



## CHIFA Discussion on Newborn Care #2

Who is caring for the newborn?

19 February to 30 March 2018

FULL TEXT (78 pp)

With thanks to ENAP Metrics (Every Newborn Action Plan) for financial support for this discussion, and to the members of the CHIFA working group on Newborn Care for their technical support.

<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>

There were 99 contributions from 40 CHIFA members in 18 countries (Brazil, Canada, Georgia, India, Kenya, Nigeria, Pakistan, Philippines, Rwanda, South Africa, South Sudan, Sudan, Sweden, Tanzania, Turkey, Uganda, UK, USA). Special thanks to our super-contributors Sue Prullage (11 messages) and Ruth Davidge (8 messages) - we have learned so much from your work in Rwanda and South Africa, respectively.

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

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

Subject: [chifa] Newborn Care: Introduction to Part 2

Welcome to Part 2 of our global discussion on Newborn Care: Who is caring for the newborn? How can they be better supported?

When? 19 February to 30 March 2018

Where? The discussion will take place here on the CHIFA forum. All messages will have 'Newborn Care' in the subject line so you can easily distinguish from other CHIFA messages.

Please help to publicise this discussion. Forward this message to your friends, colleagues, networks, Facebook and LinkedIn groups, and encourage everyone to join us. Please point them to our landing page here: <http://www.hifa.org/news/join-chifa-global-discussion-newborn-care-low-and-middle-income-countries>

People can also join CHIFA direct here: <http://www.hifa.org/join/join-chifa-child-health-and-rights>

### INTRODUCTION

Who will step up during the next decade to implement and integrate life-saving interventions and services for newborns? Decision-making leading to the implementation of newborn health services and interventions within broader health programmes requires multiple actors and levels of involvement. It is only with the mobilisation of communities and civil society, health workers and professional groups, and parents as well as leadership and champions within the health system, that the implementation of quality newborn care will be integrated into existing health system structures. These very groups are our CHIFA members, and we invite you to contribute to the next phase of the discussion.

## BACKGROUND

We are now four years on from the publication of The Lancet Every Newborn series. This series provided the evidence for the launch of the Every Newborn Action Plan, a global multi-partner project that aims to end preventable maternal and newborn deaths, and stillbirths by 2030. The Lancet series included an article titled 'Who has been caring for the baby?' which reviewed the progress made in bringing newborn health to the forefront of the child health agenda, and reminded us of the 1990s when newborn care, particularly care for sick newborns, was viewed as too complex and technological - out of reach for lower income health systems.

The Lancet Every Newborn series provided firm evidence that interventions and services for newborns, including those born small and sick, are affordable. Rising levels of facility deliveries globally mean that more newborn deaths are occurring within hospitals, and over two-thirds of these deaths could be prevented with effective hospital care of small and sick newborns. For example, up to 70% of preterm deaths could be averted with the provision of basic inpatient care including warmth, feeding support, infection prevention and kangaroo mother care. Such care does not need to be unaffordable for health systems; in fact, the cost of failing to provide this care could be far greater.

## QUESTIONS

We ask CHIFA members (>3500 child health professionals in 140 countries worldwide):

1. Who is the health worker caring for the newborn? In your countries and programmes who is caring for small and sick newborns? Midwives and nurses? Obstetricians? Who are the champions of newborn care? Has this changed?
2. Where in the hospital are small and sick newborns cared for? What infrastructure, equipment, commodities, guidelines are needed for small and sick newborn care?
3. How is the family involved in caring for small and sick newborns? Is there family centred care in neonatal units? Are your facilities implementing kangaroo mother care? What does family-centred care mean in your context? What can be done to strengthen the quality of family-centred care?
4. Who in the ministry is responsible for newborn programmes, at the national level? What about referral systems? What about measurement and accountability?
5. Who are the key players in the global health architecture for newborn care? UNICEF is making newborns their advocacy priority this year. Is this the UN responsibility alone? What about WHO, donors, professional groups and academics?

## ABOUT THE CHIFA NEWBORN CARE PROJECT

The CHIFA Newborn Care Project supports the CHIFA community (>3500 child health professionals worldwide) in global discussions to explore and address how to improve quality of care for newborns within the overall care continuum, particularly for those born small and sick in low and middle-income countries.

The Project is supported by the Every Newborn Action Plan (ENAP), which aims to end preventable newborn deaths and stillbirths by 2030. The work is contributing valuable, diverse perspectives to inform the World Health Organization-led Quality, Equity Dignity (QED) efforts for women and newborns, building on the technical and advocacy work of ENAP.

We are grateful for the technical support of leading newborn health professionals from ENAP, London School of Hygiene and Tropical Medicine, Makerere University, Save the Children, USAID and others.

Best wishes, Neil

Joint Coordinator, CHIFA Project on Newborn Care

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

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

CHIFA profile: Neil Pakenham-Walsh is the coordinator of the HIFA campaign (Healthcare Information For All) and assistant moderator of the CHIFA forum. He is current chair of the Dgroups Foundation ([www.dgroups.info](http://www.dgroups.info)), which supports 700 communities of practice for international development, social justice and global health. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG neil@hifa.org

From: "Corazon B Bernabe, Philippines" <mho.abradeilog@gmail.com>

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

Subject: [chifa] Newborn Care (2) Newborn care in the Philippines

Hi Neil. This is what we have in the Philippines, particularly in the rural area where I can from - island municipality

1. Who is the health worker caring for the newborn? In your countries and programmes? who is caring for small and sick newborns? Midwives and nurses? Obstetricians? Who are the champions of newborn care? Has this changed?

Mainly healthcare is rendered by BHW (Volunteer health worker) and the midwife. We have our MNCHN program and small and sick babies gets to be referred to paediatrician if and when they are available. Otherwise the municipal health officer, usually GP like myself handles them using our training in IMCI

2. Where in the hospital are small and sick newborns cared for? What infrastructure, equipment, commodities, guidelines are needed for small and sick newborn care?

All of the hospitals have pediatric wards, but the specialist may not always be available and the equipments and commodities are very basic and usually lacking. Only the facilities in the big cities and mainland would be equipped but they can be very costly and not accessible.

3. How is the family involved in caring for small and sick newborns? Is there family centred care in neonatal units? Are your facilities implementing kangaroo mother care? What does family-centred care mean in your context? What can be done to strengthen the quality of family-centred care?

In the rural area the families would be continuing the care at home and given instructions. But if they're admitted, usually they are just informed of the baby's condition with care being rendered by health workers.

KMC [\*see note below] is still a new concept for us.

Family-centered care for me is when the family is directly involved not only in decision making and consenting but more in the actual care of the patient. Whatever participating they can be involved with will be taught for them to handle. This will help in the faster recovery of patient and the family understanding

The health workers must be oriented in the concept and importance of family-centered care.

4. Who in the ministry is responsible for newborn programmes, at the national level? What about referral systems? What about measurement and accountability?

At the national level we have the department of health (DOH) that has it's own divisions. But the implementation is handled at the local level because of devolution

5. Who are the key players in the global health architecture for newborn care? UNICEF is making newborns their advocacy priority this year. Is this the UN responsibility alone? What about WHO, donors, professional groups and academics?

DOH as the national body, but we have specialist groups that collaborate.

Ma. Corazon B. Bernabe, MD  
Philippines

HIFA profile: Corazon B Bernabe is Municipal Health Officer at LGU in the Philippines. mho.abradeilog AT gmail.com

[\*Note from HIFA moderator (Neil PW): KMC = Kangaroo Mother Care. 'Kangaroo care or kangaroo mother care, sometimes called skin-to-skin care, is a technique of newborn care where babies are kept skin-to-skin with a parent, typically their mother.'

[https://en.wikipedia.org/wiki/Kangaroo\\_care](https://en.wikipedia.org/wiki/Kangaroo_care)]

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (3) Q1. Who is the health worker caring for the newborn?

Dear CHIFA colleagues,

Each week we shall explore a question on Newborn Care, prepared by the CHIFA Newborn Care working group. This week we look at Question 1:

1. Who is the health worker caring for the newborn? In your countries and programmes who is caring for small and sick newborns? Midwives and nurses? Obstetricians? Who are the champions of newborn care? Has this changed?

We have already heard this morning from Corazon Bernabe, Philippines (thank you Corazon), from where she writes:

"Mainly healthcare is rendered by BHW (Volunteer health worker) and the midwife. We have our MNCHN program and small and sick babies gets to be referred to paediatrician if and when they are available. Otherwise the municipal health officer, usually GP like myself handles them using our training in IMCI."

Would it be useful to outline a typology of 'health worker attendance' from the perspective of the mother/newborn?

This might perhaps look like:

1. Mother and baby alone or cared for by family members
2. Traditional birth attendant (untrained, or trained in basic care)
3. Community health worker (presumably this is a highly diverse group, ranging from those with no skills in childbirth/newborn care to those with basic skills)

4. Community midwife/nurse in primary care setting
5. Newborn care team in hospital setting (basic newborn care - with or without obstetrician and paediatrician)
6. Newborn care team in hospital setting (comprehensive newborn care).

The above is probably quite inadequate - I offer it here as a discussion starter and look forward to hear your views/comments. Indeed, perhaps there is an already-agreed typology, in which case please do let us know. Or perhaps it makes more sense to define the typology on the basis of the care provided rather than the provider (as in 'unskilled' versus 'skilled basic' versus 'skilled comprehensive')?

Many thanks, Neil

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

CHIFA profile: Neil Pakenham-Walsh is the coordinator of the HIFA campaign (Healthcare Information For All) and assistant moderator of the CHIFA forum. He is current chair of the Dgroups Foundation ([www.dgroups.info](http://www.dgroups.info)), which supports 700 communities of practice for international development, social justice and global health. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG neil@hifa.org

From: "Joseph Ana, Nigeria via Dgroups" <CHIFA@dgroups.org>  
 To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
 Subject: [chifa] Newborn Care (4) Q1. Who is the health worker caring for the newborn? (2) Typology of newborn care providers

Dear All,

I would want to go more with Neil's typology' than categorise them under 'unskilled' versus 'skilled basic' versus 'skilled comprehensive')

But in doing so I would add two increasingly available locations/groups that are 'competing' with health facilities for patients in LMICs. So the amended typology will look like this:

1. Mother and baby alone or cared for by family members
2. Traditional herbalist / native doctor increasingly being used due to poor access/unavailability of other providers, cultural beliefs and norms, ignorance and illiteracy
3. Religious houses also increasingly competing for attention due to weak health system/lack of health facilities, religious beliefs, illiteracy and poverty
4. Traditional birth attendant (untrained, or trained in basic care)
5. Community health worker (presumably this is a highly diverse group, ranging from those with no skills in childbirth/newborn care to those with basic skills)
6. Community midwife/nurse in primary care setting
7. Newborn care team in hospital setting (basic newborn care - with or without obstetrician and paediatrician)
8. Newborn care team in hospital setting (comprehensive newborn care).

Joseph Ana.

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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:

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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 (5) Q1. Who is the health worker caring for the newborn? (3) Staffing of neonatal units

This is such a great topic and I think we will find a variety of answers and perhaps something we can change with education and time.

'Who is the health worker caring for the newborn? In your countries and programmes ? who is caring for small and sick newborns? Midwives and nurses? Obstetricians? Who are the champions of newborn care? Has this changed?'

The Chiesi Foundation and COINN is just completing a survey of all the neonatal units in Rwanda. We have 2 pending but what we can share at this point is the people caring for babies in the neonatal units are: nurses and midwives often responsible for up to 20 babies per nurse per day shift going down to 1 nurse for all the babies at night. The average was 2 nurses on days and 1 nurse on night no matter how many patients there were. When the orientation process was surveyed the average was 7 - 10 days of orientation prior to being responsible for the babies. There was very little didactic associated with orientation most was on the job training with whomever was scheduled for the day. The premature mortality rate across the country was higher than the asphyxia rate. When questioned about things related to prematurity (cup feeding, developmental care and positioning; adding humidity to the incubator and taking care of a baby in incubator etc.) revealed the participants are often very uncomfortable to comfortable caring for infants that need this level of care.

As I have advocated in the past education is needed. As the doctor from the Philippines wrote they were caring for babies using the IMCI guidelines. The IMNCI guidelines give information on how to identify danger signs in a baby less than 2 months of age in order for the infant to be transported to the nearest hospital. But as they wrote that is costly and often not feasible. Transport of these vulnerable infants need to be addressed also. They are often placed in the back of an ambulance with an individual not trained in neonatal care.

But I think what else needs to be addressed is the staffing of the units. It is very difficult to assess and maintain continual assessment of vulnerable babies when there are 2 nurses for over 40 babies or even 20 babies. The staffing at night is worse where they often went down to one nurse and sometimes turned the care over the busy midwifery staff.

Sincerely,  
Sue Prullage DNP, APN, 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: "Sara Tornquist, Sweden/Kenya" <saratornquist1@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (6) Kangaroo mother care (1) Neonatal follow-up care

How about kangaroo care for premature, small and vulnerable babies?

I am a midwife from Sweden and here we have resources so its not easy to compare. But, I have been working at a community Clinic in Kenya on and off since 2011 and simple things like uninterrupted skin-to-skin care was not done the first time I was there, and it seems like its not a usual procedure in spite the well researched benefits for both baby and mother.

Another thing is the fact that mother and babies are leaving the clinics very soon after birth, no matter if its a vulnerable baby and/or mother and the schedule to come back is following the immunization program, not the guidelines for neonatal/postpartum follow ups. This means the baby might get the BCG and polio vaccination at discharge, or at the next few days (if they come back) and then they are to come back at around 45-50 days of age.

CHIFA profile: Sara Tornquist is a Midwife at Karolinska University Hospital, Sweden. Professional interests: Breastfeeding, respectful maternity care, equality, equity, universal health care. Email address: saratornquist1 AT gmail.com

From: "Lily Kak, USA" <lkak@usaid.gov>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (7) Q1. Who is the health worker caring for the newborn? (4) Staffing of neonatal units (2)

I would like to thank Sue Prullage for sharing very interesting and relevant information about the neonatal units in Rwanda. I look forward to learning more about the results of the survey once it is completed. USAID and UNICEF are supporting a multi-country survey of neonatal units and will have results from 8-9 countries by the end of this year. Your preliminary findings regarding severe nursing shortage in the units makes me wonder if family-centered care can help alleviate the staffing shortage by involving parents in doing some of the non-medical tasks. Do you think this would be feasible in the Rwandan context? FCC is now a national policy in India and we will learn a lot from

there as the policy is rolled out. Please refer to Dr. Arti Maria's comment and link to her ISQUA presentation from last week. [ <http://www.hifa.org/dgroups-rss/link-isqua-webinar-family-centred-care> ]

Lily Kak

HIFA 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. lkak AT usaid.gov [www.hifa.org/projects/newborn-care](http://www.hifa.org/projects/newborn-care) [www.hifa.org/support/members/lily-1](http://www.hifa.org/support/members/lily-1)

From: "Nkuranga John Baptist, Canada" <nkuranga.baptist@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (8) Q1. Who is the health worker caring for the newborn? (5) Staffing of neonatal units (3)

Very well stated Prullage, with that kind staffing it is barely not feasible to provide quality care services and respond to unique needs of premature infants or the lower birth weight infants. Am glad that such data can be generated to help use it to talk to decision makers.

Is there a foreseeable way out? Are there innovative ways to go about it? Would empowering parents to take over some tasks in the safest way a possibility, what are the dangers?? I wish I heard an answer but I think the way to go is looking for a new approach to the current situation.

Nkuranga

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: "Sue Prullage, Rwanda" <sue.prullage@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (9) Family-centred care

I liked the video of FCC in India. At many of the neonatal units in Rwanda mothers are involved in the care of the infants even giving NG tube feedings. What I could see that is needed is a developed program of what is expected and not expected of them. At the hospital where I work when I am in Rwanda we have had the mothers at bedside all the time. They do the feeds, change the diapers and are around for rounds, they help each other get into KMC. As with the India experience the older or more experienced family member often assumed the role of teacher to the other families in the unit. We love this for usually one woman always step up we call them the 'mama' of the room. There are times that we have a family that doesn't understand the feeding times and this experience person will take it under their responsibility to make sure the family that is struggling is ready to give the feeds. Sometimes the family never catch on and the 'mama' will assign another mother to feed the baby. This is something I think they would not allow in India. But with such a low staff we utilize our mothers very much.

Recently the government has hired 'mentor' nurses and doctors who come to spend 2 days to a week in each neonatal unit in the country. These mentors are to be experts and round with the staff to discuss the baby. Nice concept but they give conflicting advice sometimes and focus on things that maybe could be better left alone. Recently they have demanded that we do not allow the mothers in the NICU due to possible infection. We have stood the ground that this is not family centered care. But if these mentors are going all over the country telling the staff to not let the family in due to possible infection the care for neonates are going backwards instead of forward. I think we should share this research with the mentors stating that infection rate went down!! Wonderful work in India.



Sue Prullage DNP, APN, NNP/PNP-BC

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. She is a member of the CHIFA Newborn Care working group.

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From: "Sue Prullage, Rwanda" <sue.prullage@gmail.com>

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

Subject: [chifa] Newborn Care (10) Family-centred care (2) Staffing of neonatal units (4)

One of the survey questions [\*see note below] was related to if the parents give the NG feeding and the majority of the facilities stated that the parents did give the feedings. With this kind of staffing the infants would not receive their feedings without the parents to feed them. The problem with this process is the amount the infant receives is mother reported. In my own experience I have seen the nurse tell the mother what to give the baby yet she was unable to produce the amount ordered but will not say anything at first. This is another whole issue 'breastfeeding there is an overall feeling that a mother does not have a problem with breastfeeding. So women will struggle for days to produce milk before it is discussed.

I think the family can play a role and should be involved in KMC and cue based feedings this would take a small part of the burden. But there is no other alternative to well trained specialized nurses available to listen to families and to assess babies. Do we need the standards of the developed nations that determines neonatal staffing?? This will be a huge commitment from the government. The knee jerk response may be to just beef up the staffing but without neonatal education it will give more warm bodies but not necessarily decrease mortality. Perhaps we should look at what nurses/midwives are required to do during the shift. Do time studies perhaps they are spending a great deal of time doing non-nursing things such as running to pharmacy or lab. But we need to document what they do. Our survey asked about what they know and learn but not a great deal about how they spend their time.

Sue Prullage DNP, ANP, NNP/PNP

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. She is a member of the CHIFA Newborn Care working group.

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

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sue.prullage@gmail.com

[\*Note from HIFA moderator (Neil PW): Sue refers to the Chiesi Foundation and COINN survey of all neonatal units in Rwanda]

From: "Mmusetsi Mokwatsi, South Africa" <ratolaonemok@gmail.com>

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

Subject: [chifa] Newborn Care (11) Q1. Who is the health worker caring for the newborn? (6)

Good Morning all. I hope this email finds you all well.

Thank you for these discussions, they are very necessary.

In the Northern Cape Province of South Africa, the newborns are cared for by a number of professionals (Nurses, Doctors and other allied professionals) all contributing toward the care of newborns. At the district hospitals, newborns are cared for in maternity units (because there are no dedicated neonatal units) before being discharged home. Here their care is mostly done by midwives and medical officers. Newborn care at Kimberley hospital (Tertiary hospital) is done in a dedicated neonatal unit and here the care is done by the professional nurses who some of them have undergone speciality training in neonatal and child nursing. There are medical officers who are supervised by a paediatrician.

The Province has a programme or framework called Maternal, Neonatal, Child and Women's Health and Nutrition (MNCWHN) which has been cascaded down from the national department of health. This framework set out the objectives that must be achieved and the care that should be provided. Newborn care and Management of Small and Sick Neonates (MSSN) are located within this programme, and this programme is cascaded down to the districts where there are districts coordinator for the programme. There is regular MSSN training that happens including helping babies breathe, and this usually takes place at the districts level by district paediatricians working in the District Clinical Specialist Teams (DCST).

Small and Sick Neonates receives the same care as that of sick newborns. They are cared for by the same health professionals at their different spheres. If they are at the district hospital, they will be cared for by a medical team comprising of a medical officer and nurses who have been prepared at neonatal or child nursing specialities. Some districts have a paediatric dyad (Paediatric Nurse and Paediatrician) within the district clinical specialist team, in which case the small and sick neonates will be under their care. Other districts do not have the complete team, the care will be done by a medical officer and the nursing team.

There is a move to train community health workers to carry out paediatric care during their home visits. The department of health is working together with other stakeholders to address the curriculum for the community health workers. I just completed my Masters studies in Child Nursing, thus qualifying as an Advanced Nurse Practitioner. This is a new level in South Africa, and in the next decade the advanced nurse practitioner will play a critical role in implementing key interventions to ensure quality new-born care, both clinically and academically.

We do not have dedicated newborn champions. The championing is done by some of us who are passionate about quality child health. we do this on a small scale in our workplaces and by referrals from our colleagues who are in other specialities.

Kind regards

Mmusetsi Mokwatsi

CHIFA profile: Mmusetsi Mokwatsi is a Child Nurse Specialist at the Kimberley Hospital Complex in South Africa. Professional interests: Health policy development, Clinical Leadership, Clinical Research, Child advocacy, Child Nurse development, community involvement in child health, Clinical governance. ratolaonemok AT gmail.com

From: "Mari Tvaliashvili, Georgia" <tvaliashvilimari@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dggroups.org>  
Subject: [chifa] Newborn Care (12) Q1. Who is the health worker caring for the newborn? (7) Newborn care in Georgia

Dear all,

In Georgia, all maternity homes have specific levels such as: I, II and III. The supplier of all levels of perinatal service must have a quality assurance program that includes a clinical audit system of documented paragraphs and / or delivery of cases of near-miss cases, as well as a quarterly documented record of the following basic data:

- A) Number of primary cesarean sections (as well as their share in the total number of childbearing) low risk women;
- B) Total number of obstetrical bleeding (in case of vaginal delivery and cesarean section);
- C) Transfer of mothers in critical care department and / or other facility;
- D) Number of maternal deaths according to reasons;
- E) Transfer of newborns to newborn intensive service provider and / or other institution (according to weight categories);
- F) Number of intrinsic mortality;G) the number of cases of neonatal mortality according to the reasons.

II level of neonatal care provides a service delivery for healthy, durable (=34 0/7 weeks gestational age) and newborns of moderate intensity.

Perinatal service provider may, in exceptional cases, provide II level obstetrical care and III level neonatal care services simultaneously. This applies only to the institutions which have been granted the level of perinatal service up to April 1, 2017. Annual turnover of these institutions should be =1800 childbearing year (or = 150 births per month) and they should also have a newborn intensive care unit (department, etc.). The exception is the decision of the Coordination Group to provide perinatal services to the medical institution (annual turnover <1800) Whose reach is more than 120 minutes before the supplemental supplemental (III level) perinatal care service provider and is located in the border settlement area. Within the mentioned perinatal service, the institution has the right to receive early childbirth and provide III level neonatal care in accordance with the applicable legislation.

The supply of sub-specialty (III level) care for maternal and newborns should be provided in the perinatal center, which is a multi-profile clinic (subtype "AC") or referral multiprocessor (sub "AD") ("On determination of classification of medical institutions" Minister of Defense 2016 It is part of the Order N01-9 / N of March 4). In addition, the auxiliary beds should be 150 or more. 1/5 or more of this bedside should have a bed beds. The Center provides high quality medical care for interdisciplinary management of pregnancy and child complications. Perinatal Center carries out obstetric and neonatal care as both physiological and risk-free pregnancy and childbearing, Rendered patients management The suppliers of this service should have a unit of intensive management (NICU) unit (department, department, etc.), intensive care and critical state management unit (department, department, etc.) and powerful laboratory-diagnostic capabilities , Therapeutic and surgical profile specialists Domoba.

Newborn care for sub-specialty (III) levels may be provided with pediatric multi-profile hospitals (subtypes "AC 1 ") and pediatric referral multi-profile hospitals (subtype "AD 1"(Order N01-9 / N of March 4, 2016 of the Minister of Labor, Health and Social Affairs of Georgia on Determination of Classification of Medical Institutions) having NNUU units (Department, Department, etc.) Provide intensive / critical neonatal services, including cases of referral patients In addition, in the specialized hospitals providing the newborn intensive care service (NICU), which have obtained a permit for a stationary institution (with appropriate permit attachment) for enactment of this Order. At this level all the newborn health care services need to have intensive / critical care or have a very small (<1500 g) and / or low gestational age (<34 weeks).

CHIFA profile: Mari Tvaliashvili works at National Center for Disease Control and Public Health, NCDC, and is based in Georgia. Mari works in non-communicable disease department, maternal and child health division as a data quality assessment and analytics specialist of Georgian Birth Registry (GBR). She is a CHIFA Country Representative for Georgia.

<http://www.hifa.org/forums/chifa-child-health-and-rights/country-representatives/10>

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

tvaliashvilimari AT gmail.com

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

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

Subject: [chifa] Newborn Care (13) Family-centred care (3)

Thank you, Sue! I think the type of responsibility given to parents will be context-specific. In the India example, parents were not asked to provide NG feeding since it is a medical task and may affect safety. Safety will be a key consideration for encouraging the introduction and rollout of the family centered approach in countries. I think We need more evidence on the safety considerations. I hope we hear from our colleagues in India.

Lily

HIFA 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. [www.hifa.org/projects/newborn-care](http://www.hifa.org/projects/newborn-care)

[www.hifa.org/support/members/lily-1](http://www.hifa.org/support/members/lily-1)

email: lkak AT usaid.gov

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

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

Subject: [chifa] Newborn Care (14) Q1. Who is the health worker caring for the newborn? (8) Staffing of neonatal units (5)

In South Africa sick and small babies are cared for in hospitals at various levels and with varying resources.

Who is caring for babies?

- In level one hospitals they will be cared for by general nurses and/or midwives with daily rounds by a medical officer
- In level two and three hospitals they will be cared for by general nurses and/or midwives and will have 24hr medical cover(intern/medical officer/registrar) that and consultant oversight by a paediatrician or neonatologist.
- Identification and referral of sick and small babies in the community occurs through home visits by community care givers, and assessment by nurses in primary health care clinics

Do they rotate?

- There is regular rotation of medical officers.
- There is some degree of nursing rotation but less than for medical officers.

What training do they have?

- Generally neither the medical officers nor the nurses have received specialised training in caring for sick or small newborns.
- Some nurses and doctors may have completed self study modules of the Perinatal Education Program ( <https://bettercare.co.za/>) or received in service training (from a couple of days up to week) on routine management of newborns and care of sick and small babies

- Some nurses particularly in level 2/3 hospitals may have advanced training in intensive care, paediatrics or midwifery. There is some content in midwifery training on identifying and immediate management of sick and small babies. A small handful may have received specialised neonatal training before it was discontinued.

What interventions are being implemented?

- Recommendation that at least 50% of maternity/neonatal staff should be non rotational
- Lobbying for specialized neonatal nurse training
- Recommendation that at district hospitals the neonatal units should be managed by advanced midwives and at regional and tertiary level the neonatal unit manager should have a relevant advanced qualification
- Progressive increase in nursing staff with relevant advanced qualifications staffing neonatal units at level 2/3 hospitals
- Increase in outreach support visits to level one hospitals by paediatricians/neonatologists at level 2/3 hospitals (recommended 1 visit per month/hospital)
- Weekly telephonic consultant rounds at district hospitals
- Regular supportive supervision focusing on clinical governance by specialised clinical teams based in each district focused on maternal and child health
- Standardised clinical records and systems in some provinces.

God bless  
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 Neonatal Nurses Association of Southern Africa, NNASA. She is a Registered Nurse and on the board of the Council of International Neonatal Nurses, COINN. ruth.davidge AT kznhealth.gov.za [www.nnasa.org.za](http://www.nnasa.org.za) [www.nnasa.org.za](http://www.nnasa.org.za)

From: "Ruth Davidge, South Africa" <rdavidge@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (15) Q1. Who is the health worker caring for the newborn? (9) Family-centred care (4)

Sorry forgot to add:

Family centered care:

- This is encouraged but still not well implemented
- Most hospitals offer lodging facilities for breast feeding mothers
- Mothers are encouraged to participate in care of their babies including tube feeds, oral medications, changing nappies etc
- Visiting of fathers and siblings is encouraged but has slow uptake
- Skin to skin care is practiced from birth in labour wards
- Skin to skin is recommended and is slowly being practiced in post natal units
- Most hospitals offer at least 2 beds for 24hr KMC care of small babies
- Many level 2 hospitals have stand alone KMC units

Data management:

- All hospitals are now required to analyse every stillbirth or neonatal death using the Perinatal problem identification program (PPIP) <https://www.ppip.co.za/>
- These are discussed monthly at a perinatal meeting with senior management and action plans developed
- Basic data on births and deaths are captured using DHIS 2 <https://www.dhis2.org/>
- In KZN we are in the process of adding further neonatal data elements to DHIS including discharge diagnosis, cause of death and implementation of basic care eg immunisations, KMC, nasal CPAP et al

- In KZN we are rolling out a neonatal dashboard to capture the results of quality of care assessments for use in every hospital (based on national recommendations)

Resources/ Oversight:

- There are national guidelines on the management of sick and small babies
- There are national norms for bed numbers, infrastructure, equipment and consumable requirements for neonatal units et al
- There is a national system for 24 hr death reporting
- There is an evolving system of monitoring and assessment of implementation and quality of care

God bless

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

From: "Ruth Davidge, South Africa" <rdavidge@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (16) Family-centred care (5)

We have discussed in KZN the possibility of increased parental responsibility for recording of observations and feeds etc and believe this is feasible and could be helpful in settings with very high nurse patient ratios. However it is dependent on parental presence (lodging facilities), parental literacy and time to orientate parents to what is required and what danger signs are (and this time may not be available in really bad settings)

God bless

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

From: "Ruth Davidge, South Africa" <rdavidge@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (17) Family-centred care (5)

That is very concerning Sue!! [\*see note below]

So often when external experts are brought in they dont understand local context. It is critical that whatever teaching or supervision is given in whatever context that it has been standardised (among teachers) and is in line with current evidence and national/local guidelines. Presenting mixed messages is a sure way of ensuring zero compliance and worsening standards of care.

God bless

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

[\*Note from CHIFA moderator (Neil PW): Ruth is responding to a message from Sue Prullage,

Rwanda, in which Sue wrote: 'Recently the government has hired 'mentor' nurses and doctors who come to spend 2 days to a week in each neonatal unit in the country. These mentors are to be experts and round with the staff to discuss the baby. Nice concept but they give conflicting advice sometimes and focus on things that maybe could be better left alone. Recently they have demanded that we do not allow the mothers in the NICU due to possible infection. We have stood the ground that this is not family centered care. But if these mentors are going all over the country telling the staff to not let the family in due to possible infection the care for neonates are going backwards instead of forward. I think we should share this research with the mentors stating that infection rate went down!!'

From: "Ruth Davidge, South Africa" <rdavidge@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (18) Staffing of neonatal units (6)

Sadly what nurses are expected to do during their shift is hugely underestimated and a large amount of time is spent on non clinical work. There have been a number of studies looking at this and an assessment tool (NAS) was used in a neonatal unit here to help the hospital determine on a day by day basis the patienty accuity and the need to employ agency nurses or not.

I was interested to find the attached tool [\*see note below] in a neonatal record at a private hospital. I doubt however there is any effective response to work load/accuity studies and therefore wonder whether it is worth the time it takes to complete?

It is interesting in the attached tools how only one tool looks at administrative duties - otherwise all focus is on clinical duties.

God bless

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

[\*Note from HIFA moderator (Neil PW): CHIFA does not carry attachments. However, she has kindly agreed to forward attachments one-to-one on request. Her email is ruth.davidge AT kznhealth.gov.za ]

From: "Anil Cherian, Uganda/South Sudan" <anilcherian@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (19) Neonatal sepsis

I wish to join the conversation - Part 2 Global Discussion.

My context; I am based in Kampala train mid-level health workers for South Sudan.

One major cause of neonatal death and most of this is early onset neonatal sepsis. However I find that there is a "conceptual gap" and that the concept of early onset neonatal sepsis and the peri-natal risk factors and ethology is hardly discussed. One of our midwifery students did her research on this topic and found that 30-45% of the infants born at a level 3 health centre (Primary Health Centre which is managed by nurses and midwives) were " at risk of sepsis". One of the reasons for this could that 21% of the women who delivered and included in the study were HIV positive, 36% had four or more pelvic examination. While the midwives conducted most pelvic examination with gloves, sterile packs or vulval swabbing with anti-septic solution were not practices. Again most of the delivery packs

were not completely sterile. I am unable to put a reliable figure to the proportion of early newborn deaths due to neonatal sepsis, I would suspect that it would be around 25% if not more.

In this context the administration of parenteral antibiotic becomes and I recollect a study done by Abay Bang et al which showed that if a risk criteria was taught to health workers and they were also trained to administer IM antibiotics in the postpartum period the mortality due to early onset neonatal sepsis could be reduced.

Anil

CHIFA profile: Anil Cherian is the Director of the ICMDA National Institute of Health Sciences Jonglei in South Sudan. Professional interests: Paediatrics, Public Health, Health Economics. anilcherian 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 (20) Q1. Who is the health worker caring for the newborn? (10) Community health workers

Dear CHIFA colleagues,

One of the groups of health workers caring for the newborn are Community Health Workers. Indeed, as we have discussed much on our sister forum HIFA ([www.hifa.org/joinhifa](http://www.hifa.org/joinhifa)), CHWs often have a vast range of responsibilities, often with little if any specific training to identify and address life-threatening problems. They also typically work in relative isolation.

I would like to highlight WHO training materials produced (in 2015) for CHWs whose responsibilities include newborn care (usually in the home). Here is the overview:

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These training materials provide guidance for community health workers to conduct home visits in the antenatal period and the first weeks after the baby is born. They promote that families seek care from a skilled health professional for antenatal care and care at birth and support families in adopting appropriate home care practices for the mother and baby, during pregnancy and after childbirth. The materials draw on experiences of training community health workers in caring for the newborn at home in several research studies, particularly the SEARCH study in India and the NEWHINTS study in Ghana.

The course is based upon adult learning principles to achieve the required competencies for counselling families about pregnancy care and caring for newborns at home. It includes classroom learning, group discussions, games, role plays and most importantly, hands-on supervised field practice in a health facility and in the community.

The course will need to be adapted at country level to ensure that it is consistent with national policies, care standards and the health systems. It is clearly recognized that training is only one component of a programme for delivering effective interventions at community level. Once trained, community health workers will require supplies, regular supervision, and support from the health system to ensure they provide consistent and high-quality services.

Course objectives are to develop community health workers' competence in; communication skills and building a good relationship with the family when making a home visit; counselling the family on the importance of antenatal care, planning for birth in a health facility, home care for pregnant women and appropriate newborn care practices immediately after birth;



assessing breastfeeding, danger signs and weight in a newborn, deciding to refer or provide care at home depending on the results of the assessment, and advising families on optimal care practices for the newborn;

assisting families to provide extra care for the small baby.

This training course is part of the WHO-UNICEF package "Caring for newborns and children in the community" which is aimed at increasing the coverage of household and community interventions that will reduce newborn and child mortality and promote the healthy growth and development of young children. The package consists of 3 courses, namely on caring for the newborn at home, promoting healthy growth and development, and caring for the sick child. These courses can be offered separately or in combination, according to a country's needs.

[http://www.who.int/maternal\\_child\\_adolescent/documents/caring-for-the-newborn-at-home/en/](http://www.who.int/maternal_child_adolescent/documents/caring-for-the-newborn-at-home/en/)

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Joint Coordinator, CHIFA Project on Newborn Care

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

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

CHIFA profile: Neil Pakenham-Walsh is the coordinator of the HIFA campaign (Healthcare Information For All) and assistant moderator of the CHIFA forum. He is current chair of the Dgroups Foundation ([www.dgroups.info](http://www.dgroups.info)), which supports 700 communities of practice for international development, social justice and global health. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG neil@hifa.org

From: "Clare Hanbury, UK" <clare@childrenforhealth.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (21) Family-centred care (7)

Have you [\*see note below] considered involving the siblings in the parenting discussions? Very often young adolescent siblings support the mother and help to care for other members of the family. They can be more literate than mothers and may help their parents remember the instructions given by health care workers.

Best wishes  
Clare Hanbury

CHIFA profile: Clare Hanbury qualified as a teacher in the UK and then worked in schools in Kenya and Hong Kong. After an MA in Education in Developing Countries and for many years, Clare worked for The Child-to-Child Trust based at the University of London's Institute of Education where, alongside Hugh Hawes and Professor David Morley she worked to help embed the Child-to-Child ideas of children's participation in health into government and non-government child health and education programmes in numerous countries. Clare has worked with these ideas alongside vulnerable groups of children such as refugees and street children. Since her MSc in International Maternal and Child Health, Clare has worked freelance and focuses on helping government and non-government programmes to design and deliver child-centered health and education programmes where children are active participants. Clare has worked in many countries in East and Southern Africa and in Pakistan, Cambodia and the Yemen. Her current passion is for distilling health information for teachers, health workers and others into simple practical health messages actionable by children.

<http://www.hifa.org/projects/citizens-parents-and-children>

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Email: clare.hanbury AT zen.co.uk

[\*Note from CHIFA moderator (Neil PW): Clare refers to the message from Ruth Davidge, South Africa: Newborn Care (16) Family-centred care (5)]

From: "Mickey Rostoker, Canada" <mrostoker@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (22) Staged implementation of a two-tiered hospital-based neonatal care package in Uganda

A new publication in the BMJ Global Health highlights the well thought out and well structured newborn program in Mbale Regional Referral Hospital, Uganda. The lead author is Dr. Kathy Burgoine, a British paediatrician who has been on site in Mbale with her physician husband for a few years. That is a serious advantage for doing the good work most internationalists can only dream about.

Staged implementation of a two-tiered hospital-based neonatal care package in a resource-limited setting in Eastern Uganda

Kathy Burgoine, Juliet Ikiror, Sylvia Akol, Margaret Kakai, Sara Talyewoya, Alex Sande, Tom Otim, Francis Okello, Adam Hewitt-Smith, Peter Olupot-Olupot  
DOI: 10.1136/bmjgh-2017-000586 Published 19 February 2018  
<http://gh.bmj.com/content/3/1/e000586?cpetoc>

Both within HIFA & CHIFA we have often been reminded of the good work that can be accomplished when there is the political will to do so. Too often there are good ideas floating around but few willing to invest the time and energy to build upon initial creativity.

What local hospital & federal MOH protocols are needed to see that this kind of endeavour continues with locally empowered authorities & health professionals?

One thing that I have not seen is the existence of 'small centers of excellence'. We tend to think of centers of excellence as being large, but perhaps small centers should have the benefit of having their successful programs visited by physicians, nurses, administrators who look after newborns in other Uganda jurisdictions.

Ultimately, political will has to be there at multiple levels and each level has to be supportive of the other. What happens when the foreign specialist leaves? How many internationalist health workers have designed and implemented programs with their host country colleagues and on top of that trained others to carry on the work, only to see everything fall apart when the foreigner leaves?

Uganda has lots of fine clinicians. What holds the other regional referral hospitals (and even district hospitals) from doing the same good work as Mbale?

Ever mindful that one's utterances can be ill informed, I am ready to accept the fact that similar good newborn programs are in place around the country, but that it is only Mbale that has published.

Mickey Rostoker

Jean-Francois (Mickey) Rostoker  
BA, MD, CCFP, FCFP  
Associate Clinical Professor/Family Practice/University of British Columbia/Vancouver/Canada  
Assistant Clinical Professor/Family Medicine/University of Saskatchewan/Regina/Canada

HIFA profile: Mickey Rostoker is Associate Clinical Professor, Family Medicine (MD, FCFP) at the University of British Columbia in Vancouver, Canada. Professional interests: Empowering health

workers in primary care, Upgrading skills of TBAs in developing countries, Postabortal care training in developing countries, mentoring midwifery students. mrostoker AT gmail.com

From: "Sue Prullage, Rwanda" <sue.prullage@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (23) Staged implementation of a two-tiered hospital-based neonatal care package in Uganda (2)

This is a wonderful article and project. In my own experience I have seen a lot of investment of education at the community level and not much investment of education at the hospital level. The author documented that education, family involvement and not rotating staff decreased mortality. This program would flow well with family centered care.

I also like that it was an 18 module education program. Neonatal care encompasses so much I am glad to see they took the time to try and address most of the common issues.

Sue Prullage DNP, APN, NNP/PNP

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. She is a member of the CHIFA Newborn Care working group.  
<http://www.hifa.org/projects/newborn-care>  
<http://www.hifa.org/support/members/geralyn-sue-0>  
sue.prullage@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 (24) UNICEF petition to stop the tragedy of 7,000 newborns dying every day

The text below is reproduced from the UNICEF website, with a petition 'to call on health ministers and leaders gathered at the World Health Assembly on 2126 May to stop the tragedy of 7,000 newborns dying every day'. Read online and sign the petition here: <https://www.unicef.org/every-child-alive/>

7,000 newborn babies are dying every day

That means that, as you read this, a new mother is grieving the loss of her child. As is another. And another.

The scale of these losses is unthinkable. It's preventable. And YOU can do something about it. Raise your voice to demand affordable, quality health care for every mother and newborn. Take 30 seconds to sign this petition there's not a minute to waste.

'Sign the petition

I call on health ministers and leaders gathered at the World Health Assembly on 2126 May to stop the tragedy of 7,000 newborns dying every day.'

'We are failing the world's youngest citizens. Although the world has made dramatic progress in reducing global rates of under-five child mortality, newborn deaths have declined at a slower pace.

'A child's birth and the 28 days that follow are the most dangerous period of her life. Almost half of all under-five children who died in 2016 were newborns.

'These children are not dying because we don't have the tools to save them. More than 80 per cent of all newborn deaths are caused by three preventable and treatable conditions: complications due to prematurity or during delivery, and infections like sepsis, meningitis and pneumonia.

'But treatment and interventions are not reaching the mothers and children who need them most the families who live in the most disadvantaged areas, enduring the harshest conditions.

'No parents should experience the heartbreak of watching their child suffer or die.

'The world can and must do better...'

'We can end preventable newborn and child deaths in our lifetime but we need more than a single drug or intervention.. We need governments, health-care workers, communities and families to come together to provide affordable, quality health care for every mother and baby, starting with the most vulnerable.

'UNICEF is calling for universal health coverage...'

'UNICEF helps save newborn lives by connecting women and babies with vital resources like skilled birth attendants and pre- and postnatal care.'

--

Best wishes, Neil

Joint Coordinator, CHIFA Project on Newborn Care

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

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

CHIFA profile: Neil Pakenham-Walsh is the coordinator of the HIFA campaign (Healthcare Information For All) and assistant moderator of the CHIFA forum. He is current chair of the Dgroups Foundation ([www.dgroups.info](http://www.dgroups.info)), which supports 700 communities of practice for international development, social justice and global health. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG neil@hifa.org

From: "Joseph Ana, Nigeria via Dgroups" <CHIFA@dgroups.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (25) PACK Nigeria Adult and PACK Child

On HIFA and CHIFA forums it has been shared many times that literally, context is everything, especially in health matters. External expertise is often needed and occasionally the only answer but it behoves the external experts to first ensure that they understand the environment, cultures, socio-economic circumstance of those they are asked to support and train and help to serve the patient better.

Our recent experience with PACK Nigeria guide for all cadres of PHC clinicians is that the pilot went very smoothly to produce excellent results because PACK Global and PACK Western Cape South Africa were localised to fit the PHC in Nigeria. It took six months to localise by a team comprised of local physicians, community health practitioners, nurses and midwives. The team consulted thirteen existing guidelines and protocols in use in PHCs and invited subject experts e.g. in mental health, HIV, TB for their input. In addition before finalising the guide there was an end-user consultation and questionnaire survey, whose ideas were taken into account.

Policy makers, managers and providers need to take context in their interventions in Newborn care.

We are about to scale up PACK Nigeria Adult. [<http://knowledgetranslation.co.za/programmes/pack-nigeria-adult/>]

PACK Child has completed pilot and is in use in South Africa.

Funding allowing, we shall be Localising PACK Child for Nigeria this year. Work is on to get a sponsor.

Joseph Ana.

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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, Servicem & 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 (26) 10 life-saving products for newborn care

Thank you for a wonderful discussion last week! I am learning so much by reading about your experiences and your views that are so grounded in reality. Please keep them coming!! Earlier this week, UNICEF launched a campaign, 'Every Child Alive: the Urgent Need to End Newborn Deaths. They published a very strong (and beautiful) report rich with data, the urgency to do more, and the importance of quality of care. I especially liked the reference to the four 'Ps to enhance quality of care: Place (clean functional health facilities equipped with water, soap and electricity), people (competent human resource), products (10 life-saving commodities/equipment), and power (empowering girls, mother and families to demand receive quality care. Last week, the CHIFA discussion made a lively contribution to the issues related to place, people, and power. I would love to hear your views about products. The 10 life-saving articles that the report refers to are bag and mask for newborn resuscitation, antibiotics, blankets and cloth for thermal care, chlorhexidine, CPAP, oxygen concentrator, phototherapy machines, micronutrient supplements during pregnancy, tetanus toxoid, and thermometers. Are these products available in your health facilities? How can global and

national stakeholders support the availability and accessibility of these products? What are the challenges that we must consider if we are to overcome barriers? What can we do to engage the private sector? What is the role of innovations and innovators?

Lily Kak

HIFA 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.

[www.hifa.org/projects/newborn-care](http://www.hifa.org/projects/newborn-care)

[www.hifa.org/support/members/lily-1](http://www.hifa.org/support/members/lily-1)

lkak AT usaid.gov

From: "Joseph Ana, Nigeria via Dgroups" <CHIFA@dgroups.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (27) 10 life-saving products for newborn care  
(2)

This is a Child forum but all the same I share our experience in the Pilot of PACK Nigeria Adult guide for PHC workers in Nigeria because implementers of Newborn/Child care programmes / projects can learn from the PACK (Practical Approach to care Kit) experience: 'From May to November 2016 HRIWA Nigeria, with support from KTU University of Cape Town, and BMJ, localised the PACK guide and training materials, aligning content with Nigerian regulations, clinical protocols and available diagnostic tests, equipment and medications. The result is PACK Nigeria Adult, a single, integrated, comprehensive, evidence-informed, policy-aligned clinical guide to support all cadres of health care worker managing adult patients in PHCs in Nigeria. The pilot in 2017 followed the localisation of the guide.

Relevant to what we are discussing on CHIFA is that before training (Master trainers Training in each state) commenced, the State Primary Health Care Development Agencies (SPHCDA) in the three states were provided with a list of all the medicines, tests and equipment included in PACK so that they could ensure that the necessary resources were in place.

They were also encouraged to develop a communications plan to help promote PACK not just to the clinicians themselves but also to all those who are responsible for the delivery of primary health care services in the state and to the patients and communities they serve'.

We found that getting the state authorities to get the 'facilities Ready' was a key indicator for a successful pilot.

Joseph Ana.

Africa Center for Clin Gov Research & Patient Safety

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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: "Kausar S Khan, Pakistan" <kausar.skhan@aku.edu>

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

Subject: [chifa] Newborn Care (28) 10 life-saving products for newborn care

(3) Report: Every Child Alive: The urgent need to end newborn deaths

The report [[https://www.unicef.org/publications/index\\_102640.html](https://www.unicef.org/publications/index_102640.html)] draws attention to a very serious issue i.e. rate of still births. However, it offers a service oriented solution, and does not address the social determinants of still births. For example, it is not enough to cite the well known variable of income and education, but to ignore empowerment issues like the place of woman in her family, and the social mechanism that control women. It ignores the fact that services cater to the practical needs of women, and not her strategic interests. (this is a well known dyad for gender analysis of women's status in society). It could have used the ecological framework to probe into social causes of still births. Furthermore, it draws no attention to the functionality of health systems and their determinants. It could have analyzed this phenomenon with the help of WHO report on social determinants of health, and used its framework to examine the social determinants of still births.

CHIFA profile: Kausar Skhan is with the Community Health Sciences Dept of Aga Khan University, Karachi, Pakistan. kausar.skhan AT aku.edu

From: "Anjuli Borgonha, UK" <anjuli.borgonha@lshtm.ac.uk>

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

Subject: [chifa] Newborn Care (29) Stillbirth

Thanks Kausar for raising the important issue of stillbirths.

In 2016 The Lancet released an influential series of Ending Preventable Stillbirths which can be found here:

<http://www.thelancet.com/series/ending-preventable-stillbirths>

The series page includes a roadmap for eliminating, by 2030, one of the most neglected tragedies in global health today.

HIFA profile: Anjuli Borgonha is the Communications Manager for the Every Newborn Action Plan metrics project at the Centre for Maternal, Adolescent, Reproductive, and Child Health (MARCH), the central hub for women's and children's health within the London School of Hygiene & Tropical Medicine in the UK. MARCH 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 (30) Q2. Where in the hospital are small and sick newborns cared for?

Dear CHIFA colleagues,

Thank you for your contributions to the discussion so far! We now start our second week and, on behalf of the CHIFA Newborn Care working group, I invite you to comment on Question 2:

Q2. Where in the hospital are small and sick newborns cared for? What infrastructure, equipment, commodities, guidelines are needed for small and sick newborn care?

We look forward to hear your experience, past or present, in looking after newborn babies in a hospital setting (ranging from the smallest rural health facility through to district and referral hospitals). Did you have the staffing and equipment to deal effectively with the situation?

We would be interested to hear your experience with antenatal care, childbirth (including caesarean and other emergency obstetric capacity), neonatal resuscitation, prevention and management of sepsis, and special newborn care facilities for preterm newborns (incubators, oxygen, CPAP...).

What are the priorities for staff to achieve better health outcomes?

With thanks,  
Neil

Joint Coordinator, CHIFA Project on Newborn Care  
<http://www.hifa.org/projects/newborn-care>

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

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (31) Highlights of Week 1

Dear CHIFA colleagues,

Below are some selected highlights from the first week of our discussion. Thank you to all contributors so far. Special thanks to Sue Prullage (Rwanda) and Ruth Davidge (South Africa) for generously sharing their experience and expertise in Rwanda and South Africa, respectively. It would be wonderful to hear from people working in other countries also. Please share your experience/observations/anecdotes with newborn care by sending an email to [chifa@dgroups.org](mailto:chifa@dgroups.org)

#### RWANDA

Sue Prullage, Rwanda: The Chiesi Foundation and COINN is just completing a survey of all the neonatal units in Rwanda. We have 2 pending but what we can share at this point is the people caring for babies in the neonatal units are: nurses and midwives often responsible for up to 20 babies per nurse per day shift going down to 1 nurse for all the babies at night. The average was 2 nurses on days



and 1 nurse on night no matter how many patients there were. When the orientation process was surveyed the average was 7 - 10 days of orientation prior to being responsible for the babies. There was very little didactic associated with orientation most was on the job training with whomever was scheduled for the day. Th

Sue Prullage, Rwanda: Transport of these vulnerable infants need to be addressed also. They are often placed in the back of an ambulance with an individual not trained in neonatal care.

Sue Prullage, Rwanda: Recently the government has hired 'mentor' nurses and doctors who come to spend 2 days to a week in each neonatal unit in the country. These mentors are to be experts and round with the staff to discuss the baby. Nice concept but they give conflicting advice sometimes and focus on things that maybe could be better left alone. Recently they have demanded that we do not allow the mothers in the NICU due to possible infection. We have stood the ground that this is not family centered care.

Sue Prullage, Rwanda: Do we need the standards of the developed nations that determines neonatal staffing?? This will be a huge commitment from the government. The knee jerk response may be to just beef up the staffing but without neonatal education it will give more warm bodies but not necessarily decrease mortality. Perhaps we should look at what nurses/midwives are required to do during the shift. Do time studies perhaps they are spending a great deal of time doing non-nursing things such as running to pharmacy or lab.

Sue Prullage, Rwanda: At many of the neonatal units in Rwanda mothers are involved in the care of the infants even giving NG tube feedings.

## SOUTH AFRICA

Ruth Davidge, South Africa: In level two and three hospitals they will be cared for by general nurses and/or midwives and will have 24hr medical cover(intern/medical officer/registrar) that and consultant oversight by a paediatrician or neonatologist.

Ruth Davidge, South Africa: What training do they have?

- Generally neither the medical officers nor the nurses have received specialised training in caring for sick or small newborns.

Ruth Davidge, South Africa: What interventions are being implemented?

- Recommendation that at least 50% of maternity/neonatal staff should be non rotational  
- Lobbying for specialized neonatal nurse training  
- Recommendation that at district hospitals the neonatal units should be managed by advanced midwives and at regional and tertiary level the neonatal unit manager should have a relevant advanced qualification

Ruth Davidge, South Africa: Family centered care:

- This is encouraged but still not well implemented

## UGANDA

Mickey Rostoker, Canada: A new publication in the BMJ Global Health highlights the well thought out and well structured newborn program in Mbale Regional Referral Hospital, Uganda.

Staged implementation of a two-tiered hospital-based neonatal care package in a resource-limited setting in Eastern Uganda

## INDIA

Lily Kak, USA: I think the type of responsibility given to parents will be context-specific. In the India example, parents were not asked to provide NG feeding since it is a medical task and may affect safety. Safety will be a key consideration for encouraging the introduction and rollout of the family

centered approach in countries. I think We need more evidence on the safety considerations. I hope we hear from our colleagues in India.

Best wishes, Neil

Joint Coordinator, CHIFA Project on Newborn Care

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

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

From: "Sue Prullage, Rwanda" <sue.prullage@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (32) Q2. Where in the hospital are small and sick newborns cared for? (2)

Q2. Where in the hospital are small and sick newborns cared for? What infrastructure, equipment, commodities, guidelines are needed for small and sick newborn care?

Here is the information from the survey we just did in Rwanda. We queried did they have this equipment; how many units? and how many were functioning.

Oxygen: Every facility had some form of oxygen either concentrators, O2 tanks or walled oxygen.

CPAP: 33.7% had no available CPAP the remaining 66.3% had access to one machine where some facilities had as many as nine machines (not all functional).

Pulse oximeters: only one hospital did not have the ability to perform pulse oximeter. The range for oximeters were one to ten units once again not all were functional.

IV pumps: 25% of the facilities did not have pumps. 75% had access to at least one pump up to ten pumps. The same pattern not all the pumps were functional.

Breast pumps: 68.5% did not access to a breast pump. The remaining 31.5% had at least one up to three pumps not all functional.

Every hospital had access to phototherapy and NG tubes.

In a previous study I did in a catchment in Rwanda (surveyed 13 health centers) there was more than sufficient thermometers, stethoscopes, ambu bags and bulbs.

The basic equipment such as thermometers, stethoscopes were present. But to the important equipment such as CPAP, IV pumps, oxygen there seems to be a lack of access and is probably causing the staff to ration what is available. In my own experience we have split oxygen to ensure that all babies receive some oxygen but the exact amount is not known and is really a dangerous practice. For one baby may need 1 liter of oxygen but the other baby may only need 0.5 L which puts them at risk for hyperoxia thus affecting lungs and eyes etc. I know that in Rwanda when CPAP first came to one hospital they actually studied how many infants died because they did not have access to the machine that was being used on another infant. This was done to show how important CPAP is needed for these infants. In several of the hospitals we queried they were creating their own CPAP

with water bottles and tubing (we did this for a long time). All in the hope that the homemade CPAP will help the babies.

Sue Prullage DNP, APN, 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. She is a member of the CHIFA Newborn Care working group.

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

<http://www.hifa.org/support/members/geralyn-sue-0sue.prullage@gmail.com>

From: "Sara Tornquist, Sweden/Kenya" <saratornquist1@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (33) Q2. Where in the hospital are small and sick newborns cared for? (3)

Dear all,

My quite slim experience from low income settings are that 1. mothers and babies are too often discharged far too early due to limited space 2. The knowledge of the needs of small and vulnerable babies are quite inadequate. 3. The need for better knowledge on neonatal resuscitation is huge. With this comes of course training but also RESOURCES

My experience is that a lot of the change is put on the staff. Staff who is working at long hours, many times 6-7 days a week with very low pay. Staff who might have a diploma or certificate in nursing and more than likely went through training in a very busy environment with very little supervision and support.

We can have all the guidelines and protocols in the world, but if there is not a ton more resources put in health care, and in maternal and child health, nothing will change. Money is needed at all levels. In the health care system and in the educational system.

Best regards,  
Sara TÅrnquist  
Karolinska University Hospital and Karolinska Institute

Master in Midwifery, Bachelor in Nursing, Bachelor in Social Science , Master in Gender Studies,  
Master in Global Health

CHIFA profile: Sara Tornquist is a Midwife at Karolinska University Hospital, Sweden. Professional interests: Breastfeeding, respectful maternity care, equality, equity, universal health care. Email address: saratornquist1 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 (34) Neonatal resuscitation

Below are the citation and abstract of a new open-access paper in the Archives of Disease in Childhood.

CITATION: Pejovic NJ, Trevisanuto D, Lubulwa C, et al Neonatal resuscitation using a laryngeal mask airway: a randomised trial in Uganda Archives of Disease in Childhood 2018;103:255-260. <http://dx.doi.org/10.1136/archdischild-2017-312934>

## ABSTRACT

**Objective:** Mortality rates from birth asphyxia in low-income countries remain high. Face mask ventilation (FMV) performed by midwives is the usual method of resuscitating neonates in such settings but may not always be effective. The i-gel is a cuffless laryngeal mask airway (LMA) that could enhance neonatal resuscitation performance. We aimed to compare LMA and face mask (FM) during neonatal resuscitation in a low-resource setting.

**Setting:** Mulago National Referral Hospital, Kampala, Uganda.

**Design:** This prospective randomised clinical trial was conducted at the labour ward operating theatre. After a brief training on LMA and FM use, infants with a birth weight >2000g and requiring positive pressure ventilation at birth were randomised to resuscitation by LMA or FM. Resuscitations were video recorded.

**Main outcome measures:** Time to spontaneous breathing.

**Results:** Forty-nine (24 in the LMA and 25 in the FM arm) out of 50 enrolled patients were analysed. Baseline characteristics were comparable between the two arms. Time to spontaneous breathing was shorter in LMA arm than in FM arm (mean 153s (SD±59) vs 216s (SD±92)). All resuscitations were effective in LMA arm, whereas 11 patients receiving FM were converted to LMA because response to FMV was unsatisfactory. There were no adverse effects.

**Conclusion:** A cuffless LMA was more effective than FM in reducing time to spontaneous breathing. LMA seems to be safe and effective in clinical practice after a short training programme. Its potential benefits on long-term outcomes need to be assessed in a larger trial.

## WHAT IS ALREADY KNOWN ON THIS TOPIC?

Birth asphyxia contributes to almost 1 million neonatal deaths.

Positive pressure ventilation is the most important component of successful neonatal resuscitation.

Ventilation with face mask (FM) is a difficult skill to master, particularly in low-income settings.

## WHAT THIS STUDY ADDS?

A cuffless laryngeal mask airway (LMA) reduced time to spontaneous breathing compared with FM during newborn resuscitation in a low-resource setting.

LMA is effective and easy to use after a short-term training programme even in the hands of inexperienced staff.

## EXTRACTS

Each year, intrapartum-related complications (birth asphyxia) result in 1.2 million stillbirths, 700 000 term newborn deaths and an estimated 1.2 million babies developing neonatal encephalopathy (previously called hypoxic ischaemic encephalopathy).<sup>1 2</sup> Of these, 96% occur in low-income and middle-income countries.<sup>3 4</sup> Successful resuscitation could prevent a large proportion of these deaths and improve the outcomes of neonates surviving asphyxia.<sup>3 5 6</sup> Therefore, all birth attendants, including physicians, midwives and nurses ought to have the knowledge and skills required to perform neonatal resuscitation.

From: "Nick Spencer, UK" <N.J.Spencer@warwick.ac.uk>

To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (35) Report: Every Child Alive: The urgent need to end newborn deaths (2) Social determinants of stillbirth and infant mortality

Thanks to Kauser Khan for drawing attention to the social determinants of stillbirth and infant mortality. Improvements in service delivery may have some impact but are not able to address the fundamental drivers of these adverse perinatal outcomes. Lack of education, poverty and female disempowerment all increase the risk of adverse perinatal outcomes as well as increasing the risk of lack of access to healthcare. Health professionals have a duty to address these drivers as well as promoting service improvements. As Kauser suggests, the WHO Commission Report on Social Determinants of Health is essential reading providing convincing evidence for advocacy.

Nick Spencer

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ISSOP President

CHIFA 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: "Melissa Morgan, USA/UK" <Melissa.Morgan@lshtm.ac.uk>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (36) Kangaroo mother care (2)

Sara,

I'm a neonatologist from San Francisco and a researcher with the MARCH Centre at LSHTM, and have worked in neonatal units in Kenya, Uganda, and India. I fully agree that kangaroo care is practiced suboptimally in many low-resource facilities for a variety of reasons. We recently published a study in the Journal of Global Health (<http://www.jogh.org/documents/issue201801/jogh-08-010701.htm>) exploring the feasibility and acceptability of KMC among clinically unstable neonates weighing =2000g at a hospital in Uganda. We found that the median daily duration of skin-to-skin contact ranged from 4.5 to 9.7 hours, and few neonates achieved the target duration of 18 hours per day (mothers were counselled to practice KMC as close to continuously as possible). Barriers to the practice of KMC included lack of resources (beds/space, monitoring devices), privacy issues, inadequate education, and difficulties motivating mothers to devote time to KMC. Recommendations from parents and local healthcare providers included staff/peer counselling, resources, family support, and community outreach. We concluded that KMC for unstable neonates was feasible and acceptable at this Ugandan hospital. There remains a need for an evidence-based approach to consistently define stability criteria for KMC to improve care, and randomised controlled trials are urgently needed to demonstrate the effect of KMC on survival among unstable neonates in low-resource settings. Would be interested to hear others' thoughts on this topic.

Here are a few other helpful references on KMC:

Cochrane Review (2016):

[http://www.cochrane.org/CD002771/NEONATAL\\_kangaroo-mother-care-reduce-morbidity-and-mortality-low-birthweight-infants](http://www.cochrane.org/CD002771/NEONATAL_kangaroo-mother-care-reduce-morbidity-and-mortality-low-birthweight-infants)

Kangaroo mother care to reduce morbidity and mortality in ...

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

Evidence from this updated review supports the use of KMC in LBW infants as an alternative to conventional neonatal care, mainly in resource-limited settings. Further ...

WHO guidelines on interventions to improve preterm outcomes (2015):

[http://apps.who.int/iris/bitstream/10665/183037/1/9789241508988\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/183037/1/9789241508988_eng.pdf)

Systematic review of KMC literature (2016):

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4871067/>

From: "Indira Narayanan, USA" <inarayanan6@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (37) Staffing of neonatal units (7)  
Family-centred care (8)

Related to the discussions taking place I am sending the following comments.

Having looked after neonatal units in India earlier, and visited many in Africa among the major challenges frequently noted include inadequate staffing, notably nurses. While in some centers in India there are well qualified and trained nurses, a number are not so skilled in the care of the high risk/small and sick babies, especially in many centers in Africa. Equipment and supplies, especially single use items and safe blended oxygen with adequate monitoring in the baby are also deficient. More emphasis is required on quality of care including prevention of infection and maintenance, review and use of data.

Family oriented approach and KMC are important globally. Even maternal involvement in the neonatal unit where we initiated in our hospital in the 80's was found to be useful. We found that they provide support to the nursing staff by taking part in the non-specialized care. This intervention also helped in building up confidence and competence in the mother to promote subsequent home care of the baby after discharge which often take place earlier than in high income countries, partly due to large numbers of babies in countries such as India.

[ Refs- (a.) Narayanan I, Singh S, Singhal R, Gatwala G. Maternal participation in the care of the high-risk neonate. *Ind. Pediatr.* 1986; 23: 796-797. And (b) Narayanan I, Gupta A, Mandal RN, Chugh R, Singh I. Early mother - infant interaction: Global perspectives and developing country concerns. *J.Trop.Pediatr.* 1987; 33: 120-123.] It is heartening to note increased interest in family-oriented facility based newborn care.

Now I have been in the arena of global health for 19 years in Africa, Asia and LAC. Currently being an Adjunct Professor in Pediatrics/Neonatology at the Georgetown University Medical Center, my colleagues and I have collected information from some hospital neonatal units in Uganda, Indonesia and India to highlight the state of facility readiness for the care of the high risk/small and sick babies that is just ready for sending for publication.

Best,  
Indira

Indira Narayanan MD  
Independent Consultant  
Global Maternal & Newborn Health, and Nutrition

Adjunct Professor, Pediatrics/Neonatology  
Georgetown University Medical Center,  
Washington, DC  
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CHIFA profile: Indira Narayanan is currently Adjunct Professor, Pediatrics/Neonatology at the Georgetown University Medical Center, Washington DC, USA and Independent Consultant, Global Maternal and Newborn Health. Professional interests: Maternal and Newborn Health, research, improving newborn care with emphasis on compassionate/respectful quality of care, health policies, program implementation, capacity building, social and behavior change communication. Her research includes the seminal randomized controlled studies on proving for the first time in world literature the clinical implications of the anti-infective properties of raw and heated, human milk in neonatal units carried out during her work of 20 years in India. inarayanan6 AT gmail.com

From: "Gulbin Gokcay, Turkey" <gokcay@superonline.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (38) Stillbirths (2)

Dear Friends,  
I would like to share a copy of our article on stillbirths from Turkey. [\*see note below]  
With my best regards,  
Gulbin Gokcay  
Professor in Social Pediatrics  
Istanbul University  
Institute of Child Health  
Turkey

CHIFA profile: Gulbin Gokcay is Professor at the Istanbul University Institute of Child Health, Turkey. Professional interests: Pediatric Epidemiology, Immunization, Breastfeeding, Pediatric nutrition, Well Child Care, Social Pediatrics. gokcay AT superonline.com

[\*Note from CHIFA assistant moderator (Neil PW): CHIFA does not carry attachments. The full text is freely available here:

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5509129/> ]

From: "Hemant Nandgaonkar, India" <nandgaonkar.hemant@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (39) Kangaroo mother care (3)

Thank you for enumerating reasons for poor practice of KMC. Recently I came across one study, where one group was not given KMC. I pointed out that it's NOT acceptable and unethical to deny KMC to control group. I feel such studies should be discouraged.

CHIFA profile: Hemant Nandgaonkar is an occupational therapist at Hands On Therapy Concepts in India. Professional interests: Early Intervention, Neonatal Therapy, Hand Therapy, Sensory Integration Therapy. nandgaonkar.hemant AT gmail.com

From: "Mike English, Kenya" <MEnglish@kemri-welcome.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (40) Staffing of neonatal units (8)

At a recent meeting in Nairobi emerging data were discussed with senior Kenyan nurses and paediatricians that indicate how much care for newborns is actually not done. This results from the very high patient to nurse ratios and the huge volume of tasks that nurses are expected to complete in caring for the sickest babies. Sick newborns are especially vulnerable to the major deficits in human resources for health and action is required to address this issue if we are to make gains in newborn survival.

Mike

HIFA profile: Mike English trained as a General Paediatrician in the UK but has worked in Kenya (where he is still based) for over 20 years supported by a series of Wellcome Trust research fellowships. He initially formed the Child and Newborn Health Group but this transitioned in 2011 to the broader Health Services Unit which Mike heads in collaboration with Kenya's Ministry of Health, the Kenya Paediatric Association and the University of Nairobi. He also leads the Oxford Health Systems Research Collaboration (OHSCAR). He is a member of the CHIFA Newborn Care working group.

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

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

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From: "Mari Tvaliashvili, Georgia" <tvaliashvilimari@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (41) Q1. Who is the health worker caring for the newborn? (11)

Before discharge of the mother and newborn, in the maternity home pediatric physician talks to each mother and describes how to take care of a baby at home, while on duty nurse retreats newborn and wraps again in ward.

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Number of primary cesarean sections - 12775

Total number of obstetrical bleeding (more than 1 Litre) - 141

Transfer of mothers in critical care department and / or other facility - 111 ( during post-natal period) 68 (pregnant women)

Number of maternal deaths according to reasons- indirect causes 28%, embolism 7%, ectopic pregnancy 7%, bleeding 22%, sepsis 22%, unknown 14% (2016 year data)

Transfer of newborns to newborn intensive service provider and / or other institution 1888

the number of cases of neonatal mortality 6.3 per 1000 live birth (2016 year data).

CHIFA profile: Mari Tvaliashvili works at National Center for Disease Control and Public Health, NCDC, and is based in Georgia. Mari works in non-communicable disease department, maternal and child health division as a data quality assessment and analytics specialist of Georgian Birth Registry (GBR). She is a CHIFA Country Representative for Georgia.

<http://www.hifa.org/forums/chifa-child-health-and-rights/country-representatives/10>

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

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From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (42) World Birth Defects Day: 3 March 2018

World Birth Defects Day

<http://www.who.int/life-course/news/events/world-birth-defects-day-2018/en/>

More than 8 million babies worldwide are born each year with a serious birth defect. Birth defects are a leading cause of death in the first year of life, and babies who survive may be physically or mentally disabled, taking a costly toll on their families, communities and nations.

The March of Dimes and more than 50 other international organizations are joining together for World Birth Defects Day, observed every year on March 3, to raise awareness of this serious global problem and advocate for more surveillance, prevention, care and research to help babies and children.'

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Best wishes, Neil

Joint Coordinator, CHIFA Project on Newborn Care

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

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From: "Sara Hassanain, Sudan" <sarahazim@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (43) Q2. Where in the hospital are small and sick newborns cared for? (3) Village midwives and community health workers

Q2. Where in the hospital are small and sick newborns cared for? What infrastructure, equipment, commodities, guidelines are needed for small and sick newborn care?

It is worth telling that around 80% of deliveries in Sudan take place in rural settings and the entry point for sick new-borns should be the village midwives (VMWs) however the needed skills and equipment are yet lacking. Short scale projects are in place aiming at training VMWs on new-born resuscitation skills and helping babies breathe. The outcome of these projects was promising. Sudan is now applying a primary health care expansion project that relies on VMWS, Community health workers (CHWs) and medical assistance however the specific skills for handling some of maternal and child health issues needs more investments and strengthening. For example early case picking and referring for the during pregnancy risk factors like malaria or high blood pressure/preeclampsia, as causative factors for low birth weights or growth restriction as well as new-born sickness needs systemized strengthening.

The 'integrated community case management interventions are still in a limited coverage stages though it is an excellent platform for early maternal/pre natal' management and could also be a triage system for most at risk new-borns who are expected to have low birth weight due to congenital malaria and for sepsis and pneumonia signs. Rigorous identification of priority diseases and training of CHWS in new-born management, enforcement of community based health management information system, and efficient referral are really needed.

In central and urban areas, district hospitals, secondary and tertiary levels hospitals are the places where precise care is provided. Several challenges are in place such as the severe cuts in public expenditures on mother and child health interventions. Dealing with new-born is dealt with as sophisticated interventions and consultants and paediatricians are the main care givers in addition to nurses.

From a personal experience I can tell that empirical treatment and guidelines are not well updated nor enforced. Treatment of early signs of neonatal sepsis could be based on very risky and expensive antibiotics. Polypharmacy is also practised which is mainly due to lack of guidelines enforcement. Private sector is taking over and the new-born management is very expensive. Unless the family is covered by 'Prepayment Plans/insurances getting incubation or hospitalisation might be impossible. Oxygen concentrators are not emplaced in an equitable manner in Sudan. Infection control is also a challenging area for new-born health management and control.

I believe things couldn't improve unless the government increases the public spending and put maternal and child health as a priority on its top political agenda. Implementation and increasing coverage of low cost and grass root interventions might also help.

CHIFA profile: Sara Hassanain is a Sudanese Pharmacist and is Coordinator of the Comprehensive Approach to Lung Health, helping pneumonia in children and working at The Association of Public Health Research. She has worked for 2 years with the Khartoum State Ministry of Health. sarahazim 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 (44) Highlights of Week 2

Dear CHIFA colleagues,

Thank you for your contributions during Week 2 of our discussion on Newborn Care. During this week we discussed Question 2: Where in the hospital are small and sick newborns cared for? What infrastructure, equipment, commodities, guidelines are needed for small and sick newborn care? We also heard further contributions on questions 1, 3, 4 and 5. During Week 2 we heard from CHIFA members in Georgia, India, Pakistan, Rwanda, South Africa, Sudan, Sweden, Turkey, UK, and USA.

Below are selected highlights:

**1. WHO IS THE HEALTH WORKER CARING FOR THE NEWBORN? IN YOUR COUNTRIES AND PROGRAMMES → WHO IS CARING FOR SMALL AND SICK NEWBORNS? MIDWIVES AND NURSES? OBSTETRICIANS? WHO ARE THE CHAMPIONS OF NEWBORN CARE? HAS THIS CHANGED?**

**CHWs and Village Midwives**

Sara Hassanain, Sudan: It is worth telling that around 80% of deliveries in Sudan take place in rural settings and the entry point for sick new-borns should be the village midwives (VMWs) however the needed skills and equipment are yet lacking. Short scale projects are in place aiming at training VMWs on new-born resuscitation skills and helping babies breathe.

**Staffing of neonatal units**

Mike English, Kenya: At a recent meeting in Nairobi emerging data were discussed with senior Kenyan nurses and paediatricians that indicate how much care for newborns is actually not done. This results from the very high patient to nurse ratios and the huge volume of tasks that nurses are expected

to complete in caring for the sickest babies. Sick newborns are especially vulnerable to the major deficits in human resources for health and action is required to address this issue if we are to make gains in newborn survival.

Sara Tornquist, Sweden: My quite slim experience from low income settings [including Kenya] are that 1. mothers and babies are too often discharged far too early due to limited space 2. The knowledge of the needs of small and vulnerable babies are quite inadequate. 3. The need for better knowledge on neonatal resuscitation is huge. With this comes of course training but also RESOURCES.

Neonatal units: Sudan

Sara Hassanain, Sudan: From a personal experience I can tell that empirical treatment and guidelines are not well updated nor enforced. Treatment of early signs of neonatal sepsis could be based on very risky and expensive antibiotics. Polypharmacy is also practised which is mainly due to lack of guidelines enforcement.

## 2. WHERE IN THE HOSPITAL ARE SMALL AND SICK NEWBORNS CARED FOR? WHAT INFRASTRUCTURE, EQUIPMENT, COMMODITIES, GUIDELINES ARE NEEDED FOR SMALL AND SICK NEWBORN CARE?

Corazon B Bernabe, Philippines (Week 1): All of the hospitals have pediatric wards, but the specialist may not always be available and the equipments and commodities are very basic and usually lacking.

Sue Prullage, Rwanda: Here is the information from the survey we just did in Rwanda. We queried did they have this equipment; how many units? and how many were functioning. Every facility had some form of oxygen either concentrators, O2 tanks or walled oxygen.

CPAP: 33.7% had no available CPAP the remaining 66.3% had access to one machine

Breast pumps: 68.5% did not access to a breast pump. The remaining 31.5% had at least one up to three pumps not all functional.

Every hospital had access to phototherapy and NG tubes.

Sue Prullage, Rwanda: The basic equipment such as thermometers, stethoscopes were present. But to the important equipment such as CPAP, IV pumps, oxygen there seems to be a lack of access and is probably causing the staff to ration what is available. In my own experience we have split oxygen to ensure that all babies receive some oxygen but the exact amount is not known and is really a dangerous practice. For one baby may need 1 liter of oxygen but the other baby may only need 0.5 L which puts them at risk for hyperoxia thus affecting lungs and eyes etc.....€. In several of the hospitals we queried they were creating their own CPAP with water bottles and tubing (we did this for a long time). All in the hope that the homemade CPAP will help the babies.

## 3. HOW IS THE FAMILY INVOLVED IN CARING FOR SMALL AND SICK NEWBORNS? IS THERE FAMILY CENTRED CARE IN NEONATAL UNITS? ARE YOUR FACILITIES IMPLEMENTING KANGAROO MOTHER CARE? WHAT DOES FAMILY-CENTRED CARE MEAN IN YOUR CONTEXT? WHAT CAN BE DONE TO STRENGTHEN THE QUALITY OF FAMILY-CENTRED CARE?

Kangaroo Mother Care

Melissa Morgan, USA: I'm a neonatologist from San Francisco and a researcher with the MARCH Centre at LSHTM, and have worked in neonatal units in Kenya, Uganda, and India. I fully agree that kangaroo care is practiced suboptimally in many low-resource facilities for a variety of reasons. ...

Barriers to the practice of KMC included lack of resources (beds/space, monitoring devices), privacy issues, inadequate education, and difficulties motivating mothers to devote time to KMC.

Sue Prullage, Rwanda: At many of the neonatal units in Rwanda mothers are involved in the care of the infants even giving NG tube feedings.

Lily Kak, USA: I would like to thank Sue Prullage for sharing very interesting and relevant information about the neonatal units in Rwanda. I look forward to learning more about the results of the survey once it is completed. USAID and UNICEF are supporting a multi-country survey of neonatal units and will have results from 8-9 countries by the end of this year. Your preliminary findings regarding severe nursing shortage in the units makes me wonder if family-centered care can help alleviate the staffing shortage by involving parents in doing some of the non-medical tasks. Do you think this would be feasible in the Rwandan context?

Ruth Davidge, South Africa: Family centered care: This is encouraged but still not well implemented.

Engaging children in health care

Clare Hanbury, UK: Have you [\*see note below] considered involving the siblings in the parenting discussions? Very often young adolescent siblings support the mother and help to care for other members of the family. They can be more literate than mothers and may help their parents remember the instructions given by health care workers.

4. WHO IN THE MINISTRY IS RESPONSIBLE FOR NEWBORN PROGRAMMES, AT THE NATIONAL LEVEL? WHAT ABOUT REFERRAL SYSTEMS? WHAT ABOUT MEASUREMENT AND ACCOUNTABILITY?

Sara Hassanain, Sudan: I believe things couldn't improve unless the government increases the public spending and put maternal and child health as a priority on its top political agenda.

5. WHO ARE THE KEY PLAYERS IN THE GLOBAL HEALTH ARCHITECTURE FOR NEWBORN CARE?

Lily Kak, USA: Earlier this week, UNICEF launched a campaign, 'Every Child Alive: the Urgent Need to End Newborn Deaths. They published a very strong (and beautiful) report [[https://www.unicef.org/publications/index\\_102640.html](https://www.unicef.org/publications/index_102640.html)] rich with data, the urgency to do more, and the importance of quality of care. I especially liked the reference to the four Ps to enhance quality of care: Place (clean functional health facilities equipped with water, soap and electricity), people (competent human resource), products (10 life-saving commodities/equipment), and power (empowering girls, mother and families to demand receive quality care).

Nick Spencer, UK: Thanks to Kauser Khan for drawing attention to the social determinants of stillbirth and infant mortality. Improvements in service delivery may have some impact but are not able to address the fundamental drivers of these adverse perinatal outcomes. Lack of education, poverty and female disempowerment all increase the risk of adverse perinatal outcomes as well as increasing the risk of lack of access to healthcare. Health professionals have a duty to address these drivers as well as promoting service improvements. As Kauser suggests, the WHO Commission Report on Social Determinants of Health is essential reading providing convincing evidence for advocacy.

Best wishes, Neil

Joint Coordinator, CHIFA Project on Newborn Care

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

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From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (45) Q3. How is the family involved in caring for small and sick newborns?

Dear CHIFA colleagues,

Thank you for your contributions to the discussion so far! We now start our third week and, on behalf of the CHIFA Newborn Care working group, I invite you to comment on Question 3:

**3. HOW IS THE FAMILY INVOLVED IN CARING FOR SMALL AND SICK NEWBORNS? IS THERE FAMILY CENTRED CARE IN NEONATAL UNITS? ARE YOUR FACILITIES IMPLEMENTING KANGAROO MOTHER CARE? WHAT DOES FAMILY-CENTRED CARE MEAN IN YOUR CONTEXT? WHAT CAN BE DONE TO STRENGTHEN THE QUALITY OF FAMILY-CENTRED CARE?**

We have already heard from CHIFA members on some of these questions. Below we hear from Philippines, Rwanda, South Africa and other LMICs. We look forward to hear more. Email: [chifa@dgroups.org](mailto:chifa@dgroups.org)

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Sue Prullage, Rwanda: At many of the neonatal units in Rwanda mothers are involved in the care of the infants even giving NG tube feedings.

Sue Prullage, Rwanda: I think the family can play a role and should be involved in KMC and cue based feedings this would take a small part of the burden. But there is no other alternative to well trained specialized nurses available to listen to families and to assess babies.

Lily Kak, USA: I would like to thank Sue Prullage for sharing very interesting and relevant information about the neonatal units in Rwanda... Your preliminary findings regarding severe nursing shortage in the units makes me wonder if family-centered care can help alleviate the staffing shortage by involving parents in doing some of the non-medical tasks. Do you think this would be feasible in the Rwandan context?

Ruth Davidge, South Africa: Family centered care - This is encouraged but still not well implemented

- Most hospitals offer lodging facilities for breast feeding mothers
- Mothers are encouraged to participate in care of their babies including tube feeds, oral medications, changing nappies etc
- Visiting of fathers and siblings is encouraged but has slow uptake
- Skin to skin care is practiced from birth in labour wards...

Ruth Davidge, South Africa: We have discussed in KZN the possibility of increased parental responsibility for recording of observations and feeds etc and believe this is feasible and could be helpful in settings with very high nurse patient ratios. However it is dependent on parental presence

(lodging facilities), parental literacy and time to orientate parents to what is required and what danger signs are (and this time may not be available in really bad settings)

Corazon B Bernabe, Philippines: In the rural area the families would be continuing the care at home and given instructions. But if they're admitted, usually they are just informed of the baby's condition with care being rendered by health workers... KMC is still a new concept for us.

Melissa Morgan, USA: I'm a neonatologist from San Francisco and a researcher with the MARCH Centre at LSHTM, and have worked in neonatal units in Kenya, Uganda, and India. I fully agree that kangaroo care is practiced suboptimally in many low-resource facilities for a variety of reasons. ... Barriers to the practice of KMC included lack of resources (beds/space, monitoring devices), privacy issues, inadequate education, and difficulties motivating mothers to devote time to KMC.

Clare Hanbury, UK: Have you considered involving the siblings in the parenting discussions? Very often young adolescent siblings support the mother and help to care for other members of the family. They can be more literate than mothers and may help their parents remember the instructions given by health care workers.

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With thanks,  
Neil

Joint Coordinator, CHIFA Project on Newborn Care  
<http://www.hifa.org/projects/newborn-care>

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CHIFA profile: Neil Pakenham-Walsh is the coordinator of the HIFA campaign (Healthcare Information For All) and assistant moderator of the CHIFA forum. He is current chair of the Dgroups Foundation ([www.dgroups.info](http://www.dgroups.info)), which supports 700 communities of practice for international development, social justice and global health. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG neil@hifa.org

From: "Sue Prullage, Rwanda" <sue.prullage@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (46) Q3. How is the family involved in caring for small and sick newborns? (2)

**HOW IS THE FAMILY INVOLVED IN CARING FOR SMALL AND SICK NEWBORNS? IS THERE FAMILY CENTRED CARE IN NEONATAL UNITS? ARE YOUR FACILITIES IMPLEMENTING KANGAROO MOTHER CARE? WHAT DOES FAMILY-CENTRED CARE MEAN IN YOUR CONTEXT? WHAT CAN BE DONE TO STRENGTHEN THE QUALITY OF FAMILY-CENTRED CARE?**

In the unit where I work and many units across Rwanda the families are providing the bathing, diapering and feedings either NG, cup or breastfeeding. Recently due to fear of infection there has been a call to limit the time of the mothers in the room. The literature is not positive for not allowing families around their babies. I would suggest that possibly the infection could be related to poor staffing and difficulty for the staff to take time to wash between each baby. The majority of the

facilities had running water, soap and gel yet 7.2% of the hospitals did not have running water and 4.2% did not have soap, 42.3% did not have hand gel at each bedside. So this would make one wonder if they had the availability to wash hands was it related to lack of time to do so that could be contributing to the infection rate in hospitals. The call to remove families may demonstrate that by doing this it will not decrease the mortality rate as much as possibly contributing to it by requiring overworked staff to pick up more work. As demonstrated from the video of family centered care in India the families are excited to be involved in the care of their infants. They are conscientious to wash their hands and take every precaution needed to get their baby home. Our experience has shown that the mothers do wash their hands if they don't the other mothers in the room remind them.

India is on the right track by utilizing the family to care for their own baby. We are doing it but need better policies related to what a family can do or not do. 39.2% did not have family visiting policies yet only 12% of the facilities did not allow parents to participate in their infants care. 83.5% allowed the parents to give NG feeds, and 83.9% gave education about how to give feeds yet 78.5% did not have a written family NG feed policy. I think family should be used in the NICU but with specific task and guidelines. Policies should be written to prevent overuse by the overworked staff and to allow the families to be involved.

Sue Prullage DNP, APN, 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. She is a member of the CHIFA Newborn Care working group.

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

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

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From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (47) Q3. How is the family involved in caring for small and sick newborns? (3)

Dear all,

Thank you Sue, Ruth, Melissa, Clare and others for your valuable contributions (1-4 below). Would you like to say any more about family-centred care in your country? It seems there is wide variation in approach. How might family-centred care be safely promoted and supported in countries (and hospitals) where this is not the case? Would it be helpful to pull together case studies from different countries (perhaps COINN, the Council of International Neonatal Nurses) is already doing this, or could be supported to do more?

All: please feel free to contribute on any aspect of newborn care. Background information and questions are available here: <http://www.hifa.org/news/how-can-we-improve-care-small-and-sick-newborns-low-and-middle-income-countries>

1. We have heard that family-centred care is a reality in many neonatal units across Rwanda, where 'families are providing the bathing, diapering and feedings either NG, cup or breastfeeding'... 'the families are excited to be involved in the care of their infants. They are conscientious to wash their hands and take every precaution needed to get their baby home. Our experience has shown that the mothers do wash their hands if they don't the other mothers in the room remind them'. Sue notes,

however, 'there is no other alternative to well trained specialized nurses available to listen to families and to assess babies'.

2. Ruth Davidge, South Africa, notes that family-centered care is 'encouraged but still not well implemented'. Corazon B Bernabe, Philippines, says: 'usually they [parents] are just informed of the baby's condition with care being rendered by health workers... KMC is still a new concept for us.'

3. Melissa Morgan, USA, notes that kangaroo care is practiced suboptimally in many low-resource facilities for a variety of reasons... Barriers to the practice of KMC included lack of resources (beds/space, monitoring devices), privacy issues, inadequate education, and difficulties motivating mothers to devote time to KMC.'

4. Clare Hanbury, UK asks: 'Have you considered involving the siblings in the parenting discussions? Very often young adolescent siblings support the mother and help to care for other members of the family. They can be more literate than mothers and may help their parents remember the instructions given by health care workers.'

Best wishes, Neil

Joint Coordinator, CHIFA Project on Newborn Care

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

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CHIFA profile: Neil Pakenham-Walsh is the coordinator of the HIFA campaign (Healthcare Information For All) and assistant moderator of the CHIFA forum. He is current chair of the Dgroups Foundation ([www.dgroups.info](http://www.dgroups.info)), which supports 700 communities of practice for international development, social justice and global health. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG neil@hifa.org

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

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

Subject: [chifa] Newborn Care (48) Amref Health Africa and newborn care in Ethiopia

Are any CHIFA members involved in this new programme in Ethiopia. which aims to improve maternal and newborn care? I note the programme appears to be tackling the continuum of care from community to facility. There is no mention of family-centred care, but this is presumably included in the approach?

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<http://www.africanreview.com/finance/economy/amref-health-africa-and-ge-healthcare-to-strengthen-africa-s-healthcare-systems>

Initially, Amref Health Africa and GE [GE Healthcare] will work together with Intrahealth and Project HOPE on a new programme in Ethiopia, where GE will provide medical equipment at 20 health centres and four primary hospitals to widen access to antenatal screenings, essential newborn care and to upskill health workers.



The technology will include portable ultrasound for antenatal screening, baby warmers, anesthesia and resuscitation equipment used during childbirth and phototherapy devices which help mitigate jaundice in babies.

Through a focus on task-shifting, health workers such as midwives who operate in remote communities where access to medically trained personnel is often limited or non-existent, will be taught essential skills to perform additional tasks such as antenatal scans, ensuring that critical, potentially life-saving services are available to the most at-risk patients.

“Strengthening primary care and the broader referral system is an essential building block towards the attainment of universal health coverage in Africa,” said Farid Fezoua, president and CEO at GE Healthcare Africa.

He added, “Our approach combines relevant technologies, skills development and localised service delivery into one scalable deployment model. Early pilots have shown promising results and together with Amref Health Africa and our other implementation partners, we have a dedicated and local team monitoring and evaluating these programs to share learnings across the continent.”

According to WHO, approximately 830 women die every day from preventable causes related to pregnancy and childbirth, with maternal mortality higher in women living in rural areas and among poorer communities. Almost all maternal deaths (99 per cent) occur in developing countries. More than half of these deaths occur in sub-Saharan Africa. The situation remains challenging for infants and newborns. While the total number of under-five deaths dropped to 5.6mn in 2016 from 12.6mn in 1990, 7,000 newborns still die every day, according to UNICEF. In sub-Saharan Africa, approximately one child in 13 dies before his or her fifth birthday, while in the world's high-income countries the ratio is one in 189.

One target under Sustainable Development Goal 3 is to reduce the global maternal mortality ratio to less than 70 per 100 000 births, with no country having a maternal mortality rate of more than twice the global average. To that end, skilled care before, during and after childbirth can save the lives of women and newborn babies, according to WHO.

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Best wishes, Neil

From: "Ruith Davidge, South Africa" <rdavidge@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (49) Q3. How is the family involved in caring for small and sick newborns? (4)

We are fortunate in the public sector of SA (speaking particularly about Kwa Zulu Natal) that all our hospitals offer lodging facilities for our mothers. The quality of this service varies greatly but does ensure that mothers are available to provide breast milk and support for their baby. This is a great gift for mothers, newborns and facilities alike but frequently comes at the cost of care for families/siblings at home who may land up being cared for next door neighbors if no family are available. Mothers often are away from employment or schooling so there is a cost to their presence at the bed side apart from the bed and meals provided by the facility.

These mothers deliver basic care for their baby including et al: naso gastric/cup feeding and breast feeding, changing nappies, administering oral medications, cleaning the baby's incubator, bathing

baby etc. There is limited involvement in decision making and policies regarding visiting of siblings and fathers varies greatly between facilities.

It has been suggested that mothers could also be involved in recording basic observations for their babies following close support and education but this has not been trialed or implemented at any facility yet.

All our facilities offer skin to skin care at birth, some offer skin to skin in post natal and all offer 24hr KMC for preterm babies even if this is only 2 beds in the post natal unit.

God bless

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 Neonatal Nurses Association of Southern Africa, NNASA. She is a Registered Nurse and on the board of the Council of International Neonatal Nurses, COINN. ruth.davidge AT kznhealth.gov.za [www.nnasa.org.za](http://www.nnasa.org.za)

From: "Pauline Njoroge, Kenya" <paulinenjoroge370@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (50) Q3. How is the family involved in caring for small and sick newborns? (5) Kangaroo mother care (4)

Great Conversation.

In Kenya, Kangaroo Mother Care is being uptake well in most facilities within the Country. Working in the Country's capital - Nairobi and in the high volume facilities, the concept has worked in reducing the reliance to incubators, reduced formula milk required for the babies as well as reduced hospital stay for the babies. Mothers and fathers are actually liking and embracing it.

Having facility based champions has worked well for us. However, the major challenge we have had is lethargy among health workers in initiating babies in KMC as well as facility based constraints such as limited space. At times mothers also view KMC room as a special room.

I look forward to a world where KMC is recommended as a form of care and not just as a concept.

Regards.

CHIFA profile: Pauline Njoroge is Programme Assistant at Save the Children International-Kenya. Professional interests: Holds a great interest in maternal and newborn health where we give each child an opportunity to survive and thrive. I also hold a great passion in reproductive health especially for the adolescent girls. paulinenjoroge370 AT gmail.com

From: "Mary Nyikuri, Kenya" <mnyikuri@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (51) Staffing of neonatal units (9)

Colleagues,

To contribute to the question of who is caring for sick newborns in facilities, a scope around Nairobi's (Kenya) public, faith based and private hospitals indicates that newborns are cared for mainly by nurses. While the high end private facilities ensure that these nurses have specialised training in neonatal care, the public and faith based hospitals deploy any nurse irrespective of their speciality. Additionally, students play a major role in the care of hospitalised newborns in both public and faith based facilities.

kind regards  
Mary

CHIFA profile: Mary Nyikuri is a PhD student at the Kenya Medical Research Institute, KEMRI. mnyikuri AT gmail.com

From: "Sue Prullage, Rwanda" <sue.prullage@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (52) Kangaroo mother care (5)

In our neonatal unit we do intermittent KMC and have a KMC room. What we have found is the nurses do not embrace it as a treatment and forget to tell the family to do it. Yet the other mothers help each other put their babies in KMC. I agree with Pauline from Kenya that until the staff embraces it the procedure will remain a concept. I tried to make it more uniform by adapting a KMC Scoring Sheet from Groote Schuur Hospital and Kalafong KMC Unit. (I have attached it). I thought if the staff was required to score the baby daily they'd begin to see the benefit of KMC and ensure it is done. This has not happened and the sheet is utilized very infrequently.

We have the KMC room but the families see it as the next step to being discharged and they only put babies in there that are very close to discharge. The mothers do not do prolong KMC but treat the room as stepdown and the very next day after admit begin to ask for discharge.

Training isn't the answer for the staff has had lots of training about KMC. What would be very interesting is to do a qualitative study to look at what the nurses and families feel about KMC and what the barrier is?

Sue Prullage DNP, APN, 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. She is a member of the CHIFA Newborn Care working group.  
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To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (53) Kangaroo mother care (6)

My attitude to KMC changed once I understood the evidence behind the recommendations and the improved outcomes. Training should focus on the research done on the benefits of KMC.

Compliance with KMC implementation improved once hospitals were informed it was standard of care at provincial and national level including for term babies. Skin to skin care is also included in ESMOE/HBB training. It needs to be promoted by multiple role players at multiple levels to ensure an unequivocal message is given. All hospitals in SA are starting to be assessed as to their compliance with KMC norms.

God bless

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 Neonatal Nurses Association of Southern Africa, NNASA. She is a Registered Nurse and on the board of the Council of International Neonatal Nurses, COINN. ruth.davidge AT kznhealth.gov.za [www.nnasa.org.za](http://www.nnasa.org.za)

From: "Sue Prullage, Rwanda" <sue.prullage@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (54) FAO Mary Nyikuri, Kenya - Staffing of neonatal units (10)

Dear Mary,

Could you share the staffing ratio in Kenya? And does it change with acuity of the infants? Do you have the same amount of nurses on days and nights? Can you describe the specialized training is it hospital based or university based?

Thank you. I put it on the forum because I think it is an interest to everyone who and how many are how many are caring for the neonates

Sue Prullage DNP, APN, 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. She is a member of the CHIFA Newborn Care working group.

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From: "Ochiawunma Ibe, USA" <ochiibe@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (55) Kangaroo mother care (7)

Colleagues,

I posit that we have all the evidence we need regarding the impact of Kangaroo mother care (KMC) on the survival of clinically stable preterm infants. With previous contributors reporting that we need to advocate for KMC implementation by the nurses and midwives that care for these infants in the health facilities the question then is how much of the evidence around KMC is incorporated into the preservice training curriculum of these professionals. How much of KMC have we incorporated into the training of medical doctors, nurses, midwives, clinical officers especially in low and middle income countries where it is desperately needed even though there is evidence of its usefulness in

advanced settings. This link to a systematic review on enablers and barriers for KMC could be useful in this discourse.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4750435/>

Thanks

CHIFA 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. ochi.ibe AT icf.com

From: "Melissa Morgan, USA/UK" <melissa.morgan@lshtm.ac.uk>

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

Subject: [chifa] Newborn Care (56) Kangaroo mother care (8)

Sue,

Thank you for your input [Newborn Care (52) Kangaroo mother care (5)]. I have heard similar feedback about the use of KMC scoring sheets in other African facilities. It's quite interesting to hear that some mothers view the KMC room as a stepdown unit. There have been a number of qualitative and mixed methods studies evaluating barriers to KMC in facilities, including a study in a Ugandan hospital that we recently published as well as several systematic reviews (links below for anyone who might be interested).

Melissa

<http://www.jogh.org/documents/issue201801/jogh-08-010701.htm>

<https://academic.oup.com/heapol/article/32/10/1466/4093363>

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4439040/pdf/pone.0125643.pdf>

Barriers and Enablers of Kangaroo Mother Care Practice: A ...

[www.ncbi.nlm.nih.gov](http://www.ncbi.nlm.nih.gov)

Kangaroo mother care (KMC) is an evidence-based approach to reducing mortality and morbidity in preterm infants. Although KMC is a key intervention package in newborn ...

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4750435/pdf/BLT.15.157818.pdf>

Kangaroo mother care: a systematic review of barriers and ...

[www.ncbi.nlm.nih.gov](http://www.ncbi.nlm.nih.gov)

Methods. We searched PubMed, Embase, Scopus, Web of Science and the World Health Organization's regional databases, for studies on kangaroo mother ...

CHIFA profile: Melissa Morgan is Assistant Professor of Neonatology at the University of California San Francisco; London School of Hygiene & Tropical Medicine in the USA. Professional interests: Kangaroo mother care, focused on initiation in health facilities before clinical stabilisation, Oxygen therapy in newborns, including guidelines for preterm neonates, Neonatal resuscitation, neonatal sepsis, simulation-based training of health workers. melissa.morgan 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 (57) Supporting data use to improve monitoring and accountability for newborn health

(forwarded from Healthy Newborn Network)

### Healthy Newborn Network Spotlight

#### Newborn Numbers: Supporting data use to improve monitoring and accountability for newborn health

A key factor in changing the trajectory for newborn survival is accessing and utilizing the most recent numbers - mortality, coverage of care, funding, human resources. Reliable and current data can be used to demonstrate the need to tackle this problem and identify where the gaps remain, as shown by the recently released Countdown to 2030 report [<http://countdown2030.org/>]. For newborn health, HNN ensures that our users have access to the most up-to-date data in order to raise awareness about the burden, remaining gaps as well as to link data on newborn health to other factors, such as fertility, health worker density and health expenditure.

We have recently updated the Healthy Newborn Network's Newborn Numbers page to align with the updated Countdown to 2030 report country profiles. Established in 2014 as part of the effort to strengthen country analytical capacity to collect and use data, the Newborn Numbers page provides a central location of the most recently published data relating to newborn survival and health ? including under-5, neonatal and maternal mortality, stillbirths, cause of death, preterm birth rates, coverage of interventions, health financing and contextual data. It includes a comprehensive database that can be downloaded with an extensive list of indicators for 197 countries. It also includes an interactive data visualization tool allowing 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. The heat maps visually demonstrate cross-country comparisons of indicators.

All of this data is already in the public domain but available in multiple locations (websites and peer-review journals). Newborn Numbers just consolidates this information in order to support those interested in newborn health to better access and use data for advocacy and decision making. Check out the updated Newborn Numbers page here: <https://www.healthynewbornnetwork.org/numbers/>  
Neil

From: "I Abdulkadir, Nigeria via Dgroups" <CHIFA@dgroups.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (58) Kangaroo mother care (9)

In Nigeria, KMC indeed appears to be a promising intervention as many more facilities continue to implement it. In my experience it is easily accepted by mothers and their families though challenging to practice the continuous KMC as desired. Efficient and sustained counselling and support gets most mothers motivated to practice it.

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: "Indira Narayanan, USA" <inarayanan6@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (59) Staffing of neonatal units (10)

Dear All,

I am glad to see the discussions on staffing related to facility-based care of the newborn. This includes the care of the high risk/small and sick babies who need a considerable degree of care. Both medical (Pediatricians/trained physicians) and nursing staff are important, but the latter are particularly critical as they provide the greatest proportion/duration of care required.

In a recent study that we carried out including some centers in Uganda, Indonesia and India, we noted that in some referral hospitals in Africa, based on the bed strength, the nurse bed ratio was 1:15 or worse, especially at night. The situation can be aggravated by the frequent practice of having more than one baby in a cot/incubator. Interestingly, nearly half the babies in the neonatal units were more than 2500 gm. Not all are really sick but are often transferred to the unit for extra observation or minimal care that the centers feel cannot be provided in the maternity wards. Hence we feel that adding the term, "at-risk or high-risk" to the small and sick babies may have relevance. In addition, this also highlights the need for increasing staffing in the maternity wards and not just in neonatal units. It is true that task shifting and use of mothers in the non-specialized care of the baby can help. However, this is a make shift arrangement as, ultimately, we need skilled, qualified staff.

While it is the responsibility of all concerned to achieve this end, Pediatricians can play a significant role to this end. Motivated, trained Pediatricians/ Neonatologists working with skilled nurses are knowledgeable on what is required for the proper care of these babies. Through their relevant professional bodies, they can strongly advocate for more trained skilled nurses and doctors. In addition, the latter group in well-functioning centers have the responsibility to promote and be involved in training/mentoring of others. While involvement of mothers will still be important, their role will then be for other issues such as the provision of breast milk, kangaroo mother care and being part of the family centered care. All of these are evidence-based benefits for the baby, for empowering the women and building their confidence in the subsequent home care of the baby; not just to cover the lack of suitable care providers.

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building, social and behavior change communication. Her research includes the seminal randomized controlled studies on proving for the first time in world literature the clinical implications of the anti-infective properties of raw and heated, human milk in neonatal units carried out during her work of 20 years in India. inarayanan6 AT gmail.com

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To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (60) Stillbirths and neonatal deaths

The importance of numbers cannot be over-emphasized. However, neonatal mortality cannot be fully estimated by merely counting newborn deaths, difficult as it may be. Based on experience on caring for the newborn in low and middle-income countries and on a recent study of facility-based care of the newborn, I feel it is necessary to also look into two additional data to get a better picture. In all countries stillbirths, notable fresh stillbirths need to be taken into account as in some centers, some neonatal deaths may, for a variety of reasons, be recorded as still births. Additionally, babies that are discharged against medical advice (DAMA), should also be taken into account. Some of these are taken home because of the families' perception of the futility of care in a sick baby, especially where they have to pay for it. Hence, although the exact numbers of stillbirths that have been wrongly classified or the proportion of the DAMA babies that die at home or in another facility may not be clear, documenting all three components can give a more holistic picture and highlight what other interventions need to be considered.

Thank you,  
Indira

From: "Dharmendra Kumar Dewan, India via Dgroups" <CHIFA@dgroups.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (61) Stillbirths and neonatal deaths (2)

Dear All

While fully endorsing Prof Dr Indira Narayanan's evidence based inputs (she was heading NNUnit at KSCH Delhi when I was a Paediatric Resident at LNJP hospital), a few complementary observations are:

1. In low income countries domiciliary deliveries or those attended by untrained birth attendants need to be factored-in while calculating/estimating Neonatal Mortality rates
2. Due to improving Neonatal facility care structures more & more of neonatal deaths are expected to be in the VLBW/extremely premature babies ...this calls for capacity building & up-gradation of skills in staff (nurses specially as also pointed out by Madam Dr Narayanan)
3. Since Still births are reflective of (mainly) the quality of Antenatal care and the fresh neonatal deaths (of obstetric & paediatric care at birth), staff orientation on identifying and dealing appropriately & promptly, can make a significant difference if such practices get institutionalized.
4. There is a need for the governments (in underdeveloped or developing countries) to start regularly sourcing ground level data (births & deaths--civil registration system) thru creating



robust systems instead of relying on small sample sized field surveys every two to four years (which normally cover only < 1 % of the total population)... this data analyzed regularly will help policy formulation even for creating posts at hospitals (of nurses, doctors, paediatricians etc).

5. Family care is important aspect but surely cant substitute the facility care (although this platform can be optimized to instill in mothers & care givers in families, a sense of ease in handling the newborn, in holding the baby to breast, in KMC technique (in a demystified manner) etc.

thanks

Dr d k dewan

Ex State MCH Officer ( & later as Director Family Welfare) , govt of Delhi

CHIFA profile: Dharmendra Kumar Dewan is Director Family Welfare, Directorate of Family Welfare, Government of Delhi, India. Professional interests: Public Health issues on Maternal & Child Health: Neonatal care strengthening, Improving institutional deliveries & quality care, Childhood immunization, Gender Ratio imbalance & role of regulations & Acts. dharmdewan22 AT yahoo.co.in

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To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (62) Stillbirths and neonatal deaths (3)

Thank you, Dr. Dewan for your reply and very useful comments. My comments focussed on the facility births as my recent study was in that area. Home births are indeed important.  
Indira

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From: "Sara Tornquist, Sweden/Kenya" <saratornquist1@gmail.com>  
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Subject: [chifa] Newborn Care (63) Kangaroo mother care (10)

Dear all, at the nearest hospital to the Clinic I work at in Kenya they claim to do KMC. They point to a poster on the wall. Mothers are located at the postnatal ward and come to the neonatal ward to express milk and feed their babies with a sond. The babies lies in incubators, that are usually not turned on.

My question is: how can we MEASURE HIGH (PROPER AND CORRECT) QUALITY KMC?

Another topic is skin to skin care, I usually say "uninterrupted skin-to-skin care" to point out the importance to not disturb and interrupt. Dont touchen, dont try to make the baby latch, dont stress. Dont weigh, dont mesure.... Dont separate mother and baby after sectio, or while suturing.

By skin-to-skin care we dont mean 10-15 minutes, its preferable at least 2 hours. Only for the mother to get up, go to urinate and wash. Then back skin-to-skin.

The medical benefits for mother and child are to great to ignorera.

But, routines and habits are so strong. Mothers very rarely oppose to skin-to-skin, but often we blame them for not doing this.

Best regards,  
Sara

HIFA profile: Sara Tornquist is a Midwife at Karolinska University Hospital, Sweden.  
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From: "Sarah Moxon, UK" <sarah.moxon@lshtm.ac.uk>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (64) Kangaroo mother care (11)

Hi All,

Thanks, Sara, for your important question and thank you to others for their important comments on the challenges of scaling up KMC in the health system. These challenges are well documented and so often vary between country, culture and health system. As Sara says, the barriers to effective scale up are more often related to flaws in the system than refusal of mothers or lack of willingness from families to provide KMC.

Within this paper, published as part of series on health system bottlenecks for maternal and newborn health (led by UNICEF and WHO), there is a helpful visual figure which outlines the health system requirements for KMC at different levels of the health system and how different entry points allow KMC to be integrated into small and sick newborn care:

<https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-15-S2-S5> In addition to other factors that have been mentioned in this discussion, this analysis also identified lack of health information and standardized measurement systems as a major challenge to improving coverage and quality of KMC.

The question of how we can measure high quality KMC has received a lot of attention in recent years. For those working within the system to implement KMC, I'd draw attention to this paper, which presents the results of a consensus based approach to identity a core set of indicators to track effective implementation of KMC. In simpler language , this paper answers the question: What should we

measure to make sure that everything in the system is working to enable mothers to provide KMC effectively? <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5644361/>

I think lots of clinicians and managers will find this helpful to identify a minimum set of indicators to track KMC in their facility.

Thanks,  
Sarah

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. [www.hifa.org/projects/newborn-care](http://www.hifa.org/projects/newborn-care) [www.hifa.org/support/members/sarah-2](http://www.hifa.org/support/members/sarah-2)  
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From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (65) Highlights of Week 3 - Kangaroo Mother Care

Dear CHIFA colleagues,

Thank you for your contributions during Week 3 of our discussion on Newborn Care. During this week we explored Question 3:

How is the family involved in caring for small and sick newborns? Is there family centred care in neonatal units? Are your facilities implementing kangaroo mother care? What does family-centred care mean in your context? What can be done to strengthen the quality of family-centred care?

There were several contributions on kangaroo mother care. I remember meeting Nathalie Charpak, one of the leading pioneers of KMC, at the Geneva Health Forum about 10 years ago. It is wonderful to see how such a low-tech intervention has contributed to saving the lives of so many preterm and low-birthweight newborns. Below are five selected highlights:

1. Pauline Njoroge, Kenya: In Kenya, Kangaroo Mother Care is being uptake well in most facilities within the Country. Working in the Country's capital - Nairobi and in the high volume facilities, the concept has worked in reducing the reliance to incubators, reduced formula milk required for the babies as well as reduced hospital stay for the babies. Mothers and fathers are actually liking and embracing it.
2. Sue Prullage, Rwanda, In our neonatal unit we do intermittent KMC and have a KMC room. What we have found is the nurses do not embrace it as a treatment and forget to tell the family to do it... We have the KMC room but the families see it as the next step to being discharged and they only put babies in there that are very close to discharge... Training isn't the answer for the staff has had lots of training about KMC. What would be very interesting is to do a qualitative study to look at what the nurses and families feel about KMC and what the barrier is?
3. Ruth Davidge, South Africa: My attitude to KMC changed once I understood the evidence behind the recommendations and the improved outcomes. Training should focus on the research done on the

benefits of KMC. Compliance with KMC implementation improved once hospitals were informed it was standard of care at provincial and national level including for term babies.

4. Melissa Morgan, USA: I'm a neonatologist from San Francisco and a researcher with the MARCH Centre at LSHTM, and have worked in neonatal units in Kenya, Uganda, and India. I fully agree that kangaroo care is practiced suboptimally in many low-resource facilities for a variety of reasons... Barriers to the practice of KMC included lack of resources (beds/space, monitoring devices), privacy issues, inadequate education, and difficulties motivating mothers to devote time to KMC.

5. I Abdulkadir, Nigeria: In Nigeria, KMC indeed appears to be a promising intervention as many more facilities continue to implement it. In my experience it is easily accepted by mothers and their families though challenging to practice the continuous KMC as desired. Efficient and sustained counselling and support gets most mothers motivated to practice it.

Best wishes, Neil

Joint Coordinator, CHIFA Project on Newborn Care

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

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

CHIFA profile: Neil Pakenham-Walsh is the coordinator of the HIFA campaign (Healthcare Information For All) and assistant moderator of the CHIFA forum. He is current chair of the Dgroups Foundation ([www.dgroups.info](http://www.dgroups.info)), which supports 700 communities of practice for international development, social justice and global health. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG [neil@hifa.org](mailto:neil@hifa.org)

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To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (66) Q4: Who is responsible for newborn programmes at the national level?

Dear CHIFA colleagues,

Welcome to Week 4 of our discussion on Newborn Care!

This week we would like to invite you to consider Question 4:

**WHO IN THE MINISTRY IS RESPONSIBLE FOR NEWBORN PROGRAMMES, AT THE NATIONAL LEVEL? WHAT ABOUT REFERRAL SYSTEMS? WHAT ABOUT MEASUREMENT AND ACCOUNTABILITY?**

Have you been involved in working with government in preparing national policy and practice guidelines for newborn care? What have been the main challenges?

Can you comment on how well the government empowers health workers at primary, district and national levels to give the best care possible to newborns? How could support be improved? How well does the referral system work for mothers and newborns - from primary to district level? from district to national level?

On the subject of 'measurement and accountability', we have heard about difficulties in measuring stillbirths and neonatal deaths (we have also learned, alarmingly, that some early neonatal deaths are miscategorised as stillbirths). We invite more comments on this. Have you been involved in efforts to measure the delivery of health services and/or quality of care, at national, district or facility level? What are the challenges and lessons learned? How would we define Universal Health Coverage in the context of newborn care?

The above is intended only as a guide, and you are free to contribute on \*any\* aspect of newborn care. For background info on this discussion, see <http://www.hifa.org/news/join-chifa-global-discussion-newborn-care-low-and-middle-income-countries>

Best wishes, Neil

Joint Coordinator, CHIFA Project on Newborn Care  
<http://www.hifa.org/projects/newborn-care>

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

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Subject: [chifa] Newborn Care (67) Q4: Who is responsible for newborn programmes at the national level? (2)

Hi All

Greetings from India.

Responding to some of the discussions generated over the last 3 weeks I have the following to submit:

India country overview : India has demonstrated steady commitment to improve the QoC for sick newborn in both policy and action. The country has witnessed improvement in infrastructure & systems strengthening over the last 8 to 10 years with establishment of District SNCUs in each of the distr & institutionalising a structured Facility Based Newborn Care (FBNC) across these. For the last few years, there has been a focus on improving QoC: setting up of District Early Intervention Centres (DEIC), MAA program (a nationwide launch of breast feeding program), Family Participatory Care (FPC) & now LaQkshya initiative (to strengthen Delivery Rooms & OTs) are some of the initiatives taken by our government.

One can visit the link to view more of these guidelines:  
<http://nhm.gov.in/nrhm-components/rmnch-a/child-health-immunization/child-health/guidelines.html>

While systems & practices wrt Newborn care are getting better by the day there are gaps at certain districts, yet to catch up.

Mid 2017, Ministry of Health, Government of India directed a rapid assessment of certain High Priority (those districts with the highest mortality) District Special Newborn Care Units (SNCUs) to assess gaps in newborn care & to identify possible solutions. The assessment covered domains of infrastructure, HR adequacy, equipment- supplies, practices & protocols according to a structured format.

These were conducted by a team of Experts of which I too was a part. Some of the key gaps that I observed were w.r.t. :

- HR inadequacies with their suboptimal job satisfaction & attrition (at times resulting in upto 50% staff vacancies), Some local facility level policy gaps such as non-designation of staff for critical areas such as SNCU, frequent staff rotations among all areas resulting in lack of ownership for newborn unit by any fixed team of staff.
- Continuing relatively high fresh still birth rates & asphyxia events & asphyxia related mortality proportions point towards scope of improvement in Obstetric Care & need to strengthen & capacity build esp. w.r.t. neonatal resuscitation.
- Relative overcrowding of the SNCUs with sometimes babies ~~are~~ not so sick babies that could better be cared for at peripheral New Born Stabilising Units (NBSUs) or even by mothers' side & thru their involvement in care.
- Referrals from private set ups being too late & often without pre-transport stabilisation.
- Training and capacity gaps exist among those providing care at birth. Practices reflect gaps in protocol driven practices (although STPs exist) with relative overuse of antibiotics, oxygen & IV fluids.
- Separation from mothers (at times stretching for days) seems not justified with scope of better inclusion of mothers in care of their sick newborns.
- Lack of regular post natal ward rounds.
- Present infrastructure of facilities has shortcomings wrt supporting baby & mothers being roomed in together & pro-mother facilities conducive to support her 24x7 engagement in care.
- Post discharge follow up at the facility & linkages for community followup need strengthening.

Some of the commendable steps being taken by our government include standardisation of various operational & training Guidelines for various programs, considering infrastructural revisions to promote family centred care & KMC, concept of mother-newborn care units, strengthening delivery rooms & OTs, Creating universal opportunities for capacity building, mentoring & auditing mechanisms by state medical colleges to act as state resource centres, putting in place systems for perinatal death audits & Child death Reviews, having checklists for care etc Having uniform Govt of India online SNCU database that helps to monitor, audit & compare performances objectively and use data further to motivate states to outperform each other, creating Mother-child tracking systems, trying to form linkages through public-private partnerships.

Hence, given the huge size & population of our country with diverse socio-cultural & demographic heterogeneity across, challenges have & will continue to emerge. However, a strong technical knowhow, backed by a strong political-will, with committed, untiring efforts at the highest level, against a backdrop of the iterative learnings from other countries as well as our own, will pave the way for us to achieve the SDG targets.

regards

Thanks & warm regards  
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CHIFA profile: Arti Maria is Professor & Head, Dr.Ram Manohar Lohia Hospital, New Delhi, India. Professional interests: Looking after the inborn and referral neonatal units of north India, at Post Graduate teaching Institute of Medical Education & Research of Dr Ram Manohar Lohia Hospital, New Delhi, catering to provide quality care to the sick newborns referred from various parts of North India. Practicing, teaching and engaging in research in neonatology for the last about 22 years in various prestigious teaching hospitals of India. Over the last 10 years, we have innovated and institutionalised family centred care (FCC) for sick newborns, that is now a national health program to be scaled up through the public health system of India. I have led and initiated various research aspects of FCC including developing an implementation framework, doing QI initiatives to improve various neonatal outcomes and engage in Qualitative aspects as well as the followup outcomes of family centred care (FCC). Has some pioneering work on preterm brain injury (PVL) as part of her DM dissertation. Has been a central coordinating team member with IndiaCLEN, and participated in various public health projects. Email address: artimaria AT gmail.com

From: "Marcio Accioly Sippel Fossari, Brazil"  
<prof.marcio.fossari@univali.br>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (68) Q4: Who is responsible for newborn programmes at the national level? (3)

At this point, I believe We have (in Brazil) a lot to do. I work for a city government and We are happy with our child death numbers, but We need to stabilize that in an acceptable index. I work with municipal empowers at primary care and soon as possible, I will share with You our organization to communicate the primary care equips about gestational results and schedule for the first home visit of the mother and the baby.

We visit our colleagues at NICU for to establish what are the key points for neonatal death and stillbirth. I have a guide from Brazilian federal government that is very good for teaching or guide the investigation of death from a child under one year.

Universal Health Coverage in newborn care is starting to be discussed in a care for the first 1.000 (one thousand) days of life for the fetus and the mother, until the first birthday. My personal opinion is If We start to look for the fetus as a citizen, a person with all the rights, We will go for a better future.

I would like to write more, but I will translate our work for a full context and share with these nice people, that like too much to read.

Our city is ItajaÃ, from the State of Santa Catarina from the country of Brazil. We are at the south of Brazil.

Thank You very much.

My best Wishes.

CHIFA profile: Marcio Fossari is a medical doctor from Brazil, currently working for the public system 100%. His interests include child and maternal health, including ways to improve the management of childbirth by non-medical people. marcio.fossari AT gmail.com

From: "Mary Kinney, South Africa" <mkinney@savechildren.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (69) Kangaroo mother care (12)

Dear all

Thank you for the interesting email discussion regarding KMC and all of the useful resources. There is a Kangaroo Mother Care Workshop will be taking place now in Drakensberg, KZN South Africa and it will be good to hear from those at the meeting what is being discussed.

On the Healthy Newborn Network, there is a KMC page with a lot of different resources including a Kangaroo Mother Care Resource Toolkit - learn more here.

<https://www.healthynewbornnetwork.org/issue/kangaroo-mother-care/> As we are looking to keep the toolkit update and relevant, please share materials you would like to add a resources (you can email mkinney AT savechildren.org

Save the Children has been promoting the KMC Challenge since 2016 to raise awareness about the importance of this intervention, to demonstrate some of the physical realities a woman experiences when she provides KMC and to open up dialogue around the enablers and barriers. KMC may be low-cost and low-tech compared to an incubator, but there are still associated costs to the mother, family and health system which should be recognized. See below a blog summarizes why we started the challenge and some first reactions. We have since taken the challenge to Women Deliver, IPA, COINN and ICM meetings as well as to internal Save the Children meetings with positive response. It would be good to know if others have tried the challenge as part of training and advocacy efforts.

<https://www.healthynewbornnetwork.org/resource/kangaroo-mother-care-challenge-brief/>

A challenge to you: Try kangaroo mother care for one day (Mary Kinney's blog from August 2016)

Recently a dedicated pediatrician invited me to visit her neonatal intensive care unit to see firsthand all of the work her team was doing to improve newborn care. Their efforts were impressive, especially given the crowded and under-resourced setting. One thing in particular stood out, however: not one mother was practicing kangaroo mother care (KMC) even though the unit had six dedicated beds for that purpose. In this facility, we asked mothers and caregivers why they were not practicing KMC. Their reasons included, 'My C-section wound is too sore,' 'Her mother is sleeping,' 'I am too tired,' and 'His mother is in the bathroom.'

What can be done to improve coverage and quality of KMC, in this hospital and around the world?

Every day, more than 41,000 babies are born preterm before 37 weeks gestation and preterm birth complications are now the leading cause of death among all children under 5 years, with over 3,000 dying each day. KMC, a well-known, feasible, and cost-effective intervention, requires continuous skin-to-skin contact between the baby and mother for at least 20 hours every day and exclusive breastfeeding. Although the intervention could prevent thousands of these deaths, it is not being used effectively in most settings, and only a very small proportion of preterm babies receive this life-saving intervention.



The KMC Acceleration Partnership (KAP), a global consortium of organizations active in promoting the uptake of KMC, is looking for answers to this question. The partnership has called for increased and concentrated action at global and national levels to achieve a 50 percent increase in coverage of KMC by 2020. Dr. Queen Dube is a pediatrician who works closely with the Partnership to scale up quality KMC services in Malawi. She believes we need a shift away from the message that KMC is an easy or cheap solution. While it is less expensive and more effective than conventional neonatal intensive care, there are still costs to the health system, the mother, the family, and the community, all of which need to be considered in planning for scaleup. Quality KMC requires trained health workers to support and care for the mother and baby, space in a health facility for KMC beds, and community support for the mother to be at the facility and to care for her baby upon discharge.

In May 2016, Save the Children launched the 'Kangaroo Mother Care Challenge' at the Women Deliver conference in order to raise awareness about some of these realities. The challenge asked people to practice KMC with a baby doll for 24 hours (including sleeping in an upright position with the baby still on the front of the person skin-to-skin). Twenty-five people agreed to take on the challenge. While only a handful succeeded in making it the full 24 hours, all of them told us what an eye-opening experience it was. Check out their stories below.

We are now taking the KMC Challenge to the meetings of the Council of International Neonatal Nurses and the International Pediatrics Association in Vancouver in August, and to additional meetings leading up to World Prematurity Day in November 2016.

Will you take on the Kangaroo Mother Care Challenge? Follow #KMCchallenge on Twitter to see who else does and share your experiences.

What people said about the KMC Challenge

I think the biggest challenge was trying to sleep at night. Trying to lie on my back, propped up with the for pillows that I had in my hotel room, and not rolling over onto the doll. I can only begin to imagine what it must be like for a mother carrying in KMC position a baby much heavier than my doll, who is peeing and pooing, needing feeding when she may only have rags for nappies, no spare clothes for herself, and no luxury hotel pillows to prop herself up with. These women are amazing, but let's recognise the challenges to better support them and their babies.

- Dr. Hannah Blencowe, LSHTM

The curious thing was that about 30 minutes after starting the doll KMC, I had the same feelings of sedation and calm that I recall having when I did KMC with my own children. Maybe there is a marketing opportunity here!

- Dr. Anthony Costello, WHO

First putting on the wrap was incredibly complicated. Normally I would just use a scarf. I wore the baby for two hours, and during that time I experienced stigma and people were less willing to network with me. I was overheating and sweating which made me unprofessional in appearance. So I made the decision to take off the baby and put it in my purse, which is the 'baby in a bag' scenario! What this really highlights is the challenge of doing good practice in kangaroo care.

- Whitney Sogol, Concern Worldwide

There are positives and negatives. There are definitely women who have come up to me and said I couldn't do that if I had a preterm baby.

- Dr. James Litch, GAPPS

It is so difficult, so hard. But I only try to think that my mom carried me for three months since I was a preterm baby. That's 1972. We have to go back to natural and go back to this approach of kangaroo mother care.

- Endang Handzel, CDC

I took the challenge for about four hours. During that time, I found myself on high alert and being very sensitive to every move—checking every now and then to make sure the child was in the right position, not slipping down, neck not twisted, hat not off, and careful of not moving and twisting too fast. This was challenging and my reaction was total respect and appreciation to mothers who do this in real life to save the lives of premature babies.

- Doris Maholo-Saydee

Personally, I was thrilled to have the opportunity to take part in this simulation of KMC. I'm happy to report that I succeeded in 'wearing the baby' for the full 24-hours (even while sleeping) and I confess it was a bit hard to give the baby back at the end of the 24-hour period! I felt that I gained not only more attention, but also more respect and credibility while speaking about maternal/newborn health issues during the conference...while actually 'practicing' KMC! The exercise raised the awareness of many colleagues (both within and beyond the conference venue), who were curious and intrigued enough to ask questions. This also made me improve my own understanding of and ability to explain to others the importance and impact of KMC.

-Erin Anastasi, UNFPA

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CHIFA 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. She is a member of the CHIFA working group on Newborn Care:

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

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From: "Shirish Tiwari, India" <shirish.tiwari07@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (70) Q4: Who is responsible for newborn programmes at the national level? (4)

Dear all,

Greetings from India!

I have been associated and working in the field of maternal, newborn care and nutrition from the past five years and I have worked in almost five states of India. This gives the clear picture of the status of programs that have been initiated at national or state level and what has trickled down to the grass root. For example, the flagship program of RMNCH+A involves a majority of elements and components to address maternal and newborn care primary and secondary level but discrepancies implementation with the added shortage of skilled staff deteriorates the condition to an unaccepted level which does not provide the desired outcome. Consequently, there are training and supportive

supervision sessions been formulated and even conducted at the various level of implementation but the quality and effectivity have not been uniformly maintained at all.

Moreover, with the underlying gaps and incoming challenges, different programs and guidelines have been issued from time to time. This has further elevated the miscommunication among the primary and secondary level staff for better implementation so that targets could be achieved. In which the newborn care has always been at a critical point. The start of INAP envisaged from ENAP [\*see note below] is a full package in itself but hardly been implemented in its proper sense. The program management unit and the medical officers responsible for its implementation are still in nascent stage. The question then comes is how can we expect from the ground level staffs and caregivers to have full potential and knowledge to efficiently implement at primary and grassroots level where there should be very clear understanding is of dire need.

At this point in crossroads, we should put every program related to maternal and newborn on one table and strategies should be formulated in such a way that the program will strengthen and uplift at the bottom level according to their requirements and issues. I believe this path and vision should be carried with a participatory and proactive approach at every level of implementation irrespective of region, state or country. We need to ponder on these lines and from the perspective of ground realities.

With regards,  
Shirish

CHIFA profile: Shirish Tiwari is project coordinator at Nutrition International in India. Professional interests: Reproductive, Maternal and Child Health, Nutrition. shirish.tiwari07 AT gmail.com

[\*Note from HIFA moderator (Neil PW): INAP = India Newborn Action Plan. ENAP = Every Newborn Action Plan]

From: "Judith Robb McCord, USA" <jmccord@pciglobal.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (71) Family-centred care (9) Kangaroo mother care (13)

Hello Neil and others and forgive my delayed response. I am actually attending the KMC South Africa workshop and have been so impressed with the level of commitment and caliber of work highlighted here — from Ghana to Iran and Bangladesh, Malawi and South Africa, we have engaged in some excellent discussions regarding the continued importance of KMC as a life-saving intervention for early/small babies and the need for continued learning and harmonization as country teams move to introduce and scale KMC.

In terms of family engagement in care of the small/sick newborn, Every Preemie—SCALE is currently testing a family-led model of care in Balaka district, Malawi that is based on strengthening clinical competence among health care providers at the community, hospital and health center level and empowering mothers and other family members to actively engage in the care of the small newborn while in the facility. In addition to training health care providers in Essential Care for Every Baby and Essential Care for Small Babies (ECEB/ECSB) and in Family-Led Care, we worked with MOH counterparts to 1) design an orientation guide for providers to use when a mother/baby pair is being admitted to KMC and prior to discharge, and 2) to design low-literacy materials for family members to use to monitor their babies while in the KMC unit and once home post discharge. The emphasis is ensuring that family members are confident in caring for their babies once home and that they will understand ~~normal~~ for their baby and be able to recognize when there is a problem that needs medical attention. We're also actively building referral linkages with the Health

Surveillance Assistants so that they find families who do not return for their follow up visits and encourage and accompany them (where necessary) to the facility for this important care.

Participants at the South Africa KMC conference were really excited about the "family empowerment" aspect of Every Premie's Family-Led Care model. We have designed implementation research to measure the effect of the model and should have mid-term results this summer and will have final results late 2018/early 2019. We hope to have something to say about newborn outcomes including reduction in % of facility-KMC newborns who died before discharge and increase in the % of KMC newborns who showed adequate weight gain at their first facility-based follow up visit. We will keep you posted on progress!

As a next step in Balaka district, Malawi, we are going to work with the district hospital to start introducing the concept of family-led care and KMC for the sick newborns who are receiving more advanced care so that they too will benefit from this important intervention.

Please see [www.everypremie.org](http://www.everypremie.org) for the Family-Led Care materials including our provider orientation flip chart and family monitoring forms.

Many thanks for hosting this excellent exchange. Best, Judith R-M

Judith Robb-McCord, MAAS, MPH  
Vice President, Technical Leadership & Support and Senior Director, Every Premie—SCALE

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PCI's Mission is to Empower People to Enhance Health, End Hunger, and Overcome Hardship

CHIFA profile: Judith Robb-McCord is Senior Director, Every Premie-SCALE (Scaling, Catalyzing, Advocating, Learning, and Evidence-Driven) at Project Concern International, PCI, in the USA. Judith has over 25 years of international public health experience, including program leadership in maternal, newborn and child health; reproductive health and family planning; malaria; and HIV/AIDS. She has worked with a variety of global and national partners to create long-range strategies and to design and implement projects for improved health outcomes primarily in Africa and Asia. jmccord AT pciglobal.org

From: "Sue Prullage, South Africa" <sue.prullage@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (72) Q4: Who is responsible for newborn programmes at the national level? (5)

'Can you comment on how well the government empowers health workers at primary, district and national levels to give the best care possible to newborns? How could support be improved? How well does the referral system work for mothers and newborns - from primary to district level? from district to national level?'

As I have written before the nurses/midwives that are working in neonatal units are working in difficult situations. They are working with minimal to no orientation as to how to handle these small or sick babies. They are working very short staffed average of 2 during the day going down to 1 at night. They have lack of equipment and working equipment. There doesn't seem to be much empowerment going on. There is interest by the MoH to look at why babies are dying and they are beginning to look at systems which may show these deficiencies that were mentioned before. Things often move slowly. I think to improve the situation it will take a huge commitment to manpower (educated manpower), ensuring that there are sufficient equipment to care for the babies. Often the districts are working with one cpap machine and no IV pumps, some of the larger hospitals have more equipment but it seemed several of them had lots of broken equipment (need a qualified technician on duty to fix them and many of the hospitals said they had technicians yet the machines are broken). Perhaps they need a source of parts for broken machines is why the machines were non-functioning in spite of having a technician.

Referral: There is a clear cut guideline that states that infants less than 2 kg are to go to the neonatal unit from the health center. What becomes a problem is when an infant needs to go from district to a national level. Often the national level hospital is hours away and there are no guidelines on how to send a baby safely. There are no neonatal transport systems in Rwanda. In my experience we transport a baby with a nurse who works in the neonatal unit. But she has limited equipment to take with her and no help if the baby decompensates along the way for she is alone. We often see the doctors transfer babies that seem futile. Perhaps a clear statement as to who and what babies should be transferred. For example an omphalocele transferred to a unit that doesn't have a ventilator, no working cpap or available incubators because it is stated that they need to be transferred to a higher level. Often the parents refuse transport because of cost and hardship for the family.

The MoH needs to address out born infants. Currently at one of the larger provincial hospitals it is the practice to admit all out born babies to the pediatric unit where there are no cpap, machines, IV's, incubators and they are next to infectious infants. Clear cut guidelines need to be developed. A commitment to minimal transport (neo nurse to go, IV in place with fluids, KMC) with written guidelines who can transport. Sometimes a nurse from another unit is sent for a sick baby thus putting that infant at risk.

Geralyn Sue Prullage DNP, APN, 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. She is a member of the CHIFA Newborn Care working group.  
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From: "Mary Nyikuri, Kenya" <mnyikuri@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (73) FAO Mary Nyikuri, Kenya - Staffing of neonatal units (12)

Dear Sue and colleagues,

Staffing in newborn units in Kenya vary a lot the different sectors. For the high end private hospital, staffing for the very sick is 1:1 and the stable is 1:3. This ratio does not change whether day or night,

for the public hospital the staffing ranges between 1:15 to 1:25 irrespective of the acuity. There are two nurses during the day and one nurse at night. For the faith based hospitals, the staffing is also per ward and not per number of newborns and it ranges between 1: 8 to 1:53. Two nurses work during the day and one nurse works during the night. This is similar to the public hospital and takes a similar pattern on the weekends. Training for nurses in Kenya starts at diploma, continues to degree, and masters levels and a nurse can either be trained at a public or private training institution. Diploma level training is for general nursing with less emphasis on newborn care.

Kind regards  
Mary

CHIFA profile: Mary Nyikuri is a PhD student at the Kenya Medical Research Institute, KEMRI.  
mnyikuri AT gmail.com

From: "Hemant Nandgaonkar, India" <nandgaonkar.hemant@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (74) Improving neurodevelopmental outcomes

We are developing the new program of early intervention since a year. We could do it in one hospital so far. Its aim is to reduce developmental morbidity by early intervention.

The hospital is a children private hospital and away from the city. Most of the hospitals refer to Occupational therapist after NICU discharge and it's usually 3 months age of the baby. But if risk factor for developmental morbidity are present then we encourage neuro protective measures right in NICU itself. The program we are offering is regarding training the staff in NICU for neuroprotective strategies and early stimulation to improve long term outcome.

HIFA profile: Hemant Nandgaonkar is an occupational therapist at Hands On Therapy Concepts in India. Professional interests: Early Intervention, Neonatal Therapy, Hand Therapy, Sensory Integration Therapy. nandgaonkar.hemant AT gmail.com

From: "Sue Prullage, Rwanda" <sue.prullage@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (75) Staffing of neonatal units (13)

The staffing [as reported by Mary Nyikuri, Kenya] is similar to what we found. That it is by ward and that it is the same as internal medicine or any other ward. Yet the staff is working with cpap and IV as well as responding to deliver and resuscitation. Literature from other countries show that staffing affects mortality.

As well as education and certification. I know in Kenya you have a MScN in neo do the individuals that graduate from this group work in hospitals or are the primarily administrators or educators? Where I volunteer the Bachelor program has one course in neonatal where they do a clinical in the neo unit. This exposes them to neo but by no means prepares them to work there. The general nurses are similar they receive minimal training in neo issues. Our research showed the average time for orientation to working in neo units was 7 days. I personally believe this is inadequate.

I wonder how long is the orientation process in Kenya? Is it uniform and mandatory for all to work in neo units to complete a program? I am asking questions because I do not think Kenya and Rwanda are the only ones dealing with this issue of poor staffing and orientation. That maybe there should be collaboration to stand strong on these issues

Sue Prullage DNP, APN, 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. She is a member of the CHIFA Newborn Care working group.  
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From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (76) Highlights of Week 4 - Who in the ministry is responsible for newborn care?

Dear CHIFA colleagues,

Thank you for your contributions during Week 4 of our discussion on Newborn Care. Here are the responses to Question 4, which is a multipart question:

4.1: WHO IN THE MINISTRY IS RESPONSIBLE FOR NEWBORN PROGRAMMES, AT THE NATIONAL LEVEL? Have you been involved in working with government in preparing national policy and practice guidelines for newborn care? What have been the main challenges?

Arti Maria, India: India has demonstrated steady commitment to improve the QoC for sick newborn in both policy and action... Some of the commendable steps being taken by our government include standardisation of various operational & training Guidelines for various programs, considering infrastructural revisions to promote family centred care & KMC, concept of mother-newborn care units, strengthening delivery rooms & OTs, Creating universal opportunities for capacity building, mentoring & auditing mechanisms by state medical colleges to act as state resource centres, putting in place systems for perinatal death audits & Child death Reviews, having checklists for care etc Having uniform Govt of India online SNCU database that helps to monitor, audit & compare performances objectively and use data further to motivate states to outperform each other, creating Mother-child tracking systems, trying to form linkages through public-private partnerships.

Shirish Tiwari, India: The flagship program of RMNCH+A involves a majority of elements and components to address maternal and newborn care primary and secondary level but discrepancies implementation with the added shortage of skilled staff deteriorates the condition to an unaccepted level which does not provide the desired outcome.

QUESTION A: The above responses suggest the national government of India has comprehensive newborn care policies in place, but that there is perhaps a major gap between policy and practice. Would Arti and Shirish - and others - like to comment on the challenges of developing and implementing national policy on newborn care?

QUESTION B: What is the situation in other countries? Is there a strong national newborn care policy? To what extent is this being implemented?

4.2: WHAT ABOUT REFERRAL SYSTEMS? Can you comment on how well the government empowers health workers at primary, district and national levels to give the best care possible to newborns? How could support be improved? How well does the referral system work for mothers and newborns - from primary to district level? from district to national level?

Sue Prullage, Rwanda: There is a clear cut guideline that states that infants less than 2 kg are to go to the neonatal unit from the health center. What becomes a problem is when an infant needs to go from district to a national level. Often the national level hospital is hours away and there are no guidelines on how to send a baby safely. There are no neonatal transport systems in Rwanda. In my experience we transport a baby with a nurse who works in the neonatal unit. But she has limited equipment to take with her and no help if the baby decompensates along the way for she is alone. We often see the doctors transfer babies that seem futile. Perhaps a clear statement as to who and what babies should be transferred. For example an omphalocele transferred to a unit that doesn't have a ventilator, no working cpap or available incubators because it is stated that they need to be transferred to a higher level. Often the parents refuse transport because of cost and hardship for the family.

QUESTION C: Sue, please would you be able to clarify about the 2kg rule. Is this for transfer from the health centre to the district hospital? The lack of specialised ambulance transport is clearly a major danger for referral. (I am reminded of the time I witnessed a major road traffic accident in Mali - the 'ambulance', when it eventually came, was empty - no equipment, no trained personnel.) Can others comment on the situation in their country?

4.3: WHAT ABOUT MEASUREMENT AND ACCOUNTABILITY? On the subject of 'measurement and accountability', we have heard about difficulties in measuring stillbirths and neonatal deaths (we have also learned, alarmingly, that some early neonatal deaths are miscategorised as stillbirths). We invite more comments on this. Have you been involved in efforts to measure the delivery of health services and/or quality of care, at national, district or facility level? What are the challenges and lessons learned? How would we define Universal Health Coverage in the context of newborn care?

The responses to this question have, so far, centred around the measurement of quality of kangaroo mother care.

QUESTION D: Can CHIFA members comment further on measuring the numbers of stillbirths and neonatal deaths? (One commentator suggested that some early neonatal deaths may be classified as stillbirths - can anyone provide further information on this alarming possibility?)

QUESTION E: In the era of the Sustainable Development Goals, how can we define Universal Health Coverage in the context of newborn care?

Best wishes, Neil

Joint Coordinator, CHIFA Project on Newborn Care

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

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

CHIFA profile: Neil Pakenham-Walsh is the coordinator of the HIFA campaign (Healthcare Information For All) and assistant moderator of the CHIFA forum. He is current chair of the Dgroups Foundation ([www.dgroups.info](http://www.dgroups.info)), which supports 700 communities of practice for international development, social justice and global health. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG [neil@hifa.org](mailto:neil@hifa.org)



From: "I Abdulkadir, Nigeria via Dgroups" <CHIFA@dgroups.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (77) Q4: Who is responsible for newborn programmes at the national level? (6)

In the ministry, in Nigeria, neonatal programmes and policies are handled under the Directorate of child health and partly under reproductive health as Maternal and child health programmes. It is mainly however, under child health department.

One has been opportuned to work on policy at national level, currently however the society of neonatal medicine in the country is providing the much desired push and coordination to ensure appropriate attention is accorded to neonatal issues.

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: "Sue Prullage, Rwanda" <sue.prullage@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (78) Referral of newborns

To clarify the 2 kg rule it is from the health center to the hospital

Sue Prullage DNP, APN, 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. She is a member of the CHIFA Newborn Care working group.  
<http://www.hifa.org/projects/newborn-care>  
<http://www.hifa.org/support/members/geralyn-sue-0sue.prullage@gmail.com>

From: "Joseph Ana, Nigeria via Dgroups" <CHIFA@dgroups.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (79) Q4: Who is responsible for newborn programmes at the national level? (7) Closing the gap between policy and practice

Do the Ministries actually handle neonatal care in Nigeria?. And is the management of neonatal care in Nigeria uniform? From the federal ministry policies and strategies to the states and local government levels, the management varies widely. It varies even more at the points-of-care from primary health to secondary and tertiary care levels. A lot is said of 'maternal and child care' but in fact there are not many devoted and functional neonatal care facilities across the country, which is why neonatal care remains poorly coordinated and poorly delivered.

For sure there are well constructed and published policies and aspirations but at the point of delivery there is very much more work to do if Nigeria is to achieve its plans for saving neonates.

Joseph Ana.

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From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (80) Q5: Who are the key global players for newborn care?

Dear CHIFA colleagues,

Thank you for your valuable contributions so far! Over the coming week we invite you to consider Question 5:

**Q5: WHO ARE THE KEY PLAYERS IN THE GLOBAL HEALTH ARCHITECTURE FOR NEWBORN CARE?** UNICEF is making newborns their advocacy priority this year. Is this the UN responsibility alone? What about WHO, donors, professional groups and academics?

The 'top 20' list of global health actors (in general, not specific to newborn health) are listed in the report 'Mapping Global Health Architecture to Inform the Future' (2015) as follows (from 1 to 20):

1. World Health Organization
2. Bill & Melinda Gates Foundation
3. Gavi, the Vaccine Alliance
4. The Global Fund to Fight AIDS, Tuberculosis and Malaria
5. MÃ©decins Sans FrontiÃ¨res
6. UNICEF
7. World Bank
8. Centers for Disease Control and Prevention
9. Joint UN Programme on HIV/AIDS
10. UNITAID
11. National Institutes of Health
12. Roll Back Malaria Partnership
13. Save the Children International
14. US Agency for International Development
15. Stop TB Partnership
16. UN Population Fund
17. Food and Agricultural Organization of the UN
18. Partnership for Maternal, Newborn and Child Health
19. PATH
20. UN Development Programme

Ref:

[https://www.chathamhouse.org/sites/files/chathamhouse/field/field\\_document/20150120GlobalHealthArchitectureHoffmanColePearcey.pdf](https://www.chathamhouse.org/sites/files/chathamhouse/field/field_document/20150120GlobalHealthArchitectureHoffmanColePearcey.pdf)

What would you say are the 'top 20' global actors for newborn health? Perhaps more importantly: What are their relative roles? And how well do they cooperate and collaborate with one another (or not) for collective impact? (It's interesting that one of the three key points made in the above research paper is this: 'Many global health actors support knowledge generation and technical cooperation activities, and very few support sharing of intellectual property, guideline development and surveillance activities'.)

#### EVERY NEWBORN ACTION PLAN (ENAP)

Arguably the greatest step forward for newborn health collaboration and collective action is the Every Newborn Action Plan (ENAP), a collaborative roadmap to ending preventable newborn deaths, launched in 2014 and steered by many of the above listed actors (and many more). 'If we commit to working together as a global community to take the specific actions outlined in the Every Newborn action plan, we can achieve our vision of a world in which there are no preventable deaths of newborns or stillbirths, where every pregnancy is wanted, every birth celebrated, and women, babies and children survive, thrive and reach their full potential and in doing so create equitable societies and transform human development.'

We look forward to hear from steering group members of ENAP and others. Could you describe further what ENAP is aiming to achieve, and how this is being achieved? What are the main challenges?

The ENAP Metrics group is currently supporting CHIFA to contribute to this collective effort through the CHIFA Newborn Care Project (<http://www.hifa.org/projects/newborn-care>). What more can global health communities of practice such as CHIFA do to help engage the full range of stakeholders and thereby accelerate progress towards the ENAP vision?

For the benefit of those who have joined in the past few days, here is background to the current discussion:

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

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 (81) Q4: Who is responsible for newborn programmes at the national level? (8) Closing the gap between policy and practice (2)

This is absolutely correct [Joseph Ana, Nigeria (79)]. Ministry handles programmes and policies at national level while a Gulf of gap exist between policies and implementation at facility level. At the level of care there exist little or no neonatal care facilities to a large populace. While majority of the level I and II neonatal care are only unsatisfactorily, inaccessibly and most times unaffordably available at tertiary health facilities which are albeit supposed to provide level III or IV care. A number of non government private for fund facilities also provide scanty haphazard level I care with worse still very poor referral system and facilities.

There is a need to define and disseminate minimum bench mark for neonatal levels of care in Nigeria while ministries ensure these are respected by facilities.

The government will need to do more in terms of provision of standardized optimally functional neonatal care levels I- III/IV, provide facilities, provide equipment, manpower and training and as well collaborate with and provide supervision, mentorship, monitoring and support to private facilities providing neonatal care.

Above all, the local government, state and federal government will need to work synchronously towards set goals for any meaningful success to be recorded in provision of neonatal care.

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 (82) Neonatal deaths and hypoxic ischemic encephalopathy

Dear CHIFA and HIFA-Zambia colleagues,

Below are the citation and abstract of a new paper in the Medical Journal of Zambia. The authors conclude that 'Hypoxic ischemic encephalopathy as a cause of early neonatal death is commoner in term neonates but also common in preterm'. They refer to the need for improved resuscitation at birth. They refer to Apgar scores, but without indicating whether this refers to scores at 1 minute or 5 minutes.

Previous messages on CHIFA have focused on follow-up care of newborns with brain injury, but prevention (through adequate antenatal/intrapartum care and resuscitation) is arguably more important. Can anyone comment on the quality of antenatal/intrapartum care and resuscitation efforts. What percentage of hypoxic ischaemic encephalopathy might have been avoided with basic antenatal/introapartum care and resuscitation? What training in resuscitation is available at different levels of the health system?

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CITATION: A comparison of early neonatal deaths among preterm infants with term neonatal deaths at the University Teaching Hospital, Lusaka, Zambia

P. Kamfwa, Y. Ahmed, B. Vwalika

Medical Journal of Zambia, Vol 44, No 4 (2017)

<https://www.ajol.info/index.php/mjz/article/view/168220>

#### ABSTRACT

Background: Prematurity is a common complication that contributes significantly to high neonatal mortality. In spite of many efforts by the government and other partners, non-significant decline has been achieved in the recent past. Globally, 15 million babies are born preterm (<37 weeks gestation) each year, and more than 1 million of those do not survive their first month of life. Preterm birth accounts for 75% of all perinatal mortality in some series thus identifying the determinants of preterm deaths is very crucial for policy improvement. This study was aimed at establishing factors associated with preterm deaths at UTH compared to those of term neonatal deaths.

Methods: A case-control study was conducted among 208 neonates that were early neonatal deaths i.e. within 7 days in neonatal intensive care unit (NICU) at UTH in 2015. Antenatal and intrapartum details (parity, multiple pregnancy, birth weight, antenatal steroid exposure, antibiotic exposure, and the indication of admission to NICU) were obtained from 104 neonates that were preterm (between 24- 36 completed weeks gestation) and had died and of a further 104 term neonates (>37 weeks gestation) that died around the same time. The data was collected by interview administered structured questionnaire and analyzed by SPSS v21. Bivariate analysis was used to identify variables for multivariate logistic regression model to identify obstetric determinants amongst deaths in neonates that were preterm compared to those born at term.

Results: There were few differences between the two groups. The sex of the neonate significantly influenced the odds of dying. We confirmed that male neonates had a 57.1% higher risk than females (42.9%) of dying during the early neonatal period. More term neonates that died were male (P=0.0031) and had a very poor Apgar score (1-3) (P=0.0048). Both the indications for admission to NICU and cause of death were different in the two groups with preterms (P<0.0001) and terms P=0.0309. On multivariate regression analysis, poor Apgar score was associated with six-fold odds of RDS. More preterm neonates had died despite receiving steroids. None of the other factors reached statistical significance (adjOR 6.0, 95% CI 3.03-11.92, p<0.0001). Poor Apgar score was also the only factor associated with sepsis, though it was a neonate with a good Apgar score that had higher odds of dying due to sepsis. Primiparity was associated with a 2.6-fold odds (95% CI 1.03 to 6.68, p=0.04) of hypoxic ischaemic encephalopathy. On logistic regression, a preterm neonate dying only had a higher odds of being a LBW (<2500g) than any other factor [adjusted OR 132.72 (95% CI 39.49 to 387.66) P<00001]. Considering the main causes of death, hypoxic ischemic encephalopathy in preterm neonates was only associated with poor Apgar score (i.e. <7) [adjusted OR 2.03 (95% CI 1.12 to 3.67) P=0.02]. Sepsis in term neonates OR 0.2 (95% CI 0.15 to 0.54) P<00001]. Respiratory distress syndrome in preterm neonates dying was only associated with poor Apgar score [adjusted OR 6.01 (3.03 to 11.92) P<00001].

Conclusions: Hypoxic ischemic encephalopathy as a cause of early neonatal death is commoner in term neonates but also common in preterm. Sepsis is commoner in preterm neonates as a cause of early neonatal death. Comparing different causes of death, poor Apgar score featured in all cases calling for improved resuscitation.

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Best wishes, Neil

Working together for health in Zambia - Join HIFA-Zambia: <http://www.hifa.org/forums/hifa-zambia>

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

HIFA profile: Neil Pakenham-Walsh is the coordinator of HIFA-Zambia and the HIFA campaign (Healthcare Information For All - [www.hifa.org](http://www.hifa.org)) and current chair of the Dgroups Foundation ([www.dgroups.info](http://www.dgroups.info)), which supports 700 communities of practice for international development, social justice and global health. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG neil@hifa.org

From: "Neil Pakenham-Walsh" <neil.pakenham-walsh@ghi-net.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>

Subject: [chifa] Q5: Who are the key players in the global health architecture (2)

Who are the key players in the global health architecture for newborn care? Here is a preliminary list of 7 key players (can you suggest others?):

1. World Health Organization
2. UNICEF
3. Partnership for Maternal, Newborn and Child Health
4. Save the Children International
5. Healthy Newborn Network
6. US Agency for International Development
7. Bill & Melinda Gates Foundation

Are you familiar with the work of any of the above in newborn care? If so, please send a brief description to: [chifa@dgroups.org](mailto:chifa@dgroups.org)

Possible guidance questions might included:

1. What are your key strengths? How do these relate to other key players?
2. What challenges do you face in your work?
3. How might your impact be maximised?

Best wishes, Neil

Joint Coordinator, CHIFA Project on Newborn Care

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

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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 (84) Community-based intervention for maternal and newborn health

Dear CHIFA and HIFA-Zambia colleagues,

Below are the citation and abstract of a new paper from Zambia. The findings are consistent with the work by Anthony Costello and others on the impact of women's groups.

CITATION: Jacobs C.; Michelo C.; Chola M.; Oliphant N.; Halwiindi H.; Maswenyeho S.; Baboo K.S.; Moshabela M.

Evaluation of a community-based intervention to improve maternal and neonatal health service coverage in the most rural and remote districts of Zambia.

PLoS ONE. 13 (1), 2018. Article Number: e0190145.

Date of Publication: January 2018.

<http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0190145>

ABSTRACT

Background: A community-based intervention comprising both men and women, known as Safe Motherhood Action Groups (SMAGs), was implemented in four of Zambia's poorest and most remote districts to improve coverage of selected maternal and neonatal health interventions. This paper reports on outcomes in the coverage of maternal and neonatal care interventions, including antenatal care (ANC), skilled birth attendance (SBA) and postnatal care (PNC) in the study areas.

Methodology: Three serial cross-sectional surveys were conducted between 2012 and 2015 among 1,652 mothers of children 0-5 months of age using a 'before-and-after' evaluation design with multi-stage sampling, combining probability proportional to size and simple random sampling. Logistic regression and chi-square test for trend were used to assess effect size and changes in measures of coverage for ANC, SBA and PNC during the intervention.

Results: Mothers' mean age and educational status were non-differentially comparable at all the three-time points. The odds of attending ANC at least four times (aOR 1.63; 95% CI 1.38-1.99) and SBA (aOR 1.72; 95% CI 1.38-1.99) were at least 60% higher at endline than baseline surveillance. A two-fold and four-fold increase in the odds of mothers receiving PNC from an appropriate skilled provider (aOR 2.13; 95% CI 1.62-2.79) and a SMAG (aOR 4.87; 95% CI 3.14-7.54), respectively, were observed at endline. Receiving birth preparedness messages from a SMAG during pregnancy (aOR 1.76; 95% CI, 1.20-2.19) and receiving ANC from a skilled provider (aOR 4.01; 95% CI, 2.88-5.75) were significant predictors for SBA at delivery and PNC.

Conclusions: Strengthening community-based action groups in poor and remote districts through the support of mothers by SMAGs was associated with increased coverage of maternal and newborn health interventions, measured through ANC, SBA and PNC. In remote and marginalised settings, where the need is greatest, context-specific and innovative task-sharing strategies using community health volunteers can be effective in improving coverage of maternal and neonatal services and hold promise for better maternal and child survival in poorly-resourced parts of sub-Saharan Africa.

--

Best wishes, Neil

Joint Coordinator, CHIFA Project on Newborn Care  
<http://www.hifa.org/projects/newborn-care>

From: "William Keenan, USA" <william.keenan@health.slu.edu>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (85) Q5: Who are the key players in the global health architecture (3)

Missing from this list: the providers. ICM, IPA, FIGO and ICN at the minimum. [\*see note below]

Bill Keenan

CHIFA profile: Bill Keenan is a pediatrician at Saint Louis University, USA. Professional interests include neonatal health. keenanwj AT slu.edu

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

ICM = International Confederation of Midwives

IPA = International Paediatric Association

FIGO = International Federation of Gynecology and Obstetrics

ICN = International Council of Nurses]

From: "Michael K. Visick, USA" <visickmnc@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (86) Q5: Who are the key players in the global health architecture (2)

Yes, in agreement with Bill, I would add:  
IPA  
ICM  
AAP (American Academy of Pediatrics)  
Laerdal Global Health  
LDSC (LDS Charities)  
ACNM (American College of Nurse Midwives)

Best,  
Michael

CHIFA profile: Michael K. Visick is a Pediatrician, MNC Technical Specialist, LDSCharities, AAP, USA. Professional interests: Global maternal and child health and survival. Email address: visickmnc 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 (87) Q5: Who are the key players in the global health architecture (5)

Dear All,

I would have thought that adding national associations / groups would lead to duplication (indirectly) since the international global organisations are made up of and comprise the national ones. Except maybe for non governmental organisations and charities like The Gates Foundation.

Joseph Ana.

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From: "Massimo Serventi, Tanzania" <massimoser20@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (88) Q5: Who are the key players in the global health architecture (6)



Dear friends, if by 'key players' you mean All actors engaged in the preservation of life for newborns I'd rather say that the major role is played by the available local health staff, paid by local governments.

I take the opportunity to write the following: expatriate doctors/nurses, experts of public health arriving from UN agencies, whoever does not belong to a particular area or culture of a poor country should refrain from working there. I am one of the above expatriates, I made so many mistakes, I became rich working with the poor.

To send doctors in Angola where there are 1200 local doctors unemployed is a wrong move.

To recruit expatriate to fight malnutrition is a nonsense:they should stay home and fight obesity.

Things are changing, poor countries have quality&quantity staff enough to offer health service to all.

Massimo  
Gulu  
Uganda

CHIFA profile: Massimo Serventi is a paediatrician at AISPO (Associazione Italiana per la Solidarieta fra I Popoli), Italy. Professional interests include child malnutrition, pediatric hospitals, drugs for children, sustainability of services for children. ser20 AT hotmail.it

From: "Sue Prullage, Rwanda" <sue.prullage@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (89) Breastfeeding

"Are Kenyan women and babies really that different??? when it comes to breastfeeding"  
<http://www.hifa.org/dgroups-rss/immunisation-what-can-children-do-3-newborn-care-76>

Dear Sarah,

You bring up a very important point. Are African women any different when it comes to breastfeeding struggles? I would suggest not at all. As a person who has worked in a neonatal unit we have seen infants be admitted for presumed sepsis and placed on antibiotics. When we looked at the CBC the labs were normal and when appropriate questions about breastfeeding asked it becomes evident the mother had been struggling. When an infant is only available to the midwives in the general ward for 24 hours it is difficult to ascertain how well the breastfeeding is going. Education is not given and there is a general belief that breastfeeding is innate and everyone is capable of doing it without an issue. Real assessment of latch and positioning should be part of morning rounds. Not just the question how is it going?

Then the struggle in the neonatal unit. The longer a baby is in the unit and unable to suckle the more the mothers struggle. I watched this for years before I decided to bring a hospital grade double pump to the unit. The nurses said the mothers wouldn't use it. And I know the government is fearful of infection from this avenue. But breastmilk is drying up in neonatal units. We give the formula but the family cannot continue to pay for the formula once discharged and they babies are going home to cows milk or worse. So I brought the pump. I didn't bring it down to the unit at first but one day a mother was crying at the bedside. When asked what the problem was it was her milk was drying up. No wonder the infant had been losing weight for several days (although I would ask everyday was she making milk and the answer was yes). She would give what she got with hand expression and no one else noticed any different since the mother's feed the babies. So I talked the nurses and the mother into trying the pump. Within 36 hours she was pumping 150cc and this baby went home on total breastfeeding. I say all of this to say our mothers in the neo units in Africa struggle as much as any mother of a premature infant who if born in an developed country would be told to start pumping at 6 hours. Literature shows that hand expression is good but over time the mother will need a pump. 64% of the neonatal units in Rwanda have a breast pump (not hospital grade but a pump of some sort).

Could we not dialogue about why we have a different standard for mothers in one part of the world compared to another when they both suffer with the same issue. Could we not give guidelines of cleaning the units?

Sue Prullage DNP, APN, 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. She is a member of the CHIFA Newborn Care working group.

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[sue.prullage@gmail.com](mailto:sue.prullage@gmail.com)

From: "Carole Kenner, USA via Dgroups" <CHIFA@dgroups.org>

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

Subject: [chifa] Newborn Care (90) Q5: Who are the key players in the global health architecture (7) COINN

I would suggest COINN should be added-Council of International Neonatal Nurses, Inc. (COINN).

Carole Kenner

ckenner835@aol.com

CHIFA profile: Carole Kenner is Dean and Professor at Northeastern University Bouve College of Health Sciences, Boston, USA. She is also President of Council of International Neonatal Nurses. Her interests include maternal and child health. c.kenner AT neu.edu

From: "William Keenan, USA" <william.keenan@health.slu.edu>

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

Subject: [chifa] Newborn Care (91) COINN (2)

Excellent point. Bill

CHIFA profile: Bill Keenan is a pediatrician at Saint Louis University, USA. Professional interests include neonatal health. keenanwj AT slu.edu

From: "Alfred Ocen, Uganda" <ocenalt@gmail.com>

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

Subject: [chifa] Newborn Care (92) Q5: Who are the key players in the global health architecture (8) Community Health Workers

Dear Friends,

I am in agreement with Massimo Serventi to greater extend that at the local level in the community, Village Health Team/Para-social workers or local health workers are key players as evidenced in Uganda. Only needed thing to empower them in order to have quality improvement in their endeavors and link to the main Health facilities effectively and efficiently.

Regards

Alfred

Gulu

Uganda

CHIFA profile: Alfred Ocen is Information and Communication Technology, Community facilitator and Data Officer at Health Alert - Uganda. Professional interests: Advocacy specialist, M&E Officer and Community Health Worker. ocenalt 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 (92 [93]) Q5: Who are the key players in the global health architecture? (8)

Dear CHIFA colleagues,

Thank you for your contributions on the question: Who are the key players in the global health architecture?

We started with a list of the leading UN agencies (WHO and UNICEF), the leading NGO in this field (Save the Children), two leading partnerships (Partnership for Maternal, Newborn and Child Health) and Healthy Newborn Network, and two major funders (Gates Foundation and USAID).

It would be great to hear from representatives (or observers) of the above, to hear more about the special roles of each of the above organisations in the global newborn care architecture, and perhaps some comments on how these organisations coordinate their work for maximum impact.

In addition to the above, CHIFA members added professional organisations such as ICN, ICM, COINN and FIGO. We look forward to hear more about these organisations, too, and how they coordinate with the above.

We were reminded by Massimo that the 'key player' is the frontline healthcare provider. Indeed, it could be argued that the 'key player' (in a different sense) is the individual newborn child and his/her mother and family. Everything that the aforementioned 'key players in the global health architecture' do must directly or indirectly empower frontline healthcare provider(s) and families to realise the right to health of the newborn child.

I return to the question about how organisations can have more collective impact. Partnerships such as PMNCH and HNN seem key here, as well as WHO/UNICEF's role as convenors?

The wider framework of the Sustainable Development Goals is also presumably critical in defining a shared vision against which impact can be measured: "By 2030, end preventable deaths of newborns... with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births..." Would anyone like to say more about the SDG framework and newborn health?

In summary, we look forward to learn more about the 'key global players' in the conventional sense (UN agencies, NGOs, Partnerships, Professional Associations), and how they support others (eg governments, health professionals, citizens) to improve the health of newborns.

Best wishes, Neil

Joint Coordinator, CHIFA Project on Newborn Care  
<http://www.hifa.org/projects/newborn-care>

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CHIFA profile: Neil Pakenham-Walsh is the coordinator of the HIFA campaign (Healthcare Information For All) and assistant moderator of the CHIFA forum. He is current chair of the Dgroups Foundation ([www.dgroups.info](http://www.dgroups.info)), which supports 700 communities of practice for international development, social justice and global health. Twitter: @hifa\_org FB: facebook.com/HIFAdotORG neil@hifa.org

From: "Dharmendra Kumar Dewan, India via Dgroups" <CHIFA@dgroups.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (95) Q5: Who are the key players in the global health architecture? (11)

Dear all

This is to supplement on the topic of critical importance world over especially in African & Southeast Asian countries that have high burden of NNM... [\*see note below] The key players here should seriously consider taking up the role of being direct stakeholders when it comes to roping in the huge corporate private health institutional platform existing in predominantly urban settings where costs of institutional neonatal care are prohibitive but the state of the art infrastructure (including neonatal transportation), remains underutilized specially when the same could be useful in offloading the crowded understaffed poorly managed deficient infrastructure in public sector... Firming up cost & quality care deals on behalf of the government is one such action. The current focus of DPs [\*] is mainly in trainings & capacity building (only trainings primarily, without aiding infrastructural strengthening) and monitoring the system with very little actual ground level handholding to remove operational bottlenecks thru facilitating the genuine hard working government program officers...

Best regards  
Dr D k dewan

CHIFA profile: Dharmendra Kumar Dewan is Director Family Welfare, Directorate of Family Welfare, Government of Delhi, India. Professional interests: Public Health issues on Maternal & Child Health: Neonatal care strengthening, Improving institutional deliveries & quality care, Childhood immunization, Gender Ratio imbalance & role of regulations & Acts. dharmdewan22 AT yahoo.co.in

[\*Note from HIFA moderator (Neil PW): NNM = Neonatal Mortality; DPs = Directors of Programmes]

From: "Dharmendra Kumar Dewan, India via Dgroups" <CHIFA@dgroups.org>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (96) Q5: Who are the key players in the global health architecture? (12)

Sir  
By DPs I was meaning Development Partners [\*see note below]

Further, I have superannuated now and involved now in public health consultancy.

Regards

Dr dk dewan

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[\*Note from HIFA moderator (Neil PW): Thank you for the correction, Dharmendra]

From: "William Keenan, USA" <william.keenan@health.slu.edu>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (97) Q5: Who are the key players in the global health architecture? (13)

Dear friends,

Excellent points have been made about the opportunities of governmental leadership on behalf of improving the lot for women and children.

Two reminders:

- 1) Mortality, while important in itself, is a stand-in for morbidity which is life long.
- 2) again, I hope all of us can support the providers especially professional leadership to work vigorously with clear focus on the well being of mothers and children. Quite important to any progress.

Bill Keenan

William J. Keenan, MD  
Professor of Pediatrics  
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From: "Ruth Davidge, South Africa" <rdavidge@gmail.com>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (98) Standardizing Nursing Monitoring Charts (2)

Hi Sylvia

We have standardized all our neonatal and pediatric nursing and medical records and admin systems and audit tools in KZN (51 hospitals)  
I am happy to share with whoever would like them.

God bless  
info@nnasa.org.za

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From: "Samantha Sadoo, UK" <samantha.sadoo@lshtm.ac.uk>  
To: "CHIFA - Child Health and Rights" <CHIFA@dgroups.org>  
Subject: [chifa] Newborn Care (99) Neonatal deaths and hypoxic ischemic encephalopathy (2)

Dear Neil,

In relation to the question below [What percentage of hypoxic ischaemic encephalopathy might have been avoided with basic antenatal/introapartum care and resuscitation? What training in resuscitation is available at different levels of the health system?], this meta analysis estimates that neonatal resuscitation in the facility setting may reduce intrapartum-related neonatal mortality by 30%. The impact in the community/ home-based setting is unclear, though estimated to reach 20%.

<https://bmcpublikealth.biomedcentral.com/articles/10.1186/1471-2458-11-S3-S12>

Best,  
Sam

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END

*Compiled by Neil Pakenham-Walsh, 2 April 2018*