



CHIFA Discussion on Newborn Care #2

Who is caring for the newborn?

19 February to 30 March 2018

SHORT EDIT

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).

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? And where? Who are the champions of newborn care? Has this changed?

NPW (UK): A potential typology of healthcare providers caring for the newborn:

1. Mother and baby alone or cared for by family members
2. Traditional birth attendant (untrained/ trained in basic care)
3. Community health worker (a 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, without/ with obstetrician and paediatrician)
6. Newborn care team in hospital setting (comprehensive newborn care)

The above is probably quite inadequate- 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')?

JA (Nigeria): I would add two increasingly available groups that are 'competing' with health facilities for patients in LMICs, before traditional birth attendants.

- Traditional herbalist / native doctor (increasingly being used due to poor access/unavailability of other providers, cultural beliefs and norms, ignorance and illiteracy)
- Religious houses (also increasingly used due to weak health system/ lack of health facilities, religious beliefs, illiteracy and poverty)

CBB (Philippines): In the Philippines, healthcare is rendered mainly by BHW (volunteer health workers) and the midwife. We have our MNCHN program, and small and sick babies are referred to the paediatrician if and when they are available. Otherwise the municipal health officer, usually a GP handles them using their training in IMCI.

MM (South Africa): 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 newborn care, both clinically and academically.

NPW (UK): As we have discussed much on our HIFA forum, CHWs often work in relative isolation and have a vast range of responsibilities, often with little if any specific training to identify and

address serious problems. The WHO produced training materials in 2015 to provide guidance for CHWs conducting home visits in the antenatal period and the first weeks after the baby is born. They promote a skilled health professional to provide antenatal and intrapartum care, and support families in adopting appropriate home care practices for the mother and baby, during pregnancy and after childbirth. The guidance was written using experiences of training CHWs in home newborn care in research particularly the SEARCH study in India and the NEWHINTS study in Ghana.

http://www.who.int/maternal_child_adolescent/documents/caring-for-the-newborn-at-home/en/

SH (Sudan): 80% of deliveries in Sudan take place in rural settings and the entry point for sick newborns should be the village midwives (VMWs), however the needed skills and equipment are lacking. Short scale projects are in place aiming at training VMWs on newborn resuscitation, and Sudan is applying a primary health care expansion project that relies on VMWs, CHWs and medical assistance. The specific skills for handling some of maternal and child health issues needs more investments and strengthening eg. early case recognition and referral for antenatal risk factors like malaria or preeclampsia, as causative factors for low birth weight or growth restriction. Rigorous identification of priority diseases, enforcement of a community-based health management information system, and efficient referral are really needed.

Staffing of neonatal units

IN (USA): Both medical 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 we noted that in some referral hospitals in Africa, the nurse bed ratio was 1:15 or worse, especially at night, and exacerbated by the fact there is often more than one baby in a cot/incubator. Interestingly, nearly half the babies in the neonatal units were more than 2500g, not all are really sick but are often admitted for extra observation or minimal care that isn't adequately provided on maternity wards. This highlights the need for increasing staffing in the maternity wards 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.

ST (Sweden): My experience is that a lot of the change is put on the staff, who work long hours with low pay, and may have gone 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 nothing will change without more money at all levels in the health care system and the educational system.

MN (Kenya): In Nairobi, whilst the high end private facilities ensure that the nurses have specialised training in neonatal care, in the public and faith based hospitals they deploy any nurse irrespective of their speciality, and students also play a major role. For the high end private hospital, staffing for the very sick is 1:1 and the stable is 1:3 whether day or night; for the public hospitals the staffing ranges between 1:15 to 1:25, with two nurses during the day and one at night. For the faith based hospitals, the staffing ranges between 1:8 to 1:53. Training for nurses in Kenya starts at diploma, continues to degree, and masters levels and can be at a public or private training institution. Diploma level training is for general nursing with less emphasis on newborn care.

SP (Rwanda): The Chiesi Foundation and COINN is just completing a survey of all the neonatal units in Rwanda. Information we can share: usually 2 nurses during the day responsible for up to 20 babies each, and only 1 nurse for all the babies at night. The average orientation was 7-10 days prior to being responsible for the babies, and included mostly on the job training with whomever was scheduled for the day. Do we need the standards of the developed nations that determines adequate staffing? The knee jerk response may be to just increase staffing without neonatal education so will not necessarily decrease mortality. Perhaps we should look at what nurses/midwives are required to do during the shift, including time spent on non-nursing things such as running to pharmacy or lab. Our survey asked about what they know and learn but not a great deal about how they spend their time.

RD (South Africa): 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. An assessment tool (NAS) was used in a

neonatal unit here to help the hospital determine on a day by day basis the patient acuity and the need to employ agency nurses or not.

SP (Rwanda): Recently the government has hired 'mentor' nurses and doctors who come to spend 2 days to 1 week in each neonatal unit in the country. These mentors are said to be experts and do ward rounds with the staff to discuss the babies. 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 our ground that this is not family centered care.

RD (South Africa): So often when external experts are brought in they don't understand local context. It is critical that whatever teaching or supervision is given in whatever context that it has been standardised 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.

JA (Nigeria): We recently produced a PACK Nigeria guide for all cadres of clinicians, by adapting PACK Global and PACK Western Cape South Africa to fit the PHC in Nigeria, aligning content with Nigerian regulations, clinical protocols and available diagnostic tests, equipment and medications. It took six months to adapt by a team comprised of local physicians, community health practitioners, nurses and midwives, consulting thirteen existing guidelines and protocols and inviting subject experts e.g. in mental health, HIV, TB for their input. Before finalising the guide there was an end-user consultation and questionnaire survey, whose ideas were taken into account.

RD (South Africa): Generally 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 a week). 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.

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

RD (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
- 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 telephone 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

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?

MM (South Africa): In the Northern Cape Province of SA, at the district hospitals newborns are cared for in maternity units (because there are no dedicated neonatal units) by mostly midwives and medical officers. Newborn care at the tertiary hospital is done in a dedicated neonatal unit by the professional nurses who may have undergone speciality training in neonatal and child nursing. There are medical officers who are supervised by a paediatrician.

SP (Rwanda): From a survey we just did in Rwanda, we found that the basic equipment such as thermometers, stethoscopes, ambu bags, NG tubes and phototherapy were present. But there seems to be a lack of access for other important equipment such as CPAP, IV pumps, oxygen 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, putting babies at risk of hypoxia/ hyperoxia. 68.5% of units did not access to a breast pump.

LK (USA): UNICEF recently published a report referring to 10 life-saving articles for newborn care: bag and mask for newborn resuscitation, antibiotics, blankets and cloth for thermal care, chlorhexidine, CPAP, oxygen concentrator, phototherapy, micronutrient supplements during pregnancy, tetanus toxoid, and thermometers. 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?

SH (Sudan): Guidelines are not well updated nor enforced, for example treatment of early signs of neonatal sepsis could be based on risky expensive antibiotics. Polypharmacy is also practised which is mainly due to lack of guidelines enforcement regarding empirical treatment.

CBB (Philippines): Only the facilities in the big cities and mainland would be equipped but they can be very costly and not accessible.

SH (Sudan): In Sudan the private sector is taking over and the new-born management is very expensive. Unless the family is covered by 'Prepayment Plans/insurances, affording hospitalisation might be impossible.

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?

Family-centred care

IN (USA): A family-oriented approach and KMC are important globally. Even maternal involvement in the neonatal unit which 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.

Narayanan I, Singh S, Singhal R, Gatwala G. Maternal participation in the care of the high-risk neonate. *Ind. Pediatr.* 1986; 23: 796-797.

SP (Rwanda): Where I work we have had the mothers at bedside all the time. As well as the feeds, they change diapers and are present for rounds, they help each other get into KMC. With inadequate staffing the babies may otherwise not receive their feeds. 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. What I could see that is needed is a developed program of what is expected and not expected of them.

SP (Rwanda): A problem with feeds 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? The longer a baby is in the unit and unable to suckle the more the mothers struggle. I bought a hospital grade pump which helps improve milk supply and breastfeeding, and reduces need to give formula/ other milk. Mother will often not report if they are unable to produce enough milk and this should be monitored closely.

SP (Rwanda): Our survey found that 12% of Rwandan 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.

SP (Rwanda): Recently due to fear of infection there has been a call to limit the time of the mothers in the room. I would suggest that possible the infection could be related to poor staffing, equipment, and difficulty for the staff to take time to wash between each baby. 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. The call to remove families 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.

RD (South Africa): Mothers are encouraged to participate in care of their babies including tube feeds, oral medications, cleaning the incubator, changing nappies etc. 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 danger signs. Visiting of fathers and siblings is encouraged but has slow uptake. We are fortunate in the public sector at KZN that all our hospitals offer lodging facilities for our mothers with meals. 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 neighbours. Mothers often are away from employment or schooling adding to the cost.

LK (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. We need more evidence on the safety considerations.

JRM (USA): Please see- www.everypreemie.org for the Family-Led Care materials including our provider orientation flip chart and family monitoring forms.

CH (UK): Have you considered involving the siblings in the parenting discussions? 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.

[Kangaroo Mother Care](#)

RD (South Africa): Skin to skin care is practiced from birth in labour wards, and is slowly being practiced in postnatal units. Most hospitals offer at least 2 beds for 24hr KMC care of small babies, and many level 2 hospitals have standalone KMC units.

MM (USA): We recently published a study in Uganda (<http://www.jogh.org/documents/issue201801/jogh-08-010701.htm>) exploring the feasibility and

acceptability of KMC among clinically unstable neonates weighing ≥ 2000 g. 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.

PN (Kenya): In Kenya, KMC is being taking up well in most facilities, and has worked to reduce the reliance on incubators, formula milk and reduced hospital stay. Mothers and fathers are actually liking and embracing it. Having facility based champions has worked well for us. However, a major challenge is lethargy among health workers in initiating babies in KMC as well as facility based constraints such as limited space.

SP (Rwanda): We have found that 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 tried to make it more uniform by using a KMC Scoring Sheet- 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. Training isn't the answer as the staff have had lots of training about KMC. The families see it as the next step to being discharged and rather than prolonging KMC, they treat the room as stepdown and the very next day after being admitted they begin to ask for discharge.

ST (Sweden/Kenya): At a hospital 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. The babies lies in incubators that are usually not turned on. How can we measure high quality (proper and correct) KMC?

SM (UK): 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.

OI (USA): We have all the evidence we need regarding the impact of Kangaroo mother care (KMC) on the survival of clinically stable preterm infants. The question then is how much of the evidence around KMC is incorporated into the training curriculum of these professionals.

RD (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. 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 regarding their compliance with KMC norms.

MK (South Africa): I recently visited a facility where none of the 6 beds dedicated for KMC were being used for it; the reasons provided by the mothers/ caregivers included, 'My C-section wound is too sore,' 'Her mother is sleeping,' 'I am too tired,' 'His mother is in the bathroom.'

Save the Children has been promoting the KMC Challenge since 2016 to raise awareness, 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. The challenge asks 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). This is what one participant said: "I think the biggest challenge was trying to sleep at night. Trying to lie on my back, propped up with the four 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 poeing, 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”.

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

KMC Resource Toolkit: <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 (email mkinney AT savechildren.org)

JRM (USA): Every Preemie—SCALE is currently testing a family-led model of care in Malawi. 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 admitted to KMC and prior to discharge, and 2) to design low-literacy materials for family to use to monitor their babies while in the KMC unit and once home post discharge, ensuring that family members are confident in caring for their babies. We're also actively building referral linkages with the Health Surveillance Assistants to improve follow up visit attendance. We should have mid-term results this summer and final results late 2018/early 2019 regarding outcomes including mortality and weight gain.

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

Who is responsible at the national level?

IA (Nigeria): In the ministry in Nigeria, neonatal programmes and policies are handled mainly under the Directorate of child health, and partly under reproductive health as Maternal and child health programmes.

AM (India): India has witnessed improvement in infrastructure & systems strengthening over the last 8-10 years with establishment of SNCUs in each of the districts & institutionalising structured Facility Based Newborn Care (FBNC). Government strategies include standardisation of operational & training guidelines, considering infrastructural revisions to promote family-centred care & KMC, concept of mother-newborn care units, creating Mother-child tracking systems, trying to form linkages through public-private partnerships, as well as creating a uniform government online SNCU database that helps to monitor, audit & compare performances objectively and use data further to motivate states to outperform each other, with systems for perinatal death audits and reviews, checklists for care etc. Specific initiatives include setting up of District Early Intervention Centres (DEIC), MAA program (a nationwide launch of breast feeding program), Family Participatory Care (FPC), and LaQshya initiative (to strengthen Delivery Rooms & OTs). You can view more of these guidelines: <http://nhm.gov.in/nrhm-components/rmnch-a/child-health-immunization/child-health/guidelines.html>

MM (South Africa): 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 sets 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).

ST (India): I have seen the status of programs (eg.RMNCH+A) that have been initiated at national/ state level and what has trickled down to the grassroots; there are major discrepancies in implementation. With the underlying gaps and 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. The start of INAP [India Newborn Action Plan] envisaged from ENAP [Every Newborn Action Plan] is a full package in itself but has hardly been implemented; the program management unit and the medical officers involved are still in nascent stage.

JA (Nigeria): A large gap exists between policies and implementation at facility level, particularly in a number of non government private for fund facilities which provide scanty haphazard level I care with very poor referral systems and facilities.

Measurement and accountability

MT (Georgia): In Georgia, the supplier of all levels of perinatal service must have a quality assurance program that includes a clinical audit system including near-miss cases, as well as a quarterly documented record of the following basic data: A) Number of primary cesarean sections; B) Total number of obstetric bleeding; C) Transfer of mothers in critical care department and/or other facility; D) Number of maternal deaths according to causes; 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 cause.

RD (South Africa): 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. There is a national system for 24 hr death reporting, and basic data on births and deaths are captured using DHIS 2 <https://www.dhis2.org/> - 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. There are national norms for bed numbers, infrastructure, equipment and consumable requirements for neonatal units. We also have national guidelines on the management of sick and small babies. We have standardized all our neonatal and pediatric nursing and medical records, admin systems and audit tools in Kwazulu Natal (51 hospitals)- I am happy to share with whoever would like them.

DKD (India): There is a need for the governments to start regularly sourcing ground level data (births & deaths-civil registration system) through creating robust systems instead of relying on small sample sized field surveys every 2-4 years. This data analysed regularly will help policy formulation even for creating posts at hospitals (of nurses, doctors etc).

IN (USA): The importance of numbers cannot be over-emphasized. However, neonatal mortality cannot be fully estimated by merely counting newborn deaths, but also stillbirths, notably fresh stillbirths. 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. Documenting all three components can give a more holistic picture and highlight what other interventions need to be considered.

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?

NPW (UK): Who are the key players in the global health architecture for newborn care?

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

BK (USA): Missing from this list at the minimum:
8. ICM = International Confederation of Midwives
9. IPA = International Paediatric Association
10. FIGO = International Federation of Gynecology and Obstetrics
11. ICN = International Council of Nurses

MKV (USA): I would add:
12. AAP= American Academy of Pediatrics
13. Laerdal Global Health
14. LDSC= LDS Charities
15. ACNM= American College of Nurse Midwives
CK (USA): I would add
16. COINN= Council of International Neonatal Nurses

LK (USA): Earlier this week, UNICEF launched a campaign, 'Every Child Alive: the Urgent Need to End Newborn Deaths; report here [https://www.unicef.org/publications/index_102640.html]
I especially liked the reference to the 4 P's 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 quality care).

KS: This UNICEF report draws attention to a very serious issue- 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 variables of income and education, but to ignore empowerment issues like the place of the 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. It could have used the ecological framework to probe into the 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.

NS (UK): As above, the WHO Commission Report on Social Determinants of Health is essential reading providing convincing evidence for advocacy. 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.

NPW (UK): 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.' The ENAP Metrics group is currently supporting CHIFA to contribute to this collective effort through the CHIFA Newborn Care Project.

MR (Canada): A new publication highlights the well thought out and well structured newborn program in Mbale Regional Referral Hospital, Uganda, led by foreign specialists. Kathy Burgoine et al. Staged implementation of a two-tiered hospital-based neonatal care package in a resource-limited setting in Eastern Uganda. *BMJ Global health*.

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