health community in exploring issues and priorities towards ending preventable newborn deaths and stillbirths by 2030. This discussion will contribute to global efforts such as the World Health Organization-led Quality, Equity Dignity (QED) efforts for women and newborns, building on the technical and advocacy work of Every Newborn Action Plan (ENAP). The ENAP, a multi-partner initiative backed by a World Health Assembly Resolution, has set national targets of <12 neonatal deaths per 1000 live births, and <12 stillbirths per 1000 total births by 2030 as part of the Sustainable Development Goals.

For the coming week we aim to build a collective understanding of the issue. What is the size of the problem? How many newborns die every day, where, and what are the causes?

As a starter for our discussion, I would like to reproduce a paragraph from Joy Lawn's message to CHIFA a few weeks ago:

"Each year 2.7 million newborns die with 98% of these deaths in low and middle income countries, and more than 80% are small, with preterm infants being at greatest risk. Now that 80% of the world's births are in hospitals, more newborn deaths are occurring in hospitals, and over two-thirds of these deaths could be prevented with effective hospital care for small and sick newborns. Major mortality reduction is possible even before adding comprehensive or intensive newborn care BUT to reach the SDG 3 target of a neonatal mortality of fewer than 12 per 1000 live births, every country will have to be on a pathway to providing more comprehensive newborn care as outlined in The Lancet Every Newborn series and the Every Newborn Action Plan, endorsed by all countries in 2014."

What more do we know about newborn deaths at global and national levels? How many deaths occur in the home or community, and how many happen at the health centre, district

hospital or referral hospital level? What are the medical causes of these deaths? How many might have been prevented with better antenatal care, with better basic newborn care, and with better (for those who get it) comprehensive newborn care?

For every newborn death, there are many more babies who are born with severe disability, including hypoxic brain damage, often leading to enormous suffering for the child and family. How much of this disability could have been prevented by better basic (and comprehensive) care?

And what about the trends in newborn deaths and morbidity? We hear that newborn deaths are going down year on year, but progress is much slower than with under-5 mortality. Why?

Over the coming days, I look forward to hearing from you and developing a shared understanding of the issue.

Please send your thoughts to: [hifa@dgroups.org](mailto:hifa@dgroups.org)

Best wishes, Neil

From: "Tom Lissauer, UK" <[t.lissauer@imperial.ac.uk](mailto:t.lissauer@imperial.ac.uk)>  
To: "CHIFA - Child Health and Rights" <[CHIFA@dgroups.org](mailto:CHIFA@dgroups.org)>  
Subject: [chifa] Newborn Care (5) Essential Hospital Services (3) Newborn care in Rwanda

Sue, you will be pleased to know that the situation regarding neonatal care in Rwanda should improve!

The Royal College of Paediatrics and Child Health has started a programme to improve neonatal care in 12 District Hospitals over the next 2 years. This includes a UK paediatric doctor and nurse spending 6 months in each of the hospitals to provide training and help improve delivery of neonatal care, followed by ongoing mentorship by a trained Rwandan paediatrician and nurse.

Other neonatal training programmes have recently started or are about to begin.

Of course there is a serious shortage of staff, but hopefully the training of many of them will improve, and will hopefully be evident when you do a repeat survey.

Regards,

Tom Lissauer

CHIFA profile: Tom Lissauer is a Consultant Paediatrician at St. Mary's Hospital, London, UK. He is author of the Illustrated Textbook of Paediatrics. [t.lissauer@imperial.ac.uk](mailto:t.lissauer@imperial.ac.uk)

From: "Sue Prullage, Rwanda" <[sue.prullage@gmail.com](mailto:sue.prullage@gmail.com)>  
To: "CHIFA - Child Health and Rights" <[CHIFA@dgroups.org](mailto:CHIFA@dgroups.org)>  
Subject: [chifa] Newborn Care (6) Newborn care in Rwanda (3)

This is good news I know there is a group from Canada working in neo care also. Maybe we should all coordinate our efforts it would save on resources.

Sue Prullage

HIFA profile: Geralyn Sue Prullage is a member of the board of the Council of International Neonatal Nurses (COINN). She has worked in Rwanda since 2008 and has helped establish a

neonatal unit in a district hospitals. She has a doctorate in Nursing Practice (DNP) and is a certified neonatal/pediatric nurse practitioner. sue.prullage AT gmail.com \_\_\_\_\_  
From: "Christabel Enweronu-Laryea, Ghana via Dgroups" <CHIFA@dgroups.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (7) Causes of poor neonatal care in health facilities

This week should be a time for those of us in high burden countries to also deeply reflect on some invisible causes of poor neonatal care and outcome in health facilities. A few that are within our circle of control and influence come to mind:

1. Faculty: What are the standards of knowledge and skills training (neonatal) for undergraduate and postgraduate trainees in our nursing and medical schools? What is the quality of the output from our institutions? How sustainable are external efforts if we do not improve the quality of training?
2. Accreditation and certification (examination) bodies: Are the standards and approach appropriate for improving neonatal outcome in that setting? Is improving quality of care for newborns a priority?
3. Hospital management teams: What is the evidence that improving quality of care for newborns is a priority? How useful are the monitoring tools?

CHIFA profile: Christabel Enweronu-Laryea is an Associate Professor of Paediatrics and Child Health at University of Ghana School of Medicine and Dentistry and a Consultant Paediatrician at Korle Bu Teaching Hospital in Accra, Ghana. Her professional interests include teaching paediatrics and providing intensive care for newborns. She is a member of the CHIFA working group on Newborn Care:

From: "Ruth Davidge, South Africa" <rdavidge@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (8) Nursing care for sick and small babies

I totally agree that the issue of inadequate nursing care is neglected. The failure to provide specifically allocated and trained nurses to care for sick and small babies is a huge problem and is not adequately addressed in the literature or global recommendations.

The allocation of midwives to the care of sick and small newborns will always result in a conflict in priorities particularly in low resource settings as midwives have to choose whether to focus their time on the mother or the baby. Frequently hospitals allocate experienced and trained midwives to the labour ward and allocate junior, inexperienced and untrained nurses to the nursery.

It is critical that globally there is increased advocacy that nurses are trained to care for sick and small babies specifically (neonatal nurses) and are permanently (non rotational) allocated to the care of these vulnerable babies.

Neonatal mortality has been relatively unchanged for the last 20 years. If we continue with business as usual we will continue to see the same result.

God bless  
Ruth Davidge

RN RM Certificate in Neonatal Intensive Care  
Provincial Neonatal Coordinator-KZN  
President NNASA  
Tel: 0769866880  
Email: ruth.davidge@kznhealth.gov.za  
info@nnasa.org.za

Ruth Davidge is Neonatal Coordinator at PMB Metro, Hospitals Complex Western, Kwa-Zulu Natal, South Africa. She is President of the NNASA (Neonatal Nurses Association of Southern Africa). She is a Registered Nurse and on the board of the Council of International Neonatal Nurses (COINN). [www.nnasa.org.za](http://www.nnasa.org.za), [www.nnasa.org.za](http://www.nnasa.org.za) ruth.davidge AT kznhealth.gov.za

From: "Clare Gilbert, UK" <Clare.Gilbert@lshtm.ac.uk>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (10) Retinopathy of Prematurity

Speaking as an ophthalmologist who has watched the "third epidemic" of blindness due to ROP [Retinopathy of Prematurity] unfold in many middle (and increasingly in low-middle) income countries, I would make a plea that

1. ROP and its risk factors are included in training curricula / in-service training for nurses (and paediatricians and neonatologists) so they understand their role in prevention
2. Adequate equipment to safely deliver and monitor oxygen in delivery rooms and neonatal units is a clear policy objective
3. Those involved in policies re neonatal care work with ophthalmologists who are knowledgeable about ROP, so that it is included across all relevant policies, included screening and treatment of the sight-threatening stages of ROP, which is highly cost effective.

The number of ROP blind infants is increasing dramatically in some countries as neonatal care expands, as the above have often not been considered. Lack of ophthalmologists is a challenge in many countries, but new imaging systems mean that members of the neonatal team could

Professor Clare Gilbert FRCOphth; MD; MSc (Epidemiology)  
Disability and Eye Health Group  
Email: clare.gilbert@lshtm.ac.uk  
Tel: + 44 207 958 8332 (direct line)

International Centre for Evidence in Disability (ICED)

<http://disabilitycentre.lshtm.ac.uk>

International Centre for Eye Health (ICEH)

<http://iceh.lshtm.ac.uk>

Department of Clinical Research

London School of Hygiene & Tropical Medicine

<http://lshtm.ac.uk>

Postal Address

Room 393 South Courtyard

Department of Clinical Research

London School of Hygiene & Tropical Medicine

Keppel Street,

London WC1E 7HT

CHIFA profile: Clare Gilbert co-directs the International Centre for Eye Health with Professor Allen Foster. The Centre is a WHO Collaborating Centre for the Prevention of blindness, and is based at the London School of Hygiene and Tropical Medicine, UK. The aim is to prevent blindness, particularly in low and middle income countries. The Centre does this in two broad ways: firstly by undertaking research, to provide the evidence needed by planners and managers so they can plan programmes for the prevention of blindness that are tailored to the needs of communities, and secondly, through education, including a one year MSc in Community Eye Health in London, and support for two, 3 month courses in Community Eye Health in Southern Africa. The Centre also manages up to 30 one week courses on VISION2020 in all regions of the world, and produces the Community Eye Health Journal which goes free of charge, four times a year to over 20,000 eyecare professionals in more than 150 countries ([www.cehjournal.org](http://www.cehjournal.org)). The Centre produces other educational materials, as required, and also "links" eye departments in the UK with training institutions in Africa, for capacity building and skills transfer. Clare has been Medical Advisor to Sightsavers International since 1995. Clare.Gilbert AT lshtm.ac.uk

From: "Lily Kak,USA" <lkak@usaid.gov>

To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>

Subject: [chifa] Newborn Care (11) Essential Hospital Services (4)

The Kenya study on inpatient sick newborn care is indeed very timely. As basic essential newborn care has become mainstreamed in newborn programs, there is a growing global interest in addressing the special needs of the most vulnerable infants - the small and sick newborns - to further reduce neonatal mortality. USAID and the Every Premie project team are collaborating with several partners, including UNICEF, WHO, Save the Children, University Research Corporation and others to support governments conduct a multi-country situational analysis of inpatient sick newborn and young infant care (0-60 days). The objective of this assessment is to describe the national enabling environment for service implementation and quality of inpatient care. The data collection tools are currently being field tested and will be available for implementation by November. They are intended for use by governments to inform the development of national plans for strengthening inpatient newborn and young infant care.

I am delighted to learn about the Rwandan initiative to strengthen inpatient care in 12 district hospitals over two years in Rwanda. In my recent visit to Malawi, I was excited to learn that the Pediatric and Child Health Association and Rice University are supporting the government to strengthen care of sick newborns in district hospitals. And I know there are other countries that have also begun to strengthen sick newborn care.

As more and more countries strengthen inpatient newborn care at the district level, we will need to work on many aspects of care - human resource (neonatal nursing), provider skills, equipment, safety, commodities, electricity, water, etc. Working on just one aspect will not be sufficient to make a change. This is going to be a challenge but let us take on that challenge because we must!

Lily Kak

CHIFA profile: Lily Kak is Team Lead for Newborn Health at USAID, Washington DC. She is a member of the CHIFA working group on Newborn Care:

<http://www.hifa.org/projects/newborn-care>

<http://www.hifa.org/support/members/lily-1>

lkak AT usaid.gov

From: "Kojo Ahor- Essel, Ghana via Dgroups" <CHIFA@dgroups.org>

To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>

Subject: [chifa] Newborn Care (12) Neonatal jaundice

I will want to make mention of the seemingly lack of training/knowledge about neonatal jaundice among health workers as well as the communities. Many babies are dying or developing permanent disabilities which are preventable. We will have to increase education on this topic, especially in the remote, hard-to-reach communities.

CHIFA profile: Kojo Ahor- Essel, MD, is a paediatrician interested in neonatology at the Korle Bu Teaching Hospital, Accra, Ghana. Professional interests: Neonatology.  
kojopriestyych AT yahoo.com

From: "Judith Robb-McCord, USA" <jmccord@pciglobal.org>

To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>

Subject: [chifa] Newborn Care (13) Preterm birth as a critical component of newborn morbidity and mortality

Good morning,

Thank you for facilitating this discussion. As we know, complications related to preterm birth are currently the greatest cause of under-five mortality globally. While we can continue to learn more about where newborn deaths are occurring, we know that many early/small babies are born at home without the critical care they need; or are released from inpatient care and sent home while still dangerously small and unstable. Service delivery and care limitations (in the facility and at home) and community beliefs that discourage care-seeking behaviors for preterm/LBW babies, can propel these already vulnerable newborns to unnecessary mortality.

It is exciting to see this groundswell of interest in strengthening inpatient newborn care. Strategies and programs designed to improve facility-based care must also include parent/caregiver empowerment strategies so that families can meaningfully engage in the care of the newborn in the facility and then at home post-discharge. At the same time, community linkages need to be bolstered to ensure newborns receive critical follow up care in their homes and in health care facilities. Community messaging and mobilization can also emphasize that early/small babies can survive and thrive when given the care they need.

Many of you may already know about the Preterm Birth/Low Birth Weight Country Profiles developed by USAID's Every Premie--SCALE project for 25 low-income countries\* predominantly in SE Asia and sub-Saharan Africa. For those of you who are interested, you can find the country profiles here. The profiles provide an overview by country of several risk factors related to preterm birth (including adolescent birth rate, birth interval, hypertension and violence against women), and coverage of reproductive health services and care during pregnancy, birth and the postnatal period. You can also find information regarding select health workforce, health policy, health information and community engagement indicators. The profiles also captured information regarding the inclusion of the 10 WHO Recommendations for improved preterm birth outcomes in national clinical standards for hospital level care.

Please browse these country profiles as they paint an interesting picture of where risk around preterm birth lies, strengths and gaps in services across the reproductive and maternal health continuum of care, and the enabling environment for the management of preterm birth and early/small babies by country.

Looking forward to engaging on this compelling topic over the next several weeks. Feel free to be in touch with questions/clarifications.

Best, Judith R-M

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (14) Saving Newborn Lives Champions Toolkit

The message below was posted on HIPNet today...

--

#### SAVING NEWBORN LIVES CHAMPIONS TOOLKIT

Save the Children has a long and successful history of collaborating with newborn health champions to advocate for robust policies and programs to reduce global neonatal mortality. We have worked with pediatricians, midwives, members of parliament, ministers of health, journalists, celebrities, and many other champions to advocate for the availability of and access to routine and emergency newborn care services and supplies, improve the quality of newborn care services, and increase knowledge about and demand for newborn care, all in the interest of giving newborns the greatest chance to begin their lives healthy and strong.

This Champions Toolkit stems from this history, helping to systematize efforts within program offices and to share learning among country offices and with others beyond Save the Children. The toolkit provides guidance and a set of practical tools to help program staff and

others strategically partner with champions for maximum impact. While working with champions is one of many tactics, it is an important one and critical for raising the profile of development issues and achieving specific policy and advocacy goals tied to programmatic work.

## DOWNLOAD

Champions Toolkit (2nd edition)

[https://www.healthynewbornnetwork.org/hnn-content/uploads/SNL-Champions\\_Toolkit\\_final-wforms\\_web2.pdf](https://www.healthynewbornnetwork.org/hnn-content/uploads/SNL-Champions_Toolkit_final-wforms_web2.pdf)

Toolkit Forms (editable)

[https://www.healthynewbornnetwork.org/hnn-content/uploads/SNL-Champions-Toolkit\\_final2-wformsLinks.pdf](https://www.healthynewbornnetwork.org/hnn-content/uploads/SNL-Champions-Toolkit_final2-wformsLinks.pdf)

Save the Children guidance on impact stories

<https://www.healthynewbornnetwork.org/hnn-content/uploads/Impact-Stories-Guidance.pdf>

## CONTENTS

### 1. Welcome, Purpose, and Introduction to Champions

- Â· Purpose of this Toolkit and Intended Audience
- Â· How the Toolkit Is Organized
- Â· How This Toolkit Connects to Other Resources and Tools
- Â· What Is a Champion?
- Â· Why Engage Champions?
- Â· How Working with Champions Fits the Broader Advocacy Planning Context

### 2. Champion Checklist

### 3. The First Step: Deciding If and When to Engage a Champion

### 4. Identifying Appropriate Champions

- Â· Kinds of Champions and Assessing Alignment
- Â· Risk Assessment and Vetting Champions

### 5. Approaching, Recruiting, and Establishing a Relationship

### 6. Cultivating and Supporting Champions: Increasing Engagement and Influence

- Â· Champion Cultivation and Support
- Â· Ensuring Strategic and Effective Champion Involvement
- Â· Sustaining a Long-Term Relationship

### 7. Monitoring and Evaluating Influence, Engagement, and Effectiveness

- Â· Why Monitor and Evaluate the Work of Champions
- Â· What to Monitor and Evaluate
- Â· When to Monitor and Evaluate
- Â· How to Monitor and Evaluate

### 8. Documentation

- Â· Purpose
- Â· What to Document
- Â· Where, When, and How to Document

## 9. Mini Case Studies

John Engels | Saving Newborn Lives | Director of Advocacy, Communications & Knowledge Management | O: 202.794.1593 | Skype: john.engels4 | C: 301.821.2829

Access the latest research, data, and thought leadership on newborn health:

[www.healthynewbornnetwork.org](http://www.healthynewbornnetwork.org)

--

Best wishes, Neil

From: "Sue Prullage, Rwanda" <sue.prullage@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (15) Retinopathy of Prematurity (2)

I think this is a very important topic. I agree we need more training on why a neonate would need oxygen versus CPAP. In my experience in the nursery where I work the tendency is to begin with oxygen and not think of CPAP when the infant remains tachypneic yet saturations are within normal limits. It is a similar way that we did things in the US in the 80's we were very liberal with our oxygen and didn't understand the danger.

In countries where ophthalmologist are rare and infants are not followed up I would imagine the ROP blindness is higher than we can imagine.

Sue Prullage DNP, RN, NNP/PNP-BC

CHIFA profile: Geralyn Sue Prullage is a member of the board of the Council of International Neonatal Nurses (COINN). She has worked in Rwanda since 2008 and has helped establish a neonatal unit in a district hospitals. She has a doctorate in Nursing Practice (DNP) and is a certified neonatal/pediatric nurse practitioner. sue.prullage AT gmail.com

From: "Sue Prullage, Rwanda" <sue.prullage@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (16) Causes of poor neonatal care in health facilities (2)

1. Faculty: What are the standards of knowledge and skills training (neonatal) for undergraduate and postgraduate trainees in our nursing and medical schools? What is the quality of the output from our institutions? How sustainable are external efforts if we do not improve the quality of training?

In many countries the education for undergraduate and postgraduate trainees is minimal and in an infancy phase. What I have seen is that a group of students with minimal experience go through a post graduate program and instead of allowing them to work in a neonatal unit many are recruited to teach the next cohort. This is going to keep the level of attainment at knowledge level only and not advance to advanced applied theory or even as an expert in neonatology. I agree that the quality of training is needed and this may mean a commitment

by the university to hire an expert from another country to spend time in their country teaching and helping students move from knowledge to applied knowledge.

2. Accreditation and certification (examination) bodies: Are the standards and approach appropriate for improving neonatal outcome in that setting? Is improving quality of care for newborns a priority?

This is something COINN is thinking about and have made inquiries. But before we can move to accreditation and certification we need a commitment from the government that declares there is a neonatal nurse or doctor and develop the competencies needed to be call this. This takes a commitment from the government and nursing councils to really think about and contact other countries as to what is a competent neonatal nurse.

3. Hospital management teams: What is the evidence that improving quality of care for newborns is a priority? How useful are the monitoring tools?

In my experience there are not a lot of monitoring tools. Neonatal mortality is collected, how many small for gestation infants were delivered, KMC use. But there are not monitoring tools related to feeding, IV use, antibiotic use and simple to use tools would be beneficial.

Sue Prullage DNP, RN, NNP/PNP-BC

CHIFA profile: Geralyn Sue Prullage is a member of the board of the Council of International Neonatal Nurses (COINN). She has worked in Rwanda since 2008 and has helped establish a neonatal unit in a district hospitals. She has a doctorate in Nursing Practice (DNP) and is a certified neonatal/pediatric nurse practitioner. [sue.prullage@gmail.com](mailto:sue.prullage@gmail.com)

From: "Nkuranga John Baptist, Canada" <[nkuranga.baptist@gmail.com](mailto:nkuranga.baptist@gmail.com)>  
To: "CHIFA - Child Health and Rights" <[CHIFA@dgroups.org](mailto:CHIFA@dgroups.org)>  
Subject: [chifa] Newborn Care (17) Preterm birth as a critical component of newborn morbidity and mortality (2)

Thank you Judith for highlighting Preterm survival as a major contributor to general neonatal mortality and if not addressed we may never achieve the desired targets but thanks goes to all who have contributed to this discussions.

1. I wish to re-emphasize the need for capacity building, address knowledge gaps and skills transfer to health care workers who are taking care of those babies. To my knowledge we don't know what is considered as variability gestation age in the lowest resource countries. In many places in Sub-Saharan Africa babies born at 32 weeks gestation are considered non-viable [?non-viable - NPW, moderator] and counted among still birth, we know its not entirely lack of resources but knowledge gaps across the spectrum of health care givers (Obstetricians, Paediatricians, general physicians, midwives, nurses, but also health facilities administrators). We can make significant change if only all efforts involve all those involved in perinatal-neonatal care.

2. WHO is pushing for quality improvement initiatives, there is obviously good evidence to support integrating evidence based quality improvement practices to impact on the outcome of preterm and term neonates. Even in developed countries Quality improvement initiatives

have dramatically reduced morbidity among extreme preterm neonates, the Canadian Neonatal Network (CNN) through EPIQ projects) has shown there is so much to do with evidence based quality improvement. Within the context of low-income countries, how best to initiate and integrate such initiatives considering local realities? An example of WHO 10 recommendations for preterm survival, how many countries have implemented them as a standard of care? You may well be aware of Antenatal corticosteroid controversies in low income countries, why didn't they work as expected in reference to high income countries? Perhaps, on going studies mentioned in early discussions will shade light to the particularities of such settings.

3. I believe there is still need for political commitment on international and National level, there is need to invest much more resources to support strategies, much needed changes to reverse the current trend of neonatal mortality. I want to believe that already identified evidence based practices, if they were well implemented would bring appreciable reductions in mortality and morbidity. The big gap that needs to be addressed is skills and knowledge gap, attitude and behavior change of health care professions. An example of this is how the funding from Global fund, helped many countries contain HIV pandemic, in Rwanda for instance almost every health worker in any health care facility knows what to do with HIV patient. It took enormous effort with training, coaching, sustained mentorship programs, availability of protocols and guidelines that are strictly adhered to. The context is different and the resources may not be the same but I think there is need for the same attitude while thinking on how to move forward.

4. Well stated, family centred care and empowering families to actively be involved in their in-hospital patients and post discharge care may if well implemented be part of the solution to staff shortage.

Nkuranga,  
Perinatal-Neonatal

CHIFA profile: Nkuranga John Baptist is Perinatal-Neonatology Fellow at Western University in Canada. Professional interests: Pre-term survival in low resource countries. nkuranga.baptist AT gmail.com

From: "Clare Gilbert, UK" <Clare.Gilbert@lshtm.ac.uk>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (18) Retinopathy of Prematurity (3)

This is indeed the case: ROP has become the commonest cause of potentially avoidable blindness in many middle income countries, and is likely to extend to Africa as neonatal intensive care services expand in the region.

Clare

CHIFA profile: Clare Gilbert co-Directs the International Centre for Eye Health with Professor Allen Foster. The Centre is a WHO Collaborating Centre for the Prevention of Blindness, and is based at the London School of Hygiene and Tropical Medicine, UK. The aim is to prevent blindness, particularly in low and middle income countries. The Centre does this in two broad ways: firstly by undertaking research, to provide the evidence needed by

planners and managers so they can plan programmes for the prevention of blindness that are tailored to the needs of communities, and secondly, through education, including a one year MSc in Community Eye Health in London, and support for two, 3 month courses in Community Eye Health in Southern Africa. The Centre also manages up to 30 one week courses on VISION2020 in all regions of the world, and produces the Community Eye Health Journal which goes free of charge, four times a year to over 20,000 eyecare professionals in more than 150 countries ([www.cehjournal.org](http://www.cehjournal.org)). The Centre produces other educational materials, as required, and also "links" eye departments in the UK with training institutions in Africa, for capacity building and skills transfer. Clare has been a Medical Advisor to Sightsavers International since 1995. Clare.Gilbert AT lshtm.ac.u

From: "Mary Kinney, South Africa" <mkinney@savechildren.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (19) 7,000 newborns die every day

Dear colleagues

Greetings. Today, UNICEF, WHO and other members of the UN Inter-Agency Group for Child Mortality Estimation (IGME) released the new child mortality data [<http://www.childmortality.org/>] for 196 countries showing that 7,000 newborns die every day. The report [<https://data.unicef.org/resources/levels-trends-child-mortality/>] has a heavy focus newborn mortality because the data reveal that the rate of newborn deaths is not decreasing as quickly as that of children aged one to five. As a result, newborns account for a growing proportion of child deaths with each passing year.

Healthy Newborn Network (HNN) [<https://www.healthynewbornnetwork.org/>] is an online community dedicated to addressing critical knowledge gaps in newborn health. Easy access to reliable newborn health data is fundamental towards helping decision-makers allocate resources effectively and prioritize implementation efforts to improve access and quality of care for mothers and babies. Newborn Numbers [<https://www.healthynewbornnetwork.org/numbers/>] on HNN aims to improve the understanding and use of data in decision making for newborn health. It includes the global burden of newborn deaths including when, when and why newborns are dying as well as solutions for preventing deaths and resources available for action on newborn health. The page hosts the most centralized and trusted location for accessing the latest global, regional and national estimates related to newborn health. By synthesizing information gathered from the major global resources, such as Global Health Repository, the UN Inter-agency Group for Child Mortality Estimation and papers published in The Lancet, Newborn Numbers includes mortality estimates, cause of death data, coverage of care for key newborn-health related interventions, contextual indicators, human resources and financing indicators. The interactive data visualization tool, a new feature on HNN, allows users to easily and quickly make graphs with over 50 newborn-related indicators. The multi-dimension query functionality of the tool makes it easy to select multiple indicators and countries from cross-country comparisons. You can also download a sub-set of data into excel to create your own graphs. The heat maps visually demonstrate cross country comparisons of indicators. With the release of the new mortality estimates today, we will be updating these resources in the coming weeks.

Access Newborn Numbers at:

<http://www.healthynewbornnetwork.org/page/newborn-numbers>

#### 5 key facts about newborn health

1. 2.6 million newborn deaths in 2016 along with 2.6 million stillbirths and 303,000 maternal deaths (estimates for 2015).
2. 46% of children who die under 5 years are newborns. 3 main causes of newborn death—prematurity, complications during childbirth, and neonatal infections.
3. 77% of newborn deaths occur in Southern Asia or sub-Saharan Africa. Five countries accounted for half of all newborn deaths: India, Pakistan, Nigeria, the Democratic Republic of the Congo and Ethiopia.
4. The day a baby is born is the most dangerous day of a child's life in all countries.
5. Over two-thirds of newborn deaths are preventable with known, cost-effective, low-tech maternal and newborn health interventions.

Best wishes

Mary

Mary Kinney | Save the Children | Senior Specialist, Global Evidence and Advocacy, Saving Newborn Lives

[www.savethechildren.org](http://www.savethechildren.org)

Cell: +27 83 444 8211

[mkinney@savechildren.org](mailto:mkinney@savechildren.org)

Skype: maryvkinney | Twitter: @maryvkinney

Access the latest research, data, and thought leadership on newborn health:

[www.healthynewbornnetwork.org](http://www.healthynewbornnetwork.org)

HIFA profile: Mary Kinney is a Senior Specialist for Global Evidence and Advocacy with Save the Children US's program Saving Newborn Lives providing technical analysis and writing support specifically in the area of maternal, newborn and child health. She is passionate about using evidence in global and national advocacy efforts and enjoys working with large global teams to translate evidence into policy action. Some of her recent global activities include the Quality, Equity, Dignity for services global advocacy group of Every Woman Every Child, The Lancet Ending preventable stillbirth series, The Lancet Every newborn series, and Born Too Soon: The Global Action Report for Preterm Births. She is based in South Africa and holds a Master's degree in international relations from the University of Cape Town. MKinney AT savechildren.org

From: "Neil Pakenham-Walsh" <[neil.pakenham-walsh@ghi-net.org](mailto:neil.pakenham-walsh@ghi-net.org)>

To: "CHIFA - Child Health and Rights" <[CHIFA@dgroups.org](mailto:CHIFA@dgroups.org)>

Subject: [chifa] Newborn Care (20) 7,000 newborns die every day (2)

Many thanks to Mary Kinney for highlighting this timely press release from WHO and partners. I reproduce it in full below. Read online here:

<http://www.who.int/mediacentre/news/releases/2017/daily-newborn-deaths/en/>

7 000 newborns die every day, despite steady decrease in under-five mortality, new report says

At current trends, 30 million newborns will die within first 28 days of life between 2017 and 2030

News release

19 OCTOBER 2017 | NEW YORK/GENEVA/WASHINGTON DC - Every day in 2016, 15 000 children died before their fifth birthday, 46% of them or 7 000 babies died in the first 28 days of life, according to a new UN report.

Levels and Trends in Child Mortality 2017, reveals that although the number of children dying before the age of five is at a new low 5.6 million in 2016, compared with nearly 9.9 million in 2000 – the proportion of under-five deaths in the newborn period has increased from 41% to 46% during the same period.

“The lives of 50 million children under-five have been saved since 2000, a testament to the serious commitment by governments and development partners to tackle preventable child deaths,” said UNICEF Chief of Health, Stefan Swartling Peterson. “But unless we do more to stop babies from dying the day they are born, or days after their birth, this progress will remain incomplete. We have the knowledge and technologies that are required we just need to take them where they are most needed.”

At current trends, 60 million children will die before their fifth birthday between 2017 and 2030, half of them newborns, according to the report released by UNICEF, the World Health Organization, the World Bank and the Population Division of UNDESA which make up the Inter-agency Group for Child Mortality Estimation (IGME).

Most newborn deaths occurred in two regions: Southern Asia (39%) and sub-Saharan Africa (38%). Five countries accounted for half of all new-born deaths: India (24%), Pakistan (10%), Nigeria (9%), the Democratic Republic of the Congo (4%) and Ethiopia (3%).

“To achieve universal health coverage and ensure more newborns survive and thrive, we must serve marginalized families,” says Dr Flavia Bustreo, Assistant Director-General for Family, Women’s and Children’s Health at WHO. “To prevent illness, families require financial power, their voices to be heard and access to quality care. Improving quality of services and timely care during and after childbirth must be prioritized.”

The report notes that many lives can be saved if global inequities are reduced. If all countries achieved the average mortality of high-income countries, 87% of under-five deaths could have been averted and almost 5 million lives could have been saved in 2016.

“It is unconscionable that in 2017, pregnancy and child birth are still life-threatening conditions for women, and that 7 000 newborns die daily,” said Tim Evans, Senior Director of Health Nutrition and Population at the World Bank Group. “The best measure of success for Universal Health Coverage is that every mother should not only be able to access health care easily, but that it should be quality, affordable care that will ensure a healthy and productive life for her children and family. We are committed to scaling up our financing to support country demand in this area, including through innovative mechanisms like the Global Financing Facility (GFF).”

Pneumonia and diarrhea top the list of infectious diseases which claim the lives of millions of children under-five globally, accounting for 16% and 8% of deaths, respectively. Preterm birth complications and complications during labour or child birth were the causes of 30% of newborn deaths in 2016. In addition to the 5.6 million under-5 deaths, 2.6 million babies are stillborn each year, the majority of which could be prevented.

Ending preventable child deaths can be achieved by improving access to skilled health-professionals during pregnancy and at the time of birth; lifesaving interventions, such as immunization, breastfeeding and inexpensive medicines; and increasing access to water and sanitation, that are currently beyond the reach of the world's poorest communities.

For the first time, mortality data for older children age 5 to 14 was included in the report, capturing other causes of death such as accidents and injuries. Approximately 1 million children aged 5 to 14 died in 2016.

"This new report highlights the remarkable progress since 2000 in reducing mortality among children under age 5," said UN Under-Secretary-General for Economic and Social Affairs Mr. LIU Zhenmin. "Despite this progress, large disparities in child survival still exist across regions and countries, especially in sub-Saharan Africa. Yet many deaths at these ages are easily preventable through simple, cost-effective interventions administered before, during and immediately after birth. Reducing inequities and reaching the most vulnerable newborns, children and mothers are essential for achieving the SDG target on ending preventable childhood deaths and for ensuring that no one will be left behind."

The report also notes that:

In sub-Saharan Africa, estimates show that 1 child in 36 dies in the first month, while in the world's high income countries, the ratio is 1 in 333.

Unless the rate of progress improves, more than 60 countries will miss the UN Sustainable Development Goal (SDG) to end preventable deaths of newborns by 2030 and half would not meet the target of 12 neonatal deaths per 1,000 live births by 2050. These countries account for about 80% of neonatal deaths in 2016.

Notes to editors

Broadcast quality images and b-roll available here. Download the report here.

About UN-IGME

The United Nations Inter-agency Group for Child Mortality Estimation or UN IGME was formed in 2004 to share data on child mortality, harmonise estimates within the UN system, improve methods for child mortality estimation report on progress towards child survival goals and enhance country capacity to produce timely and properly assessed estimates of child mortality.

UN-IGME is led by UNICEF and includes WHO, the World Bank Group and the United Nations Population Division of the Department of Economic and Social Affairs. For more information visit: <http://www.childmortality.org/>

For further information, please contact:

Kimberly Chriscaden

WHO Geneva  
Telephone: +41 79 603 1891  
Email: chriscadenk@who.int

Christian Lindmeier  
WHO, Geneva  
Telephone: +41 79 500 6552  
Email: lindmeierch@who.int

Yemi Lufadeju  
UNICEF New York  
Telephone: +1 917 213 4034  
Email: glufadeju@unicef.org

Rita Wallace  
UNICEF New York  
Telephone: +1 917 909 9542  
Email: rwallace@unicef.org

#### Related links

WHO's work on child health  
Fact sheets  
Newborns: reducing mortality  
Children: reducing mortality  
Infographics  
Newborn and child health

From: "Ruth Davidge, South Africa" <rdavidge@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (21) Essential Hospital Services (5) Essential package of neonatal care

In Kwa Zulu Natal, South Africa we have developed a standardised neonatal record keeping system and a facility based essential package of neonatal care and assessment tools. These are based in part on systems/tools developed/rolled out by the National DOH. These will be used in all 52 hospitals providing maternity services in the Province.

The facility will use assessment and support tools throughout the year. They will score themselves monthly against set targets using a facility dashboard. On a quarterly basis these will be presented at district meetings with senior management. Thereafter they will be collated and reports sent to provincial and national MNCWH program managers.

Facilities will be supported in this process though weekly telephonic consultant rounds, monthly specialist outreach visits and 1-2 monthly support visits from a district clinical specialist team consisting of an advanced midwife and paediatric nurse and in some districts a paediatrician and obstetrician et al. These in turn are supported by a provincial paediatric specialist and neonatal nurse

These systems are being rolled out over the next year and scoring and reporting will commence in 2019.

I have attached the provisional Dashboard to give you some idea of what will be expected.  
[\*see note below]

God bless  
Ruth Davidge

RN RM Certificate in Neonatal Intensive Care  
Provincial Neonatal Coordinator-KZN  
President NNASA

Tel: 0769866880  
Email: ruth.davidge@kznhealth.gov.za  
info@nnasa.org.za

CHIFA profile: Ruth Davidge is Neonatal Coordinator at PMB Metro, Hospitals Complex Western, Kwa-Zulu Natal, South Africa. She is President of the NNASA (Neonatal Nurses Association of Southern Africa). She is a Registered Nurse and on the board of the Council of International Neonatal Nurses (COINN). [www.nnasa.org.za](http://www.nnasa.org.za),  
[www.nnasa.org.za](http://www.nnasa.org.za) ruth.davidge AT kznhealth.gov.za

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (22) Retinopathy of Prematurity (4)

Thank you Clare and Sue,

Meanwhile I just received an alert from the OA journal The Lancet Global Health reporting on blindness worldwide. Interestingly, these two new papers do not mention retinopathy of prematurity as a cause of blindness.

Global causes of vision loss in 2015: are we on track to achieve the Vision 2020 target?

Published online: October 11, 2017

Charumathi Sabanayagam, Ching-Yu Cheng

The Lancet Global Health

[http://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(17\)30412-6/fulltext](http://www.thelancet.com/journals/langlo/article/PIIS2214-109X(17)30412-6/fulltext)

Global causes of blindness and distance vision impairment 1990-2020: a systematic review and meta-analysis

Published online: October 11, 2017

Seth R Flaxman, Rupert R A Bourne, Serge Resnikoff, Peter Ackland, Tasanee Braithwaite, Maria V Cicinelli, Aditi Das, Jost B Jonas, Jill Keeffe, John H Kempen, Janet Leasher, Hans Limburg, Kovin Naidoo, Konrad Pesudovs, Alex Silvester, Gretchen A Stevens, Nina Tahhan, Tien Y Wong, Hugh R Taylor

on behalf of the Vision Loss Expert Group of the Global Burden of Disease Study

The Lancet Global Health

[http://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(17\)30393-5/fulltext](http://www.thelancet.com/journals/langlo/article/PIIS2214-109X(17)30393-5/fulltext)

In contrast, I found this third paper (2016) which states: 'Among the causes of blindness that are avoidable and/or treatable, retinopathy of prematurity (ROP) leads as a cause where an impact could be made by using a multidisciplinary approach and collaboration among stakeholders, including physicians, nurses, other caregivers, hospital administrators, and parents... However, in middle- and low-income countries with regional variation in technology and capacity, limited health resources may well limit the care of the premature newborn as the survival of smaller and less mature infants increases.<sup>6</sup> In these regions, ROP blindness may account for up to 40% of blindness.' (I assume this latter figure relates to paediatric blindness)

and:

'An estimated 20,000 infants [worldwide?] had severe visual impairment or blindness with almost half as many again with mild or moderate impairment.'

CITATION: Retinopathy of prematurity blindness worldwide: phenotypes in the third epidemic

Graham E Quinn. Eye Brain. 2016; 8: 3136.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5398741/>

--

Let's build a future where children are no longer dying for lack of healthcare information - Join CHIFA: <http://www.hifa.org/forums/chifa-child-health-and-rights>

Joint Coordinator, CHIFA Project on Newborn Care

<http://www.hifa.org/projects/newborn-care>

Martin Becker, UK/Rwanda" <martin.becker@nhs.net>

To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>

Subject: [chifa] Newborn Care (23) FAO Ruth Davidge - Auditing of newborn care

Dear Ruth

Thanks for sharing the dashboard. I note it includes several audits:

- Quality of care Sick/Prem (Clinical/Record audit)
- Resuscitation Assessment
- Quality of care-Encephalopathy (Clin/Record audit)
- Skills audits score
- Labour ward Assessment
- Post natal Assessment
- Quality of care Well Term (Clinical/Record audi )

Have you details of how these audits are being done.

We launched a Neonatal program in several hospitals in Rwanda including various audits and I would be interested to learn from your way of auditing clinical practice.

Thanks

Martin

CHIFA profile: Martin Becker is a retired Consultant Paediatrician at Cambridgeshire Community (NHS) Services in the UK. He has been involved in establishing and evaluating ETAT+ training in hospitals in Rwanda and Paediatric Palliative Care in Uganda. martin.becker AT nhs.net

From: "Martin Becker, UK/Rwanda" <martin.becker@nhs.net>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (24) Essential Hospital Services (6) FAO Mike English, Kenya

Dear Mike [Mike English, Kenya]

Thank you for the information about this impressive study.

The Open BMJ paper referred to includes a reference to the "East African Community Integrated Reproductive, Maternal, Newborn, Child, and Adolescent Health Strategic Plan 2016-2021."

which had not yet been published.

Do you know if it is accessible now?

Thanks

Martin

HIFA profile: Martin Becker is a retired Consultant Paediatrician at Cambridgeshire Community (NHS) Services in the UK. He has been involved in establishing and evaluating ETAT+ training in hospitals in Rwanda and Paediatric Palliative Care in Uganda. martin.becker AT nhs.net

From: "Dayo Ajayi-Obe, UK" <ejayaiob@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (25) Where are babies born?

I would like to raise the question of where are our babies being born? 'A Review article on the current state of neonatal care in Lagos State, Nigeria in 2016' which is not yet published reveals that only 15% of mothers deliver within the public healthcare system, 45% in the private healthcare system and 40% of mothers are delivered by traditional birth attendants. Traditional birth attendants are a heterogeneous group: faith based, auxiliary healthcare workers and traditional spiritualists with no training when it comes to looking after the new born baby. Most of the traditional birth attendants will transfer the babies to the hospital but the state in which they are transferred is poor, hence the high mortality. I advocate that these traditional birth attendants require training in resuscitation (Helping Babies Breathe) and train them on how to safely transfer babies. I know that the drive is for babies to be born within the hospital setting but accessing healthcare can be complex for various reasons.

CHIFA profile: Dayo Ajayi-Obe is a Consultant in Hammersmith in the U.K. ejayaiob AT gmail.com

From: "Lily Kak, USA" <lkak@usaid.gov>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (26) Where are babies born? (2) Training of  
Traditional Birth Attendants

The question of whether we should train traditional birth attendants to resuscitate newborns was a real dilemma for a global public-private alliance that came together in 2010 with the support of USAID and the American Academy of Pediatrics to roll out Helping Babies Breathe. After much discussion, the alliance made a deliberate decision to focus on improving the capacity and quality of care in health facilities. This meant that our strategy focused on training skilled birth attendants and not traditional birth attendants. We felt that there was a lot of work to be done to ensure that resuscitation skills and equipment were available in all health facilities. With increasing institutional delivery in many countries, closing this quality gap in health facilities is of paramount importance. The issue of training TBAs has long been controversial and an emotional debate; the group decided that it would be more constructive to focus on a non-controversial approach that is likely to have greater impact.

Lily Kak

HIFA profile: Lily Kak is Newborn Health Team Lead at USAID in the USA. Professional interests: Newborn Health. lkak AT usaid.gov \_\_\_\_\_

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (27) ADC: Neurodevelopmental outcomes for  
high-risk neonates in a low-resource setting

Dear CHIFA colleagues,

Archives of Disease in Childhood has just published a review that relates to a major (and as yet uncovered) aspect of our current discussion: the prevention and management of severe neurological damage in the perinatal period. The citation and abstract are below. Unfortunately the full text is restricted-access.

CITATION: Neurodevelopmental outcomes for high-risk neonates in a low-resource setting  
Kate M Milner, Trevor Duke, Andrew C Steer, Joseph H Kado, Lanjeta Koyamaibole, Rakei Kaarira, Kelera Namudu, Susan Woolfenden, Anne E Miller, Kathryn E Oâ€™Heir, Eleanor F G Neall, Gehan Roberts  
<http://dx.doi.org/10.1136/archdischild-2017-312770>

Abstract

Worldwide, most neonates who survive prematurity and serious illness reside in low-resource settings where developmental outcome data and follow-up care are limited. This study aimed to assess in Fiji, a low-resource Pacific setting, prevalence and risk factors for moderate to severe neurodevelopmental impairment (NDI) in early childhood among high-risk neonates compared with controls. Retrospective cohort study comparing long-term outcomes for high-risk neonatal intensive care unit patients (n=149) compared with matched term, normal birth

weight neonates (n=147) discharged from Colonial War Memorial Hospital between November 2008 and April 2010. NDI was defined as one or more of cerebral palsy, moderate to severe hearing or visual impairment, or global developmental delay using Bayley Scales of Infant and Toddler Development Third Edition (ie, score <70 in =1 of cognitive, language or motor domains). At median (IQR) age 36.1 (28.3, 38.0) months, prevalence of moderate to severe NDI % (95% ?CI, n) in high-risk and control groups was 12 (5 to 17, n=13) and 5 (2 to 12, n=5), respectively, an increased risk ratio (95% ?CI) of 2.7 (0.8 to 8.9). Median gestational age (weeks (median, IQR)) in the high-risk group was 37.5 (34.40) weeweeks. Among high-risk neonates, gestational age, birth weight, asphyxia, meningitis and/or respiratory distress were significantly associated with risk of NDI. Prevalence of NDI was high among this predominantly term high-risk neonatal cohort compared with controls. Results, including identified risk factors, inform efforts to strengthen quality of care and models of follow-up for high-risk neonates in this low-resource setting.

--

Best wishes, Neil

From: "I Abdulkadir, Nigeria via Dgroups" <CHIFA@dgroups.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (28) Where are babies born? (3) Training of  
Traditional Birth Attendants (2)

Hi, [in response to Dayo Ajayi-Obe, UK]

This is not quite at variance with national data. Your suggestion has been on the table for quite sometime even if in the meantime as a short term intervention, as they (TBAs) transform to community based health volunteers (CBHV) while intermediate and long term intervention should be to train appropriate cadre of staff who are empowered to function as dictated by law. Opponents to this view however, will not hear of this rightly because as mentioned the diversity and non-regulation of this category of self appointed volunteers leaves much to be desired. Some states who perceive this group as actually a significant group attending to deliveries and perhaps contributing to morbidity and or mortality are looking at programmes to engage and transform them to CBHV with less role of delivering women but encouraging women to access facility delivery. To what extent this will succeed will be determined by evaluation.

DR ABDULKADIR ISA  
Dept of Paed ABU Zaria  
+2348023607277  
+2348186365618

CHIFA profile: I Abdulkadir is a Lecturer and consultant paediatrician/neonatologist, a member of the paediatric association of Nigeria and currently the head of department of paediatrics Ahmadu Bello University/ Teaching Hospital Zaria, Kaduna in northern Nigeria where access and affordability to healthcare remain great challenges. I have worked as consultant to organisations/ programmes including GHAIN, PATHS and CHAI. I am committed to teaching, training and research towards improving child health with particular interest in newborn health. isaburamla AT yahoo.com

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (29) Facilitators and Barriers to Engaging  
Communities in Maternal and Newborn Health Programs

Below are extracts from a new post on the Maternal Health Task Force  
<https://www.mhtf.org/2017/10/19/facilitators-and-barriers-to-engaging-communities-in-maternal-and-newborn-health-programs>

Several community-based interventions have achieved impressive results, driving increases in the utilization of maternal and newborn health services, improvements in the quality of care and even reductions in maternal mortality. Involving community members throughout the process of designing, implementing and evaluating maternal and newborn health interventions is critical to the success and sustainability of programs...

Community-based interventions to improve maternal and newborn health are only successful and sustainable over time when the communities themselves are engaged and are equipped with the resources they need to be successful. A deeper understanding of how to involve communities effectively and respectfully is key to making a lasting, positive impact for mothers and newborns.

Read the full, open access paper, "Factors affecting effective community participation in maternal and newborn health programme planning, implementation and quality of care interventions."

<https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-017-1443-0>

--

Best wishes, Neil

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (30) Nursing care for sick and small babies (3)  
Global neonatal workforce (2)

I am re-sending this message from Sue Prullage to ensure it is seen by those interested in Newborn Care. Many thanks, Neil

From "Sue Prullage, Rwanda"  
To "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject [chifa] ADC: Strengthening the global paediatric workforce (6)

Hi

I agree we need trained doctors and nurses in the neonatal unit. I would advocate for trained neonatal nurses. I am a pediatric and neonatal nurse practitioner and I can say the training was very different. If we want neonatal nurses their training would be specific to gestational differences and the first 2 years of life. If we try to roll neonatology into pediatric training then have to include up to 18 years of life. This will take away from neonatal training time.

It would be beneficial if the WHO would say that nurses and midwives that work in neo units should be trained as neo nurses. Unfortunately their stand for LMIC is that a nurse should be trained as a generalist so they can be utilized all over the hospital. I understand this is a huge commitment and will take time to accomplish but it is just in layer that needs to be addressed to attack neonatal mortality.

Sue Prullage

HIFA profile: Geralyn Sue Prullage is a member of the board of the Council of International Neonatal Nurses (COINN). She has worked in Rwanda since 2008 and has helped establish a neonatal unit in a district hospitals. She has a doctorate in Nursing Practice (DNP) and is a certified neonatal/pediatric nurse practitioner. sue.prullage AT gmail.com

From: "Ochiawunma Ibe, USA" <ochiibe@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (31) Training of Traditional Birth Attendants  
(3)

I agree that training traditional birth attendants to perform neonatal resuscitation may not move the dial towards reduced neonatal mortality but as Dayo highlights they are still conducting many deliveries in low resource settings and as such training them to be effective support for mothers prenatally with strong linkages to the health facilities and in situations when then deliveries happen in the community recognizing the danger signs in neonates for referral to the health facilities will go along way in achieving the outcomes we desire for the newborns. We must make them part of the team though their roles will not be to perform the resuscitation.

HIFA profile: Ochiawunma Ibe is Senior Community Health Technical Advisor at the Maternal and Child Survival Program (MCSP) in the USA. Professional interests: Community Health Workers and Community Management, Policy and Planning for Community Health, Integrated Service delivery and developing viable integrated community health platforms. Highly accomplished and results-oriented public health professional with 15+ years successful experience with increasing responsibility in HIV& AIDS Care and support; Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Orphans and Vulnerable Children (OVC) and Multi-sectoral nutrition programming; directly managing & achieving significant results in USAID and USG/PEPFAR funded programs. Strong background in community- health system strengthening and service delivery for Maternal and Child Health, with skills in community engagement and behavior change, synergies between Nutrition, Water Sanitation and Hygiene (WASH), Health, Gender, Agriculture and Emergency preparedness. ochi.ibe AT icf.com

From: "Marti Perhach, USA" <marti.is@me.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (32) Group B streptococcal infection

Thank you, Neil, for posting the info below! [\*see note below] As a group B strep stillbirth mom and cofounder of Group B Strep International (GBSI), I'd like to add about the importance of educating all pregnant women and new parents as to the signs and symptoms of group B strep disease (GBS) in babies. As most of you probably know, GBS is a leading cause of sepsis and meningitis worldwide. Unfortunately, many of the GBS stories on our website could have had much better outcomes with something as simple as health care providers having a conversation with their pregnant patients to call if they had any vaginitis symptoms, urinary tract infection symptoms, an unexplained fever or low or no fetal movement and, also, to give new parents a list of signs of GBS infection to watch out for in their newborn BEFORE they leave the hospital. (Other types of infection could also cause the same symptoms so even more reason to be alert.)

It's also important for perinatal health care providers and emergency room personnel to know the symptoms and not be dismissive of parents' concerns which sadly happens sometimes. We have the honor of a GBS mom contributing the audio clip of her son, Aayan, making the grunting/groaning sound that is a common yet often unrecognized sign of GBS meningitis (and possibly meningitis from other causes as well). It's available on our website at <https://www.groupbstrepinternational.org/recognize-the-symptoms-of-infection.html> along with a downloadable list of signs in English (Spanish and French soon!) Our GBS brochure is linked from the top of this page: <https://www.groupbstrepinternational.org/more-about-gbs-and-how-to-help-protect-your-baby.html>

I also wanted to add that GBSI sponsors October as Prenatal-onset GBS Disease Recognition Month <https://www.groupbstrepinternational.org/-what-is-group-b-strepprenatal-onset-3.html> and February as International Prenatal Infection Month <https://www.groupbstrepinternational.org/downloadable-prenatal-infection-prevention-materials.html>.

Best!  
Marti Perhach  
marti.perhach@gbs-intl.org

From: "Lily Kak, USA" <lkak@usaid.gov>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (33) "Do No Harm" technical briefs - Oxygen and respiratory care, thermal support, infection management/prevention, and feeding

First, Do No Harm: the First Step in Improving the Quality of Small and Sick Newborn Care

As institutional delivery increases in most countries, a growing number of newborns have access to facility-based care. However, this has not necessarily translated into significant reductions in maternal or neonatal mortality because of gaps in quality of care provided in the facilities. During a series of visits to multiple countries by a USAID team to learn about sick newborn care programs, several cross-cutting themes related to sick newborn care emerged. Below are our observations on four important areas of clinical service delivery that are relevant to most, if not all newborns: oxygen and respiratory care, thermal support, infection management/prevention, and feeding.

There is an increased availability of oxygen for inpatient newborn care; however, special vulnerabilities of newborns mean that they can be harmed as well as helped by oxygen. Because oxygen is so fundamental to high-quality inpatient newborn care, it is natural that increased availability of oxygen is one of the first steps taken into special newborn care. However, in most settings, the delivery systems provide high concentrations of oxygen, which can be toxic - especially to preterm infants. The ability to mix oxygen with air and deliver the exact amount of oxygen needed to keep blood levels of oxygen in a safe range requires routine pulse oximetry for measurement of oxygen levels in the blood and, ultimately, the use of blenders for careful titration of supplemental oxygen concentrations. Staff need an understanding of the potential harm that high levels of oxygen can do to developing eyes and lungs, and staffing ratios must allow providers to monitor their patients frequently. Retinopathy of prematurity, a developmental disorder of the eye in preterm infants, is on the rise in many middle-income countries and is becoming the leading preventable cause of child blindness. As oxygen use becomes more widespread, its introduction should be safe and should be accompanied by screening for retinopathy of prematurity among preterm infants treated with oxygen.

Thermal support for small and sick newborns has commonly been addressed with mechanical means of warming. Radiant warmers are available in many facilities, but in most countries, babies experience both cold stress and overheating because of inadequate temperature control. Non-functioning or absent temperature probes to regulate heater output were the most common reason. Two or more babies were also observed on a single radiant warmer or in a single incubator. Skin-to-skin care offers a preferable option for thermal support, even for babies receiving special care in an inpatient setting.

In all special newborn care units, maternal breast milk is the preferred source of nutrition. But only in exceptional units are mothers directly involved in feeding their infants if they are unable to suckle. Although mothers are encouraged to supply milk for their hospitalized infants, there is little early support for lactation (use of IV fluids may be prolonged), maternal presence in the unit is highly variable, and seldom is there an individualized feeding plan and daily growth monitoring with adjustment of intake as needed. Access to donor breast milk is very limited, so providers are forced to develop their own solutions when mother's milk is insufficient or not available.

In most newborn special care units there is an area for handwashing with soap and water - although not all hospitals and health centers caring for small and sick newborns have a source of running water. In many units, more attention is devoted to wearing shoe covers and cover gowns than to enforcing handwashing for health workers, mothers, and other family members. Crowding, with multiple babies sharing cots and radiant warmers also promotes the spread of infection. Some facilities are making their own waterless hand cleaner and positioning it at each bedside in the newborn care unit. Further work to identify barriers to handwashing among health care providers, mothers, and other family members can lead to customized strategies to improve hand hygiene. WHO's multimodal strategy to improve the patient safety climate can be a foundation for improving handwashing for infection prevention in newborn care areas. New guidelines are available for disinfection (reprocessing) of resuscitation equipment. Crowding requires more system-level analysis of underlying factors, such as limitations in workforce and available equipment or beds for Kangaroo Mother Care.

USAID and Every Preemie SCALE have produced a series of "Do No Harm" technical briefs covering the above four major areas of clinical service delivery for small and sick newborns. Each of these gives examples of ways that unintended harm can result during special newborn care and provides updates on current recommendations and clinical guidelines. Each brief also includes potential action steps to improve care and health outcomes - at the level of policy makers, program planners/implementers, facility managers/administrators, and health care providers. We encourage countries to use these briefs to advocate and implement high quality care for small and sick newborns.

The briefs can be found in: <http://www.everypreemie.org/donoharmbriefs/>

Lily Kak, Susan Niermeyer, Pavani Ram  
USAID Newborn Health Team

CHIFA profile: Lily Kak is Newborn Health Team Lead at USAID in the USA. Professional interests: Newborn Health. She is a member of the CHIFA working group on Newborn Care <http://www.hifa.org/projects/newborn-care>  
<http://www.hifa.org/support/members/lily-1>  
lkak@usaid.gov

From: "Kishwar Azad, Bangladesh" <kishwar.azad@googlemail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (34) Training of Traditional Birth Attendants  
(4)

We had trained TBAs in essential newborn care including Bag and mask resuscitation and aseptic practices. We conducted a RCT in 3I will send the reference later. TBAs in the intervention group were trained in BMV and mouth to mouth whereas those in intervention group were trained only in MtoM. There was no difference in neonatal mortality.

It's true that more than 30% of deliveries in the rural areas in Bangladesh still occur at the hands of TBAs. There is no point in ignoring this fact and say we must not train TBAs. Until such a time that all deliveries are conducted by SBAs, TBAs must be made 'safe' and must know when to refer. Since they are the first point of contact for newborns, they should be familiar with basic resuscitation practices.

CHIFA profile: Kishwar Azad is the Project Director for the Perinatal Care Project and Snr Hon Consultant at the Department of Paediatrics at Birdem Hospital in Bangladesh.  
kishwar.azad AT gmail.com

From: "Dayo Ajayi-Obe, UK" <ejayiob@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (34) Training of Traditional Birth Attendants  
(5)

The burden of disease is great in low income countries. In Lagos State, Nigeria alone, which has an estimated population of 20 million people with 650,00 deliveries annually and an

estimated 25350 newborn deaths that is approximately 70 newborn deaths a day. We definitely can't ignore the current role that the different stakeholders play in child birth both from a maternal and new born perspective.

Lagos State, Ministry of Health has 4012 TBA's on their list of which almost 3000 are registered. The limited number of beds and trained health professionals in the formal health sector remain an issue and even to some extent is a problem even in developed countries. The impact that one group of stakeholder plays on the outcomes of another group of stakeholders cannot be ignored and we must remember we are an ecosystem. As we know a newborn who fails to breath at birth and is starved of oxygen will end up brain damaged.

I would like to put a few questions forward: Are we maximizing the potential role that the neonatal ambu bag has in saving newborn lives, (newborns with primary apnoea) in low income resourced countries?. Has a Cochrane review been done on the outcomes of training traditional birth attendants in helping babies breathe? Can we continue to break down the HBB and essential newborn care training to the level of that TBA's can understand so that they can do what is necessary before transferring a sick baby who has a better chance of surviving intact?

The late Olikoye Ransome-Kuti, a professor of paediatrics and a former minister of health in Nigeria responded to a comment when questioned about the ability of the illiterate public to understand radio health education programs at an International conference in the mid 90's. He said it doesn't mean because a person is illiterate that he or she is not intelligent! 'Nature' itself provides education and experience, let's not underestimate human understanding, these are individuals that are familiar with the slaughtering and dissecting of animals for food within the household and so indirectly have the ability to understand simple but practical biology. After all in the developed world the public are taught how to do Basic Life Support and lives are saved. Food for thought should we be introducing essential new born care training into the secondary school curriculum? The problem is enormous!. As a Paediatrician and epidemiologist I look at numbers and how interventions if properly implemented help improve outcomes.

CHIFA profile: Dayo Ajayi-Obe is a Consultant in Hammersmith in the U.K. eajayio AT gmail.com

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (35) Group B streptococcal infection (2)

The Lancet has just published a Seminar paper on neonatal sepsis (below). Unfortunately the full text is restricted-access.

CITATION: Andi L Shane, Pablo J SÃ¡nchez, Barbara J Stoll. Neonatal sepsis. [Seminar] The Lancet. Volume 390, No. 10104, p17701780, 14 October 2017  
[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(17\)31002-4/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31002-4/fulltext)

SUMMARY: Neonatal sepsis is the cause of substantial morbidity and mortality. Precise estimates of neonatal sepsis burden vary by setting. Differing estimates of disease burden

have been reported from high-income countries compared with reports from low-income and middle-income countries. The clinical manifestations range from subclinical infection to severe manifestations of focal or systemic disease. The source of the pathogen might be attributed to an in-utero infection, acquisition from maternal flora, or postnatal acquisition from the hospital or community. The timing of exposure, inoculum size, immune status of the infant, and virulence of the causative agent influence the clinical expression of neonatal sepsis. Immunological immaturity of the neonate might result in an impaired response to infectious agents. This is especially evident in premature infants whose prolonged stays in hospital and need for invasive procedures place them at increased risk for hospital-acquired infections. Clinically, there is often little difference between sepsis that is caused by an identified pathogen and sepsis that is caused by an unknown pathogen. Culture-independent diagnostics, the use of sepsis prediction scores, judicious antimicrobial use, and the development of preventive measures including maternal vaccines are ongoing efforts designed to reduce the burden of neonatal sepsis.

--

Best wishes, Neil

From: "Joseph Ana, Nigeria via Dgroups" <CHIFA@dgroups.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (36) Training of Traditional Birth Attendants  
(6)

Dayo,

I enjoyed your posting as gory as it sounds (but it is factual). The tragedy is that as bad as the Lagos stats is they could be up to 5 or more times worse in some other parts of Nigeria, without exaggeration. A real tragedy for the families and the country.

I enjoyed the paragraph about the Founder of PHC in Nigeria, 'The late Olikoye Ransome-Kuti, a professor of paediatrics and a former minister of health in Nigeria responded to a comment when questioned about the ability of the illiterate public to understand radio health education programs at an International conference in the mid 90's. He said it doesn't mean because a person is illiterate that he or she is not intelligent! 'Nature' itself provides education and experience, let's not underestimate human understanding, these are individuals that are familiar with the slaughtering and dissecting of animals for food within the household and so indirectly have the ability to understand simple but practical biology.'

Just last week I was talking about PAK Nigeria guide [\*] for PHC workers in Nigeria and his name kept recurring. He lived in advance of his colleagues knowing how important PHC is in any health system.

We wish his colleagues doctors knew better because they would not have frustrated his efforts - he was Federal minister twice, and when he was called upon to do the same job a third time he rather created the National Primary Health Care Development Agency and was the first Head (Chairman).

We have advocated engagement of TBAs, train them, provide them with basic clean kits (and skills to help babies breathe) then monitor their practice. At least until that time when literate

health professionals are in abundance and are willing to live and work in those difficult to reach areas that TBAs thrive in.

( Are traditional birth attendants good for improving maternal and perinatal health? Yes  
BMJ 2011; 342 doi: <https://doi.org/10.1136/bmj.d3310> (Published 14 June 2011)Cite this as:  
BMJ 2011;342:d3310)

Joseph Ana.

Africa Center for Clin Gov Research & Patient Safety

@ HRI West Africa Group - HRI WA  
Consultants in Clinical Governance Implementation  
Publisher: Health and Medical Journals  
8 Amaku Street Housing Estate, Calabar  
Cross River State, Nigeria

Phone No. +234 (0) 8063600642

Visit Website: [www.hriwestafrica.com](http://www.hriwestafrica.com)

E-mail: [hriwestafrica@gmail.com](mailto:hriwestafrica@gmail.com)

CHIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007. Website: [www.hriwestafrica.com](http://www.hriwestafrica.com) Joseph is a member of the HIFA Steering Group: <http://www.hifa.org/people/steering-group> <http://www.hifa.org/support/members/joseph-0>  
jneana AT yahoo.co.uk

From: "Neil Pakenham-Walsh" <[neil.pakenham-walsh@ghi-net.org](mailto:neil.pakenham-walsh@ghi-net.org)>  
To: "CHIFA - Child Health and Rights" <[CHIFA@dgroups.org](mailto:CHIFA@dgroups.org)>  
Subject: [chifa] Newborn Care (37) 25 October Quality of Care Network  
webinar: Lessons on mentoring, supervision, and linking with communities,  
from the Maternal and Neonatal Implementation for Equitable Systems project  
in Uganda

The message below is forwarded from the GANM forum:

--

From Benedicte Walter

Sent 18 October 2017 14:02

To Benedicte Walter

Subject 25 October Quality of Care Network webinar: Lessons on mentoring, supervision, and linking with communities, from the Maternal and Neonatal Implementation for Equitable Systems project in Uganda

Join a webinar on:

Quality improvement that works: mentoring, supervision and involving the community  
Lessons from the Maternal and Neonatal Implementation for Equitable Systems project in Uganda

Wednesday 25 October 2017 at 8am EST, noon GMT, 2pm CEST, 3pm EAT and 5:30pm IST (duration: 1 hour)

To register for the online event

-----  
1. Go to <https://who-meeting.webex.com/who-meeting/onstage/g.php?MTID=e2eb630b0eea83be8695faf52721934>

2. Click "Register".

3. On the registration form, enter your information and then click "Submit".

The Network for Improving Quality of Care for Maternal and Newborn Health (Quality of Care Network), is organizing a webinar to share some of the lessons from the Maternal and Neonatal Implementation for Equitable Systems (MANIFEST) project which the Makerere University School of Public Health run in 2012-2015. The study was conducted in three districts in Eastern Uganda to help reduce maternal and neonatal deaths through the use of a participatory action research approach.

The speaker, Dr Suzanne Kiwanuka will explain how this approach involved communities, district and facility management simultaneously. She will highlight how mentoring and supervising quality improvement teams were key in seeing quality improvement take hold in a facility. Dr Kiwanuka will present some of the outcomes of the project in specific health facilities. She will emphasize the importance of continuity of supervisory teams, the use of action plans and the importance of focussed mentoring sessions for quality improvement.

The presentation will be followed by a Q & A session.

Presenter: Dr. Suzanne Kiwanuka, is a senior lecturer at Makerere University School of Public Health Kampala Uganda and a health systems and policy expert with interest in human resource policy and practice, maternal and newborn health and knowledge translation.

Who should join: Health practitioners and managers.

Read more:

The MANIFEST project has published a Supplement in Global Health Action. The lessons of the project are also documented in a series of nine Briefing Papers and a documentary.

This is a webinar in the special country highlights series of the Quality of Care Network. See here the details on all webinars in the series on capacity building for improving quality of care in health facilities: <http://www.qualityofcarenetwork.org/about/network-activities>

The Quality of Care Network brings together countries and implementing partners to deliver the vision that "Every mother and newborn receives quality care throughout the pregnancy, childbirth and postnatal periods". The Quality of Care Network is led by nine countries (Bangladesh, Côte d'Ivoire, Ethiopia, Ghana, India, Malawi, Nigeria, Tanzania and Uganda), and supports the implementation of national plans for quality improvement. Its Learning Platform is building a community of health practitioners across all levels of service delivery, to harvest local implementation ideas and share experiences within and across countries.

[www.qualityofcarenetwork.org](http://www.qualityofcarenetwork.org)

-----  
For assistance

-----  
You can contact MODERATOR Benedicte Walter at:  
walterb@who.int

Benedicte Walter  
Communication Consultant  
Maternal, Newborn, Child and Adolescent Health Department  
World Health Organisation/HQ  
Tel (UK): +44 75 76 055 038  
Skype: benedicte57  
[www.qualityofcarenetwork.org](http://www.qualityofcarenetwork.org)

--

Best wishes, Neil

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (38) Eight unanswered questions about newborn deaths and morbidity

Thank you for all your valuable contributions to date! In this first week we have explored the question/theme:

Q1. What is the size of the problem? How many newborns die every day, where, and what are the causes? How many more suffer major morbidity? What are the trends?

We read from Joy Lawn (London School of Hygiene and Tropical Medicine):

"Each year 2.7 million newborns die with 98% of these deaths in low and middle income countries, and more than 80% are small, with preterm infants being at greatest risk. Now that 80% of the world's births are in hospitals, more newborn deaths are occurring in hospitals, and over two-thirds of these deaths could be prevented with effective hospital care for small and sick newborns. Major mortality reduction is possible even before adding comprehensive

or intensive newborn care BUT to reach the SDG 3 target of a neonatal mortality of fewer than 12 per 1000 live births, every country will have to be on a pathway to providing more comprehensive newborn care as outlined in The Lancet Every Newborn series and the Every Newborn Action Plan, endorsed by all countries in 2014."

We have heard also this week:

'Most newborn deaths occurred in two regions: Southern Asia (39%) and sub-Saharan Africa (38%). Five countries accounted for half of all new-born deaths: India (24%), Pakistan (10%), Nigeria (9%), the Democratic Republic of the Congo (4%) and Ethiopia (3%).'  
<http://who.int/mediacentre/news/releases/2017/daily-newborn-deaths/en/>

and

'The main causes of newborn deaths are prematurity and low-birth-weight, infections, asphyxia (lack of oxygen at birth) and birth trauma. These causes account for nearly 80% of deaths in this age group.'  
<http://who.int/mediacentre/factsheets/fs333/en/>

For me, this raises at least eight more questions:

1. How many babies in LMICs are delivered at home versus primary health centre versus small hospital versus referral hospital?
2. How many newborn deaths occur at each of the above levels of the health system?
3. What more do we know about newborn deaths at global and national levels? Which countries are doing better than others of comparable levels of income?
4. How many deaths might have been prevented with better antenatal care?
5. How many deaths might have been prevented with better basic newborn care?
6. How many deaths might have been prevented with better (for those who get it) comprehensive newborn care?
7. For every newborn death, there are many more babies who are born with severe disability, including hypoxic brain damage, often leading to enormous suffering for the child and family. How much of this disability could have been prevented by better basic (and/or comprehensive) care?
8. And what about the trends in newborn deaths and morbidity? We hear that newborn deaths are going down year on year, but progress is much slower than with under-5 mortality. Why?

The answers to all the above may well not be known precisely, but we should be able to estimate/guesstimate. Which in turn may help inform policy and practice.

Can anyone help answer any of the above questions? What other questions should we be asking?

Best wishes, Neil

From: "Christabel Enweronu-Laryea, Ghana via Dgroups" <CHIFA@dgroups.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (39) Training of Traditional Birth Attendants  
(7) Basic neonatal resuscitation

It is important that everyone who attends birth is trained in basic neonatal resuscitation e.g. HBB. However, the focus should still be to encourage women to deliver in health facilities and for primary health care (PHC) facilities to refer the 'at risk' foetus to higher levels of care in utero.

Resuscitation at birth is not enough for quality health outcome. Quality supportive care in the hours after resuscitation is important to protect the brain from further damage.

Such post-resuscitation care is not provided by TBAs and PHC facilities in many sub-Saharan African countries. Also, extra uterine transportation has its challenges because ambulance services (where they exist) are not equipped for newborn transport. These babies arrive to hospitals many hours after resuscitation in very poor conditions. Many survive but with significant disability.

HBB, like oxygen, saves lives but improving the quality of life for survivors and families requires a system of care that reduces the risk of disability. Retinopathy of prematurity is a major cause of preventable blindness in middle income countries. Let us make every effort to ensure that receiving HBB in the community will not be the major cause of neuro developmental disability in low-resource countries in coming years.

CHIFA profile: Christabel Enweronu-Laryea is an Associate Professor of Paediatrics and Child Health at University of Ghana School of Medicine and Dentistry and a Consultant Paediatrician at Korle Bu Teaching Hospital in Accra, Ghana. Her professional interests include teaching paediatrics and providing intensive care for newborns. She is a member of the CHIFA working group on Newborn Care:

<http://www.hifa.org/projects/newborn-care>

<http://www.hifa.org/support/members/christabel>

Email address: chikalaryea AT yahoo.com

From: "Deborah van Dyke, USA" <deb@globalhealthmedia.org>

To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>

Subject: [chifa] Newborn Care (40) Teaching resources for neonatal providers

Dear colleagues,

I have been following this discussion closely and with great interest and see that a number of people have expressed the need for improving the training of neonatal providers.

Many of you may already know about our series of videos on care of small and preterm babies, but for those of you who don't, I'd like to call your attention to this comprehensive training resource for frontline providers in LMICs.

Global Health Media Project developed the Small Baby Series to bring to life many life-saving practices such as how to keep premature babies warm with skin-to-skin care, and how to feed them with a cup or feeding tube before they're strong enough to breastfeed. The series consists of 27 short teaching videos. Five are designed specifically for mothers to demystify the needs of premature infants and help them care for their babies both in the hospital and at home. Since their release earlier this year, 10,000 copies of the small baby videos have been downloaded.

The content was developed in partnership with the American Academy of Pediatrics (AAP) to complement the Essential Care for Small Babies (ECSB) training program based on the latest WHO guidelines. The videos are available in English, French and Spanish, with other languages now in the pipeline. Please contact us if you would like to narrate the videos in your local language.

The videos can be watched on our website where they are also available for free download: <https://globalhealthmedia.org/videos/smallbaby/>

The full package of ECSB educational materials can be obtained from AAP: <https://internationalresources.aap.org/> or from Laerdal Global Health: <http://www.laerdalglobalhealth.com/doc/2574/Essential-Care-for-Small-Babies>

With kind regards,

Deb

Deborah Van Dyke, Director  
Global Health Media Project  
802-496-7556

CHIFA profile: Deborah Van Dyke is the Founder and Director of Global Health Media Project, an organization producing videos that brings to life critical health care information for providers and populations in low-resource settings. Capitalizing on advances in ICT will enable distribution worldwide at lower costs via the Internet and mobile devices. She is a family practice clinician with extensive experience with Medicins Sans Frontieres/Doctors Without Borders, based in the US.  
dvandyke AT madriver.com

From: "Sue Prullage, Rwanda" <sue.prullage@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (41) How are nurses and midwives in neonatal units trained?

I would suggest one more discussion:

How are the nurses and midwives that already work in neonatal units trained? Comprehensive neonatal care touches the basics of thermoregulation etc. But there are units all over Africa that have donated CPAP machines and IV pumps. Is their understanding and training given around this equipment. Premature babies are being born at less than 1kg500 how has the staff been trained to deal with these infants. Infants with genetic dysfunction are being born in LMIC as well. The same disease entities that touch babies in high income countries are being born in LMIC and what does the staff know about these infants.

In my experience the staff of the neonatal units are not given extensive orientation to all the problems that can be encountered with prematurity and sick infants. The new nurse generally follows another nurse who hadn't been oriented or given didactic related to premature disease. In the US the orientation process is competency based and up to 12 weeks to 1 year

in length. In most LMIC the staff is moved around every few months to keep them "well rounded".

Wouldn't it be prudent for the stake holders in the lives of the premature infants to have a set of neonatal nurse competencies. Doctor competencies? A statement and commitment to what would be included in neonatal nurse orientation. Shouldn't the hospitals commit to an orientation process and leaving a team of experienced staff?

Sue Prullage

CHIFA profile: Geralyn Sue Prullage is a member of the board of the Council of International Neonatal Nurses (COINN). She has worked in Rwanda since 2008 and has helped establish a neonatal unit in a district hospitals. She has a doctorate in Nursing Practice (DNP) and is a certified neonatal/pediatric nurse practitioner. sue.prullage AT gmail.com

From: "Sunanda Kolli Reddy, India" <write2sunanda@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (42) How are nurses and midwives in neonatal units trained? (2)

I agree in principle. [with Sue Prullage, Rwanda]

However, the ideal training for developing countries should perhaps combine a general course in nursing followed by a specialist training in neonatal, or even better in perinatal Health.

Due to the limited number of specialist nurses in tertiary care Centres with ICNUs in most of our countries, the specialists available for mentoring junior nurses or spending time teaching general nurses on long duration courses may not be close to the ideal. One can perhaps think of a spoke and hub model where 5-10 smaller centres can be linked to each specialist unit wherein a two-way training can happen.

One model of a two-way training can be where Orientation and a short period of Practical training in Special care nursery units can be followed up with a batch of specialists going to the smaller centres to give a continued training under less favourable circumstances that the trainees work in. This will help trainer and trainees to learn on the job, contextualise care and find an optimal care level between the optimal and the feasible until they work jointly towards upgrading of quality. This model is not totally new but needs to be scaled up. An additional advantage is that the time the specialist nurses are away on training can be reduced.

Thanks and regards,  
Sunanda.K.Reddy

HIFA profile: Sunanda Kolli Reddy is a Developmental Paediatrician from New Delhi, India, with a special interest in Early Child Care and Development of children with neurodevelopmental problems in underserved communities. She is actively involved in health promotion, community-based research, care provider training for promoting abilities of children with special needs, through the various programmes of Centre for Applied Research

and Education on Neurodevelopmental Impairments and Disability-related Health Initiatives (CARENIDHI), which she heads ([www.carenidhi.org](http://www.carenidhi.org)). Her work in the community settings to widen the disability-in-development model of CBR encompasses the wider determinants of health and human capabilities and issues which impact the lives of the poor. She combines her experience in developmental paediatrics with the core work of CARENIDHI's grassroots convergence programmes in partnership with groups working in the area of Implementation research and policy. She is a member of the HIFA working group on Community Health Workers.

<http://www.hifa.org/projects/community-health-workers>

<http://www.hifa.org/support/members/sunanda>

Email: write2sunanda AT gmail.com

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>

To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>

Subject: [chifa] Newborn Care (43) The Safe Delivery App

(with thanks to Angela Gorman and Life for African Mothers)

See full newsletter here: <http://mailchi.mp/gntmedia/ny4olrlwj7-1825025?e=524d12f15b>

We use The Safe Delivery App [<http://www.maternity.dk/safe-delivery-app/>] in Liberia, which provides skilled birth attendants direct and instant access to evidence-based and up-to-date clinical guidelines on basic emergency obstetric and neonatal care. The app leverages the growing ubiquity of mobile phones to provide life-saving information and guidance through easy-to-understand animated instruction videos, action cards and drug lists. It can also serve as a vital training tool and equips birth attendants - even in the most remote areas - with a powerful on-the-job reference.

"I am very happy that this app was developed and I wonder why we didn't think of such a tool before! We use our phones for everything: for the internet, as a watch, for a light. If you have a smartphone, you can teach anywhere with this app - and, whenever you encounter a problem, you can access essential resources to solve it. This makes the Safe Delivery App very accessible". Heaven Workneh, Midwife Lecturer.

--

Best wishes, Neil

From: "Sarah Moxon, UK" <sarah.moxon@lshtm.ac.uk>

To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>

Subject: [chifa] Newborn Care (44) How are nurses and midwives in neonatal units trained? (3)

Thanks Sue [Sue Prullage, Rwanda, Newborn Care (41)] for this important comment.

The nursing workforce is a critical issue for those of us supporting the global Every Newborn Action Plan. Led by UNICEF, we published a series of papers in 2015 on the health system bottlenecks to scaling up newborn care using data from 12 countries collected through national stakeholder workshops <https://bmcpregnancychildbirth.biomedcentral.com/articles/supplements/volume->

[15-supplement-2](#) For small and sick newborns, the health workforce, followed closely by health financing, were viewed as critical health system challenges by participating stakeholders. Overcoming these challenges requires more than increasing the numbers of nurses lack of training and mentorship, and frequent rotation of nursing staff were all too common issues that were cited. None of this can be solved without better planning and accountability systems. Standardised levels of care with associated nursing/health worker competencies would seem like an important start for both accountability and planning purposes (how can we budget, if we do not know how many services we need? How can we train enough staff? And what skills do these staff need at what level?).

Even in high income settings, where we have good data on staff ratios and recommended nurse patient ratios based on level of neonatal care, we are more than aware of the problem of reducing the nurse to patient ratio in neonatal care. A recent study published in the British Medical Journal <http://fn.bmj.com/content/fetalneonatal/101/3/F195.full.pdf> by Watson, Modi et al showed that there is an increase in the unit mortality rate when a decreased proportion of intensive care days was provided with one-to-one nursing. This study provides evidence to support the claim that tertiary-level neonatal units with higher levels of one-to-one nursing provision have reduced mortality rates. Previous studies have also showed that a nurse cannot care for more than the recommended ratio of infants without inevitably delaying their treatment [http://adc.bmj.com/content/archdischild/96/Suppl\\_1/A36.1.full.pdf](http://adc.bmj.com/content/archdischild/96/Suppl_1/A36.1.full.pdf) Other studies have shown that additional patients per nurse is associated with a decrease in daily weight gain.

I know that COINN has been calling for a global neonatal nursing specialization in lower income settings, and we greatly support this work here in our newborn team at LSHTM. As a previously practicing neonatal nurse, I know what it is like to have insufficient hands and hours in the day to meet the complex needs of your small patients. And, having had the fortune of working in some of the most equipped children's hospitals in the world, I also know how potentially empowering it is to have strict mentoring and focus on specific competencies, as well as enough colleagues at work to cover the patient caseload.

As one of our streams of work for the Every Newborn Action Plan metrics group here at LSHTM, we have been carrying out a global consultation on levels of neonatal care for lower and middle-income settings by working closely with key partners, such as WHO, UNFPA, AMDD, Save the Children and UNICEF. To move this important agenda forward, we need the views of health workers on the ground. Please do contribute to the survey here we would like to hear from the health workers caring for newborns in hospitals in diverse settings and different health systems. The survey will be open for another week and we will be sharing the results of this later in the course of the newborn project: <https://www.healthynewbornnetwork.org/blog/launch-enap-inpatient-care-small-sick-newborns-online-survey-world-prematurity-day/>

Thanks,  
Sarah Moxon

HIFA profile: Sarah Moxon works in the Department of Infectious Disease Epidemiology, London School of Hygiene and Tropical Medicine, where she provides research and technical support to the Every Newborn Action Plan and Saving Newborn Lives project. She is a member of the CHIFA working group on Newborn Care.  
<http://www.hifa.org/projects/newborn-care>

<http://www.hifa.org/support/members/sarah-2>

Email: sarah.moxon AT lshtm.ac.uk

From: "Claire Keene, UK/Kenya" <claire.keene@ndm.ox.ac.uk>

To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>

Subject: [chifa] Newborn Care (45) Levels of care

In response to what other questions we should be asking, another topic to consider is how health systems should categorise their levels of care. It seems to be fairly widely accepted that the minimum level of care includes basic care of the newborn and basic neonatal resuscitation, and that the highest level covers intensive care, mechanical ventilation and more specialised services. But how should the care babies receive between these two ends of the spectrum be categorised, and what care should be provided at which level of hospital?

Some questions I have are:

1. What constitutes a newborn unit? Should any facility performing deliveries have a newborn unit that offers standard in-patient care, or should it be restricted to hospitals only?
2. Should non-NICU inpatient care be categorised as one level or further subdivided into basic and comprehensive care? Should some non-NICU newborn units be able to provide higher dependency care that alleviates the pressure on NICUs? Or should all high dependency care be provided at NICU level only?
3. What care could realistically be provided in a high dependency unit (CPAP? Exchange transfusion?)? Are there pivotal or distinguishing services that define a unit as a specific level of care, for example CPAP defining a high-care unit?
4. Should care be completely regionalised with basic facilities referring to central high level facilities, or should some higher level services be distributed closer to the receiving population? For example, having high dependency units at low level hospitals in rural areas. Should efforts be made to improve transport networks or should poor referral systems be compensated for by providing higher level care at more hospitals?

There are explicit guidelines for specific countries, such as the US, UK, Australia, South Africa and India, but it is unclear how these translate to LMIC that don't have their own guidelines and have very different ways of organising their health systems. Explicitly defining levels can help understand what the current capacity of a system is as well as advocate for improvements, and makes planning of resource allocation according to need easier. Uniform definitions can contribute to development of consistent service standards, and clarity allows enforcement. It also helps compare outcomes over time or between hospitals, and can improve the comparability of research. The question is how to define these levels in a low-resource, high-burden context and what the implications might be?

CHIFA profile: Claire Keene is a research intern at OHSCAR in the UK and Kenya.

Professional interests: Newborn health, Neonatal levels of care, components of neonatal health systems. clairekeene AT gmail.com

From: "Dayo Ajayi-Obe, UK" <ejayio@gmail.com>

To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (46) Neonatal jaundice (2)

Dear Kojo [Kojo Ahor-Essel, Ghana, Newborn Care (12)]

I totally agree with you the scourge of neonatal jaundice does not appear on the radar but on the ground as clinicians we continually experience the impact that kernicterus has on newborn mortality and morbidity. In the public hospitals in Lagos it was not unusual to do 4-6 exchange blood transfusions a day, 365 days a year on babies born outside the hospital, that is on average approx 1825 EBT's a year and at least 70% showed signs of kernicterus at presentation. It's not surprising for at least 15% of newborns are G6PD deficient in West Africa and neonatal sepsis is another major factor. Apart from various drugs, interestingly camphor balls used by mothers to protect the newborns clothing from cockroaches causes haemolysis in G6PD deficient individuals. Slusher et al carried out intervention studies in Nigeria 'in a randomised trial of phototherapy with filtered sunlight in African neonates' published in the NEJM in 2017. With an aim to producing a cost effective way of managing neonatal jaundice. Olusanya et al who is a coauthor has also done a systemic review on the burden of NNJ in Nigeria but more work needs to be done on estimating the burden of NNJ in sub-Saharan Africa.

CHIFA profile: Dayo Ajayi-Obe is a Consultant in Hammersmith in the U.K. eajayio AT gmail.com

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (47) A Big Global Movement for the World's Smallest Newborns

The message below is forwarded from the GANM forum.

--

Dear Colleague:

Delegates from 10 countries will gather in Malawi to discuss how to speed up the adoption of life-saving care for premature babies, especially increasing the adoption of kangaroo mother care, nutrition, and thermal care interventions. The Government of Malawi and other partners are hosting the fourth meeting of the Kangaroo Mother Care Acceleration Partnership (KAP). Dr. Fannie Kachale, director of the Reproductive Health Department, Ministry of Health, will open the meeting. Premature infants are more likely to suffer from acute and chronic medical conditions, nutritional deficiencies, vision and hearing deficiencies, cognitive and speech delays, behavioral problems and learning disabilities, and more all hindering optimal development and progression through childhood and ultimately their productivity as adults. These are especially unfortunate outcomes because most death and disability due to prematurity is preventable. By paying more attention to the world's smallest we can achieve some of the biggest development gains.

Read more about the meeting and what you can do here: [bit.ly/2l9Z0xh](https://bit.ly/2l9Z0xh)

Thank you.

Xi Rotmil

Specialist, Website Management & Social Media | Saving Newborn Lives | Save the Children

Email: [xrotmil@savechildren.org](mailto:xrotmil@savechildren.org) | Skype: xi.chen.rotmil | Phone: +1 202-640-6600

Access the latest research, data, and thought leadership on newborn health:

[www.healthynewbornnetwork.org](http://www.healthynewbornnetwork.org)

--

Best wishes, Neil

From: "Sue Prullage, Rwanda" <[sue.prullage@gmail.com](mailto:sue.prullage@gmail.com)>

To: "CHIFA - Child Health and Rights" <[CHIFA@dgroups.org](mailto:CHIFA@dgroups.org)>

Subject: [chifa] Newborn Care (48) Levels of care (2)

"1. What constitutes a newborn unit? Should any facility performing deliveries have a newborn unit that offers standard in-patient care, or should it be restricted to hospitals only?"

Interesting question. Then we would have to define 'standard in-patient care.' Policies and guidelines would have to be developed as to who can stay or who should be transferred to a higher level of care? Staff would need to be trained in the care of the small baby and all the possibilities of problems that can develop with them.

"2. Should non-NICU inpatient care be categorised as one level or further subdivided into basic and comprehensive care? Should some non-NICU newborn units be able to provide higher dependency care that alleviates the pressure on NICUs? Or should all high dependency care be provided at NICU level only?"

Once again what is basic versus comprehensive care. In my experience the lines are blurred because of the distance of the basic unit from the higher level of care. Without a true transport system infants would die before reaching the higher level of care. So whatever can be done is done and if the child worsens often the family elect to go on palliative care. Transportation of a neonate is a whole different topic but when we advocate for there to be only higher level of care in the bigger cities this will probably worsen neonatal mortality

"3. What care could realistically be provided in a high dependency unit (CPAP? Exchange transfusion)? Are there pivotal or distinguishing services that define a unit as a specific level of care, for example CPAP defining a high-care unit?"

Maybe we should go to the higher income country literature that defines the level of care.

"4. Should care be completely regionalised with basic facilities referring to central high level facilities, or should some higher level services be distributed closer to the receiving population? For example, having high dependency units at low level hospitals in rural areas. Should efforts be made to improve transport networks or should poor referral systems be compensated for by providing higher level care at more hospitals?"

I do not think that care should be completely regionalized with basic facilities referring to central high level facilities. As stated before transport alone is often the cause of death for the infant. I think a high dependency unit at low level hospitals in rural areas would be good if the staff and doctors are specially trained in neonatal issues. The transport process could be looked at and guidelines written. The process is at the institution where I practice is to send

whatever nurse is available to get the child at the health center. He or she is not trained to anticipate complications, glucose levels are not monitored, they often do not have equipment to treat respiratory distress, IV's are not started and small vulnerable infants go without glucose for hours as they travel to the higher level unit. KMC is sometimes used and sometimes not.

There is much work that needs to be done to help neonates in LMIC.

Sue Prullage

HIFA profile: Geralyn Sue Prullage is a member of the board of the Council of International Neonatal Nurses (COINN). She has worked in Rwanda since 2008 and has helped establish a neonatal unit in a district hospitals. She has a doctorate in Nursing Practice (DNP) and is a certified neonatal/pediatric nurse practitioner. sue.prullage AT gmail.com

From: "Sue Prullage, Rwanda" <sue.prullage@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (49) How are nurses and midwives in neonatal units trained? (4)

Sarah, [Sarah Moxon, UK, Newborn Care (44)]

I agree staffing is a huge issue in neonatal units in LMIC countries. Sometimes the nurses work 3-4 nurses to 40 patients. Terrible staffing. If we do one-to-one care I advocate that if the nurse is not trained as a neonatal nurse just doing one on one is not going to help. These issues are multifocal and I am happy there are many people trying to help with the issues.

Sue Prullage

HIFA profile: Geralyn Sue Prullage is a member of the board of the Council of International Neonatal Nurses (COINN). She has worked in Rwanda since 2008 and has helped establish a neonatal unit in a district hospitals. She has a doctorate in Nursing Practice (DNP) and is a certified neonatal/pediatric nurse practitioner. sue.prullage AT gmail.com

From: "I Abdulkadir, Nigeria via Dgroups" <CHIFA@dgroups.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (50) Neonatal jaundice (3)

Dear colleagues,

In Nigeria similar situation abound, however several researchers locally have worked on neonatal jaundice in different regions and states in the country. 3 years ago a group of researchers (from Zaria, Jos, Kano, Lagos, and Asaba) worked under the name Stopping Kernicterus in Nigeria with collaborators including Slusher and Wennberg from the US. Their yet unpublished work, which won the global health innovative award 2016, showed how maternal education and early access to care remarkably reduced incidence of Kernicterus. These group of researchers developed several tools for education of mothers and different categories of health workers.

Experiences of some of these researchers also working with LED Tube phototherapy device have shown how such device remarkably reduced the rate of EBT. The Nigerian society of neonatal medicine NISOMN has been able to push, through the contribution of its members, the recognition of jaundice as an important cause of morbidity that contributes to neonatal mortality. The recently launched Nigerian every newborn action plan recognises that jaundice needs to be addressed as part of strategy to reduce neonatal morbidity and deaths.

My take will be that harnessing these works and properly situating the different components into the current health care system so that appropriate relevant interventions are implemented at appropriate levels of health care will go along way to address the issue. Key among such intervention is educating mothers and health care workers.

DR ABDULKADIR ISA Dept of Paed ABU Zaria +2348023607277 +2348186365618

CHIFA profile: I Abdulkadir is a Lecturer and consultant paediatrician/neonatologist, a member of the paediatric association of Nigeria and currently the head of department of paediatrics Ahmadu Bello University/ Teaching Hospital Zaria, Kaduna in northern Nigeria where access and affordability to healthcare remain great challenges. I have worked as consultant to organisations/ programmes including GHAIN, PATHS and CHAI. I am committed to teaching, training and research towards improving child health with particular interest in newborn health. isaburamla AT yahoo.com

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (51) Messages 1-50 in full

Dear all,

Thank you for your contributions so far. We are coming to the end of our second week (4 weeks in total) and we have already had 50 contributions from 23 contributors (below) in 10 countries (Bangladesh, Canada, Ghana, India, Kenya, Nigeria, Rwanda, South Africa, UK, USA).

Have you just recently joined CHIFA or missed some of the messages? You may be interested to download a PDF of the full text of all messages so far:

[http://www.hifa.org/sites/default/files/publications\\_pdf/CHIFA\\_Newborn\\_Care\\_discussion\\_FULL\\_%2350.pdf](http://www.hifa.org/sites/default/files/publications_pdf/CHIFA_Newborn_Care_discussion_FULL_%2350.pdf)

As an aide-memoire, here are the four broad themes we are addressing (you are welcome to respond to these or any other aspect of newborn care):

1. What is the size of the problem? How many newborns die every day, where, and what are the causes? How many more suffer major morbidity? What are the trends?
2. What do we know about quality of care (QOC) in the home, community and primary health centres? What level of care is available for small and/or sick newborns?
3. What do we know about QOC in district hospitals and referral hospitals? What level of care is available for small and/or sick newborns?
4. In what ways are health workers empowered/disempowered to provide adequate quality of care for newborns? (For example in relation to: skills, equipment, information/ data, systems support, medicines, incentives/ salaries, communication facilities)

Further info: <http://www.hifa.org/news/join-chifa-global-discussion-newborn-care-low-and-middle-income-countries>

Thanks to our 23 contributors so far:

Christabel Enweronu-Laryea, Ghana (2)  
Claire Keene, UK/Kenya  
Clare Gilbert, UK (2)  
Dayo Ajayi-Obe, UK (3)  
Deborah van Dyke, USA  
I Abdulkadir, Nigeria (2)  
Joseph Ana, Nigeria  
Judith Robb-McCord, USA  
Kishwar Azad, Bangladesh  
Kojo Ahor-Essel, Ghana  
Lily Kak, USA (3)  
Marti Perhach, USA  
Martin Becker, UK/Rwanda (2)  
Mary Kinney, South Africa  
Mike English, Kenya  
Moderator (13)  
Nkuranga John Baptist, Canada  
Ochiawunma Ibe, USA  
Ruth Davidge, South Africa (3)  
Sarah Moxon, UK  
Sue Prullage, Rwanda (7)  
Sunanda Kolli Reddy, India  
Tom Lissauer, UK

Best wishes, Neil

From: "Ruth Davidge, South Africa" <rdavidge@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (52) How are nurses and midwives in neonatal units trained? (5)

Thanks Sarah and Sue

I support your comments completely.

As a neonatal nurse working in a middle income country I have been employed by the Dept of Health to improve the standards of neonatal care Kwa-Zulu Natal province. I am responsible to support care in 52 hospitals and indirectly in 100s of clinics offering delivery services. I have been a central figure in drawing up standardized neonatal records, guidelines, standards of care, audit tools et al and in mentoring staff in implementing these systems.

My question is - if I had not received neonatal training would I have been employed and if not who would have been employed? And if no one had been employed would this process have occurred?

In our country we are being asked to justify the need for neonatal training as the belief is that a midwife or paediatric nurse has sufficient training to manage a baby. Currently the paediatric nurse training contains no neonatal content. The midwifery training includes a limited neonatal component which focuses on the well baby, resuscitation, identification of risk factors and problems and immediate management. This is inadequate for long term management of sick and small babies.

We currently have about 80 public hospitals offering neonatal intensive care and about 270 offering basic care for sick and small babies. In addition there another about 100 hospitals offering neonatal care in the private sector.

The current recommendations from the national advisory committee for morbidity and mortality in children (CoMMiC) state that there should be a staged acquisition of skills

#### NICUs

All NICUs should have trained neonatal nurse unit managers  
Once those are in place then all shift leaders should be trained  
Once these are in place then 50% of the unit staff should be trained

#### Level One nurseries:

As above but the training required would be advanced midwifery with an expanded neonatal component.

In order to meet the first step in this process we need approximately 180 neonatal nurses and 270 advanced midwives. As soon as you move to the next level in order to just provide 1 neonatal nurse or advanced midwife per shift you would need an additional 900 neonatal nurses and 1350 advanced midwives!

In 2011 SANC registered nurses included 2506 advanced midwives and 615 neonatal nurses. How many of these are in the country is unknown. There have been no new neonatal nurses trained for at least the last 10 years.

We have a system as described by Sunanda of mentorship by specialists. Each district has a team of specialists aimed at improving MNCWH health. Currently there is no requirement for a neonatal nurse on these teams.

Litigation is escalating rapidly. In my province alone over 80% of health litigation is obstetric/paediatric and the vast majority are neonatal claims. Over the last few years these cases have cost the provincial DOH R6.5 billion. I have to ask how much employing neonatal nurses would cost in comparison to the cost of litigation let alone ongoing management of neonatal morbidity and loss of life?

God bless  
Ruth Davidge

RN RM Certificate in Neonatal Intensive Care

Provincial Neonatal Coordinator-KZN  
President NNASA

Tel: 0769866880  
Email: ruth.davidge@kznhealth.gov.za  
info@nnsa.org.za

CHIFA profile: Ruth Davidge is Neonatal Coordinator at PMB Metro, Hospitals Complex Western, Kwa-Zulu Natal, South Africa. She is President of the NNASA (Neonatal Nurses Association of Southern Africa). She is a Registered Nurse and on the board of the Council of International Neonatal Nurses (COINN). [www.nnsa.org.za](http://www.nnsa.org.za), [ruth.davidge AT kznhealth.gov.za](mailto:ruth.davidge@kznhealth.gov.za)

From: "Ruth Davidge, South Africa" <rdavidge@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (53) Levels of care (3) Newborn care in rural hospitals

In South Africa we are focusing on developing care at lower levels as transport is a problem with often lengthy delays and there is inadequate capacity in central hospitals.

We are developing capacity for delivering nCPAP [\*] at rural hospitals. This is supported by monthly visits from a consultant paediatrician and bimonthly visits from the specialist team.

God bless  
Ruth Davidge

KZN Neonatal Coordinator  
Pres. NNASA

Tel: 0769866880  
Ruth.davidge@kznhealth.gov.za

CHIFA profile: Ruth Davidge is Neonatal Coordinator at PMB Metro, Hospitals Complex Western, Kwa-Zulu Natal, South Africa. She is President of the NNASA (Neonatal Nurses Association of Southern Africa). She is a Registered Nurse and on the board of the Council of International Neonatal Nurses (COINN). [www.nnsa.org.za](http://www.nnsa.org.za), [ruth.davidge AT kznhealth.gov.za](mailto:ruth.davidge@kznhealth.gov.za)

From: "Sue Prullage, Rwanda" <sue.prullage@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (54) Newborn care in rural hospitals (2)  
Referral and transport

This is a big issue in Rwanda also. In the capital there are two hospitals that have ventilators. Often they send the babies to the big referral hospital for surgery, but if they need further ventilation they are transferred to another hospital with the local ambulance service. This often leads to the neonate arriving with the ETT [endotracheal tube] dislodged and cold. So transport is one level of neonatal care that needs to be addressed.

One of the MScN neonatal health students did her dissertation on intrahospital transport and demonstrated significant finding is the infants arriving to the neo unit cold and in respiratory distress. It is a huge issue. Hopefully she can make a difference. She is currently working on a grant to provide transport simulation skills. If this proves to be effective may be it can be taught at other hospitals.

As for the hospitals far from the capitol transfer of a critically ill infant isn't often done because of the long hours of transport and keeping the baby stable during that time. They often are left to die in the district hospitals. It takes a different education to transport a critical ill infant. In these same hospitals often these critical ill infants are transported from the health center in respiratory distress, cold and hypoglycemic. Basic neonatal care stuff. This is a huge issue and affects the neonatal mortality that we so want to decrease.

Sue

HIFA profile: Sue Prullage is a Neonatal Nurse Practitioner at the Kibogora Hospital in the USA. Professional interests: Neonatal education and healthcare in low to middle income countries, Providing education to nurses/midwives that already work in neonatal units. sue.prullage AT gmail.com

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (55) Having trouble keeping up?

Dear all,

Thanks again for your valuable contributions to this discussion so far.

The CHIFA Newborn Project working group met yesterday by skype to review progress and a few people mentioned they were having trouble keeping up with the number of emails (now 54 and rising). If we're having trouble this probably means you are too!

Here are a few tips you may find useful:

1. You can set up a filter on your Inbox so that all messages with [chifa] in the subject line are directed automatically to a special CHIFA folder. That way, you can browse the messages when you want, rather than deal with them in your Inbox.

2. CHIFA now has an RSS feed on the CHIFA forum page:  
<http://www.hifa.org/forums/chifa-child-health-and-rights> or you can go direct to the RSS feed here: <http://www.hifa.org/rss-feeds/10>

3. If you missed the first 50 messages of this thread, we have compiled them here for you in full:

[http://www.hifa.org/sites/default/files/publications\\_pdf/CHIFA\\_Newborn\\_Care\\_discussion\\_FULL\\_%2350.pdf](http://www.hifa.org/sites/default/files/publications_pdf/CHIFA_Newborn_Care_discussion_FULL_%2350.pdf)

At the end of the discussion (24 November) we'll prepare a fulltext compilation plus summaries for you.

If you need any help/advise, please feel free to contact me at: [neil@hifa.org](mailto:neil@hifa.org)

All best wishes, Neil

From: "Neil Pakenham-Walsh" <[neil.pakenham-walsh@ghi-net.org](mailto:neil.pakenham-walsh@ghi-net.org)>  
To: "CHIFA - Child Health and Rights" <[CHIFA@dgroups.org](mailto:CHIFA@dgroups.org)>  
Subject: [chifa] Newborn Care (56) Eight unanswered questions about newborn deaths and morbidity (2)

Last week we raised eight questions about newborn deaths and morbidity (below). We discussed these briefly at our CHIFA Newborn care working group meeting on Friday 27 October, and in our small group we were unable to come up with any easy answers. We committed to try to find some answers 'behind the scenes' and get back to you. In the meantime, we look forward to \*your\* thoughts around any of the questions below.

1. How many babies in LMICs are delivered at home versus primary health centre versus small hospital versus referral hospital?
2. How many newborn deaths occur at each of the above levels of the health system?
3. What more do we know about newborn deaths at global and national levels? Which countries are doing better than others of comparable levels of income?
4. How many deaths might have been prevented with better antenatal care?
5. How many deaths might have been prevented with better basic newborn care?
6. How many deaths might have been prevented with better (for those who get it) comprehensive newborn care?
7. For every newborn death, there are many more babies who are born with severe disability, including hypoxic brain damage, often leading to enormous suffering for the child and family. How much of this disability could have been prevented by better basic (and/or comprehensive) care?
8. And what about the trends in newborn deaths and morbidity? We hear that newborn deaths are going down year on year, but progress is much slower than with under-5 mortality. Why?

It may well be that some of the above need to be worded differently, but in this first discussion we are trying to get a handle on the size and shape of newborn deaths and morbidity, with a view to address gaps and ways forward in later discussions. Would you have any thoughts on any of the above, or direct us to specific experts to respond?

Meanwhile, are there other questions relating to newborn deaths and morbidity that you would like to raise?

Best wishes, Neil

From: "Neil Pakenham-Walsh" <[neil.pakenham-walsh@ghi-net.org](mailto:neil.pakenham-walsh@ghi-net.org)>  
To: "CHIFA - Child Health and Rights" <[CHIFA@dgroups.org](mailto:CHIFA@dgroups.org)>  
Subject: [chifa] Newborn Care (57) Where are babies born? (4) Where do newborns die?

Dear CHIFA colleagues,

In the first week of our discussion, Dayo Ajayi-Obe (UK) raised the fundamental question: "Where are our babies being born?" She noted that in Lagos State, Nigeria, 15% of mothers deliver within the public healthcare system, 45% in the private healthcare system and 40% of mothers are delivered by traditional birth attendants. She advocated that traditional birth attendants require training in resuscitation and on how to safely transfer babies.

We look forward to comparable data from other countries.

Two closely related questions that we subsequently raised are:

1. How many babies in LMICs are delivered at home versus primary health centre versus small hospital versus referral hospital?  
and
2. How many newborn deaths occur at each of the above levels of the health system?

The answers to these questions will not be straightforward, and it would be impossible to give precise figures. But we need to develop a collective understanding about the circumstances (not just the medical causes) of newborn deaths.

Best wishes, Neil

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (58) Where do newborns die? (2) Newborn deaths in India

Dear CHIFA colleagues,

Where do newborns die? The Lancet has just published data from India that help to answer this question, at least from the perspective of urban versus rural populations.

'This study is, to our knowledge, the first to directly quantify cause-specific time trends for child deaths in India from 2000 to 2015. The variation in mortality rates by sex, urban and rural areas, and poorer and richer states also provides a crude assessment of the effect of the National Health Mission programmes. Our analyses show substantial declines in mortality rates at ages 159 months from pneumonia, diarrhoea, mmeasles, and acute bacterial sepsis or severe infection and among neonates in rates from infection, birth asphyxia or trauma, and tetanus. However, mortality rates for prematurity or low birthweight \*rose\* [my emphasis] (mostly comprising term births with low birthweight) modestly in rural areas and poorer states.'

Indeed, the actual data could arguably be better portrayed as a \*substantial\* rather than a modest rise in mortality: 'Prematurity or low birthweight mortality rates rose in rural areas (from 13.2 per 1000 livebirths in 2000 to 17.0 per 1000 livebirths in 2015) and in poorer states (from 11.3 per 1000 livebirths in 2000 to 17.8 per 1000 livebirths in 2015), but fell in urban areas and in richer states.'

A linked Comment notes: 'The large and sustained difference in mortality rates for those younger than 5 years and newborns between rural and urban areas of India should be a point of concern for other low-income and middle-income countries, especially those with large rural populations.'

PAPER: Changes in cause-specific neonatal and 159-monthth child mortality in India from 2000 to 2015: a nationally representative survey

Million Death Study Collaborators

Published: 19 September 2017

DOI: [http://dx.doi.org/10.1016/S0140-6736\(17\)32162-1](http://dx.doi.org/10.1016/S0140-6736(17)32162-1)

The Lancet, Volume 390, No. 10106, p1972-1980, 28 October 2017

[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(17\)32162-1/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)32162-1/fulltext)

COMMENT: Child mortality: the challenge for India and the world

Shams El Arifeen et al.

Published: 19 September 2017

DOI: [http://dx.doi.org/10.1016/S0140-6736\(17\)32469-8](http://dx.doi.org/10.1016/S0140-6736(17)32469-8)

The Lancet, Volume 390, No. 10106, p1932-1933, 28 October 2017

[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(17\)32469-8/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)32469-8/fulltext)

Best wishes, Neil

From: "Ruth Davidge, South Africa" <rdavidge@gmail.com>

To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>

Subject: [chifa] Newborn Care (59) Referral and transport (2)

I agree transporting is a major issue

The things that should be considered:

1. Increasing the use of skin to skin during transport
2. Teaching the S.T.A.B.L.E course developed by a neonatal nurse - Chris Carlson - aimed at stabilising babies prior to transfer
3. The use of retrieval teams based at central hospitals that can go and stabilise and return with the baby.

God bless

Ruth Davidge

KZN Neonatal Coordinator

Pres. NNASA

Tel: 0769866880

[Ruth.davidge@kznhealth.gov.za](mailto:Ruth.davidge@kznhealth.gov.za)

CHIFA profile: Ruth Davidge is Neonatal Coordinator at PMB Metro, Hospitals Complex Western, Kwa-Zulu Natal, South Africa. She is President of the NNASA (Neonatal Nurses Association of Southern Africa). She is a Registered Nurse and on the board of the Council of International Neonatal Nurses (COINN). [www.nnasa.org.za](http://www.nnasa.org.za), [www.nnasa.org.za](http://www.nnasa.org.za) ruth.davidge AT kznhealth.gov.za

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (60) Where do newborns die? (3) Most newborns die at home

As we continue to build a collective understanding of the size of the problem of newborn mortality and morbidity, I was interested to see this fact sheet on the WHO website. In particular, I note a key point that partly answers our question Where do newborns die, namely: \*Most of these newborns die at home\*.

--

Newborns: reducing mortality  
Fact sheet, October 2017

#### Key facts

- In 2016, 46% of all under 5 child deaths were among newborn infants, babies in their first 28 days of life (the neonatal period) — up from 40 % in 1990.
- Globally 2.6 million children died in the first month of life — approximately 7 000 newborn deaths every day with about 1 million dying on the first day and close to 1 million dying within the next 6 days.
- Children who die within the first 28 days of birth suffer from conditions and diseases associated with lack of quality care at birth or skilled care and treatment immediately after birth.
- The main killers of children under 5 in 2016 included preterm birth complications, pneumonia, intrapartum related events, diarrhoea, neonatal sepsis and malaria.
- The vast majority of newborn deaths take place in developing countries where access to health care is low. Most of these newborns die at home, without skilled care that could greatly increase their chances for survival.

--

Best wishes, Neil

From: "Sue Prullage, Rwanda" <sue.prullage@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (61) Where do newborns die? (4) Most newborns die at home (2)

- Children who die within the first 28 days of birth suffer from conditions and diseases associated with lack of quality care at birth or skilled care and treatment immediately after birth.

I think this statement is 2 fold. Lack of quality care at birth or skilled care and treatment immediately after birth. I think HBB [\*1], ECEB [\*2] speak to this and perhaps there should be a consensus worldwide to utilize it. There are many people at the table working, but each has their own brand of help. Could we all work together and decide one method of teaching?

LMIC will follow the teaching of the person who invests into them even if their teaching isn't evidence based. Could the interested stakeholders come together and create a program that everyone would agree on?

- The main killers of children under 5 in 2016 included preterm birth complications, pneumonia, intrapartum related events, diarrhoea, neonatal sepsis and malaria.

The above birth complications are diagnosed and treated at the district hospitals. Shouldn't quality care of the providers here be ensured for accurate diagnosis and treatment? Neonatal education needs to be added to medical, nursing and midwifery schools. The midwife program generally has 2 courses both designed for identification and preparation of a neonate for transfer. We are not going to help these babies if the staff receiving the neonate have not been trained in neonatal care.

- The vast majority of newborn deaths take place in developing countries where access to health care is low. Most of these newborns die at home, without skilled care that could greatly increase their chances for survival.

This is one of the most interesting statements. In my experience and I wonder if others in LMIC countries have the same experience the families do not want their babies to go to the neonatal units. Is it the cost? Is it the disruption of the family dynamics? Or is it a feeling of hopelessness that the baby will die anyway even after spending time at the neonatal unit. When neonatal care was first offered at the hospital where I volunteer the families would consider it a death sentence to be admitted there. They had no dedicated staff, no functioning equipment and the doctors and nurse that were placed in there to work were unexperienced in neonatology. Is it improved? Slightly we have a dedicated staff and equipment. But now we struggle with the staff to patient ratio; orientation of new nurses and the feeling from administration that three nurses for 40 to 60 babies is adequate going down to one nurse at night. If the staff complains they sometimes will pull another nurse from another unit to help do vital signs but they do not know normal vital signs for a neonate.

I am advocating a strong statement for having trained skilled attendants at delivery. Clear set guidelines of when a baby is to be transferred and how they are to be transferred. And a global set of neonatal competencies for nurses and doctors who work in neonatology. An ideal orientation program for nurses that could be accessed centrally and each country could take it and develop it in their context. A central group of experts in the field available for consultation.

Sue Prullage DNP, RN, NNP/PNP-BC

CHIFA profile: Geralyn Sue Prullage is a member of the board of the Council of International Neonatal Nurses (COINN). She has worked in Rwanda since 2008 and has helped establish a neonatal unit in a district hospitals. She has a doctorate in Nursing Practice (DNP) and is a certified neonatal/pediatric nurse practitioner. [sue.prullage@gmail.com](mailto:sue.prullage@gmail.com)

[\*Note from HIFA moderator (Neil PW):

HBB = Helping Babies Breathe <https://www.healthynewbornnetwork.org/partner/helping-babies-breathe/>

ECEB = Essential Care for Every Baby <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/helping-babies-survive/Pages/Essential-Care-Every-Baby.aspx> \_\_\_\_

From: "Alexander Manu, UK via Dgroups" <CHIFA@dgroups.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (62) Where do newborns die? (5) Most newborns die at home (3)

Dear Neil,

Thanks for the reference and reiterating this. I have seen this same statement for the past decade or more following important contributions from Prof Lawn et al in the Lancet Series. Initially, this was ascribed to lack of access. I think going forward, we are beginning to understand that access is not just geographical or even financial. Published and empirical evidence suggests that families still prefer to deliver at home when a facility shares boundary with them. What I am not sure about is whether healthcare providers know and understand what families want. I think this brings us back to the issues of Quality, Equity and Dignity.

Why would a woman who carried a pregnancy alone for 9 months and has a huge belly be subjected to the affront of not having shaved the perineum just because she chose to deliver in a health facility? Women feel depressed already about not having a helper to take them to the facility and will not want to have a "skilled provider" in the health facility insult her for not having a partner. When women bring their newborns to facilities with presumed illness, how are they received? Do health workers sometimes consider the costs to the woman to come all the way to the facility with a problem that they (the health workers) consider insignificant.

Nonetheless, given the quality of care in these facilities with "skilled attendants", mothers are still not provided all the information they need, or their babies die anyway!

In many instances, these deaths that occurred "at home" were after the families had contacts with health facilities. Their deaths were merely postponed till they occurred at home. I dare say that, even if the "most" in this cliché represents 60% or 70%, a good 30%-40% of newborns are also dying in facilities under the care of "skilled providers".

I believe that if we want to reduce deaths of newborns at home, we must be prepared to improve quality of care at health facilities to save babies dying from preventable causes in these facilities and staff attitudes should change towards a focus on providing quality, quality and quality. Quality that makes health facilities attractive to pregnant women and their families. Quality that makes facility delivery not only life-saving but aspirational to mothers and their families. Quality that seeks to support the woman presenting under unfortunate circumstances rather than chastising them. When health systems can deliver these, "Most newborns will not die" needlessly let alone talk about the place.

Of course, another important component in the access equation is referral pathways. Families must have links to facilities through effective referrals. These referrals, however, will be effective if and only if the destination facility can provide appropriate care of adequate quality to save newborn lives. Investment in transport and the economic losses in being in the facility and leaving the entire family unattended coupled with unapproved expenditure women must make for these facility attendances must be worth it. Unless health systems address some of these issues, it will prove worthwhile for a woman to deliver at home or sit at home and try home remedies whilst their children die.

My contributions will end with adding that we still need to find mechanisms to reach mothers at home whose babies die because they are not allowed to take them to health facilities or they do not know when newborns fall ill. Women's groups, community health workers, community mobilisation and other mechanisms that are sustainable are warranted.

Dr Alexander A Manu (Ghana)  
PhD DLSHTM MSc MD BSc  
Senior Clinical Research Associate (Newborth Health Epidemiology)  
Liverpool School of Tropical Medicine  
Website: [www.cmnh.lstmed.ac.uk](http://www.cmnh.lstmed.ac.uk)

"As long as there's breath, there's hope"

CHIFA profile: Alexander Manu is a Clinical research fellow (Medical doctor) and PhD student at the Ghana Health Service & London School of Hygiene and Tropical Medicine. Professional interests include: 1. Reproductive and child health issues; 2. Public health interventions and research especially pro-poor and pro-deprived/marginalised people interventions; 3. Equity and equality issues in health service and systems; 4. Health systems improvement; 5. Infectious and tropical disease epidemiology. makmanu128 AT yahoo.co.uk

From: "John Osborne, UK" <osbornes.chiswick@virgin.net>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (63) Teamwork: midwifery, obstetric, and newborn care

Dear colleagues, as a retired obstetrician gynaecologist I have read with interest the correspondence on neonatal care.

I worked in Africa in my youth and have travelled excessively in the African continent.

My experience in Africa and as a teaching hospital consultant in London one thing has always been very clear to me and that is that teamwork is vital.

One cannot expect good outcomes if the paediatricians receive babies damaged by intrapartum care. We must strive to improve the obstetric care at the same time as providing the neonatal facilities.

Following a recent visit to Rwanda I have been trying to help to forge links between the RCOG and the Ministry of health in Rwanda. I personally feel that a great deal to be achieved by providing experienced mentors to assist with the training of the local obstetric trainees and midwives on site.

John Osborne FRCOG.

HIFA profile: John Osborne is a Consultant Obstetrician/Gynaecologist based in London. He is currently working with the charity TASK Womens Health, which aims to use information

technologies such as mobile phones to support middle-level reproductive health workers in Africa. osbornes.chiswick AT virgin.net

From: "Dave Woods, South Africa" <pepcourse@mweb.co.za>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (64) Enabling local staff to manage their own continuing education

In reply to the message from John Osborne. Where it is not affordable nor practical to send experienced mentors to assist with training in under resourced countries, much can still be achieved by enabling the local staff to manage their own continuing education provided appropriate learning material is made available. In South Africa we have successfully provided this opportunity to over 100 000 midwives and doctors in the past 25 years. The material can be bought or read on-line from [www.bettercare.co.za](http://www.bettercare.co.za) We have one course book which specifically addresses the management of the mother and fetus during labour. One of the recent additions is a booklet on the use of a Philips wind-up Doppler fetal heart rate monitor for facilities with an unreliable electricity supply.

Best wishes, Dave Woods

HIFA profile: Dave Woods is Emeritus Professor in Neonatal Medicine at the School of Child and Adolescent Health, University of Cape Town, South Africa. He is Chairman of the Perinatal Education Trust and Eduhealthcare, both not-for-profit non-government organisations that develop appropriate self-help distance learning material for doctors and nurses who care for pregnant women and their children in under-resourced communities. He has 30 years experience as a clinical neonatologist, with particular interests in perinatal care and training of health professionals. He is currently developing paper-based continuing learning material in maternal care, newborn care, child health, and care of adults and children with HIV/AIDS. He is also participating in the design and development of wind-up appropriate health technology for poor countries. [www.pepcourse.co.za](http://www.pepcourse.co.za) pepcourse AT mweb.co.za

From: "Joseph Ana, Nigeria via Dgroups" <CHIFA@dgroups.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (65) Most newborns die at home (4)

Alexander Manu hit many nails on the head in his posting. We cant agree more.

We recall receiving information about a 'quack' clinic in a remote village and leading the inspections team to close the site. We arrived the village and truly saw a shack called a 'specialist medical centre and maternity home'!. After handing the attending quacks on duty to the policemen in our team, we closed the clinic doors and boarded our cars to leave. On the road we were met by the Villagers led by the Chiefs who pleaded that 'they know that the clinic we had just closed is not okay but it is better than the public health centre because in the clinic the people are always there 24/7, whereas the health centre closes by latest 3pm even though they open by 10am. The health centre staff are always rude to them and ask them to go and buy their prescription drugs outside. The staff also demand extra payment even after they pay the government fees.'

In such situations even if government provides the best physical access like roads the women would rather deliver at home. This was the point that a traditional birth attendant (TBA) made in another occasion when asked why she thought women preferred to go to them (TBAs).

There is no substitute to fully embed patient centred practice by skilled health workers in health facilities if most women shall be attracted to attend there. This is the central point that we stress when we introduce Clinical Governance to facilities, public or private.

Joseph Ana.

Africa Center for Clin Gov Research & Patient Safety

@ HRI West Africa Group - HRI WA  
Consultants in Clinical Governance Implementation  
Publisher: Health and Medical Journals  
8 Amaku Street Housing Estate, Calabar  
Cross River State, Nigeria

Phone No. +234 (0) 8063600642  
Visit Website: [www.hriwestafrica.com](http://www.hriwestafrica.com)  
E-mail: [hriwestafrica@gmail.com](mailto:hriwestafrica@gmail.com)

HIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007. Website:

[www.hriwestafrica.com](http://www.hriwestafrica.com) Joseph is a member of the HIFA Steering Group:

<http://www.hifa.org/people/steering-group>

<http://www.hifa.org/support/members/joseph-0>

jneana AT yahoo.co.uk

From: "Cliff O'Callahan, USA" <[cliff.o'callahan@midhosp.org](mailto:cliff.o'callahan@midhosp.org)>

To: "CHIFA - Child Health and Rights" <[CHIFA@dgroups.org](mailto:CHIFA@dgroups.org)>

Subject: [chifa] Newborn Care (66) Group B streptococcal infection (2)

It's wonderful to see all the work that's been done to decrease the morbidity and mortality from perinatal GBS.

I was struck by how different the epidemiology of neonatal sepsis is in East Africa where GBS is practically never seen. Something to be aware of because teaching medical staff there, and making policy around screening etc, needs to be reflective of the local epidemiology.

cliff

Cliff O'Callahan, MD, PhD, FAAP

Pediatric Faculty and Director of Nurseries, Middlesex Hospital

Associate Professor Pediatrics, UCONN; Assistant Professor Family Medicine Quinnipiac U

90 South Main Street, Middletown, CT 06457.

Office: 860-358-6300; Desk: 860-358-6407; Fax: 860-358-8320

[www.middlesexhospital.org](http://www.middlesexhospital.org)

Member American Board Pediatrics Global Health Task Force; Physician Adviser Opportunity Knocks; Past Chair, AAP Section on International Child Health & Multidisciplinary Action Group, AAP Section Forum Management Committee

CHIFA profile: Cliff O'Callahan is past Chair of the American Association of Pediatrics (AAP) Section on International Child Health. He is a Paediatrician in the Faculty for the Middlesex Hospital Family Practice Program, and Director of Nurseries, Middlesex Hospital in the USA. He developed a rural health promoter system in the northern jungle areas of Guatemala in the early 90s and returns there annually. The AAP Section on International Child Health is committed to improving the health and well-being of the world's children. This will be accomplished by addressing the needs of children and those who are dedicated to improve their health and well-being through education, advocacy, research, service, and the facilitation of effective global partnerships. [www.aap.org](http://www.aap.org) [www.aap.org/section/ich](http://www.aap.org/section/ich) cmocallahan AT aap.net

From: "John Osborne, UK" <osbornes.chiswick@virgin.net>

To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>

Subject: [chifa] Newborn Care (67) Enabling local staff to manage their own continuing education (2)

Dear Dave and colleagues, I certainly was not implying that it was not best for postgraduate education to be managed locally. I still have on my shelf some of the excellent publications that you have produced and gave me when we met in Cape Town some years ago.

This approach certainly works well in South Africa, but you have the advantage of the relatively large number of highly trained and qualified staff able to pass on their knowledge and experience.

I would suggest that for this approach to work requires a critical mass of trained teachers. Where this is not the case then I would contend that outside help can be utilised to more rapidly improve training and obstetric outcomes.

Best wishes

John Osborne

CHIFA profile: John Osborne is a Consultant Obstetrician/Gynaecologist based in London.

He is currently working with the charity TASK Womens Health, which aims to use information technologies such as mobile phones to support middle-level reproductive health workers in Africa. osbornes.chiswick AT virgin.net

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (68) Prevalence of cerebral palsy in Uganda

Dear CHIFA colleagues,

This new paper in The Lancet Global Health indicates a high prevalence of cerebral palsy in Uganda. It's not clear what proportion of cases might have been prevented with better intrapartum and newborn care. However, the authors note (paradoxically) that improvements in newborn care in LMICs, especially for preterm infants, 'will probably increase the number of preterm children with cerebral palsy; this pattern occurred in North India during 200009'.

CITATION: Prevalence of cerebral palsy in Uganda: a population-based study  
Angelina Kakooza-Mwesige, Carin Andrews, Prof Stefan Peterson, Prof Fred Wabwire Mangen, Prof Ann Christin Eliasson, Prof Hans Forssberg.

Published: 25 October 2017

Open Access

Lancet Global Health 2017

DOI: [http://dx.doi.org/10.1016/S2214-109X\(17\)30374-1](http://dx.doi.org/10.1016/S2214-109X(17)30374-1)

#### SUMMARY

**Background:** Few population-based studies of cerebral palsy have been done in low-income and middle-income countries. We aimed to examine cerebral palsy prevalence and subtypes, functional impairments, and presumed time of injury in children in Uganda.

**Methods:** In this population-based study, we used a nested, three-stage, cross-sectional method (Iganga-Mayuge Health and Demographic Surveillance System [HDSS]) to screen for cerebral palsy in children aged 2-17 years in a rural eastern Uganda district. A specialist team confirmed the diagnosis and determined the subtype, motor function (according to the Gross Motor Function Classification System [GMFCS]), and possible time of brain injury for each child. Triangulation and interviews with key village informants were used to identify additional cases of suspected cerebral palsy. We estimated crude and adjusted cerebral palsy prevalence. We did 2 analyses to examine differences between the group screened at stage 1 and the entire population and regression analyses to investigate associations between the number of cases and age, GMFCS level, subtype, and time of injury.

**Findings:** We used data from the March 1, 2015, to June 30, 2015, surveillance round of the Iganga-Mayuge HDSS. 317756 children were screened for cerebral palsy, which was confirmed in 86 (19%) of 442 children who screened positive in the first screening stage. The crude cerebral palsy prevalence was 2.7 (95% CI 2.3-3) per 1000 children, and prevalence increased to 2.9 (2.43-6) per 1000 children after adjustment for attrition. The prevalence was lower in older (8-17 years) than in younger (<8 years) children. Triangulation added 11 children to the cohort. Spastic unilateral cerebral palsy was the most common subtype (45 [46%] of 97 children) followed by bilateral cerebral palsy (39 [40%] of 97 children). 14 (27%) of 51 children aged 2-7 years had severe cerebral palsy (GMFCS

levels 45) compared with only five (12%) of 42 children aged 8-17 years. Few children (two [2%] of 97) diagnosed with cerebral palsy were born preterm. Post-neonatal events were the probable cause of cerebral palsy in 24 (25%) of 97 children.

Interpretation: Cerebral palsy prevalence was higher in rural Uganda than in high-income countries (HICs), where prevalence is about 1.8-3 cases per 1000 children. Children younger than 8 years were more likely to have severe cerebral palsy than older children. Fewer older children than younger children with cerebral palsy suggested a high mortality in severely affected children. The small number of preterm-born children probably resulted from low preterm survival. About five times more children with post-neonatal cerebral palsy in Uganda than in HICs suggested that cerebral malaria and seizures were prevalent risk factors in this population.

--

Best wishes, Neil

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (69) Thank you for sharing your experience and expertise!

Dear CHIFA colleagues,

Thank you to everyone for your contributions to our discussion on Newborn Care (full list of contributors below). We are now coming towards the end of our third week and we have had 68 contributions from 27 contributors in 10 countries (Bangladesh, Canada, Ghana, India, Kenya, Nigeria, Rwanda, South Africa, UK, USA). Special thanks to super-contributors Sue Prullage, Rwanda (9 messages) and Ruth Davidge, South Africa (6 messages).

Alexander Manu, UK  
Christabel Enweronu-Laryea, Ghana (2)  
Claire Keene, UK/Kenya  
Clare Gilbert, UK (2)  
Cliff O'Callahan, USA  
Dave Woods, South Africa  
Dayo Ajayi-Obe, UK (3)  
Deborah van Dyke, USA  
I Abdulkadir, Nigeria (2)  
John Osborne, UK (2)  
Joseph Ana, Nigeria (2)  
Judith Robb-McCord, USA  
Kishwar Azad, Bangladesh  
Kojo Ahor- Essel, Ghana  
Lily Kak, USA (3)  
Marti Perhach, USA  
Martin Becker, UK/Rwanda (2)  
Mary Kinney, South Africa  
Mike English, Kenya  
Moderator, NPW (20)  
Nkuranga John Baptist, Canada

Ochiawunma Ibe, USA  
Ruth Davidge, South Africa (6)  
Sarah Moxon, UK  
Sue Prullage, Rwanda (9)  
Sunanda Kolli Reddy, India  
Tom Lissauer, UK

For background on the discussion and themes/questions, see:  
<http://www.hifa.org/news/join-chifa-global-discussion-newborn-care-low-and-middle-income-countries>

Please continue to share your experience and expertise by sending an email to:  
chifa@dgroups.org

With thanks and best wishes, Neil

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (70) Q2 What do we know about quality of care in the home and community?

Dear CHIFA colleagues,

For the coming week I would like to suggest we address this vital question:

\*\*\*What do we know about quality of care (QOC) in the home, community and primary health centres? What level of care is available for small and/or sick newborns?\*\*\*

Do you have knowledge, experience or expertise in the above? If so, we'd love to hear from you - perhaps you have direct frontline experience at this level of care, or perhaps you have seen the consequences of poor quality of care.

Also, can you recommend any research or observation studies that look at quality of care issues at these levels?

If so, please do send a message to: chifa@dgroups.org so that we can all learn from it.

Thank you as ever for your contributions. Please send your messages to: chifa@dgroups.org

In future weeks we'll be focusing on quality of care in district and referral hospitals.

Best wishes, Neil

From: "Mary Kinney, USA" <mkinney@savechildren.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (71) World Prematurity Day, 17 November 2017

Dear colleagues,

Every year, 15 million babies are born prematurely more than one in ten of all babies around the world. World Prematurity Day [<https://www.healthynewbornnetwork.org/event/world-prematurity-day-2017/>] is a key moment to focus global attention on the leading cause of child deaths under age 5 complications from preterm birth which account for nearly 1 million deaths each year. Without a major push to reduce these deaths, we will not reach the Global Goal, endorsed by 193 countries, to end all preventable newborn and child deaths by 2030.

World Prematurity Day supports the values and goals of the Every Newborn Action Plan an initiative off the Every Woman Every Child movement which mobilizes global multi-sectoral support to save the lives and improve the wellbeing of mothers and their babies. The goal of the campaign is to increase awareness, reach and engagement around the world about the issues of premature birth, newborn health and survival. This can be accomplished through your participation in a variety of ways, such as organizing an activity or event, and sharing the messages provided in this toolkit in your social media channels.

To assist your planning, global partners have developed the 2017 World Prematurity Day toolkit available at [www.healthynewbornnetwork.org/resource/2017-world-prematurity-day-toolkit/](http://www.healthynewbornnetwork.org/resource/2017-world-prematurity-day-toolkit/)

The toolkit includes:

- An advocacy toolkit with messages and ideas for action
- A social media toolkit
- Global and country-level preterm birth estimates
- Additional resources

Visit [www.facebook.com/worldprematurityday](http://www.facebook.com/worldprematurityday) to share your World Prematurity Day experience and plans, download social media resources, and share social media links among your networks.

2017 Motto and Sub-themes

We invite you to use the World Prematurity Day 2017 motto: "Let them thrive!" You may select a sub-theme based on the needs of your event or campaign. Suggested sub-themes include:

- Quality care for the smallest
- Improving care for the smallest
- Respectful care for the smallest

Things You Can Do to Support World Prematurity Day

- Add your voice and sign-up to automatically post a message of support and awareness of prematurity through your social media community on World Prematurity Day. - Go to: <http://po.st/WPD17>
- Change your profile picture by adding a World Prematurity Day profile picture on Facebook and Twitter, helping to raise awareness without saying a word. Go to: <http://po.st/WPDtwb>
- Post in social media leading up to and on World Prematurity Day using #worldprematurityday.
- Go purple! by wearing purple, lighting your home or office purple, light a purple candle in your window or coming up with your own ways to turn the world purple in support of prematurity awareness. Share on social media with #worldprematurityday.

- Hang up a sock-line with 9 white baby socks and one smaller purple baby sock as a symbol to raise awareness for prematurity.
- Take the Kangaroo Mother Care Challenge and post photos on social media using #KMCchallenge for details check out [www.healthynewbornnetwork.org/resource/kangaroo-mother-care-challenge-brief/](http://www.healthynewbornnetwork.org/resource/kangaroo-mother-care-challenge-brief/)
- Add your event to the EFCNI Changemaker Map, an interactive map to show what has been achieved globally in order to change the situation for preterm infants and their families. <http://www.efcni.org/index.php?id=2116>
- Access materials for promotion including fact sheets, country data, and social media images. Go to the WPD Facebook page and WPD toolkit page. <https://www.healthynewbornnetwork.org/resource/2017-world-prematurity-day-toolkit/>
- Share your activity! Don't forget to tell us about your activities by completing the SurveyMonkey form [https://www.surveymonkey.de/r/World\\_Prematurity\\_Day\\_2017](https://www.surveymonkey.de/r/World_Prematurity_Day_2017)

Mary Kinney | Save the Children | Senior Specialist, Global Evidence and Advocacy, Saving Newborn Lives

[www.savethechildren.org](http://www.savethechildren.org)

Cell: +27 83 444 8211

[mkinney@savechildren.org](mailto:mkinney@savechildren.org)

Skype: maryvkinney | Twitter: @maryvkinney

Access the latest research, data, and thought leadership on newborn health:

[www.healthynewbornnetwork.org](http://www.healthynewbornnetwork.org)

HIFA profile: Mary Kinney is a Senior Specialist for Global Evidence and Advocacy with Save the Children US's program Saving Newborn Lives providing technical analysis and writing support specifically in the area of maternal, newborn and child health. She is passionate about using evidence in global and national advocacy efforts and enjoys working with large global teams to translate evidence into policy action. Some of her recent global activities include the Quality, Equity, Dignity for services global advocacy group of Every Woman Every Child, The Lancet Ending preventable stillbirth series, The Lancet Every newborn series, and Born Too Soon: The Global Action Report for Preterm Births. She is based in South Africa and holds a Master's degree in international relations from the University of Cape Town. MKinney AT savechildren.org

From: "David Southall, UK" <[director@mcai.org.uk](mailto:director@mcai.org.uk)>

To: "CHIFA - Child Health and Rights" <[CHIFA@dgroups.org](mailto:CHIFA@dgroups.org)>

Subject: [chifa] Newborn Care (72) Integration of obstetric and neonatal care

Dear CHIFA

Following an email discussion with Neil and Sarah, please can you consider re-publishing the email below that we sent to HIFA and CHIFA before the neonatal forum/ discussion became established.

We are happy also to provide our protocols on both attempts to prevent birth asphyxia and neonatal sepsis arising from obstetric problems to any members who might find them valuable.

With many thanks for your help.

David

Professor David Southall MBBS, MD, FRCPCH, OBE Honorary Medical Director MCAI, 1 Columba Court, Laide IV22 2NL, UK Mobile 0044 (0) 7710 674003 [www.mcai.org.uk](http://www.mcai.org.uk), <http://books.mcai.org.uk>, <http://ihpi.org> Registered as a SCIO (Scottish Charitable Incorporated Organisation) No. SC043467 Member of the Partnership for Maternal, Newborn and Child Health <http://www.who.int/pmnch/en/>

Director, MCAI Liberia, House 13, Phebe Hospital, Liberia Enterprise Number 051730402  
<http://www.mcai.org.uk/liberia>

From David Southall, UK [director@mcai.org.uk](mailto:director@mcai.org.uk)

Date 28/09/2017 13:44 (GMT+00:00)

To HIFA - Healthcare Information For All <[HIFA@dgroups.org](mailto:HIFA@dgroups.org)>

Subject [hifa] Integration of obstetric and neonatal care

Dear HIFA colleagues,

The proposed work outlined by Professor Lawn [\*see note below] to identify and then manage life-saving approaches to neonatal care is extremely important and hopefully will follow a similar and effective pathway as that achieved for "signal functions" in emergency obstetric care.

Following our task-sharing advanced obstetric and advanced neonatal hospital work in Liberia ([www.mcai.org.uk/liberia](http://www.mcai.org.uk/liberia)) it is clear in this low income country, where there are so few doctors, that integration of obstetric and neonatal care will have the best outcome for newborn infants.

Two main examples of the most dangerous neonatal conditions that we come across on a daily basis, support the importance of the integration of high quality obstetrics in the prevention and amelioration of neonatal conditions.

Firstly, we are all aware of the importance of the early diagnosis and effective treatment of neonatal sepsis. However, we are being constantly faced with neonates with extreme sepsis immediately after birth, which is often so far advanced that high quality Intravenous antibiotics accompanied by high dependency care are ineffective. Most of these cases of neonatal sepsis arise because of either pre-labour pre-term rupture of membranes (PPROM) or prolonged rupture of membranes (PROM) at term that are not recognised or acted upon early enough by the mother or community clinics as requiring urgent maternal antibiotics and admission to hospital and when appropriate, urgent delivery. In addition, knowing that PPRM or PROM has been present by those caring for the newborn baby must result in urgent antibiotic treatment given to the baby immediately at birth, rather than waiting for symptoms or signs of sepsis. A major understanding of obstetrics by those caring for newborn infants, as well as close communication between obstetricians, midwives and neonatal care practitioners, are vital.

Secondly we are also aware of how difficult it is, especially in low income countries where resources to treat neonates are so seriously limited, to undo the effects of hypoxia ischaemic injury to the fetal brain. Improvements in monitoring the fetus during labour and delivery require highly technical and expensive monitoring systems that cannot either be afforded or adequately used given gross limitations on the availability of suitably trained midwives and doctors in low income countries. Shortage of midwives often means that partograph measurements are also not done regularly. Low cost approaches of trying to identify fetal distress as early as possible in labour that take account of

the serious shortage of midwives on the ground are clearly needed and, if effective, would make a major impact on neonatal birth asphyxia as such a major cause of death or permanent brain damage. In Liberia, we are currently piloting such an approach by testing the feasibility of equipping mothers with a way of monitoring their own babies during labour with a simple inexpensive Doppler ultrasound probe. In addition to the standard measurements made as part of the partograph by midwives (frequently not undertaken regularly due to staff shortages), and after suitable training, mothers are asked to monitor their own unborn babies for one minute immediately after the end of each uterine contraction looking for fetal bradycardia. They then call a midwife if they suspect that the fetal heart rate is low and the midwife then intervenes to expedite delivery. In addition to identifying possible fetal distress, we have found that this approach is helping mothers to feel involved with and contributing to the care of their baby before birth.

These examples emphasise the critical importance of integrating obstetric and neonatal care for the best outcomes for both mothers and neonates. We would therefore suggest that the proposed project by the Every Newborn Metrics Group includes signal functions that are traditionally classed as "obstetric" interventions.

Finally, we have to question the appropriateness of grouping together low and middle income countries with respect to life saving ways of preventing neonatal mortality and morbidity. From our experience on the ground, the differences in origins and mechanisms of death between the two groups are so great that different systems may be needed to create maximum impact.

We would be happy to discuss further as appropriate.

Professor David Southall OBE, MD, FRCPCH Honorary Medical Director and Dr Rhona MacDonald MBChB MPH MRCPG DCH DRCOG, Chair of Trustees and Honorary Executive & Finance Director.

Maternal and Childhealth Advocacy International, MCAI, 1 Columba Court, Laide IV22 2NL, Scotland, UK. Registered as a SCIO (Scottish Charitable Incorporated Organisation) No. SC043467 Directors, MCAI Liberia, House 13, Phebe Hospital, Liberia Enterprise Number 051730402 <http://www.mcai.org.uk/liberia>

Professor David Southall MBBS, MD, FRCPCH, OBE Honorary Medical Director MCAI, 1 Columba Court, Laide IV22 2NL, UK Mobile 0044 (0) 7710 674003 [www.mcai.org.uk](http://www.mcai.org.uk), <http://books.mcai.org.uk>, <http://ihpi.org> Registered as a SCIO (Scottish Charitable Incorporated Organisation) No. SC043467 Member of the Partnership for Maternal, Newborn and Child Health <http://www.who.int/pmnch/en/> Director, MCAI Liberia, House 13, Phebe Hospital, Liberia Enterprise Number 051730402 <http://www.mcai.org.uk/liberia>

HIFA profile: David Southall is a retired Professor of Paediatrics and Honorary Medical Director of the Maternal and Child Health Advocacy International (MCAI). [www.mcai.org.uk](http://www.mcai.org.uk) David founded MCAI in 1995 and currently is directing a task-sharing programme in Liberia aimed at the training of midwives in advanced obstetrics (including abdominal surgery) and the training of nurses and midwives in advanced neonatal care. David's main interests include: medical education, approaches to healthcare based on human rights, sustained improvements in the emergency hospital care of pregnant women and adolescent girls, babies and children in disadvantaged countries, preventing the life-threatening abuse of children, and advocacy against armed conflict and the arms trade and its effects on mothers and children. director AT [mcai.org.uk](http://mcai.org.uk)

HIFA profile: Rhona MacDonald is currently the Honorary Executive Director of the international medical organisation MCAI (Maternal Childhealth Advocacy International), which works with national governments to strengthen emergency health systems particularly for pregnant women, newborn infants, and children in sub Saharan Africa and Asia. Rhona has worked as a senior editor for The Lancet and the BMJ, and is currently a freelance editor at PLoS Medicine and the WHO Bulletin. She also works on large projects for WHO, such as Prioritising Medical Devices and access to essential medicines for children, and is the editor of the popular WHO pocketbook for emergency paediatric care in low resource countries. Rhona has previously worked with MSF and Oxfam and since graduating in medicine from Aberdeen University, Scotland, UK, in 1992, has worked in several low and middle income countries, particularly Bangladesh and Romania. She is also co-founder of the International Health Protection Initiative, an Honorary Research Fellow at the University of Edinburgh, and Chair of the Board of Trustees of the medical student charity, Medsin. rhonamacdonald AT gmail.com

[\*Note from HIFA moderator (Neil PW): This refers to a message from Joy Lawn today on our sister forum, CHIFA (Child Health and Rights). In it, she invites all to complete an online survey to contribute opinions to help define the most important signal functions and levels of care for small and sick newborns. <https://www.surveymonkey.com/r/D9HZVT5> CHIFA is planning a thematic discussion on this subject from 18 October 2017. You can join CHIFA here: [www.hifa.org/joinchifa](http://www.hifa.org/joinchifa) ]

From: "Matthew Ellis, UK" <m.ellis@bristol.ac.uk>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (73) How many newborns suffer major morbidity?  
(1) Neonatal encephalopathy

Dear Colleagues

I have been following this D-group discussion with interest.

re Neil's initial list of questions I have spent part of my career trying to answer the question 'How many more (newborns) suffer major morbidity?'

I recall a WHO position statement when I set out on this journey which suggested it was a number equal to those that died. This is definitively not the case!

In the course of a PhD studying the prevalence of stillbirth, neonatal encephalopathy and its outcome I learnt that in a low intervention setting (a large South Asian maternity hospital) far more infants died due to perinatal adversity than survived severe or even moderate neonatal encephalopathy.

When all such studies were systematically reviewed and modelled more recently see Pediatric Research DOI:10.1038/pr.2013.206 the 'global' conclusions were as follows...

Neonatal encephalopathy (NE) may be due to various causes. Given 50 million home births, almost all without skilled care and the limitations around recognition and prompt intervention for fetal compromise, even when it occurs in a LMIC health facility, the major contributing factor is intrapartum hypoxic injury.

The first estimates of NE related to intrapartum events and subsequent outcomes are as follows....

- Our modeled NE incidence suggests 1.15 million babies were affected in 2010, down from 1.60 million in 1990 (0.9% annual reduction).
- Of these babies with NE, 865,000 survived of which 233,000 (UR 163342,000) had moderate-severe impairment and 181,000 (UR 82319,000) had mild cognitive or motor impairment.
- The severity of NE among incident cases is similar across high- vs. low-income settings; but the case fatality rate is much higher for severe NE in high mortality (92%) compared to low mortality (77%) settings.
- GBD2010 estimated that in the year 2010 there were 6.9 million years lived with disability (YLDs) associated with intrapartum-related NE impairment (accounting for 12% of DALYs). DALYs attributed to intrapartum-related NE accounted for 2.4% of the total GBD. Using consistent methods for 1990 and 2010, DALYs attributed to intrapartum-related NE dropped from 60.6 M in 1990 to 50.2 M in 2010, a 17% drop in the number of DALYs and a 21% drop in the rate of DALYs taking into account a higher number of births in 2010.

In comparison national estimates of causes of neonatal deaths are now undertaken routinely and suggest three-quarters of a million intrapartum related neonatal deaths worldwide. Intrapartum stillbirths have not been systematically counted in global metrics, but recent estimates suggest 1.2 million deaths.

In settings without widespread availability of maternal and newborn care, the NE-related neonatal Case Fatality Ratio is high, and the numbers of disabled survivors are fewer than previously believed when estimates were based on data from high-income countries. The low impairment rates in contexts without neonatal intensive care are promising for the scale-up of basic neonatal resuscitation programs.

However rates of impairment are highest in middle-income countries where neonatal intensive care was more recently introduced, but quality may be poor. Applying the 'first do no harm' rule of medicine it is incumbent on us all to ensure when we intervene in the neonatal period we do so with the whole package of intensive care rather than simply part of the technology and expertise required to achieve a good outcome.

CHIFA profile: Matthew Ellis is a consultant paediatrician at Southmead Hospital, Bristol, UK. He is also a Senior Clinical Lecturer Child Health, Centre for Child and Adolescent Health, Bristol University. His research interests include the public health of birth asphyxia in low income countries and the epidemiology of neurodevelopmental disorders of childhood. He is course director of the International Health BSc for medical students at Bristol University and convenor of the International Child Health Group of the Royal College of Paediatrics and Child Health. m.ellis AT bristol.ac.uk

From: "Yvonne Mrs Chief Igweh, UK" <ceo@littlebigsouls.com>  
 To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
 Subject: [chifa] Newborn Care (74) World Prematurity Day (2) LittleBigSouls  
 WPD event, London

Dear Neil and All Partners,

Thank you for the brilliant work you are doing and in hosting the platform for discussion on Neonatal Health. It is so good to hear from all participants and to follow the key issues being highlighted from various countries.

LittleBigSouls continues to work in support of the life saving efforts of clinicians and all involved in Neonatal Health and Care and we are thrilled to be able to provide our Baby Preemie and Me educational Platform this year in conjunction with our World Prematurity Day Global programs and with highly respected Speakers in Neonatal Health. Please find attached the details on this and I would be grateful for your support and participation of all who can support this in South Africa.

I am also thrilled to inform that we will be holding a World Prematurity Day Concert for the first time in the UK. It will be a beautiful Evening of Music with immensely talented and Leading Harpist Eleanor Turner and Mendi Singh the incredible Tabla Performer who have being so kind as to collaborate with us on this in support of the Day and the efforts of all engaged in the mission to help save lives.

Please find attached the formal invite [\*see note below] and I would be honoured to have you and as many partners that can attend in London. It will be on the 17th of November at the Hyatt Churchill on Portman Square from 7pm. RSVPs and tickets are online at [www.Littlebigsouls.org](http://www.Littlebigsouls.org) . Please send confirmation of your attendance to [events@littlebigsouls.org](mailto:events@littlebigsouls.org) to reserve your seat.

With Best Wishes  
Yvonne

Chief Mrs Y Igweh( MPhil) Cantab  
CEO/FOUNDER  
LITTLEBIGSOULS INTERNATIONAL CHARITABLE FOUNDATION  
CO-Founder of World Prematurity Day  
Founding Partner of The World Prematurity Network  
The Voice for the Pre-term Baby Born in Africa  
UK, Nigeria, Ghana, South Africa  
We Help Provide a Fighting Chance

CHIFA profile: Chief Mrs Yvonne Igweh (MPhil)Cantab is Founder/CEO of LittleBigSouls International Charitable Foundation in the UK, Nigeria, Ghana, and South Africa and Co-Founder of World Prematurity Day. Professional interests: Working to help improve survival and morbidity rates of pre-term babies, supporting families affected by pre-term birth, raising awareness of Pre-term Birth globally through global advocacy programs such as World Prematurity Day and The Baby Preemie & Me Annual Conference Series. Further, supporting research, education and measures to provide a fighting chance for pre-term and sick babies. [www.littlebigsouls.org](http://www.littlebigsouls.org) Email ceo AT littlebigsouls.com

From: "Lily Kak, USA" <lkak@usaid.gov>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (75) How are nurses and midwives in neonatal units trained? (6) WHO Midwifery Educator Survey

I would like to pick up on an earlier discussion regarding the need for neonatal nursing skills. I agree whole-heartedly that there is a tremendous gap in both the quantity and quality of neonatal nursing in LMIC countries. I don't think countries will be prepared to introduce a new cadre of neonatal nurses because of the widespread shortage of health providers in general, and of midwives and nurses in particular. However, as many countries have begun to prioritize care of the small and sick newborns, governments will need information on who is taking care of newborns, where they are cared for, what is the quality of care that they are receiving, what is the quality of educational programs for neonatal nursing, etc. It is time now to conduct a systematic assessment to understand the landscape that will inform countries about their human resource needs and how to strengthen it. With this in view, WHO is conducting an online multi-country Midwifery Educator Survey among all those who teach midwifery skills to care for women and newborns, including midwives, doctors, and nurses. The survey seeks to understand who cares for sick and small newborn babies and where they are cared for, how students are taught about caring for sick and small newborns, including what clinical skills are needed and what they should do to ensure the experience of the parents during these stressful times is positive. I hope that someone from WHO elaborates on this important activity and shares the status of survey.

In addition, USAID and UNICEF and multiple partners are supporting a separate multi-country situational analysis to determine facility readiness and quality of care for small and sick newborns and young infants. This activity will also provide useful information about neonatal nursing capacity and needs in 2018. We hope that all this information will galvanize countries to do more to strengthen the capacity of those who care for newborns. No longer should issues of training, deployment, task-shifting, etc, among the carers of sick newborns be ad hoc.

Lily Kak

CHIFA profile: Lily Kak is Newborn Health Team Lead at USAID in the USA. Professional interests: Newborn Health. She is a member of the CHIFA working group on Newborn Care. <http://www.hifa.org/projects/newborn-care>  
<http://www.hifa.org/support/members/lily-1>  
Email: lkak AT usaid.gov

From: "Dave Woods, South Africa" <pepcourse@mweb.co.za>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (76) Neonatal encephalopathy (2) Fetal Heart Rate Handbook

Dear All

As a group of neonatologists addressing the management of newborn infants exposed to intrapartum hypoxia it is important to also look at ways to prevent the condition. It is always sad when a healthy fetus thrives throughout pregnancy only to die or be damaged during the few hours of labour. While it is well known that the decreased uterine blood flow during prolonged or frequent contractions is usually the cause of the fetal hypoxia, maternal management often consists of giving the mother supplemental oxygen rather than stopping the contractions. The latter provides an opportunity to arrange transport or plan further

intervention. To address fetal monitoring in a primary care setting and apply fetal resuscitation (turn the mother on her side and stop contractions with oral nifedipine) we have written a small booklet (Fetal Heart Rate Handbook) that others may find useful. It can be read off our website ([www.bettercare.co.za](http://www.bettercare.co.za))

Regards, Dave Woods

CHIFA profile: Dave Woods is Emeritus Professor in Neonatal Medicine at the School of Child and Adolescent Health, University of Cape Town, South Africa. He is Chairman of the Perinatal Education Trust and Eduhealthcare, both not-for-profit non-government organisations that develop appropriate self-help distance learning material for doctors and nurses who care for pregnant women and their children in under-resourced communities. He has 30 years experience as a clinical neonatologist, with particular interests in perinatal care and training of health professionals. He is currently developing paper-based continuing learning material in maternal care, newborn care, child health, and care of adults and children with HIV/AIDS. He is also participating in the design and development of wind-up appropriate health technology for poor countries. [www.pepcourse.co.za](http://www.pepcourse.co.za) pepcourse AT mweb.co.za

---

From: "Nkuranga John Baptist, Canada" <nkuranga.baptist@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (75) Is there evidence on the best way to inform practice change?

Dear CHIFA members,

It has been indeed a great learning month understanding all initiatives that goes on around the world trying to help improve Neonatal care, thank you each one of you for contributions made and resources shared. I wish to get again your opinion on how best to create a practice changes?

1. There are efforts being made to train as many health care givers as possible but from my experience on job training may not necessary translate into skills retention, even for those who retains the skills may not necessarily put the skills into practice and overall such training may not create a practice change which saves life or improve quality > Is there evidence on the best way to inform practice change? How about combining mentorship programs with Quality improvement initiatives?
2. Regarding family centred modes of care, they can be implemented any where but definitely will take time for health care professionals at all levels to understand the concept and be ready to integrate it.
3. I refer back to Mike's comment [Mike English, Kenya (81)] - on how much information the few nurses and midwives have to record in registers obviously needs to be addressed if we hope to get fairly more accurate data. The problem is that each program and organisations comes in with a set of information they need with no harmonization or reconciliation of such

information. But I believe that is one of the importance of such a forums is for us to be aware that it can negatively impact on the quality of data and quality of care too.

Again, thank you.

CHIFA profile: Nkuranga John Baptist is Perinatal-Neonatology Fellow at Western University in Canada. Professional interests: Pre-term survival in low resource countries. nkuranga.baptist AT gmail.com

From: "Joseph Ana, Nigeria via Dgroups" <CHIFA@dgroups.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (76) Is there evidence on the best way to inform practice change? (2)

We agree with Nkuranga's comments that the last month's HIFA discussion has been very informative about Newborn care. It was a rich harvest of Knowledge.

We recently completed a six-month pilot of implementing PACK (Practical Approach to Care Kit) Nigeria guide in three states, one from a geo-political zone in Nigeria. The pilot involved 354 frontline staff in 51 PHCs (Junior Community Health Extension Workers; Community Health Extension Workers; Community Health Officers/Nurses/Midwives; Medical Officers). To effect the positive change in practice including use of the guide during consultations (90% of users reported using the guide in all consultations), reduce polypharmacy, reduce inappropriate testing, increase confidence in diagnosis and treatment overall, the PACK implementation plan has 4-Pillars ensuring that the guide is just not circulated to staff and they are not supported, rather following handing out the guide to each staff, they are introduced to three other Pillars/interventions: educational outreach model training, health facility strengthening (infrastructure, equipment, test kits and medicines), and Monitoring and Evaluation. All the four pillars are implemented in tandem. The educational outreach model meant onsite inservice training of the staff on how to use the guide and maximise the effects of its evidence based content. The training took place in each facility every two weeks, the interval giving the staff the opportunity to implement what they learnt before the next case training.

However, unlike what Nkuranga said about on the job training, all the participants in our pilot (100%) reported that this model of training in their facility (onsite inservice training) involving their immediate work colleagues is better than existing off-site training (which took them out of their facilities to a central venue, often very far away) in several respects including ensuring that all staff have the opportunity to attend the training and update their knowledge and skills ( unlike the off-site training that usually means that only the managers / senior staff attend update training and they hardly share the knowledge when they return to the facility).

Joseph Ana.

Africa Center for Clin Gov Research & Patient Safety

@ HRI West Africa Group - HRI WA  
Consultants in Clinical Governance Implementation

Publisher: Health and Medical Journals  
8 Amaku Street Housing Estate, Calabar  
Cross River State, Nigeria

Phone No. +234 (0) 8063600642  
Visit Website: [www.hriwestafrica.com](http://www.hriwestafrica.com)  
E-mail: hriwestafrica@gmail.com

CHIFA profile: Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality & Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom & e-health in the Cross River State Ministry of Health, Nigeria in 2007. Website: [www.hriwestafrica.com](http://www.hriwestafrica.com) Joseph is a member of the HIFA Steering Group: <http://www.hifa.org/people/steering-group> <http://www.hifa.org/support/members/joseph-0>  
jneana AT yahoo.co.uk

From: "Lily Kak, USA" <lkak@usaid.gov>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (77) Family-centered care

Family-Centered Care, Family-Led Care, Family-Integrated Care, Family-Participatory Care - whatâ€™s in a name? What matters is that the newborn is at the center of this approach and the family participates in the care of the newborn in the neonatal intensive care unit (NICU) and special newborn care unit (SNCU). Is this the next big thing for little things? I wofled down the numerous publications to understand the evidence, feasibility, acceptability, health systems requirements, and newborn outcomes. Many NICUs and SNCUs do not have an open-door policy except when the mother is needed for breastfeeding her stable baby. But some countries - such as Canada and India - are changing the paradigm of neonatal intensive care and integrating parents into the care team largely due to the evidence and advocacy of dynamic physicians from these countries. Does every country need a champion to advocate for such family-centered care? Does every country need to generate evidence on the approach? Are countries ready for such a paradigm-shift or is this approach more appropriate in certain contexts and not in others? Any comments from the experts?

Lily Kak

CHIFA profile: Lily Kak is Newborn Health Team Lead at USAID in the USA. Professional interests: Newborn Health. She is a member of the CHIFA working group on Newborn Care. <http://www.hifa.org/projects/newborn-care> <http://www.hifa.org/support/members/lily-1>

lkak AT usaid.gov

From: "Sue Prullage, Rwanda" <sue.prullage@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (78) How are nurses and midwives in neonatal units trained? (7)

Hi

I agree with Lily to be able to address the gaps we need to know where the gaps are. Just this week COINN, Chiesi Foundation received IRB approval to survey every nurse/midwife that works in neonatal units in Rwanda. We are collecting data about staffing, equipment, lab possibilities and education. We will be sharing the information when we finish and do the stats.

Sue Prullage

HIFA profile: Geralyn Sue Prullage is a member of the board of the Council of International Neonatal Nurses (COINN). She has worked in Rwanda since 2008 and has helped establish a neonatal unit in a district hospitals. She has a doctorate in Nursing Practice (DNP) and is a certified neonatal/pediatric nurse practitioner. sue.prullage AT gmail.com

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (79) 25 unanswered questions

Dear CHIFA colleagues,

Thank you for your wonderful contributions so far. During the course of this discussion CHIFA members from Canada, Ghana, Kenya, Rwanda, South Africa, UK and USA have raised 25 questions (or groups of questions). I list these questions below. Special thanks to Sue Prullage, Rwanda, who has responded to seven already (10,11,12,18,19,20,21). The rest remain largely unanswered. Can anyone help to answer any of the following?

1. NPW: How many babies in LMICs are delivered at home versus primary health centre versus small hospital versus referral hospital? (at global, national or local level)
2. NPW: How many newborn deaths occur at each of the above levels of the health system?
3. NPW: What more do we know about newborn deaths at global and national levels? Which countries are doing better than others of comparable levels of income?
4. NPW: How many deaths might have been prevented with better antenatal care?
5. NPW: How many deaths might have been prevented with better basic newborn care?
6. NPW: How many deaths might have been prevented with better (for those who get it) comprehensive newborn care?
7. NPW: For every newborn death, there are many more babies who are born with severe disability, including hypoxic brain damage, often leading to enormous suffering for the child and family. How much of this disability could have been prevented by better basic (and/or comprehensive) care?

8. NPW: And what about the trends in newborn deaths and morbidity? We hear that newborn deaths are going down year on year, but progress is much slower than with under-5 mortality. Why?
9. Lily Kak, USA: Does every country need a champion to advocate for such family-centered care? Does every country need to generate evidence on the approach? Are countries ready for such a paradigm-shift or is this approach more appropriate in certain contexts and not in others? Any comments from the experts?
10. Christabel Enweronu-Laryea, Ghana: Faculty: What are the standards of knowledge and skills training (neonatal) for undergraduate and postgraduate trainees in our nursing and medical schools? What is the quality of the output from our institutions? How sustainable are external efforts if we do not improve the quality of training?
11. Christabel Enweronu-Laryea, Ghana: Accreditation and certification (examination) bodies: Are the standards and approach appropriate for improving neonatal outcome in that setting? Is improving quality of care for newborns a priority?
12. Christabel Enweronu-Laryea, Ghana: Hospital management teams: What is the evidence that improving quality of care for newborns is a priority? How useful are the monitoring tools?
13. Nkuranga John Baptist, Canada: Even in developed countries Quality improvement initiatives have dramatically reduced morbidity among extreme preterm neonates, the Canadian Neonatal Network (CNN) through EPIQ projects) has shown there is so much to do with evidence based quality improvement. Within the context of low-income countries, how best to initiate and integrate such initiatives considering local realities?
14. Nkuranga John Baptist, Canada: An example of WHO 10 recommendations for preterm survival, how many countries have implemented them as a standard of care?
15. Nkuranga John Baptist, Canada: You may well be aware of Antenatal corticosteroid controversies in low income countries, why didn't they work as expected in reference to high income countries?
16. NPW: 'An estimated 20,000 infants [worldwide?] had severe visual impairment or blindness with almost half as many again with mild or moderate impairment.'
17. Dayo Ajayi-Obe, UK: Are we maximizing the potential role that the neonatal ambu bag has in saving newborn lives, (newborns with primary apnoea) in low income resourced countries?. Has a Cochrane review been done on the outcomes of training traditional birth attendants in helping babies breathe? Can we continue to break down the HBB and essential newborn care training to the level of that TBA's can understand so that they can do what is necessary before transferring a sick baby who has a better chance of surviving intact?
18. Claire Keene, UK/Kenya: What constitutes a newborn unit? Should any facility performing deliveries have a newborn unit that offers standard in-patient care, or should it be restricted to hospitals only?
19. Claire Keene, UK/Kenya: Should non-NICU inpatient care be categorised as one level or further subdivided into basic and comprehensive care? Should some non-NICU newborn units be able to provide higher dependency care that alleviates the pressure on NICUs? Or should all high dependency care be provided at NICU level only?
20. Claire Keene, UK/Kenya: What care could realistically be provided in a high dependency unit (CPAP? Exchange transfusion?)? Are there pivotal or distinguishing services that define a unit as a specific level of care, for example CPAP defining a high-care unit?
21. Claire Keene, UK/Kenya: Should care be completely regionalised with basic facilities referring to central high level facilities, or should some higher level services be distributed closer to the receiving population? For example, having high dependency units at low level hospitals in rural areas. Should efforts be made to improve transport networks or should poor referral systems be compensated for by providing higher level care at more hospitals?

22. Dayo Ajayi-Obe, UK. Where are our babies being born?
23. Ruth Davidge, South Africa: I have to ask how much employing neonatal nurses would cost in comparison to the cost of litigation let alone ongoing management of neonatal morbidity and loss of life?
24. NPW: Where do newborns die?
25. Sue Prullage, Rwanda: In my experience and I wonder if others in LMIC countries have the same experience the families do not want their babies to go to the neonatal units. Is it the cost? Is it the disruption of the family dynamics? Or is it a feeling of hopelessness that the baby will die anyway even after spending time at the neonatal unit.

Best wishes, Neil

From: "Elvira Beracochea, USA" <elvira@realizingglobalhealth.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (80) Learning from South America

Dear CHIFA colleagues,

South America has had a neonatology center with over 45 years of experience working to improve neonatal outcomes in resource limited settings. Here is the link to their website now sponsored by PAHO: <http://www.paho.org/clap/index.php?lang=en>

There are many lessons there for countries that are willing to embark in saving more newborns and improving the quality of care. I believe it takes concerted effort and several years of dedicated and focused work to improve neonatal care. For those called and committed to do make history, South American countries have many lessons to share as well as simple tools and best practices.

Sincerely,  
Dr Elvira Beracochea

HIFA profile: Elvira Beracochea is a medical doctor, global health expert and author. She is the author of "Health for All NOW" and editor and co-author of "Right-Based Approaches to Public Health" (Springer 2011) and of "Improving Aid Effectiveness in Global Health" (Springer 2015). She is the President and CEO of Realizing Global Health, Inc, based in Fairfax, USA. RGH is a global health care consulting and career development firm whose mission is to help develop sustainable and self-reliant health systems that deliver quality healthcare for everyone everywhere every day.  
[www.realizingglobalhealth.com](http://www.realizingglobalhealth.com) elvira AT realizingglobalhealth.com

From: "Mike English, Kenya" <MEEnglish@kemri-wellcome.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (81) Planning and managing newborn care -  
Reliable information systems

Hi All,

I wanted to pick up on an important and much neglected issue, that of having simple but reliable information systems. In many low-income countries sick newborns do not have their own medical record or patient number if they are sick from the time of birth they are admitted under the mother's patient number. This makes gathering statistics on sick newborns extremely difficult. Also systems in a number of places that are part of the DHIS2 system do not have modules for capturing data from newborn units as they have not traditionally been recognised as specific inpatient units. This typically means there are no data on admissions to or deaths in NBUs and thus no way to understand how, for example, mortality by weight group (eg. those 1.5 to 2.0 kg) varies. As people become more interested in newborn care they are suddenly trying to add lots of quality of care indicators to proposed neonatal registers dramatically increasing the data collection workload usually for nurses who are already overstretched. Yet there is typically no investment in the system and people that will be required to analyse and use such data. Efforts to improve newborn data must be in health information systems and not just in creating ever larger registers.

Best wishes,  
Mike

Prof. International Child Health,  
Oxford University,  
Head, Health Services Unit,  
KEMRI-Wellcome Trust Research Programme,  
Nairobi 00100,  
Kenya  
Mobile +254 (0)722 628700

Profile (Oxford): <http://www.ndm.ox.ac.uk/principal-investigators/researcher/mike-english>  
Profile (Kenya): <http://kemri-wellcome.org/author/mike/>  
[www.kemri-wellcome.org](http://www.kemri-wellcome.org)  
<https://oxlifeproject.org/>

CHIFA profile: Mike English is a paediatrician with the Child and Newborn Health Group, Kenya Medical Research Institute-Wellcome Trust Research Programme, Centre for Geographic Medicine Research, Nairobi, Kenya. [menglish AT nairobi.kemri-wellcome.org](mailto:menglish@nairobi.kemri-wellcome.org)

From: "Sarah Moxon, UK" <[sarah.moxon@lshtm.ac.uk](mailto:sarah.moxon@lshtm.ac.uk)>  
To: "CHIFA - Child Health and Rights" <[CHIFA@dgroups.org](mailto:CHIFA@dgroups.org)>  
Subject: [chifa] Newborn Care (82) Group B streptococcal infection (3)

Dear Cliff and all CHIFA members,

Thank you for your comment on perinatal group B streptococcal infection and the different epidemiology of neonatal sepsis in East Africa.

We'd like to draw attention to a new set of global estimates of the burden of Group B Streptococcal disease for women, stillbirths and children that is being released today. This is the first set of systematic estimates of the worldwide burden of GBS, which is one of the great "black holes" for public health data worldwide. These estimates show that in fact

there is GBS in all regions and some of the challenge has been that apparent variation may be due to missing cases, or missing clinical detection or lab methods. According to these estimates the highest burden in neonatal and infant GBS cases and deaths is indeed in Africa. There has also been a blind spot for measuring stillbirths due to GBS and the mother herself as GBS is a cause of severe sepsis, especially postpartum.

The estimates also found some evidence of preterm birth association with maternal GBS colonization.

Important for all of us to note the "inverse data law" where the highest burden falls on the most vulnerable yet the least data are collected to address that burden.

These new estimates are a collaboration of >100 authors and 30 institutions working to better measure GBS burden around the world. The papers (released today!) are available open access here: <http://bit.ly/GBSburden>

Kind regards,  
Sarah Moxon

CHIFA profile: Sarah Moxon works in the Department of Infectious Disease Epidemiology, London School of Hygiene and Tropical Medicine, where she provides research and technical support to the Every Newborn Action Plan and Saving Newborn Lives project. She is a member of the CHIFA working group on Newborn Care.

<http://www.hifa.org/projects/newborn-care>  
<http://www.hifa.org/support/members/sarah-2>

Email: sarah.moxon AT lshtm.ac.uk

From: "Dave Woods, South Africa" <pepcourse@mweb.co.za>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (83) Group B streptococcal infection (4)

Dear All

Interpreting the publication of Group B Streptococcal-associated perinatal deaths is confusing as colonisation of the infant is not the same as infection. Of mothers who are colonised with GBS it is estimated that only 1% of the infants will become clinically infected while 10% will become infected if chorioamnionitis is present. If the mother has a good antibody response the fetus and newborn infant will be largely protected. However some women do not mount a response limiting the benefit that could be offered by a vaccine. The vaginal colonisation rate in South Africa is very high while the rate of positive blood cultures in the infants is much lower. Hence the association may not reflect cause and effect. This makes the use of prophylactic penicillin problematic. GBS colonisation of the mother may be a marker of many other health and sociological risk factors.

Dave Woods

CHIFA profile: Dave Woods is Emeritus Professor in Neonatal Medicine at the School of Child and Adolescent Health, University of Cape Town, South Africa. He is Chairman of the Perinatal Education Trust and Eduhealthcare, both not-for-profit non-government

organisations that develop appropriate self-help distance learning material for doctors and nurses who care for pregnant women and their children in under-resourced communities. He has 30 years experience as a clinical neonatologist, with particular interests in perinatal care and training of health professionals. He is currently developing paper-based continuing learning material in maternal care, newborn care, child health, and care of adults and children with HIV/AIDS. He is also participating in the design and development of wind-up appropriate health technology for poor countries. [www.pepcourse.co.za](http://www.pepcourse.co.za) pepcourse AT mweb.co.za

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (84) FW: Seeking Expressions of Interest for implementation research to address persistent challenges preventing informed and appropriate care-seeking and effective referrals for improved maternal, newborn and child health (MNCH) outcomes

The message below is forwarded from the Core Group MNAH.

From "Michelle Shapiro (via rmnah list)" <rmnah+mshapiro=coregroup.org@lists.coregroup.org>  
To "'cgcommunity@lists.coregroup.org ...snip... rmnah@lists.coregroup.org>  
Subject [CORE Group rmnah] FW: Seeking Expressions of Interest for implementation research to address persistent challenges preventing informed and appropriate care-seeking and effective referrals for improved maternal, newborn and child health (MNCH) outcomes

Forwarded from USAID:

### Opportunity

USAID has issued an Addendum to the 2017 Global Health Challenges Broad Agency Announcement (BAA) seeking approaches for increasing effective coverage of maternal, newborn, and child health (MNCH) services through timely care-seeking and effective referrals to responsive health facilities.

### Solutions Sought

Through a BAA process, USAID, together with Resource Partners the Bill and Melinda Gates Foundation (BMGF) and the Doris Duke Charitable Foundation (DDCF), is interested in testing demand side solutions, e.g. factors that lead clients to seek care, while simultaneously addressing critical supply side gaps, such as effective referral systems, ensuring clients can reach the most appropriate level of care.

To ensure improved effective coverage of maternal, newborn and child health services, implementation research supported by this effort would ideally be nested within existing quality improvement or health system strengthening efforts. This would presumably ensure a measure of health care quality of services (e.g. equipped health facilities and a trained and motivated health workforce) is available at participating facilities.

## Eligibility

Public, private, for-profit, and nonprofit organizations, as well as institutions of higher education, non-governmental organizations, and U.S. and non-U.S. government organizations are eligible under this BAA.

## Geographic Focus

This Addendum is limited to the following countries: Afghanistan, Bangladesh, Burma (Myanmar), Democratic Republic of Congo, Ethiopia, Ghana, Haiti, India, Indonesia, Kenya, Liberia, Madagascar, Mali, Malawi, Mozambique, Nepal, Nigeria, Pakistan, Rwanda, Senegal, South Sudan, Tanzania, Uganda, and Zambia.

## Application Process

EOIs of 5 pages or less must be submitted to [harp@usaid.gov](mailto:harp@usaid.gov) by November 27, 2017. For more details see the full announcement

Upon evaluation of EOIs, selected applicants will be invited to participate in a co-design process, including a co-creation workshop where they will be joined by USAID, Resource Partners, and select invitees to collaboratively develop the research concepts. Anticipated timing and location of the co-creation workshop is the week of February 5-9, 2018 in South Africa (dates and location to be confirmed).

For more information, review the latest updates on [grants.gov](http://grants.gov). Search for "BAA-GlobalHealth-2017 - Addendum #1 Care Seeking Referrals".

## Deadlines

November 27, 2017- Expressions of Interest should be submitted no later than November 27, 2017 at 3:00PM EST to [harp@usaid.gov](mailto:harp@usaid.gov).

--

Best wishes, Neil

From: "Nick Spencer, UK" <[N.J.Spencer@warwick.ac.uk](mailto:N.J.Spencer@warwick.ac.uk)>  
To: "CHIFA - Child Health and Rights" <[CHIFA@dgroups.org](mailto:CHIFA@dgroups.org)>  
Subject: [chifa] Newborn Care (85) Inverse data law

Many thanks Sarah for introducing us to the concept of the "inverse data law" - an important extension of the "inverse care law". So many of the discussions about information and services in low income countries fail to properly account for the ways in which the most vulnerable are doubly disadvantaged by higher risk of disease combined with higher risk of lack of services and information.

Nick Spencer

Professor Nick Spencer, Emeritus Professor of Child Health,  
Division of Mental Health and Wellbeing,

Warwick Medical School,  
University of Warwick,  
Coventry CV4 9JD, UK  
Home phone: +44(0)1926 424414  
Mobile: +44(0)7542961640

ISSOP President

HIFA profile: Nick Spencer is Emeritus Professor of Child Health, School of Health and Social Studies, University of Warwick, Coventry, UK. N.J.Spencer AT warwick.ac.uk

From: "Sarah Moxon, UK" <sarah.moxon@lshtm.ac.uk>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (86) Family-centered care (2)

Thank you Lily, for this important comment. [Lily Kak, USA - Newborn Care (77) Family-centered care]

In Northern European countries (Sweden, for example) neonatal units have been fully reconstructed to home families at the centre of the unit, and nurses and doctors to work around them. Highly complex procedures are performed with very small and sick babies in skin-to-skin position. The entire workforce and system is set up to work around the family's needs. This extreme of family centered care no doubt relies on a health system that is well-equipped and resourced. I am also convinced that investment in training, team work and support infrastructure have been fundamental to the great success of this approach (although would love to hear from colleagues on this). As a nurse myself, I know that it is an entirely different skill to teach a parent of a sick child to do something than it is to do it yourself, as it involves confidence and trust. It takes time to build this into health system function.

However, this does not mean that family centred care has to be prohibitively costly, nor that resources are the only limiting factor. In fact, as with examples of successful kangaroo mother care programmes, costing evidence suggests that following initial 'start up' costs, there are long term cost saving benefits to the family centred approach. However, we should not assume that this paradigm shift to family centred care is easily achieved without investment and attention to the health system and culture.

In most settings there are forms of resistance to family-centered care. It was not long ago in the UK that mothers on the neonatal unit were perceived as jeopardising ward cleanliness and as a potential nuisance to the order and functioning of the ward. Mothers were frequently not allowed into neonatal units. Fortunately, this has now changed in the UK, but remains the case in many settings. In some of my work with colleagues in Asian countries that are working on introducing family-centred care, we have discussed newer fears of litigation cases from parents coming into neonatal wards and suing for perceived malpractice. Nurses have expressed concerns that they would be policed by parents and criticized for the care that they are providing. In other settings, perhaps where nurses may already feel disenfranchised, parents can seem a 'threat' to the nursing role. Many hospital managers simply state " we are too crowded already, where on earth will we fit everyone?"

I am convinced that there are creative and innovative ways that different settings have overcome some of these challenges and would love to hear more examples from CHIFA colleagues.

Family centred care is part of a more humanised, respectful approach to neonatal care with ample evidence that it has positive benefits for all involved. Champions are critical, but an entire health systems approach is required to change the culture of care-giving.

CHIFA profile: Sarah Moxon works in the Department of Infectious Disease Epidemiology, London School of Hygiene and Tropical Medicine, where she provides research and technical support to the Every Newborn Action Plan and Saving Newborn Lives project. She is a member of the CHIFA working group on Newborn Care.

<http://www.hifa.org/projects/newborn-care>

<http://www.hifa.org/support/members/sarah-2>

Email: sarah.moxon AT lshtm.ac.uk

From: "Ruth Davidge, South Africa" <rdavidge@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (87) Family-centered care (3)

Thank you for this discussion on family centred care - a critical aspect aspect of care but one that can be quite challenging to implement with deep seated practices and beliefs that are contrary to its adoption.

In my province we have a policy guiding hospitals on the provision of lodger facilities for mothers (and where possible fathers) of babies and children in hospital. Hospitals are required to provide accommodation and meals at least for all breast feeding mothers and up to half of their number of paediatric beds.

Fathers are permitted 24hr access to their children (although some hospitals still only allow them during visiting hours!) and sibling visiting is encouraged. In the neonatal units mothers are encouraged to practice skin to skin care as often as possible (at least once per day) until baby is ready for 24 hr KMC [\*] and assist with all feeds, bathing of baby, cleaning the incubator daily and administering oral medication. We are also considering their role particularly in KMC of observing and recording observations for their baby.

However there is still resistance and one specialist objected to their presence during the morning as they would be in the way during the round. Involvement with decision making is limited and access to medical records and participation on the round is still a way off.

God bless  
Ruth Davidge

KZN Neonatal Coordinator  
Pres. NNASA

Tel: 0769866880  
Ruth.davidge@kznhealth.gov.za

CHIFA profile: Ruth Davidge is Neonatal Coordinator at PMB Metro, Hospitals Complex Western, Kwa-Zulu Natal, South Africa. She is President of the NNASA (Neonatal Nurses Association of Southern Africa). She is a Registered Nurse and on the board of the Council of International Neonatal Nurses (COINN). [www.nnasa.org.za](http://www.nnasa.org.za), [ruth.davidge AT kznhealth.gov.za](mailto:ruth.davidge@kznhealth.gov.za)

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (88) Maternity Waiting Homes: A Viable Solution for Rural Women?

I was interested to read this blog from the Maternal Health Task Force. Extracts below. Full text here: <https://www.mhtf.org/2017/11/08/maternity-waiting-homes-a-viable-solution-for-rural-women/>

--

Maternity Waiting Homes: A Viable Solution for Rural Women?

Posted on November 8, 2017

By: Sarah Hodin, Project Coordinator II, Women and Health Initiative, Harvard T.H. Chan School of Public Health

Distance to a health facility has long been discussed as a key barrier to maternal health care utilization in rural areas, and researchers have explored innovative models for improving access. One of these models is the use of maternity waiting homes (MWHs), residential facilities located near a maternity clinic where pregnant women—often those at high risk of developing obstetric complications—can go during their third trimester and await labor and delivery. MWHs existed in rural areas of Northern Europe, Canada and the United States in the early 20th century and were introduced soon thereafter in other areas including Cuba, Nigeria and Uganda...

The use of MWHs has been linked to reductions in maternal and perinatal mortality in Ethiopia, Ivory Coast, Liberia and Zimbabwe. However, due to a lack of strong evidence in this area, researchers have not been able to conclude definitively that MWHs lead to fewer maternal deaths. Furthermore, some studies have found that MWHs did not result in a higher proportion of facility-based deliveries, indicating that the success of MWHs often depends on the local context...

--

The comment that 'researchers have not been able to conclude definitively that MWHs lead to fewer maternal deaths' is of interest. Is there evidence that MWHs lead to fewer newborn deaths?

Best wishes, Neil

From: "David Cundall, UK/Nigeria" <dbcundalls@btinternet.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (89) 25 unanswered questions (2) Newborn

## resuscitation

Thank you Neil and the team for this very timely 4 weeks discussion

I am not able to answer any of these questions [, sadly, but I would like some advice.

Nigeria Health Care Project is a small UK faith-based charity that has been supporting primary health care in rural areas of Nigeria for 25 years

For the past 6 years we have developed training in newborn resuscitation and care. We train nurses, midwives and community health extension workers in Abia, Benue and (once) Ekiti States. Most participants are local government employees.

Most of our training facilitators are Nigerians working in Nigeria

We adapted Maternal and Child Health Advocacy International/ David Southall's NLS-based resuscitation training developed in the Gambia (similar to HBB but without the non-evidence-based emphasis on suction) and make good use of Medical Aid Films neonatal resuscitation video to reinforce learning. Global Health Media's short videos are brilliant (thanks Deb!) as an adjunct to training on other aspects of newborn care at the health centre and small hospital level. We really like our 3-4 day course but recent evaluation showed that retention of resuscitation skills and knowledge is not good - not surprising as the same is true in the UK unless staff are resuscitating babies regularly. Therefore we have equipped Nigerian training facilitators with laptops with pre-loaded teaching materials so they can run small group sessions at health centres and use the opportunity for participants to practice their resuscitation skills on the same occasions.

Dave Woods et al's PEP materials from South Africa are great for people at registered nurse level but would need substantial modification for this Nigerian context. My understanding is that WHO's Essential Newborn Care and Kangaroo Mother Care courses both require a clinical facility with substantial numbers of deliveries/babies. I have not seen evidence of these (or HBB) being 'rolled out' beyond the teaching hospitals in Nigeria (but we only have links with a few places) Our intention is to tighten up on the way NHCP training is delivered so it consistently evaluates well as being appropriate, reproducible and effective with staff working in rural health centres and small hospitals.

I just wondered if we are missing anything - are there other courses/materials out there we should be looking at?

CHIFA profile: David Cundall is Coordinator of the Nigeria Health Care Project  
nhcp.org.uk nhcp AT btinternet.com

From: "Sarah Moxon, UK" <sarah.moxon@lshtm.ac.uk>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (90) Family-centered care (4) Parents on ward rounds

Thank you Ruth for this excellent example.

Lodging facilities seem an essential part of providing family centered-care. In some countries I have worked, programmes that provide meals for mothers are critical. This is especially the case for kangaroo mother care where mothers often need to be away from home (and family) for significant periods of time. I have seen some of these programmes supported by local charities as the hospital could not fund this fully (e.g. in Malawi). Regardless of the setting, amenities for mothers and families are really essential. In London, I have seen lots of creative ways to allow parents to stay near the hospital - parent "hotels" (which are not unlike student accommodation - really quite basic, but comfortable) near the hospital with voucher systems for local food outlets (for example). At one hospital, to get around the crowding issue, we had the transitional care ward designed with beds that folded up into the walls and were pulled down at night so that the space issue was solved during the day. I also like that you mentioned the involvement of wider members of the family - even siblings, I've found this to be really helpful too.

It is interesting that often the greatest resistance is to parents presence on ward rounds. I have seen this before too. I'd be interested to hear from colleagues on this.

HIFA profile: Sarah Moxon works in the Department of Infectious Disease Epidemiology, London School of Hygiene and Tropical Medicine, where she provides research and technical support to the Every Newborn Action Plan and Saving Newborn Lives project. She is a member of the CHIFA working group on Newborn Care.

<http://www.hifa.org/projects/newborn-care>

<http://www.hifa.org/support/members/sarah-2>

Email: sarah.moxon AT lshtm.ac.uk

From: "Alison Taylor, UK" <a.taylor7@brighton.ac.uk>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (91) Family-centered care (5) Parents on ward rounds (2)

Hi all

Family centred care has been extensively studied within both children's and neonatal nursing and the ideas that Sarah describes are well established in many UK hospitals. There can also be an assumption that FCC is 'naturally' practised in low income settings as seen by the presence of many (predominantly) mothers staying on children's wards and neonatal units - but this can often be more reflective of poor staffing. True family centred care should be about working with families, not despite them, to meet their child's needs and not simply accommodate parental presence and wishes. I am shocked that there continues to be a persisting attitude in some areas that parents are seen as a 'nuisance' e.g. on ward rounds. At the other end of the spectrum, expert parents who are caring for a child with complex and ongoing needs can end up becoming an unpaid member of the nursing team when it is assumed without discussion that they will lead (and want to do so) every aspect of care for their child. The focus and associated language within family centred care needs to change from that of permission, involvement and inclusion to that of negotiation, partnership and empowerment of children (where appropriate) and their families. This definitely extends to siblings as Sarah says, who (despite this being much studied) are still sometimes marginalised. That said, critics of the family centred care model have pointed out that despite

the best of intentions, the rights, interests and voice of the child can sometimes be overlooked in favour of those of the family. It can be very difficult to get the balance right.

Best wishes Alison

Alison Taylor  
Senior Lecturer  
Child Health Nursing  
School of Health Sciences  
Westlain House  
Falmer Tel: 01273 643864

CHIFA profile: Alison Taylor is Paediatric Practice Development Nurse at the Western Sussex Hospitals Trust in the UK. Professional interests: Paediatric nurse education and professional development, mentorship and preceptorship. alison.taylor AT hotmail.co.uk

From: "Alison Taylor, UK" <a.taylor7@brighton.ac.uk>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (91) Family-centered care (5) Parents on ward rounds (2)

Hi all

Family centred care has been extensively studied within both children's and neonatal nursing and the ideas that Sarah describes are well established in many UK hospitals. There can also be an assumption that FCC is 'naturally' practised in low income settings as seen by the presence of many (predominantly) mothers staying on children's wards and neonatal units - but this can often be more reflective of poor staffing. True family centred care should be about working with families, not despite them, to meet their child's needs and not simply accommodate parental presence and wishes. I am shocked that there continues to be a persisting attitude in some areas that parents are seen as a 'nuisance' e.g. on ward rounds. At the other end of the spectrum, expert parents who are caring for a child with complex and ongoing needs can end up becoming an unpaid member of the nursing team when it is assumed without discussion that they will lead (and want to do so) every aspect of care for their child. The focus and associated language within family centred care needs to change from that of permission, involvement and inclusion to that of negotiation, partnership and empowerment of children (where appropriate) and their families. This definitely extends to siblings as Sarah says, who (despite this being much studied) are still sometimes marginalised. That said, critics of the family centred care model have pointed out that despite the best of intentions, the rights, interests and voice of the child can sometimes be overlooked in favour of those of the family. It can be very difficult to get the balance right.

Best wishes Alison

Alison Taylor  
Senior Lecturer  
Child Health Nursing  
School of Health Sciences  
Westlain House

Falmer Tel: 01273 643864

CHIFA profile: Alison Taylor is Paediatric Practice Development Nurse at the Western Sussex Hospitals Trust in the UK. Professional interests: Paediatric nurse education and professional development, mentorship and preceptorship. alison.taylor AT hotmail.co.uk

From: "Lily Kak, USA" <lkak@usaid.gov>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (93) Family-centered care (6)

Thanks to Ruth and Sarah for your excellent responses re family centered care. It would be most helpful if you can share any evidence or publications on this approach from developing countries. I have found publications from the US, Canada, several European countries, and India. I would love to see some from Africa if there are any. And I am referring to family centered care which includes kangaroo mother care but is much more than that.

Thanks!

Lily Kak

CHIFA profile: Lily Kak is Newborn Health Team Lead at USAID in the USA. Professional interests: Newborn Health. She is a member of the CHIFA working group on Newborn Care <http://www.hifa.org/projects/newborn-care> <http://www.hifa.org/support/members/lily-1>  
lkak AT usaid.gov

From: "Lily Kak, USA" <lkak@usaid.gov>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (93) Family-centered care (6)

Thanks to Ruth and Sarah for your excellent responses re family centered care. It would be most helpful if you can share any evidence or publications on this approach from developing countries. I have found publications from the US, Canada, several European countries, and India. I would love to see some from Africa if there are any. And I am referring to family centered care which includes kangaroo mother care but is much more than that.

Thanks!

Lily Kak

CHIFA profile: Lily Kak is Newborn Health Team Lead at USAID in the USA. Professional interests: Newborn Health. She is a member of the CHIFA working group on Newborn Care <http://www.hifa.org/projects/newborn-care> <http://www.hifa.org/support/members/lily-1>  
lkak AT usaid.gov

From: "Samantha Sadoo, UK" <samantha.sadoo@lshtm.ac.uk>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (95) ENAP survey on the care of small and sick newborns

Dear all at CHIFA,

Just a reminder that in a few days time we will be closing the ENAP metrics survey on signal functions relating to the inpatient care of small and sick newborns. Please do lend 10 minutes of your time to contribute your views if you haven't already, and to share the survey link with colleagues. Many thanks!

<https://www.healthynewbornnetwork.org/blog/launch-enap-inpatient-care-small-sick-newborns-online-survey-world-prematurity-day/>

Dr Samantha Sadoo MBBS BSc DTM&H MRCPCH  
Research Fellow  
MARCH Centre  
London School of Hygiene & Tropical Medicine

CHIFA profile: Samantha Sadoo is a Paediatric Doctor at the London School of Hygiene and Tropical Medicine in the United Kingdom. Professional interests: Neonatology and Global Health. samantha.sadoo@lshtm.ac.uk

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (96) World Prematurity Day (3) Every Premie Country Profiles

Dear CHIFA colleagues,

Tomorrow 12 November is World Prematurity Day.

Every Premie has recently updated their Country Profiles. 'The Country Profiles of Preterm and Low Birth Weight Prevention and Care have been updated with available population-based data as of mid-2017...'

The process for developing the profiles, and what they show, is described here, together with links for each country profile:

<http://www.everypreemie.org/country-profiles/>

Data on 25 USAID priority countries are presented:

Afghanistan  
Bangladesh  
Democratic Republic of the Congo  
Democratic Republic of the Congo (French)  
Ethiopia  
Ghana

Haiti  
Haiti (French)  
India  
Indonesia  
Kenya  
Liberia  
Madagascar  
Madagascar (French)  
Malawi  
Mali  
Mali (French)  
Mozambique  
Mozambique (Portuguese)  
Myanmar (coming soon)  
Nepal  
Nigeria  
Pakistan  
Rwanda  
Senegal  
Senegal (French)  
South Sudan  
Sierra Leone  
Tanzania  
Uganda  
Zambia

The profiles 'are intended to ignite dialogue in-country and catalyze action around PTB/LBW within maternal and newborn health programming'.

Looking at few examples of country profiles, they are beautifully presented with easy-to-understand infographics. I would find it useful if they could also include a narrative summary of each country's indicators, performance and trends over time, to show how well countries are doing in relation to other countries with similar levels of development. I read that a summary is being developed that may reveal these comparative data.

Another question is: Given that these country profiles only cover USAID priority countries, what potential is there to coordinate with other bilateral agencies (and with global health agencies such as WHO and UNICEF) to produce a more comprehensive set of profiles?

I look forward to learn more about the Every Premie country profiles and how they are used.

Best wishes, Neil

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (97) World Prematurity Day (4)

In my previous message I said World Prematurity Day was 12 November. This was an error - WPD is on 17 November. Between now and the 17th we particularly welcome messages on the quality of care of preterm babies.

Best wishes, Neil

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (98) World Prematurity Day (5)

Dear CHIFA members,

(with thanks to Mary Kinney, South Africa)

Please do check out and support the Healthy Newborn Network, March of Dimes and global partners in our advocacy for World Prematurity Day.

Global partners have developed the 2017 World Prematurity Day toolkit. The toolkit includes:

- An advocacy toolkit with messages and ideas for action
- A social media toolkit
- Global and country-level preterm birth estimates
- Announcement
- Message map
- Additional resources.

<http://www.healthynewbornnetwork.org/resource/2017-world-prematurity-day-toolkit/>

Also, please support the Thunderclap here: <http://po.st/WPD17>

Anyone with a Facebook, Twitter or Tumblr account can support the Thunderclap (over 1000 organisations and individuals - including HIFA - are already supporting it) and it only takes a few seconds!

Thunderclap will send out this tweet on your page on 17 November at 7am EST:

15M babies are born preterm each year & nearly 1M will not live to their 5th birthday.  
#worldprematurityday <http://thndr.me/xTmZ6x>

Best wishes, Neil

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (99) Lancet: Mapping under-5 and neonatal mortality in Africa, 200015

Below are the citation and part of the abstract of a new paper in this week's print issue of The Lancet (11 November 2017):

CITATION: Mapping under-5 and neonatal mortality in Africa, 2000-2015: a baseline analysis for the Sustainable Development Goals

Nick Golding et al

Lancet, Volume 390, No. 10108, p21712182, 11 November 2017

DOI: [http://dx.doi.org/10.1016/S0140-6736\(17\)31758-0](http://dx.doi.org/10.1016/S0140-6736(17)31758-0)

Background: ... In this study, we aimed to generate high-resolution estimates of under-5 and neonatal all-cause mortality across 46 countries in Africa.

Methods: We assembled 235 geographically resolved household survey and census data sources on child deaths to produce estimates of under-5 and neonatal mortality at a resolution of 5–5 km grid cells across 46 African countries for 2000, 2005, 2010, and 2015...

Findings: Amid improving child survival in Africa, there was substantial heterogeneity in absolute levels of under-5 and neonatal mortality in 2015, as well as the annualised rates of decline achieved from 2000 to 2015. Subnational areas in countries such as Botswana, Rwanda, and Ethiopia recorded some of the largest decreases in child mortality rates since 2000, positioning them well to achieve SDG targets by 2030 or earlier. Yet these places were the exception for Africa, since many areas, particularly in central and western Africa, must reduce under-5 mortality rates by at least 8% per year, between 2015 and 2030, to achieve the SDG 3.2 target for under-5 mortality by 2030.

Interpretation: In the absence of unprecedented political commitment, financial support, and medical advances, the viability of SDG 3.2 achievement in Africa is precarious at best. By producing under-5 and neonatal mortality rates at multiple levels of geospatial resolution over time, this study provides key information for decision makers to target interventions at populations in the greatest need. In an era when precision public health increasingly has the potential to transform the design, implementation, and impact of health programmes, our 5–5 km estimates of child mortality in Africa provide a baseline against which local, national, and global stakeholders can map the pathways for ending preventable child deaths by 2030.

--

The implications for newborn care are not immediately clear (albeit on just a few minutes of skim-reading). I see some familiar names among the authors and would welcome any comments that would contribute to our current thematic discussion.

Best wishes

Neil

From: "Soofia Khaton, Bangladesh via Dgroups" <CHIFA@dgroups.org>

To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>

Subject: [chifa] Newborn Care (100) Newborn care in Bangladesh

I am very delighted to see so many discussion around the neonatal health. I like to discuss some thing of Bangladesh. The neonatal mortality rate of BD is now 28/1000 life birth. The SDG goal is 12/1000. If the present rate of reduction continue then in 2030 the rate will be 16/1000 l b. So to address the challenge BD has taken National Neonatal Health Programme NNHP as new intervention. In BD the most challenging is that still 60% of delivery occur in

home. So it is a big task. The key activities are - The capacity building, facility readiness for providing quality services, quality improvement initiative and community and multisectoral engagement. Promotion of ENC service with BHE and other partners. Today on 12th Nov this programs is launched in BD.

HIFA profile: Soofia Khatoon is Professor of Paediatrics at Shaheed Suhrawardi Medical College & Hospital, Sher-e Bangla Nagar, Dhaka, Bangladesh. Presently she is working as secretary general of Bangladesh Breastfeeding Foundation, Vice President of Bangladesh Neonatal Forum, Executive member of Bangladesh Paediatric Association, Bangladesh Perinatal Society, Bangladesh Society of Neurology & Disability. Professional interests include: Solving neonatal problems & improving breast feeding situation in Bangladesh. soofia\_icmh AT yahoo.com

From: "Lily Kak, USA" <lkak@usaid.gov>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (101) New advocacy resources to scale-up access to oxygen (1) World Pneumonia Day (3)

Dear colleagues,

As we focus more on the needs of sick newborns and children, we must do more to strengthen oxygen systems. It is my pleasure to forward the new oxygen advocacy resources shared by Bonnie Keith from PATH. Please see her note and links below.

Lily Kak

--

Dear Colleagues

Scaling up access to oxygen delivery is one of the most effective, and critical, actions that decision-makers can take to improve health outcomes, particularly for vulnerable populations such as newborns, children, and pregnant women. Despite the urgent need, however, this issue is not always prioritized. The reasons for this are many - including limited data, perceptions about costs, a lack of understanding of the impact on health outcomes, and the complexity of integration across the health system.

PATH announces the release of a new suite of evidence-based resources to enable country-based advocates to engage national decision-makers, policy influencers, and champions and drive discussion to improve the functionality and reliability of lifesaving oxygen delivery systems.

OXYGEN IS ESSENTIAL: [<http://sites.path.org/oxygen-therapy-resources/oxygen-primer/>]  
A Policy and Advocacy Primer helps ADVOCATES and DECISION-MAKERS understand the need for increasing access to oxygen, and how it can be done?even within contexts with limited resources. It provides the data, messages, and resources to help understand the planning, policies, and technologies involved in oxygen delivery scale-up. The materials are useful to anyone who wants to learn about scaling up access to oxygen and integrating oxygen delivery across national and subnational policies, programs, and health budgets. The primer is unbranded and customizable, allowing advocates and decision-makers to use these resources in the way that best suits their needs.

## Table of contents

- Â· Oxygen Is Essential: An Issue Brief
- Â· Oxygen Is Essential: A Policy Brief
- Â· Global Guidelines for Shaping National Oxygen Policy
- Â· Oxygen Technologies and Supplies
- Â· Guiding Questions for Oxygen Scale-up
- Â· Mapping a Future for Oxygen Access for All: Ethiopiaâ€™s Experience
- Â· Oxygen Messaging Map

The Oxygen Primer is available to download

World Pneumonia Day - November 12, 2017 ? at t bit.ly/2yXJtGh

Letâ€™s continue to advocate for ensuring equitable access to safe and efficient oxygen delivery for all, especially newborns, children, and pregnant women everywhere. Here are some additional ways in which you can help support this effort:

Â· Advocate for expanded access to oxygen. Make improved access to oxygen a reality through supportive policymaking and ensuring inclusion of oxygen delivery in national and subnational policies, programs, and health budgets, in alignment with the World Health Organizationâ€™s (WHO) new oxygen listing for the management of hypoxemia on the Model List of Essential Medicines (EML) and List for Children (EMLc).

[\[http://www.who.int/medicines/news/2017/21st\\_essential\\_med-list/en/\]](http://www.who.int/medicines/news/2017/21st_essential_med-list/en/)

Â· Promote the HO2PE: Oxygen Gives Life campaign [\[http://sites.path.org/oxygen-therapy-resources/ho2pe-campaign-toolkit/\]](http://sites.path.org/oxygen-therapy-resources/ho2pe-campaign-toolkit/) via your social media channels #OxygenGivesLife. The HO2PE campaign aims to increase global awareness of oxygenâ€™s important role in newborn, child and maternal health and call on country decision-makers to prioritize access to oxygen delivery in their efforts to achieve universal health coverage and the Sustainable Development Goals. The previous link will allow you to access a communications and social media toolkit and advocacy video, as well as the following resources:

o HO2PE: Oxygen Gives Life

infographic [http://www.path.org/publications/files/APP\\_o2\\_info.pdf](http://www.path.org/publications/files/APP_o2_info.pdf)

o Advocate for Oxygen

infographic [http://www.path.org/publications/files/DT\\_o2\\_infog\\_.pdf](http://www.path.org/publications/files/DT_o2_infog_.pdf)

Â· Learn more about PATHâ€™s oxygen-related work. Please visit our site [\[http://sites.path.org/oxygen-therapy-resources/\]](http://sites.path.org/oxygen-therapy-resources/) and PATHâ€™s oxygen publications page [\[https://www.path.org/publications/series.php?i=49\]](https://www.path.org/publications/series.php?i=49), which includes several publications related to our work on increasing access to lifesaving oxygen technologies and supplies.

Â· Link to our partners on social media by using the hashtags #United4Oxygen and #StopPneumonia.

Best wishes,  
Bonnie

Bonnie Keith, MPH  
Senior Policy & Program Officer  
455 Massachusetts Avenue NW, Suite 1000 | Washington, DC 20001 USA  
Tel: 1.202.822.0033 | 1.202.540.4348 (direct)  
[www.path.org](http://www.path.org)  
Facebook | Twitter | LinkedIn

--

Forwarded by:

CHIFA profile: Lily Kak is Newborn Health Team Lead at USAID in the USA. Professional interests: Newborn Health. She is a member of the CHIFA working group on Newborn Care <http://www.hifa.org/projects/newborn-care>

From: "Clare Gilbert, UK" <Clare.Gilbert@lshtm.ac.uk>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (102) Retinopathy of Prematurity (5)

Control of visual loss from retinopathy of prematurity in low and middle income countries

Retinopathy of prematurity (ROP) is a potentially blinding eye condition which affects infants born preterm. ROP is a major cause of blindness in children in many middle income countries and is becoming an increasingly important cause in low and low-middle income countries as neonatal services expand and more preterm babies survive. Recent estimates suggest that in the year 2010, 20,000 preterm infants become blind from ROP, and a further 12,300 survived visually impaired. All regions of the world are now affected. This study also estimated that 848,300 (range 838,400-924,700) preterm infants survive neonatal care and need to be screened, and 53,800 (range 28,800-85,000) infants need urgent treatment every year. Currently only around half of these infants are treated due to lack of services.

Full text:

<http://www.hifa.org/sites/default/files/pages/ROP%20for%20chifa%20Nov%209%202017%20C%20Gilbert1.pdf>

HIFA profile: Clare Gilbert co-directs the International Centre for Eye Health with Professor Allen Foster. The Centre is a WHO Collaborating Centre for the Prevention of blindness, and is based at the London School of Hygiene and Tropical Medicine, UK. The aim is to prevent blindness, particularly in low and middle income countries. The Centre does this in two broad ways: firstly by undertaking research, to provide the evidence needed by planners and managers so they can plan programmes for the prevention of blindness that are tailored to the needs of communities, and secondly, through education, including a one year MSc in Community Eye Health in London, and support for two, 3 month courses in Community Eye Health in Southern Africa. The Centre also manages up to 30 one week courses on VISION2020 in all regions of the world, and produces the Community Eye Health Journal which goes free of charge, four times a year to over 20,000 eyecare professionals in more than 150 countries ([www.cehjournal.org](http://www.cehjournal.org)). The Centre produces other educational materials, as required, and also "links" eye departments in the UK with training institutions in Africa, for capacity building and skills transfer. Clare has been Medical Advisor to Sightsavers International since 1995. Clare.Gilbert AT lshtm.ac.uk

From: "Sarah Moxon, UK" <sarah.moxon@lshtm.ac.uk>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (103) Quality care and follow up for preterms

With World Prematurity Day this week, and a theme that focuses on the "thrive" dimension of health as well as the "survive", I thought it important to draw attention to some of the issues beyond survival for preterm infants.

It is well-known that preterm infants are at higher risk of childhood morbidities (including adverse visual, hearing and neuro-developmental outcomes). The lower the gestational age at birth, the higher the risk of difficulties. Most premature infants, especially those <34 weeks, will require facility based care for survival, including thermoregulation, respiratory support (oxygen, continuous positive airway pressure), treatment of specific complications (feeding, seizures, jaundice) and prevention and treatment of infections. Many of these interventions carry a risk of harm when not performed with safe equipment or by trained staff. This is increasingly apparent in middle-income settings, where we have seen an increase in impairments in survivors of neonatal care, especially where complex care has been scaled up without due attention to the quality of care, as quantified in the Beyond Newborn Survival series in 2013 <https://www.nature.com/articles/pr2013202>. This has come up in some of the posts by Claire Gilbert on retinopathy of prematurity and safe oxygen therapy in the past few weeks.

Less detailed information on longer term outcomes of preterm babies is available from lower-income settings, where special care facilities are increasingly being scaled up. I was therefore pleased to see this recent cross-sectional study on the health, nutrition, and development of children born preterm and low birth weight in rural Rwanda <https://bmcpediatr.biomedcentral.com/articles/10.1186/s12887-017-0946-1> and wanted to share it with CHIFA readers.

The study looks at a cross section of children discharged from a special care unit in rural Rwanda - a unit that provides thermoregulation (incubator and KMC), oxygen therapy, IV fluids, phototherapy and assisted feeding. The study carried out home visits to children aged 1-3 years and looked at a range of health and development markers - signs of chronic and acute conditions, anthropometry, developmental stage (including motor skills, communication and social skills). The study findings are important (although not unexpected) showing high rates of abnormal health status, including signs of anaemia, respiratory disease, feeding difficulties, poor nutritional status and poor development.

Follow up programmes, early intervention (which is standard practice in higher income settings) and support services for parents of preterm survivors are needed for children born preterm to support them to thrive - this is standard practice in higher income settings.

In Rwanda, I know that steps are being taken to address this need. I've been lucky enough to visit some of the Partners in Health-Inshuti Mu Buzima supported facilities myself in the past few years. What really struck me about these facilities was the potential scalability of the approach to follow up and support for survivors of preterm birth. The follow-up programme was nurse and social worker led, with developmental checks for the infants and young children following well-designed pictorial checklists. Simplified tools and monitoring

systems had been developed for following up of the preterm babies after discharge from the special newborn care unit.

We'd love to hear more examples of such programmes around this World Prematurity Day where we are thinking about improving quality of care for preterm newborns so that these small survivors can go on to thrive in childhood.

Sarah Moxon, RN, MPH, PhD Candidate,  
Research Fellow,  
Maternal, Adolescent, Reproductive and Child Health (MARCH) Centre,  
London School of Hygiene and Tropical Medicine,  
Keppel Street,  
WC1E 7HT  
Skype: sarahgmoxon  
Email: sarah.moxon@lshtm.ac.uk

CHIFA profile: Sarah Moxon works in the Department of Infectious Disease Epidemiology, London School of Hygiene and Tropical Medicine, where she provides research and technical support to the Every Newborn Action Plan and Saving Newborn Lives project. She is a member of the CHIFA working group on Newborn Care.

<http://www.hifa.org/projects/newborn-care>

<http://www.hifa.org/support/members/sarah-2>

Email: sarah.moxon AT lshtm.ac.uk

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (104) Quality care and follow up for preterms  
(2)

Dear Sarah and colleagues,

Thanks for pointing us to this study from Rwanda.

CITATION: Health, nutrition, and development of children born preterm and low birth weight in rural Rwanda: a cross-sectional study

Catherine M. Kirk, Jean Claude Uwamungu, Kim Wilson, Bethany L. Hedt-Gauthier, Neo Tapela, Peter Niyigena, Christian Rusangwa, Merab Nyishime, Evrard Nahimana, Fulgence Nkikabahizi, Christine Mutaganzwa, Eric Ngabireyimana, Francis Mutabazi and Hema Magge

BMC Pediatrics 2017;17:191

<https://doi.org/10.1186/s12887-017-0946-1> (Open access)

Published: 15 November 2017

I was especially interested to read the results:

'Of 158 eligible preterm/LBW children discharged from the neonatal unit, 86 (54.4%) were alive and located for follow-up. Median birth weight was 1650 grams, median gestational age was 33 weeks, and 50.5% were SGA at birth. At the time of household interviews, median age was 22.5 months, 46.5% of children had feeding difficulties and 39.5% reported signs of anemia. 78.3% of children were stunted and 8.8% wasted. 67.4% had abnormal

developmental screening. Feeding difficulties ( $p = 0.008$ ), anemia symptoms ( $p = 0.040$ ), microcephaly ( $p = 0.004$ ), stunting ( $p = 0.034$ ), SGA ( $p = 0.023$ ), very LBW ( $p = 0.043$ ), lower caregiver education ( $p = 0.001$ ), and more children in the household ( $p = 0.016$ ) were associated with lower ASQ-3 scores.'

The statistic that jumps out (for me) is that more than two-thirds of these infants had abnormal developmental screening. Indeed, the authors note in the full text: 'The large number of children who could not be traced may lead to underestimation of mortality, malnutrition, and abnormal development in this study', suggesting the real figure could be even higher. Does anyone have figures from high-income countries as well as from other low-income countries, for us to compare outcomes across countries?

The question then is: What aspects of antenatal, intrapartum, neonatal, or post-neonatal care are primarily leading to such poor outcomes?

Best wishes, Neil

From: "Melissa Gladstone, UK/Malawi" <m.j.gladstone@liverpool.ac.uk>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (105) Quality care and follow up for preterms  
(3)

Hi Neil.

I certainly think it is a massive issue that is not being addressed and which is only going to increase with time. Too often we are concentrating on funding the treatment of children to make sure they survive and then little is done to make sure they thrive.

Our paper from Malawi

<http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001121> demonstrates the high prematurity rate in a community based setting and the poor outcomes in terms of both development and growth of these premature children who were mainly born late-preterm. Those who were born earlier did not survive.

I think we really need to concentrate on improving feeding, nutrition and developmental stimulation in these kids - possibly concentrating more specifically on them through programmes such as the Care for Child Development, but also thinking hard about how we support the mums in terms of feeding methods - I think too often they are expected to somehow manage exclusive expressed breast feeding - not easy, with little support - particularly when back at home when they have many other responsibilities and things to manage.

Just a few thoughts!!!

Melissa

CHIFA profile: Melissa Gladstone is a Senior Lecturer in Paediatric Neurodisability and International Child Health at the University of Liverpool in the UK. Professional interests: My interest is in all aspects of international child health but especially in growth, development and disability of children in international settings. M.J.Gladstone AT liverpool.ac.uk

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (105) Incentives for parents to attend parenting classes?

We're in the process of applying for a grant with our partners in Kampala, Uganda, to implement positive parenting classes for parents of newborns, and we're learning from other colleagues about the challenges of getting parents of newborns to attend classes. Do any of you have parenting classes that you "package" along with any other services ie. job readiness or other education for parents?

Aaron

Aaron J. Miller, MD, MPA  
Assistant Professor of Clinical Pediatrics, Weill Cornell Medicine  
Executive Director, BRANCH - Building Regional Alliances to Nurture Child Health  
branchpartners.org  
Tel: +1 646 284 6677  
Skype: aaron.miller7  
aaron@branchpartners.org

CHIFA profile: Aaron J. Miller is the Executive Director for BRANCH - Building Regional Alliances to Nurture Child Health in the U.S. Professional interests: I am a child abuse pediatrician who founded BRANCH - an NGO whose focus is on developing the capacity of health systems in LMICs to address child maltreatment as a public health issue. We helped Malawi create its first 9 One Stop Centers for child abuse and domestic violence, and we hope to expand to more countries. aaron@branchpartners.org

From: "Sue Prullage, Rwanda" <sue.prullage@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (106) Quality care and follow up for preterms (3)

Newborn Care (106) Quality care and follow up for preterms (3)

This article solidified what I have seen in Rwanda. The Rwandan Neonatal Guidelines recommend a 2 week post discharge follow-up for weight and then they are to be followed at the health centers. An organized follow-up program is important. We have it at the hospital where I work in Rwanda, but have difficulty in getting the families to return. Most will come for 1 follow-up, but very few will come for 2 or 3 follow-up visits. The only time they will come is when they realize their baby is not developing as they should and then we have no real services to help them. We refer to physical therapy if they can't sit or walk. But the children that do not meet the social and language developmental milestones we have nothing to offer them. This just demonstrates that neonatal care is multi-faceted and all of this needs to be addressed as we talk about scaling up care for premature infants.

CHIFA profile: Geralyn Sue Prullage is a member of the board of the Council of

International Neonatal Nurses (COINN). She has worked in Rwanda since 2008 and has helped establish a neonatal unit in a district hospitals. She has a doctorate in Nursing Practice (DNP) and is a certified neonatal/pediatric nurse practitioner. sue.prullage AT gmail.com

From: "Christabel Enweronu-Laryea, Ghana via Dgroups" <CHIFA@dgroups.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (107) Quality care and follow up for preterms  
(4)

Thank you so much for sharing this article from Rwanda. It calls for deep reflection. The quality of life of survivors is dependent on the quality of the whole continuum of care. For low-resource settings prevention of severe disability is our best option as there are limited resources for children with disability.

Effective post hospital discharge follow up remains a challenge for us in sub-Saharan Africa. Inadequate location address system makes tracing parents who do not return for follow up difficult. Human resource limitations especially in district hospitals limits local post-discharge care and transportation costs to larger hospitals is a burden for families etc.

A lot of work needs to be done to equip mothers on effective care for preterm babies at home. The time mothers spend in neonatal units (especially KMC ward) is a great opportunity.

Most countries have high immunization coverage. Are there tools that community health care workers can use to screen infants (hospitalised in the newborn period especially the preterm) during immunization visits? Early identification and referral of children who require extra care could reduce severe disability.

It would helpful to know what other developing countries are doing to improve the quality of follow up care for preterms and other babies discharged from their neonatal units.

CHIFA profile: Christabel Enweronu-Laryea is an Associate Professor of Paediatrics and Child Health at University of Ghana School of Medicine and Dentistry and a Consultant Paediatrician at Korle Bu Teaching Hospital in Accra, Ghana. Her professional interests include teaching paediatrics and providing intensive care for newborns. She is a member of the CHIFA working group on Newborn Care:

<http://www.hifa.org/projects/newborn-care>

<http://www.hifa.org/support/members/christabel>

Email address: chikalaryea AT yahoo.com

From: "Lincetto Ornella, Switzerland" <lincettoor@who.int>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (108) Quality care and follow up for preterms  
(5)

Dear Colleagues,

It is true, it is time to focus not only on the survival of preterm babies but also on the quality of survival for them and their families. A lot can be done to improve outcomes, keeping in

mind that these babies are at higher risk and they and their families require follow up and support well beyond the neonatal period.

Please find attached an article with data from developed countries. [\*see note below]

Best regards,

Ornella Lincetto  
WHO, Geneva

CHIFA profile: Lincetto Ornella is Medical Officer Newborn Health at the World Health Organization in Switzerland. lincetto AT who.int

[\*Note from HIFA moderator (Neil PW): CHIFA does not carry attachments and the article is copyright-protected. Below are the citation and abstract. The full text can be accessed free of charge (after free registration) on the Lancet website here:

[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(08\)60136-1/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(08)60136-1/fulltext)

CITATION: Lancet. 2008 Jan 19;371(9608):261-9. doi: 10.1016/S0140-6736(08)60136-1.

An overview of mortality and sequelae of preterm birth from infancy to adulthood.

Prof Saroj Saigal, FRCP[C] Correspondence information about the author Prof Saroj Saigal  
Email the author Prof Saroj Saigal, Prof Lex W Doyle, FRACP

**ABSTRACT:** Survival rates have greatly improved in recent years for infants of borderline viability; however, these infants remain at risk of developing a wide array of complications, not only in the neonatal unit, but also in the long term. Morbidity is inversely related to gestational age; however, there is no gestational age, including term, that is wholly exempt. Neurodevelopmental disabilities and recurrent health problems take a toll in early childhood. Subsequently hidden disabilities such as school difficulties and behavioural problems become apparent and persist into adolescence. Reassuringly, however, most children born very preterm adjust remarkably well during their transition into adulthood. Because mortality rates have fallen, the focus for perinatal interventions is to develop strategies to reduce long-term morbidity, especially the prevention of brain injury and abnormal brain development. In addition, follow-up to middle age and beyond is warranted to identify the risks, especially for cardiovascular and metabolic disorders that are likely to be experienced by preterm survivors

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>

To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>

Subject: [chifa] Newborn Care (106) World Prematurity Day is Today! Please show your support

World Prematurity Day is today 17th November! We invite all CHIFA members to help to make this day count. Please consider any or all of the following:

1. Send a message today to [chifa@dgroups.org](mailto:chifa@dgroups.org) - introduce yourself (if you have not done so previously) and tell us why you think today is so important for global health
2. Share your story of a child who was born too early.

3. Go to the the Twitter hashtag #WorldPrematurityDay <https://twitter.com/hashtag/WorldPrematurityDay?src=hash> and follow the discussion - there will be lots happening all day today! Re-tweet / like a message (or three!) to your followers.

4. Send out your own tweet. Here are suggestions from the Healthy Newborn Network:

Let them thrive! The presence of parents is vital for the development of preterm babies in hospital. #worldprematurityday

We can change the face of #premature birth. Join us Nov 17 on #worldprematurityday #LetThemThrive [Include image]

15 million babies are #borntoosoon around the world every year. Low-cost solutions exist and can save lives #worldprematurityday

Do you have a personal experience with #premature birth? Help us mark #worldprematurityday by sharing your story: [po.st/8AIv7b](https://po.st/8AIv7b)

--

Best wishes, Neil

From: "Neil Pakenham-Walsh" <[neil.pakenham-walsh@ghi-net.org](mailto:neil.pakenham-walsh@ghi-net.org)>

To: "CHIFA - Child Health and Rights" <[CHIFA@dgroups.org](mailto:CHIFA@dgroups.org)>

Subject: [chifa] Newborn Care (110) WHO's Africa

Nutrition Report highlights an increase in malnutrition in Africa

This news item is from the WHO Regional Office for Africa website. Full text here: <http://www.afro.who.int/news/whos-africa-nutrition-report-highlights-increase-malnutrition-africa>

It is notable that the 69-page full text of the report ([http://www.afro.who.int/sites/default/files/2017-11/Nutrition%20in%20the%20WHO%20African%20Region%202017\\_0.pdf](http://www.afro.who.int/sites/default/files/2017-11/Nutrition%20in%20the%20WHO%20African%20Region%202017_0.pdf)) does not mention preterm birth/prematurity. We know, however, from the Rwanda research highlighted by Sarah Moxon that '46.5% of [such] children had feeding difficulties and 39.5% reported signs of anemia; 78.3% of children were stunted and 8.8% wasted'.

--

WHO's Africa Nutrition Report highlights an increase in malnutrition in Africa. Critical gaps in data also a concern.

Abidjan, 16 November, 2017 - A newly released nutrition report by the World Health Organization (WHO) Regional Office for Africa has revealed that undernutrition is still persistent in the region and the number of stunted children has increased. The Africa Nutrition Report, launched today in Abidjan, Ivory Coast also indicates that a growing number of children under five years old are overweight. The Report describes the current status in relation to six global nutrition targets that member states have committed to achieve by 2025, and underscores findings from the recently released Global Nutrition Report...

The Report points out that while the prevalence of stunting decreased between 2000 and 2016, the absolute numbers of stunted children are in fact increasing: from 50.4 million in 2000 to 58.5 million in 2016. Stunting, or impaired growth and development happens when children experience poor nutrition, disease and lack of psychosocial stimulation. It typically

occurs before a child reaches the age of two, and the long-term consequences include poor school performance, low adult wages, lost productivity and increased risk of nutrition-related chronic diseases in adults. ..

Joint UNICEF, WHO and World Bank 2016 estimates show that the number of overweight children in Africa increased by more than 50 percent between 2000 and 2015. The Report found that 24 countries have rates between 3 and 10 percent; above this range are Algeria (12.4 percent), Botswana (11.2 percent), Comoros (10.9 percent), Seychelles (10.2 percent), and South Africa (10.9 percent).

“African Governments can, and should, take measures to prevent and reduce undernutrition by creating favourable environments for improved infant and young child feeding, improved water supplies and sanitation, and offering healthier foods in schools among other measures,” said Dr Francesco Branca, Director of the Nutrition Department at the WHO Headquarters in Geneva. Dr Branca emphasized the need to reduce consumption of refined carbohydrates and foods high in sugars and fat, which can be achieved by making sugary drinks less affordable and less appealing through taxation, labelling, and changing marketing practices.

For more information, please contact:

Maureen Nkandu

Regional Communication Manager

WHO Regional Office for Africa

Tel: +47 24139982

Email: nkandum@who.int

--

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>

To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>

Subject: [chifa] Newborn Care (110) WHO's Africa

Nutrition Report highlights an increase in malnutrition in Africa

This news item is from the WHO Regional Office for Africa website. Full text here:

<http://www.afro.who.int/news/whos-africa-nutrition-report-highlights-increase-malnutrition-africa>

It is notable that the 69-page full text of the report

([http://www.afro.who.int/sites/default/files/2017-](http://www.afro.who.int/sites/default/files/2017-11/Nutrition%20in%20the%20WHO%20African%20Region%202017_0.pdf)

[11/Nutrition%20in%20the%20WHO%20African%20Region%202017\\_0.pdf](http://www.afro.who.int/sites/default/files/2017-11/Nutrition%20in%20the%20WHO%20African%20Region%202017_0.pdf)) does not mention preterm birth/prematurity. We know, however, from the Rwanda research highlighted by Sarah Moxon that '46.5% of [such] children had feeding difficulties and 39.5% reported signs of anemia; 78.3% of children were stunted and 8.8% wasted'.

--

WHO's Africa Nutrition Report highlights an increase in malnutrition in Africa. Critical gaps in data also a concern.

Abidjan, 16 November, 2017 - A newly released nutrition report by the World Health Organization (WHO) Regional Office for Africa has revealed that undernutrition is still

persistent in the region and the number of stunted children has increased. The Africa Nutrition Report, launched today in Abidjan, Ivory Coast also indicates that a growing number of children under five years old are overweight. The Report describes the current status in relation to six global nutrition targets that member states have committed to achieve by 2025, and underscores findings from the recently released Global Nutrition Report...

The Report points out that while the prevalence of stunting decreased between 2000 and 2016, the absolute numbers of stunted children are in fact increasing: from 50.4 million in 2000 to 58.5 million in 2016. Stunting, or impaired growth and development happens when children experience poor nutrition, disease and lack of psychosocial stimulation. It typically occurs before a child reaches the age of two, and the long-term consequences include poor school performance, low adult wages, lost productivity and increased risk of nutrition-related chronic diseases in adults. ..

Joint UNICEF, WHO and World Bank 2016 estimates show that the number of overweight children in Africa increased by more than 50 percent between 2000 and 2015. The Report found that 24 countries have rates between 3 and 10 percent; above this range are Algeria (12.4 percent), Botswana (11.2 percent), Comoros (10.9 percent), Seychelles (10.2 percent), and South Africa (10.9 percent).

“African Governments can, and should, take measures to prevent and reduce undernutrition by creating favourable environments for improved infant and young child feeding, improved water supplies and sanitation, and offering healthier foods in schools among other measures,” said Dr Francesco Branca, Director of the Nutrition Department at the WHO Headquarters in Geneva. Dr Branca emphasized the need to reduce consumption of refined carbohydrates and foods high in sugars and fat, which can be achieved by making sugary drinks less affordable and less appealing through taxation, labelling, and changing marketing practices.

For more information, please contact:

Maureen Nkandu

Regional Communication Manager

WHO Regional Office for Africa

Tel: +47 24139982

Email: nkandum@who.int

--

From: "Christabel Enweronu-Laryea, Ghana via Dgroups" <CHIFA@dgroups.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (111) World Prematurity Day is Today! Please show your support (2)

We at Paediatric Society of Ghana are celebrating WPD today. This piece of work written for WPD by Catherine Segbefia (see attached document) captures the context of preterms in sub-Saharan Africa. Please kindly share widely. [\*see note below]

Christabel

CHIFA profile: Christabel Enweronu-Laryea is an Associate Professor of Paediatrics and Child Health at University of Ghana School of Medicine and Dentistry and a Consultant

Paediatrician at Korle Bu Teaching Hospital in Accra, Ghana. Her professional interests include teaching paediatrics and providing intensive care for newborns. She is a member of the CHIFA working group on Newborn Care:

<http://www.hifa.org/projects/newborn-care>

<http://www.hifa.org/support/members/christabel>

Email address: chikalaryea AT yahoo.com

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (112) World Prematurity Day is Today! Please show your support (3)

Dear Christabel and Catherine,

Thank you again for this beautiful poem.

I have tweeted it here:

[https://twitter.com/hifa\\_org/status/931518980455575552](https://twitter.com/hifa_org/status/931518980455575552)

All: please go this URL and re-tweet this to your followers. Let this poem be seen by Twitter followers worldwide - on behalf of every preemie!

Best wishes, Neil

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (112) World Prematurity Day is Today! Please show your support (3)

Dear Christabel and Catherine,

Thank you again for this beautiful poem.

I have tweeted it here:

[https://twitter.com/hifa\\_org/status/931518980455575552](https://twitter.com/hifa_org/status/931518980455575552)

All: please go this URL and re-tweet this to your followers. Let this poem be seen by Twitter followers worldwide - on behalf of every preemie!

Best wishes, Neil

From: "Sarah Zadik, UK" <sarahpaul@talk21.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (114) Involving mothers and fathers in the care of the premature baby

I am a retired UK GP/family doctor. Before I became a GP I worked in neonatal medicine in Ghana. As a GP I was aware of the effects of post-natal depression on mother-child bonding and both physical and psychosocial development of the child.

Mothers of pre-term babies are at increased risk of post-natal depression. Involving these mothers, and fathers, in the care of the premature baby, giving them encouragement and family support may alleviate the postnatal depression, which helps the baby to thrive. This does not need any expensive equipment and in the long run is just as important as the technical care in the neonatal unit.

Sarah Zadik, retired doctor, Sheffield UK

HIFA profile: Sarah Zadik is a retired GP/family doctor based in Sheffield, UK. sarahpaul AT talk21.com \_\_\_\_\_

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (115) Preterm Birth: A Critical Issue for the Mother-Baby Dyad

Dear CHIFA colleagues,

Below are extracts from a blog from the Maternal Health Task Force. Full text here: <https://www.mhtf.org/2017/11/17/preterm-birth-a-critical-issue-for-the-mother-baby-dyad/>

--

Preterm Birth: A Critical Issue for the Mother-Baby Dyad

Posted on November 17, 2017

By: Sarah Hodin, Project Coordinator II, Women and Health Initiative, Harvard T.H. Chan School of Public Health

According to World Health Organization (WHO) estimates, prematurity is the leading underlying cause of death in children under five years, with over one million babies dying each year worldwide due to complications of preterm birth. For those who survive, the consequences of being born too soon can continue throughout the life course, impacting individuals, families and communities...

The rates of prematurity are rising around the world. Of the 15 million babies born preterm every year, 60% occur in Africa and South Asia. A baby's risk of death due to prematurity depends largely on where he or she is born: In high-income countries, 50% of babies born at less than 28 weeks survive, while half of babies born at 32 weeks die in low-income countries. Moderate or late preterm babies can often be cared for effectively with simple, low-cost, evidence-based methods requiring limited technology, such as kangaroo mother care and feeding support.

Although the causes of preterm birth are complex, risk factors include maternal smoking and substance abuse, adolescent pregnancy, infections like syphilis, Group B streptococcus and malaria, pre-eclampsia, bleeding in pregnancy and premature rupture of membranes. High quality preconception and prenatal care are key factors in preventing preterm delivery...

While administering antenatal corticosteroids has been promoted as an effective way to prepare preterm babies' immature lungs for life outside the womb in case of imminent

preterm birth, the treatment is debated for its implementation challenges, including insufficient support for managing side effects...

--

The above relate to two of the '25 unanswered questions' in our discussion: 'How many newborn deaths might have been prevented with better antenatal care?', and (Nkuranga John Baptist): 'You may well be aware of Antenatal corticosteroid controversies in low income countries, why didn't they work as expected in reference to high income countries?'

Best wishes, Neil

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (116) 25 unanswered questions (3) How many babies in LMICs are delivered at home versus primary health centre versus small hospital versus referral hospital?

Dear CHIFA colleagues,

We put our 25 unanswered questions to a group of newborn care experts for their thoughts. We are grateful to Mike English (Kenya) for commenting on Question 1 (from me): How many babies in LMICs are delivered at home versus primary health centre versus small hospital versus referral hospital?

Mike English: Hi Neil, we don't know the answer to this question - or at least no better answer than is available from all the DHS work but we have recently looked at who is accessing care in Nairobi County. Results suggest almost 1 in 5 babies will need some form of facility based / coordinated care here: <http://gh.bmj.com/content/2/4/e000472.article-info>

CITATION: Estimating the need for inpatient neonatal services: an iterative approach employing evidence and expert consensus to guide local policy in Kenya  
Georgina A V Murphy, Donald Waters, Paul O Ouma, David Gathara, Sasha Shepperd, Robert W Snow, Mike English  
BMJ Global Health 2017  
DOI: 10.1136/bmjgh-2017-000472 Published 14 November 2017

## ABSTRACT

Universal access to quality newborn health services will be essential to meeting specific Sustainable Development Goals to reduce neonatal and overall child mortality. Data for decision making are crucial for planning services and monitoring progress in these endeavours. However, gaps in local population-level and facility-based data hinder estimation of health service requirements for effective planning in many low-income and middle-income settings.

We worked with local policy makers and experts in Nairobi City County, an area with a population of four million and the highest neonatal mortality rate amongst counties in Kenya, to address this gap, and developed a systematic approach to use available data to support

policy and planning. We developed a framework to identify major neonatal conditions likely to require inpatient neonatal care and identified estimates of incidence through literature review and expert consultation, to give an overall estimate for the year 2017 of the need for inpatient neonatal care, taking account of potential comorbidities.

Our estimates suggest that almost 1 in 5 newborns (183/1000 live births) in Nairobi City County may need inpatient care, resulting in an estimated 24 161 newborns expected to require care in 2017. Our approach has been well received by local experts, who showed a willingness to work together and engage in the use of evidence in healthcare planning. The process highlighted the need for co-ordinated thinking on admission policy and referral care especially in a pluralistic provider environment helping build further appetite for data-informed decision making.

--

To review the 25 questions (and add your own comments) see the Google document here: [https://docs.google.com/document/d/1nrTSYhCy6tUBG1uwAjfNf39f6pqr3fTMuqwpZI\\_cQ/edit?usp=sharing](https://docs.google.com/document/d/1nrTSYhCy6tUBG1uwAjfNf39f6pqr3fTMuqwpZI_cQ/edit?usp=sharing)

Best wishes,  
Neil

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (117) 25 unanswered questions (4) How many newborn deaths occur at each of the above levels of the health system?

Our thanks again to Mike English (Kenya) for addressing Question 2 (from me): How many newborn deaths occur at each of the above levels of the health system?

ME: Can't answer this question but we have examined data from 12 county hospitals in Kenya for a full year and about 1/3rd of all admissions to hospital in the under 5 age group are now neonates and about 1 in 6 neonatal admissions is to a paediatric ward not a newborn unit.

--

To review the 25 questions (and add your own comments) see the Google document here: [https://docs.google.com/document/d/1nrTSYhCy6tUBG1uwAjfNf39f6pqr3fTMuqwpZI\\_cQ/edit?usp=sharing](https://docs.google.com/document/d/1nrTSYhCy6tUBG1uwAjfNf39f6pqr3fTMuqwpZI_cQ/edit?usp=sharing)

Best wishes,  
Neil

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (118) 25 unanswered questions (5) Does every country need a champion to advocate for family-centered care?

Thank you Mike English (Kenya) for commenting on Question 9 (from Lily Kak, USA): Does every country need a champion to advocate for such family-centered care? Does every country need to generate evidence on the approach? Are countries ready for such a paradigm-shift or is this approach more appropriate in certain contexts and not in others? Any comments from the experts?

ME: Hi Lily, I think countries are ready for a paradigm shift but I am not sure the partner and programme and research communities are! What we need for such a paradigm shift is long term engagement with national institutions (spanning government, education, health care training centres, and professional associations) to build and sustain locally owned initiatives. There is so little coordination across groups each with its own targets and timelines that really changing cultures is going to take much longer than it might (and even if all was perfect it would take time!).

--

To review the 25 questions (and add your own comments) see the Google document here: [https://docs.google.com/document/d/1nrTSYhCy6tUBG1uwAjfNf39f6pqcrcf3fTMuqwpZI\\_cQ/edit?usp=sharing](https://docs.google.com/document/d/1nrTSYhCy6tUBG1uwAjfNf39f6pqcrcf3fTMuqwpZI_cQ/edit?usp=sharing)

Or send your reflections direct to: [chifa@dgroups.org](mailto:chifa@dgroups.org)

Best wishes,  
Neil

From: "Nick Spencer, UK" <N.J.Spencer@warwick.ac.uk>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (119) Quality care and follow up for preterms  
(6) Social determinants of newborn health

Dear colleagues,

Mortality among preterm infants in low income countries (LICs) is high and responsible for much of the high neonatal mortality in these countries. Improvements in neonatal care, as discussed in the extensive and informative contributions to the Newborn care strand, are essential but high quality neonatal care cannot overcome the basic social and economic drivers of high rates of preterm births, SGA, and neonatal mortality or the problems of development and thriving of infants born preterm as shown by Sarah Moxon and Melissa Gladstone. Maternal malnutrition and low education, both closely associated with chronic poverty, increase the risk of preterm birth and SGA. Poverty also plays a key role in increasing the risk of morbidity, poor development and growth among surviving preterm infants.

While it is imperative that health professionals work to improve neonatal care for preterm infants in LICs, we also need to recognise the social and economic drivers of the problems faced by the infants in our care and advocate for social and economic policy solutions which address these drivers drawing on the experience of LICs which have successfully introduced measures to reduce poverty and malnutrition, and increase access to education particularly for girls.

Nick Spencer

Professor Nick Spencer, Emeritus Professor of Child Health,  
Division of Mental Health and Wellbeing,  
Warwick Medical School,  
University of Warwick,  
Coventry CV4 9JD, UK  
Home phone: +44(0)1926 424414  
Mobile: +44(0)7542961640

ISSOP President

HIFA profile: Nick Spencer is Emeritus Professor of Child Health at the School of Health and Social Studies, University of Warwick in the UK. N.J.Spencer AT warwick.ac.uk

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (120) What are the standards of knowledge and skills training (neonatal) in our nursing and medical schools?

Dear CHIFA colleagues,

Our thanks to Sue Prullage (Rwanda) and Mike English (Kenya), who have responded to Christabel Enweronu-Laryea's question:

Question 10. Christabel Enweronu-Laryea, Ghana: "What are the standards of knowledge and skills training (neonatal) for undergraduate and postgraduate trainees in our nursing and medical schools? What is the quality of the output from our institutions? How sustainable are external efforts if we do not improve the quality of training?"

Answer 1, Sue Prullage, Rwanda: "In many countries the education for undergraduate and postgraduate trainees is minimal and in an infancy phase. What I have seen is that a group of students with minimal experience go through a post graduate program and instead of allowing them to work in a neonatal unit many are recruited to teach the next cohort. This is going to keep the level of attainment at knowledge level only and not advance to advanced applied theory or even as an expert in neonatology. I agree that the quality of training is needed and this may mean a commitment by the university to hire an expert from another country to spend time in their country teaching and helping students move from knowledge to applied knowledge."

Answer 2, Mike English, Kenya: "Most medical training schools I know in East Africa provide a total of 10 weeks paediatric training of which 2 weeks is neonatal care - and often the large numbers of students are not welcome on wards for infection control reasons! Degree nurses in Kenya do 2 weeks neonatal training!"

--

To review the 25 questions (and add your own comments) see the Google document here:  
[https://docs.google.com/document/d/1nrTSYhCy6tUBG1uwAjfNf39f6pqrerf3fTMuqwpZI\\_cQ/edit?usp=sharing](https://docs.google.com/document/d/1nrTSYhCy6tUBG1uwAjfNf39f6pqrerf3fTMuqwpZI_cQ/edit?usp=sharing)

Or send your reflections direct to: [chifa@dgroups.org](mailto:chifa@dgroups.org)

Best wishes,  
Neil

From: "Neil Pakenham-Walsh" <[neil.pakenham-walsh@ghi-net.org](mailto:neil.pakenham-walsh@ghi-net.org)>  
To: "CHIFA - Child Health and Rights" <[CHIFA@dgroups.org](mailto:CHIFA@dgroups.org)>  
Subject: [chifa] Newborn Care (121) Accreditation and certification

Dear CHIFA colleagues,

Our thanks to Sue Prullage (Rwanda) for her response to Christabel Enweronu-Laryea's question on accreditation and certification:

Question 11. Christabel Enweronu-Laryea, Ghana: Accreditation and certification (examination) bodies: Are the standards and approach appropriate for improving neonatal outcome in that setting? Is improving quality of care for newborns a priority?

Response: Sue Prullage, Rwanda: This is something COINN [Council of International Neonatal Nurses] is thinking about and have made inquiries. But before we can move to accreditation and certification we need a commitment from the government that declares there is a neonatal nurse or doctor and develop the competencies needed to be call this. This takes a commitment from the government and nursing councils to really think about and contact other countries as to what is a competent neonatal nurse.

--

To review the 25 questions (and add your own comments) see the Google document here: [https://docs.google.com/document/d/1nrTSYhCy6tUBG1uwAjfNf39f6pqr3fTMMuqwpZI\\_cQ/edit?usp=sharing](https://docs.google.com/document/d/1nrTSYhCy6tUBG1uwAjfNf39f6pqr3fTMMuqwpZI_cQ/edit?usp=sharing)

Or send your reflections direct to: [chifa@dgroups.org](mailto:chifa@dgroups.org)

Best wishes,  
Neil

From: "Neil Pakenham-Walsh" <[neil.pakenham-walsh@ghi-net.org](mailto:neil.pakenham-walsh@ghi-net.org)>  
To: "CHIFA - Child Health and Rights" <[CHIFA@dgroups.org](mailto:CHIFA@dgroups.org)>  
Subject: [chifa] Newborn Care (122) 25 unanswered questions (6)

Our thanks again to Sue Prullage (Rwanda), who responds to four questions from Claire Keene (UK/Kenya):

QUESTION 18. Claire Keene, UK/Kenya: "What constitutes a newborn unit? Should any facility performing deliveries have a newborn unit that offers standard in-patient care, or should it be restricted to hospitals only?"

Sue Prullage, Rwanda: "Interesting question. Then we would have to define 'standard in-patient care.' Policies and guidelines would have to be developed as to who can stay or who should be transferred to a higher level of care? Staff would need to be trained in the care of the small baby and all the possibilities of problems that can develop with them."

QUESTION 19. Claire Keene, UK/Kenya: "Should non-NICU inpatient care be categorised as one level or further subdivided into basic and comprehensive care? Should some non-NICU newborn units be able to provide higher dependency care that alleviates the pressure on NICUs? Or should all high dependency care be provided at NICU level only?"

Sue Prullage, Rwanda: "Once again what is basic versus comprehensive care. In my experience the lines are blurred because of the distance of the basic unit from the higher level of care. Without a true transport system infants would die before reaching the higher level of care. So whatever can be done is done and if the child worsens often the family elect to go on palliative care. Transportation of a neonate is a whole different topic but when we advocate for there to be only higher level of care in the bigger cities this will probably worsen neonatal mortality"

QUESTION 20. Claire Keene, UK/Kenya: "What care could realistically be provided in a high dependency unit (CPAP? Exchange transfusion?)? Are there pivotal or distinguishing services that define a unit as a specific level of care, for example CPAP defining a high-care unit?"

Sue Prullage, Rwanda: "Maybe we should go to the higher income country literature that defines the level of care."

QUESTION 21. Claire Keene, UK/Kenya: "Should care be completely regionalised with basic facilities referring to central high level facilities, or should some higher level services be distributed closer to the receiving population? For example, having high dependency units at low level hospitals in rural areas. Should efforts be made to improve transport networks or should poor referral systems be compensated for by providing higher level care at more hospitals?"

Sue Prullage, Rwanda: "I do not think that care should be completely regionalized with basic facilities referring to central high level facilities. As stated before transport alone is often the cause of death for the infant. I think a high dependency unit at low level hospitals in rural areas would be good if the staff and doctors are specially trained in neonatal issues. The transport process could be looked at and guidelines written. The process is at the institution where I practice is to send whatever nurse is available to get the child at the health center. He or she is not trained to anticipate complications, glucose levels are not monitored, they often do not have equipment to treat respiratory distress, IV's are not started and small vulnerable infants go without glucose for hours as they travel to the higher level unit. KMC is sometimes used and sometimes not."

--

To review the 25 questions (and add your own comments) see the Google document here: [https://docs.google.com/document/d/1nrTSYhCy6tUBG1uwAjfNf39f6pqcrf3fTMuqwpZI\\_cQ/edit?usp=sharing](https://docs.google.com/document/d/1nrTSYhCy6tUBG1uwAjfNf39f6pqcrf3fTMuqwpZI_cQ/edit?usp=sharing)

Or send your reflections direct to: [chifa@dgroups.org](mailto:chifa@dgroups.org)

Best wishes,  
Neil

From: "Akshaya Srikanth Bhagavathula, Ethiopia" <akshaypharmd@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (123) Emergency Obstetric and Newborn Care (EmONC) in Ethiopia

Dear CHIFA members,

In 2015, an estimated 303,000 women died due to pregnancy and child birth related complications. Of these, Sub-Saharan Africa constitutes 66 percent of the global burden, as some sources indicated. Recently, Ethiopia has launched Emergency Obstetric and Newborn Care (EmONC) assessment report. EmONC refers to the care of women and newborn during pregnancy, the time after delivery if or when women her newborn experiences serious complications. The primary objective of the report was to generate evidence on the current availability, utilization and quality of EmONC service in Ethiopia, and to measure progress since 2008 when the first assessment was implemented.

The major causes of maternal mortality in Ethiopia are haemorrhage, hypertension in pregnancy, obstructed labor, sepsis, and anemia.

The under five mortality rate in the country has also declined from 205 to 145 per 1000 live births between 1990 and 2015. During the same period, neonatal mortality has declined from 61 to 28 per 1000 live births. The primary causes of neonatal mortality are asphyxia, prematurity, sepsis and congenital abnormalities.

The report found out that since 2008, Ethiopia has seen substantial improvement in the availability of EmONC facilities per 500,000 populations (UN recommended standards). In 2008, the nation had just 11 percent of the recommended number of fully functioning EmONC facilities, nationally. However, in 2016 the proportion increased to 40 percent. Despite the improvements, a large gap remains to reach 100 percent of the recommendation.

Nearly 85 percent of facilities provided focused antenatal care, postnatal care, family planning diagnosis and treatments of Sexually Transmitted Infectious (STIs) and the Prevention of Mother-To-Child Transmission (PMTCT) package.

Over the past eight years, the Ministry of Health has constructed a number of new facilities though gaps remain in the number of primary hospitals and rural health centers if the country has to meet its own standards of facilities to population size.

Dr. Akshaya Srikanth Bhagavathula, Pharm.D  
Assistant Professor of Clinical Pharmacy,  
University of Gondar-College of Medicine and Health Sciences,  
School of Pharmacy, Gondar, Ethiopia  
+251-985051991  
Skype: akshaya.bhagavatula

HIFA profile: Akshaya Srikanth is an Assistant Professor at the University of Gondar in Ethiopia. Professional interests: Communicable and non-communicable diseases. akshaypharmd AT gmail.com

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (124) UNICEF Child Mortality Report 2017

Dear CHIFA colleagues,

(with thanks to Dieter Neuvians and HESP News)

UNICEF has just published a new report that provides useful data on newborns (and older children):

CITATION: Levels and Trends in Child Mortality Report 2017  
by Lucia Hug, David Sharrow, Yuhang Sun et al.  
United Nations Children's Fund et al., October 2017

[https://www.unicef.org/publications/files/Child\\_Mortality\\_Report\\_2017.pdf](https://www.unicef.org/publications/files/Child_Mortality_Report_2017.pdf)

Some key points:

In the context of monitoring child survival, the United Nations Inter-agency Group for Child Mortality Estimation (UN IGME) updates child mortality estimates annually.

This report presents the group's latest estimates of under-five, infant and neonatal mortality up to 2016, and assesses progress at the country, regional and global levels. For the first time, the report also provides mortality estimates for children aged 5 to 14.

The largest number of newborn deaths occurred in Southern Asia (39 per cent), followed by sub-Saharan Africa (38 per cent). Five countries accounted for half of all newborn deaths: India, Pakistan, Nigeria, the Democratic Republic of the Congo and Ethiopia.

The neonatal mortality rate fell by 49 per cent from 37 (36, 38) deaths per 1,000 live births in 1990 to 19 (18, 20) in 2016.

Children face the highest risk of dying in their first month of life, at a rate of 19 deaths per 1,000 live births. By comparison, the probability of dying after the first month but before reaching age 1 is 12 and after age 1 but before turning 5 is 11.

Progress is slower in reducing neonatal mortality rates than in reducing mortality rates in children aged 159 months. While neonatal mortality declined by 49 per cent, the mortality in children aged 159 months declined by 62 per cent from 1990 to 2016.

--

Comment (NPW): What this report does \*not\* tell us is:

How many babies in LMICs are delivered at home versus primary health centre versus small hospital versus referral hospital

How many newborn deaths occur at home versus primary health centre versus small hospital versus referral hospital

How many deaths might have been prevented with better antenatal and/or neonatal care and many other of our 'unanswered questions'

[https://docs.google.com/document/d/1nrTSYhCy6tUBG1uwAjfNf39f6pqcrf3fTMuqwpZI\\_cQ/edit#](https://docs.google.com/document/d/1nrTSYhCy6tUBG1uwAjfNf39f6pqcrf3fTMuqwpZI_cQ/edit#)

Best wishes, Neil

From: "Bolajoko Olusanya, Nigeria via Dgroups" <CHIFA@dgroups.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (125) UNICEF Child Mortality Report 2017 (2)  
Neonatal jaundice (4)

Dear Neil,

Thanks for sharing this report. I observed that it is geared towards the Sustainable Development Goals with the mantra "leave no one behind". Unfortunately, compared to prior reports from this high-powered group this latest report based, on statistical modeling, does not provide any additional useful information on the causes of neonatal deaths in the leading countries such as Nigeria to facilitate requisite interventions. For example, evidence from the vast literature (1,2) for several decades and local clinicians (3) have shown repeatedly that bilirubin-induced mortality resulting from severe neonatal jaundice is an important cause of mortality in Nigeria. This type of avoidable omission could somehow undermine the credibility of the report by potential users in the affected countries. The Global Burden of Disease (GBD) Study recently published in the Lancet (September 16) would thus appear to provide a more robust and reliable profile of causes of neonatal mortality especially in high burden countries based on the International Classification of Diseases (ICD) 10th revision. The specific contributions of severe neonatal jaundice especially in the first week of life globally is a subject of a forthcoming paper in Pediatrics provisionally scheduled for February 2018 issue. Let's hope future reports from the group will reflect the situations on the ground in many developing countries more accurately.

1. Olusanya BO, Osibanjo FB, Mabogunje CA, Slusher TM, Olowe SA. The burden and management of neonatal jaundice in Nigeria: A scoping review of the literature. Niger J Clin Pract. 2016 Jan-Feb;19(1):1-17.

<http://www.njcponline.com/article.asp?issn=1119-3077;year=2016;volume=19;issue=1;spage=1;epage=17;aulast=Olusanya>

2. Olusanya BO, Ogunlesi TA, Slusher TM. Why is kernicterus still a major cause of death and disability in low-income and middle-income countries? Arch Dis Child. 2014 Dec;99(12):1117-21.

<http://adc.bmj.com/content/99/12/1117>

3. Olusanya BO, Ezeaka CV, Ajayi-Obe EK, Mukhtar-Yola M, Ofovwe GE. Paediatricians' perspectives on global health priorities for newborn care in a developing country: a national survey from Nigeria. BMC Int Health Hum Rights. 2012 Jul 2;12:9.

<https://bmcinthealthhumrights.biomedcentral.com/articles/10.1186/1472-698X-12-9>

Cheers

Bolajoko O. Olusanya MBBS, FMCPaed, FRCPCH, PhD  
Director, Centre for Healthy Start Initiative, Ikoyi, Lagos, NIGERIA  
(Organisation in Special Consultative Status with UN-ECOSOC)  
Email: boo@hsicentre.org; bolajoko.olusanya@uclmail.net  
Website: [www.hsicentre.org](http://www.hsicentre.org)

CHIFA profile: Bolajoko Olusanya is a developmental paediatrician, and global child health advocate for vulnerable but neglected populations in low and middle-income countries. She is currently the Executive Director of the Centre for Healthy Start Initiative, an organisation in special consultative status with The United Nations Economic and Social Council (ECOSOC). boolusanya AT aol.com