Member States have made significant progress towards reducing maternal and child mortality, but still a woman dies every seven minutes in pregnancy and child birth, every hour more than two hundred under-five children die in this Region including more than one hundred newborns. Slow neonatal mortality reduction has retarded progress to MDG4 in SEAR, and tackling the first few days’ neonatal mortality is the real challenge.

Global Every Newborn Action Plan (ENAP) was developed following a systematic review of the progress in addressing newborn survival and extensive expert consultations. ENAP was endorsed at the Sixty-seventh World Health Assembly in May 2014. WHO has recently released guidelines for postnatal care (PNC) for mothers and children to be addressed.

The regional meeting on ENAP and PNC was organized to review the national newborn action plans and share successful experiences for scaling up. WHO technical guidelines on PNC for mothers and newborns were shared for ensuring uniform and universal implementation of these in Member Countries of the Region. Country teams prepared action plans for implementation of newborn action plans and postnatal care to accelerate reduction in newborn mortality. The meeting report provides highlights of the proceedings from the regional meeting.

Every newborn action plan and postnatal care for mother and newborn

Report of a regional meeting,
Colombo, Sri Lanka, 11–13 November 2014
Every new-born action plan and postnatal care for mother and newborn

*Report of a regional meeting, Colombo, Sri Lanka, 11–13 November 2014*
Contents

Acronyms ................................................................................................................................................... v

Executive summary .................................................................................................................................. vi

1. Background ......................................................................................................................................... 1

2. Opening session .................................................................................................................................. 2

3. Objectives ......................................................................................................................................... 5

4. Proceedings ....................................................................................................................................... 6
   4.1 Every Newborn Action Plan ........................................................................................................... 6
   4.2 Regional situation of newborn health and the Every Newborn Action Plan in the region ................. 8
   4.3 Bottleneck analysis (BNA) for Every Newborn Action Plans (ENAP) .................................................. 10
   4.4 Indicators for ENAP and country tracking matrix ............................................................................ 11
   4.5 Country updates ............................................................................................................................ 12
   4.6 Poster session ............................................................................................................................... 15
   4.7 WHO guidelines for postnatal care of mother and newborn ......................................................... 16
   4.8 Postnatal Care: Experiences from selected countries ..................................................................... 18
   4.9 Poster session: Postnatal care and referral pathways .................................................................... 22
   4.10 Clinical examination of the newborn ............................................................................................ 23
   4.11 Panel discussion: Specific issues of PNC ...................................................................................... 25
   4.12 Development partners’ forum ....................................................................................................... 27
4.13 Resource materials for maternal and newborn care .................. 29
4.14 Revisiting evidence on newer newborn health interventions .......... 29

5. ENAP country action plans: from discussion to action ................... 31
6. Recommendations ........................................................................ 32

Annexes

1. Address by Dr Poonam Khetrapal Singh,
   Regional Director WHO South-East Asia ........................................ 34
2. Status of newborn health programmes in countries ....................... 37
3. Agenda ....................................................................................... 45
4. List of participants ...................................................................... 46
5. List of posters from countries ...................................................... 53
**Acronyms**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC</td>
<td>antenatal care</td>
</tr>
<tr>
<td>ASHA</td>
<td>accredited social health activist</td>
</tr>
<tr>
<td>BEmONC</td>
<td>basic emergency obstetric and newborn care</td>
</tr>
<tr>
<td>BNA</td>
<td>bottle neck analysis</td>
</tr>
<tr>
<td>CEmOC</td>
<td>comprehensive emergency obstetric care</td>
</tr>
<tr>
<td>CEmONC</td>
<td>comprehensive emergency obstetric and newborn care</td>
</tr>
<tr>
<td>EMEN</td>
<td>Every Mother Every Newborn Initiative</td>
</tr>
<tr>
<td>ENAP</td>
<td>Every Newborn Action Plan</td>
</tr>
<tr>
<td>HMIS</td>
<td>health management information system</td>
</tr>
<tr>
<td>INAP</td>
<td>India Newborn Action Plan</td>
</tr>
<tr>
<td>KMC</td>
<td>kangaroo mother care</td>
</tr>
<tr>
<td>LBW</td>
<td>low birth weight</td>
</tr>
<tr>
<td>MCTS</td>
<td>mother and child tracking system</td>
</tr>
<tr>
<td>MDG</td>
<td>millennium development goal(s)</td>
</tr>
<tr>
<td>MNH</td>
<td>maternal and newborn health</td>
</tr>
<tr>
<td>NICU</td>
<td>neonatal intensive care units</td>
</tr>
<tr>
<td>NMR</td>
<td>neonatal mortality rate</td>
</tr>
<tr>
<td>PNC</td>
<td>post natal care</td>
</tr>
<tr>
<td>RMNCAH</td>
<td>reproductive, maternal, newborn, child and adolescent health</td>
</tr>
<tr>
<td>U5MR</td>
<td>under-five mortality rate</td>
</tr>
<tr>
<td>WASH</td>
<td>water sanitation &amp; hygiene</td>
</tr>
</tbody>
</table>
Executive summary

Globally, nearly 2.9 million newborns die each year, and an additional 2.6 million babies are stillborn. Newborns now account for 44% of the 18000 children under age five dying every day. The main causes of neonatal deaths are: complications of prematurity, birth asphyxia and sepsis. The Global Every Newborn Action Plan (ENAP) was developed following a systematic review of the evidence for addressing newborn survival and extensive expert consultations. ENAP was endorsed at the sixty-seventh World Health Assembly in May 2014. This action plan is a roadmap to save 3 million lives of newborns, women and stillbirths annually and is based on the evidence-based intervention packages recommended in the Lancet Every Newborn series (2014) which has emphasized that 90% coverage would be able to avert 71% neonatal deaths. Newborn health and prevention of stillbirths were not specifically addressed in the Millennium Development Goals (MDG) framework and consequently received less attention and investment. Countries have got the opportunity to fill this gap by using ENAP framework. The indicators for ENAP and the country tracking matrix are being developed for monitoring and evaluation.

Almost 55% of under-five mortality rate (U5MR) in the South-East Asia Region is due to newborn deaths and the decline in neonatal mortality rate (NMR) has been very slow over the years. Several countries have carried out a bottleneck analysis (BNA) to identify challenges and barriers in scaling up maternal and newborn health (MNH) interventions. Based on the analysis, the countries have initiated the process of developing ENAP in collaboration with multiple stakeholders to prioritize strategies and interventions to increase coverage. India has already finalized and disseminated the national ENAP. The countries have recognized that, for reduction of newborn mortality, an impact of about 52% could be achieved from interventions delivered to the newborn and 48% impact from interventions targeted at the mother. Hence, all the countries have focused interventions for both mother and baby. Almost all countries have focused on improving care to mother and baby during labour and childbirth, including management of complications as well as all other high impact interventions.
Recent World Health Organization (WHO) guidelines on postnatal care (PNC) for mothers and newborn were disseminated in the meeting. Early PNC is critical to save lives, since 40% of neonatal deaths occur in the first 24 hours of life and 56% within 72 hours. The guidelines are aimed to help countries to strengthen the institutional capacity, health system and community engagement for provision of respectful PNC for all mothers and newborns, as well as address gender and equity gaps. The guidelines highlight the importance of antenatal care (ANC), intra-partum care and PNC as a continuum to ensure the greatest impact on maternal and neonatal survival. During the meeting countries shared a variety of experiences as well as challenges to deliver PNC for mothers and newborns. The participants agreed that WHO recommendations would help standardize the PNC by adapting number and periodicity of postnatal contacts and the quality of care.

Technical updates were provided on newer newborn interventions such as: kangaroo mother care (KMC); antenatal corticosteroids for management of preterm labour; and chlorhexidine use for cord care to prevent neonatal sepsis in home deliveries, and management of newborn sepsis with simplified antibiotics regimes in situations where referral may not be possible.

Development partners shared information about technical and financial support that may be available from them in the area of newborn health. There was a consensus in the meeting that ENAP would be a useful framework to end preventable maternal and newborn deaths in the countries of the Region with technical and financial support from development partners. Based on the proceedings of the meeting country teams identified key actions that would be undertaken to reduce newborn mortality.
1. **Background**

Global attention has been drawn to the fact that each year, 289,000 women still die while giving birth and an estimated 18,000 children die every day from preventable causes. The United Nations Secretary-General’s “Global Strategy for Women’s and Children’s Health” and recent global initiatives like “A promise renewed - Call to action for child survival” have brought multiple stakeholders to propose an accelerated response to prevent maternal and child mortality.

Furthermore, “Every Newborn: An action plan to end preventable deaths” has been formulated as a road map to save 3 million lives of newborns, women and stillbirths annually. It sets out a vision of a world in which there are no preventable deaths of newborns or stillbirths, every birth is celebrated, and women, babies and children survive, thrive and reach their full potential. Every Newborn Action Plan (ENAP) has proposed goals, strategic objectives and targets to be achieved by 2035 to end newborn deaths from preventable causes, with intermediate targets for 2020, 2025 and 2030. The Lancet Every Newborn series (2014) recommends packages of evidence-based interventions across the life-course continuum within the existing country health systems that have an impact on newborn morbidity and mortality. ENAP includes guiding principles, an impact framework, milestones and indicators to measure progress. The recently published WHO postnatal care guidelines will guide the countries in reaching the targets proposed for coverage of quality of care for women around the time of birth, and care for normal, sick and small newborns in the postnatal period.

South-East Asia Region as a whole is unlikely to reach MDG 4 by December 2015. One of the main reason is that neonatal mortality reduction has been much slower. In line with the Global ENAP framework the countries have initiated development of national ENAP that appropriately links key interventions across the continuum of care, from pre-pregnancy care, care during pregnancy and childbirth to the postnatal period, underlining the inherent connections between reproductive, maternal, newborn and child health.
2. Opening session

The meeting was inaugurated by the Honourable Minister of Health Sri Lanka, H.E. Mr Maithripala Srisena. In his welcome speech, the Deputy Director (Public Health Services) of Sri Lanka, emphasized that the meeting was following up on the commitment made at the Sixty-seventh World Health Assembly on the need accelerate reduction in newborn mortality and to strengthen PNC for mother and child. The levels of neonatal mortality rates (NMR) in the Region are quite variable, with some countries reporting low rates and the others high rates. Yet, the Region has the opportunity to achieve high levels of survival as the national economies are progressively growing and health services are steadily expanding and improving.

In his inaugural speech, H.E. Mr Maithripala Srisena, the Honourable Minister of Health Sri Lanka described the strong health system in Sri Lanka. He explained that a health unit system was in existence as far back as the early twenties, to provide both preventive and curative services at the primary health care level and as a result, the country was experiencing excellent maternal and child health indices.

WHO South-East Asia Regional Director’s Message

Arturo M Pesigan, Acting WHO Representative to Sri Lanka read the message from Dr Poonam Khetrapal, Regional Director, WHO South-East Asia Region. In her message concern was expressed that only 415 days remained till December 2015 to achieve the MDGs. It is unacceptable that an estimated 1.7 million deaths occurred in the under-five age group, including about 0.9 million newborn deaths in 2013. She stressed the need to strengthen maternal and newborn health programmes urgently in all countries for accelerating reduction of newborn mortality that has shown a slower decline in the region.
The regional meeting held in April on “2015 and beyond: the unfinished agenda of MDG 4 and 5” was an important milestone and was organized under Regional Director’s flagship project on ‘Ending preventable maternal, newborn and child deaths in South-East Asia Region’ which has received unequivocal support from the Honourable Ministers of Health from Member States. It was highlighted in the meeting that maternal and newborn survival was an unfinished agenda, as the progress had been uneven both across the Region and within countries. The first ever regional Joint UN Statement on Women’s and Children’s Health released at this regional meeting in Kathmandu demonstrated strong commitment by UNFPA, UNICEF and WHO at the highest level in the Region. The statement emphasized the need for expanding coverage of evidence-based interventions along the continuum of care; reaching the unreached populations; improving the quality of care at all levels of care; ensuring efficient use of precious resources and promoting innovations; addressing social determinants and upholding the national commitments on accountability for tracking results and resources towards women’s and children’s health.

She mentioned that the Sixty-seventh World Health Assembly in May 2014 had adopted the global Every Newborn Action Plan (ENAP) to ensure reduction in maternal mortality, stillbirths and newborn mortality and bring convergence of prevention of maternal and newborn morbidity and mortality approaches. Several countries have completed the bottleneck and national ENAPs are being prepared to end preventable maternal and newborn mortality by 2030.

The Regional Director appreciated that regional meeting would review country progress on ENAP and disseminate the recently published WHO postnatal care guidelines and help countries in their planning process to strengthen interventions for ENAP and PNC.

She emphasized that partnerships combining the strengths of public and non-state organizations and civil society could not be understated. Such platforms would address health system gaps and help expand interventions in a rapid, flexible and focused way, mobilize new and significant resources, introduce innovative technological solutions, and research. In conclusion, she thanked the Government of Sri Lanka for collaboration in hosting this important meeting.
Dr Douglas Noble, Regional Health Adviser, UNICEF, Regional Office for South Asia, pronounced that UNICEF deeply valued its close working relationships with ministries of health in the countries, WHO and other partners to improve the health of children. He affirmed that protection of children, their survival and development, and their right to health was at the core of UNICEF’s work and this right was especially important in the context of twenty-fifth anniversary of the Convention on the Rights of the Child in 2014. He opined that the main causes of neonatal deaths: prematurity, low birth weight, problems during delivery and infections were preventable and almost 70% of neonatal deaths could be averted even without intensive care facilities. Nothing was more important than every child having a chance to live a long and healthy life and ensuring that every child has a healthy mother who herself must receive the best health care during and after pregnancy.

He said that ensuring equity was one of the main priorities for UNICEF. In public health, this meant extending services to the poorest and traditionally excluded groups who were more likely to have higher rates of neonatal mortality. National averages in the datasets could conceal wide differences associated with geographical and social factors within a country. That was why the core indicators in the ENAP were so important to implement. He felt that deliberations at the meeting would help countries to roll out comprehensive ENAP and strengthen postnatal care in line with postnatal care guidelines published by WHO.

Dr Martin Weber, Regional Adviser, (Maternal and Reproductive Health), WHO-Regional Office for South-East Asia Region outlined the objectives of the meeting.

Dr Rajesh Mehta, Medical Officer, Child and Adolescent Health, WHO Regional Office for South-East Asia introduced the participants from ministries of health, representatives from development partners, donors and professional associations. (See Annex 4 for list of participants).
3. **Objectives**

The objectives of the meeting were:

- to review country progress in the Every New-born Action Plan (ENAP), including successful experiences and best practices for implementation of good quality and evidence-based interventions and approaches;
- to suggest indicators needed to measure progress on newborn interventions;
- to introduce participants to the Postnatal Care (PNC) Guidelines published by WHO;
- to discuss and agree on appropriate approaches to deliver PNC in countries of the Region; and
- to develop strategies and action plans for ensuring higher coverage with newborn interventions towards acceleration in reduction of newborn mortality.
4. **Proceedings**

4.1 **Every Newborn Action Plan**

*Every Newborn Action Plan (ENAP) and Every Mother Every Newborn (EMEN) initiative: update on global developments for improving newborn and postnatal care*

Dr Severin V Xylander, Medical Officer, WHO Geneva, shared that newborn deaths accounted for 44% of the 18,000 children under age five dying every day, globally. In 2013, nearly 2.9 million newborns died each year, in addition, there were 2.6 million stillbirths. The main causes of neonatal deaths were: prematurity, low birth weight, birth asphyxia and sepsis. He emphasized that available knowledge and tools could prevent at least two thirds of these deaths. Proven interventions were available to manage preterm births, as well as to prevent and manage complications during labour (including birth asphyxia) and neonatal infections. Evidence-based interventions delivered within the reproductive, maternal, newborn and child health continuum of care would save 3 million lives at an additional investment of US$ 1.15 per capita. He informed that ENAP is directed at three interlinked goals of reduction in neonatal mortality, stillbirths and maternal mortality.

ENAP framework has proposed five strategic areas:

1. *strengthen and invest in care* during labour, birth and the first day and week of life
2. *improve the quality* of maternal and newborn care
3. *reach every woman and every newborn;* reduce inequities
4. *harness the power* of parents, families and communities
5. *count every newborn* – measurement, tracking and accountability.
Good quality care during delivery, essential care to babies soon after birth and timely detection and management of neonatal complications like asphyxia, prematurity, hypothermia and infections would help reduce neonatal mortality. Similarly, early detection and management of maternal complications such as hypertension, pre-term labour, obstructed labour, postpartum hemorrhage and sepsis would help reduce maternal mortality.

ENAP prioritizes focus on the period around birth within existing reproductive, maternal, neonatal, child and adolescent health (RMNCAH) national strategies and plans; and is not a stand-alone plan.

The Every Mother Every Newborn (EMEN) initiative has been proposed for improving quality of care around the time of childbirth. EMEN standards would be developed to ensure good quality of care focusing on:

- mothers’ knowledge about her own health and knowing where to seek care;
- service package (high impact interventions);
- health facility management systems;
- availability and use of policies and processes;
- physical environment;
- drugs, supplies, and equipment;
- workforce: numbers, competencies, regulations, and supervision;
- availability and use of data;
- patient safety and infection prevention and control; and
- health-care financing.

Global movement has been significantly built up since 2005 from a period when newborn deaths were invisible in the global goals.
4.2 Regional situation of newborn health and the Every Newborn Action Plan in the region

Dr. Rajesh Mehta, Medical Officer, Child and Adolescent Health, WHO Regional Office for South-East Asia presented the regional scenario of newborn health. He pointed out that the progress in MDG-4 status in the region showed wide variation over the last two decades. Some countries have shown marked declines in under-five mortality rate (U5MR) and decline has been slower in other countries. However, decline of U5MR had been greater than the decline in neonatal mortality rate (NMR) in all countries of the region. Due to this slow decline in NMR, the Region as a whole, with only a little more than a year remaining, might miss out on achieving the MDG-4 goal. It was noteworthy that some countries e.g. Maldives, Sri Lanka, Thailand had achieved remarkable neonatal mortality rates parallel to the developed countries.

Almost 55% of U5MR in the Region was due to neonatal deaths. He highlighted that the first 24–72 hours of life was a critical period. Forty percent of neonatal deaths occurred in the first 24 hours of life and 56% within 72 hours. Major causes of NMR in the Region were prematurity, birth asphyxia and sepsis. In addition, there were underlying causes of newborn deaths such as the well-known social determinants including poverty, low level of maternal education, adolescent pregnancy, short birth spacing, maternal under-nutrition and anaemia. In addition, several factors related to service delivery challenges like inequitable access to services, poor quality services and uneven coverage across continuum of care need to be addressed to improve the health and survival of the mother and baby. It was highlighted that national averages of NMR, concealed geographical disparities and socioeconomic disparities, which were very important details for effective planning.

It was also observed that as newborn mortality due to prematurity, birth asphyxia and sepsis declined, mortality due to birth defects would progressively assume higher proportion. Therefore, it was pertinent to include birth defects prevention and control interventions in RMNCAH programmes to further reduce neonatal mortality.

Evidence presented in the Lancet newborn series (2014) has suggested that 71% of neonatal deaths could be averted with a high coverage (90%) of
available interventions. An impact of almost 52% could be achieved from interventions delivered to the newborn and 48% impact from interventions targeted at the mother. High impact interventions included care during labour and child birth, including management of complications that could avert almost 41% neonatal deaths and comprehensive hospital care for sick and small neonates that could avert 30% neonatal deaths.

Regional strategy to strengthen newborn and child health developed earlier by WHO/UNICEF recommended the following strategic directions for reducing newborn and child mortality:

- scale up implementation throughout the continuum of care;
- reach the unreached for equity;
- effective health systems for accessible and quality care;
- private sector participation;
- improve and maintain quality of care;
- engage with families and communities; and
- action beyond the health sector.

In order to achieve the desired MDG goals, the Regional strategy recommended that above strategic directions should be guided by the life cycle approach, health equity, child rights, health system approach, partnership with private sector, and using a multisectoral partnership and be driven by community demand and ownership.

Strengthening health system capacity to deliver quality home-based care with home visits and facility-based care with special emphasis on care for small and sick neonates based on national standards and treatment protocols cannot be undervalued. Establishing neonatal–perinatal databases would help to understand the pattern and trends of mortality and morbidities among the newborns in the hospitals and help strengthen the quality of care.

ENAP provides renewed opportunity to focus on reduction in newborn mortality, still births and maternal mortality and presents a framework to implement evidence based high impact intervention packages. The SEA Region is adapting the ENAP and providing support to countries to strengthen
newborn health programmes. It was emphasized that newborn health strategies should be integrated within existing RMNCAH under the national health sector plans, and not as a vertical initiative.

4.3 Bottleneck analysis (BNA) for Every Newborn Action Plans (ENAP)

Ms Nuzhat Rafique, Regional Maternal and Newborn Health Specialist, UNICEF/ROSA informed that in-depth BNA in five high-burden countries of South Asia (Afghanistan, Bangladesh, India, Nepal and Pakistan), two high-burden countries (Indonesia and Myanmar) from EAPRO was undertaken under the leadership of the ministries of health in collaboration with partner agencies. In addition, an assessment was undertaken to develop successful country case studies in high performance countries like China, Sri Lanka and Thailand.

A standardized tool was used for BNA for the nine key interventions of ENAP across the six health system blocks: Leadership and governance, health financing, health workforce, essential medical products and technologies, health information systems and health service delivery. She shared that common set of health system constraints were found in all these high-burden countries. One of the common issues was a lack of adequate numbers of competent health-care workers, especially skilled midwives and nurses. Other common constraints were related to a limited funding specifically focused on newborn health, leading to insufficient scale-up of the nine interventions studied. For KMC, all five countries were experiencing human resource constraints. For the management of pre-term babies, all five countries reported constraints in several building blocks of health system and three countries had experienced constraints in at least four building blocks for skilled care at birth.

Specific intervention packages like prevention and management of preterm births, good quality of care for small and sick newborns in hospitals and management of severe newborn infections experienced more health systems bottlenecks. For management of small and sick newborns all the countries reported challenges across several health system blocks. In Afghanistan, Bangladesh, India and Pakistan, care around birth [comprehensive emergency obstetric care (CEmOC), basic new-born care,
neonatal resuscitation, KMC] and care for small and sick neonates had suffered from serious health system bottlenecks.

Some context-specific constraints had also been noted because of which a particular intervention might face serious bottlenecks to scale up, e.g. there were cultural barriers for practice of KMC in Afghanistan and Pakistan. In some communities, accepting skilled attendance at birth from only female health providers was a social norm.

If these identified bottlenecks were addressed, the positive impact on maternal and new-born survival would be huge. In order to move forward, countries had agreed to integrate evidence-based interventions package into existing MNH plans and develop newborn action plans in line with the global ENAP framework.

### 4.4 Indicators for ENAP and country tracking matrix

Dr Douglas Noble, Regional Health Adviser, UNICEF-ROSA shared that global teams were working to support implementation of ENAP in countries and tracking the progress. There was an agreement on ten core indicators and work was in progress for additional monitoring indicators.

#### 10 core indicators

<table>
<thead>
<tr>
<th>Impact indicators</th>
<th>1. Maternal mortality ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Stillbirth rate</td>
</tr>
<tr>
<td></td>
<td>3. Neonatal mortality rate</td>
</tr>
<tr>
<td>Coverage: Care for all mothers and babies</td>
<td>4. Skilled attendant at birth</td>
</tr>
<tr>
<td></td>
<td>5. Exclusive breastfeeding for six months</td>
</tr>
<tr>
<td></td>
<td>6. Early postnatal care for mothers and babies</td>
</tr>
<tr>
<td>Coverage: Complications and extra care</td>
<td>7. Antenatal corticosteroid use</td>
</tr>
<tr>
<td></td>
<td>8. Newborn resuscitation</td>
</tr>
<tr>
<td></td>
<td>9. KMC &amp; feeding support</td>
</tr>
<tr>
<td></td>
<td>10. Treatment of neonatal sepsis</td>
</tr>
</tbody>
</table>
Tracking of progress in ENAP implementation in countries

Dr Douglas shared that there was an agreement on the key areas of focus in the national ENAP:

- **sharpened strategies**, policies and guidelines in the ENAP;
- **data**: improving and using data;
- **quality**: Availability of EMEN Quality Initiative standards and commodities;
- **Investment**: Availability of costed plans including human resources for health and ensuring that sufficient resources were allocated;
- **Health workers**: training, deployment and support of relevant health workers;
- **Innovation and research**;
- **Engagement**: communities, civil society and other stakeholders; and
- **Parent voices and champions**: shift in social norms so that newborn deaths were unacceptable.

A global team was working on developing country tracking matrix. It was proposed to track the implementation of ENAP on a quarterly basis and inform countries and partners on progress; identifying barriers to implementation and for facilitating provision of technical support. The collected information would be shared with government for evidence-based decision-making and implementation of effective strategies.

### 4.5 Country updates

**Bangladesh - Innovative approaches**

Dr Altaf Hussain, Ministry of Health, Bangladesh reported that the national political commitment towards “A Promise Renewed Call to Action for Child Survival” was conveyed in June 2012, in Washington. High newborn mortality was recognized as a key issue. A national policy dialogue had been undertaken to prioritize newborn-related interventions. Situation
analysis and BNA had paved the way for developing ENAP. National ENAP was being prepared for scale-up with four key newborn intervention packages:

(1) essential newborn care with newborn resuscitation and chlorhexidine application;
(2) antenatal steroids for premature labour and KMC for premature and LBW babies;
(3) management of neonatal sepsis at primary health care level; and
(4) specialized newborn care at district and sub-district level hospitals.

These newborn interventions were accompanied by national scale-up of two maternal health interventions:

(1) skilled birth attendants; and
(2) functional and 24x7 basic and comprehensive emergency obstetric and newborn care (BEmONC and CEmON) at strategically-located facilities across the country.

Benchmarks had been developed to track the progress of implementation of interventions packages. Four technical working groups had been established to develop guidelines for the four key newborn interventions. Three other novel innovations - a community support network, a database to track every newborn through DHIS-2, and quality improvement had been adopted.

**India – Newborn action plan**

Dr Ajay Khera, Ministry of Health informed that a situation analysis was carried out to understand the current status with regard to maternal and newborn health issues. Twenty six million babies were born annually in the country. India reported the highest number of neonatal deaths annually in the world (approximately 758 000) with a high NMR of 29 per 1000 live births. Four states in India accounted for half of the neonatal deaths in the country and contributed 14% to the global burden. Still birth rate of 22 per 1000 births meant that a further 572 000 babies were born dead annually. Neonatal deaths accounted for 56% of under-five deaths, which was higher
than the global average of 44%. Neonatal mortality significantly varied between states and regions and with demographic and socioeconomic factors. Babies born in rural settings were twice as likely to die as those born in urban areas. In this scenario, BNA was carried out to identify the policy gaps and missing interventions. Thereafter, the India New-born Action Plan (INAP) has been developed to achieve a single digit NMR by 2030 based on the existing commitments and country specific needs. INAP is guided by the principles of integration, equity, gender, quality of care, convergence, accountability and partnerships. It presents a clear vision supported by goals, strategic interventions, priority actions and a monitoring framework. It provides a framework for the states to develop their specific action plans, as applicable to the local context.

**Nepal – Newborn home visits and recent developments**

Dr Krishna Prasad Paudel, Ministry of Health informed that between 1981 and 2011 U5MR declined from 196/1000 live births to 54; IMR from 126 to 46, and NMR from 72 to 33 per 1000 live births. MMR had declined from 539/100,000 live births in 1996 to 281 in 2006. Contraceptive prevalence had risen from 8% in 1981 to 43% in 2011. Strengthening the systems that deliver essential care to mother and babies had contributed to this success. The success of a pilot carried out in one province ensuring that community health workers, first level health facilities, families, and communities worked together to correctly identify and manage neonatal infections had paved the way to scale up to cover the whole country towards decreasing neonatal mortality.

There was urgent need for building infrastructure like newborn nurseries, newborn corners in labour rooms and NICU and training of manpower focused in neonatal health. The usefulness of having a strong link between community workers and health facility workers, referral chain, the need for a strong collaboration between the family health division and child health division and incorporating neonatal health issues in mainstream programmes were underlined.

The government of Nepal would continue to work in partnership with local NGOs, and development partners to achieve MDG targets 4 and 5 to improve the survival and quality of life of mothers and children.
4.6 Poster session

Participants from the countries (ministries of health and development partners) were invited to display posters to highlight the progress in development of newborn action plans. Country posters shared the findings of BNA and the mechanisms to address these in the proposed national newborn action plans as well as the monitoring framework.

Common issues reported in the country newborn action plans:

The following common issues and approaches could be observed from the country posters on newborn action plans (ENAP):

- strengthen the existing national strategies and health programs when developing ENAP;
- develop national ‘Quality Improvement Framework’ and create necessary management structure with tools and guidelines to operationalize the QI plan;
- lack of skilled human resources is a major impediment to service delivery; task shifting and fresh recruitments need to be considered;
- Innovations such as inter-professional training, on-line training identified as solutions for supportive supervision and motivation of the staff;
- need for more effective engagement of the community to raise awareness and community support for changing social norms and behaviours / practices;
- strengthen M&E, more support for supervision and monitoring system;
- specific benchmarks to be set to track progress towards achieving ENAP targets;
- building private–public partnerships.
- addressing technical & financial resource gaps.

In addition, countries presented posters on innovative and new approaches to reduce newborn mortality. The posters covered a range of
topics: Use of chlorhexidine for cord care at birth; management of preterm labour – use of antenatal corticosteroids; additional home visits for pre-term babies; perinatal audit and verbal autopsies; quality improvement; community participation; and integrating newborn indicators in the existing HMIS.

The poster on use of chlorhexidine for cord care at birth in Nepal presented that a projected 3000 lives of babies would be saved following the introduction of the chlorhexidine programme. Policies, standards, guidelines, annual action plans, and programme monitoring plans had been developed. Depending on the success of the project, it was proposed to integrate the use of chlorhexidine into existing maternal and child health programs throughout the countries by 2017.

Bangladesh highlighted the importance of perinatal audits in a scenario where 60% of U5MR was due to neonatal mortality. Fifty percent neonates were reported to die within the first 24 hours.

The poster on Quality improvement from Sri Lanka showed that the main focus was on quality improvement in a scenario with remarkably low MMR and IMR that country has already achieved. Developing a tool kit for quality assessment, and a neonatal surveillance system, and ventilation centres, and advanced newborn care would be future priorities.

The posters from Bangladesh and Myanmar presented the initiatives for community-based newborn care.

4.7 WHO guidelines for postnatal care of mother and newborn

Ms Fran Mc Conville, Technical Officer (Midwifery) WHO Headquarters presented the WHO guidelines for post natal care for mothers and newborns. Maternal mortality had declined over the years, yet almost 800 women died daily due to complications in pregnancy and childbirth. Majority of the deaths occurred around the time of delivery. The major causes of maternal deaths were postpartum haemorrhage, infections and exacerbation of prenatal causes such as pregnancy-induced hypertension and eclampsia.
Coverage of postnatal care visits had been low, globally. The median coverage for postnatal care for women was about 40% and 25% for newborn care during 2007-2012.

The WHO postnatal care guidelines cover issues pertaining to mother and baby from birth to six weeks (42 days) to cover the following periods:

- immediate postnatal period: first 24 hours
- early postnatal period: days 2–7
- late postnatal period: days 8–42.

The guidelines cover recommendations for the timing and frequency of PNC:

- timing of discharge from health facility after normal birth is recommended as 24 hours;
- timing of first postnatal contact for home birth is recommended as early as possible within 24 hours;
- minimum of four postnatal contacts are recommended: within 24 hours, on day-3, once between day 7 and 14, and once at 6 weeks;
- daily application of chlorhexidine for cord care after home deliveries is recommended only in high newborn mortality settings;
- bathing of baby is recommended to be delayed until after 24 hours.

The PNC guidelines have harmonized PNC for mothers and newborns and provide the content of each postnatal contact. Assessment of the newborn is consistent with the danger signs used in existing WHO packages like IMCI, IMPAC, and essential newborn care.

There was an emphasis on keeping the baby with the mother. The PNC guidelines also emphasize the importance of nutrition for the mother and baby, immunization and family planning. It was emphasized that the PNC guidelines would need to be adapted at country level for scaled implementation in line with the existing systems.
4.8 Postnatal Care: Experiences from selected countries

*Sri Lanka*

Although Sri Lanka has attained low MMR and IMR, neonatal mortality rate had been stagnant over the last few years. Intranatal care and immediate PNC coverage was high. The field public health midwife (PHM) provides at least four home visits to postnatal mothers. Guidelines are available on how to deliver the PNC package of services that includes support for exclusive breastfeeding, micronutrients supplementation for six months, examination of mother and baby to detect any danger signs and referral as required, promotion and support of family planning, and screening for postnatal depression. A very high proportion of deliveries (99.9%) are conducted by skilled birth attendants (SBA) and almost 96% are under the supervision of a specialist obstetrician. The proportion of deliveries in facilities was 99.9% (only 336 home deliveries in 2013). Thus, immediate PNC is provided by trained staff in the health institutions. The partograph is used to monitor the woman for two hours after delivery.

During the antenatal period, the mother has the opportunity to attend with her spouse three parent-crafting classes. In the third class, she is provided knowledge on PNC of the mother and baby and the frequency of visits that the PHM would undertake. The pregnant woman is provided a pregnancy card which explains detailed information on her pregnancy. A copy of this is available with the PHM as well.

<table>
<thead>
<tr>
<th>Postnatal period</th>
<th>By whom</th>
<th>Data on coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1–5 days</td>
<td>Field PHM-First home visit</td>
<td>92.2%</td>
</tr>
<tr>
<td>6–10 days</td>
<td>Field PHM-Second home visit</td>
<td></td>
</tr>
<tr>
<td>14–21 days</td>
<td>Field PHM -third home visit</td>
<td></td>
</tr>
<tr>
<td>28—35 days</td>
<td>Post natal clinic visit – attending officer-Medical officer</td>
<td></td>
</tr>
<tr>
<td>42 days</td>
<td>Field PHM- fourth home visit</td>
<td>76.7%</td>
</tr>
</tbody>
</table>

High-risk babies and pregnancies are provided more frequent home visits.
A PNC package of evidence-based maternal and newborn care interventions was available. A check list is used when the mother is discharged after her delivery from the hospital. Similarly, the PHM who undertakes the home visits also has a checklist for PNC for both mother and baby. Records are maintained for home visits and postnatal clinic visits and the data on indicators is captured by the management information system of the Family Health Bureau.

Field PHM providing PNC is supervised by a senior PHM. Challenges faced are related to improving the quality of care, integration of PNC records into the HMIS, developing a mother-baby tracking system and strengthening care for small and sick newborn care.

**Bhutan**

The experience of a pilot project on PNC delivery was presented. In Bhutan, 37% of deliveries occur at home. Neonatal mortality is 21 per 1000 live births and 80% of neonatal deaths occur in the first three days of life. Hypothermia accounted for 33% of neonatal deaths. PPH was the leading cause of maternal death. The PNC project was implemented in three districts (large population, low MNCH performance) with the objectives: to assess and address maternal and newborn health problems within the first week of postnatal period; to increase PNC coverage and to reduce maternal and neonatal mortality. The plan included undertaking one PNC home visit within three days after birth (for home based deliveries) and 3–6 days after delivery (for facility- based deliveries) by trained basic health workers.

There was an increase in coverage of PNC home visits in the three implementing districts compared to other districts (from 12–75%). A high cost of USD 30 per visit per child of delivering the home visits was largely due to the mountainous terrain and the long distance from health-care centres. Based on the pilot experience, the projected cost for scaling up was about USD 1.13 million per year for providing at least one PNC visit to all home deliveries which could decrease NMR by 30%.

Challenges in the country were to encourage women to deliver at a health facility, strengthen HMIS, address under-reporting and cut down the cost of nationwide scaling up of PNC.
Thailand

The policy of the Government of Thailand has been to provide holistic promotive, preventive and curative care by trained health-care workers to both mother and newborn baby through institutional and community-based services, maintaining equity and accessibility to services. The MCH strategy was implemented in Thailand before 1990. Integrated programme such as safe motherhood hospitals, baby-friendly hospitals are in place. The neonatal disease screening programme is well established with universal screening available for congenital hypothyroidism, phenylketonuria, G-6-PD deficiency, and hearing.

Exclusive breastfeeding is strongly supported by the health-care staff through Baby Friendly Hospital Initiative; promotion of breastfeeding in workplace; Code of Marketing; three months’ maternity leave and promoting breastfeeding in sick babies. Management of newborn and childhood illnesses is part of the curriculum in medical colleges and nursing schools. Some of the constraints identified for comprehensive newborn care include:

- limited expertise in management of very low birth weight babies and extremely low birth weight babies;
- inadequate facilities in neonatal intensive care units (NICU);
- high mortality rates in cyanotic heart diseases;
- high mortality and morbidity in birth asphyxia; and
- insufficient number of paediatric surgeons.

Future plans are to:

- develop a community health worker package;
- develop a manual for training breastfeeding experts;
- develop a manual for assessment of family love bonding hospitals;
- home-based newborn care package and sick child package;
Every new-born action plan and postnatal care for mother and newborn

- develop manuals for health volunteers on maternal and child health;
- strengthen M & E system and establish a management information system; and
- capacity building of MCH workers.

**Indonesia**

The policy of the Government of Indonesia has been to provide MCH including care for newborns free of charge. MCH services are planned and implemented in collaboration with several related programmes like immunization, diarrhoea, malaria, nutrition, maternal health and reproductive health, as well as with other sectors, professional bodies and academia. Use of the MCH Handbook since 2004 had helped in implementing services with uniform practices. Guidelines for health workers and family are available to ensure the standard of maternal and child health care.

The handbook has adopted a comprehensive approach for maternal and child health within the MNCH system. The handbook provides a comprehensive guide to mothers on maternal, newborn and child health, it including advice on regular antenatal visits, nutrition during pregnancy, danger signs, hygiene, preparedness for delivery, postpartum danger signs, and family planning methods. The neonatal health component includes essential newborn care, signs of illness, growth and development monitoring and immunization. The MCH handbook also includes maternal and child health records. MCH handbook is very user-friendly and comprehensive.

Challenges they faced included: incorrect and incomplete records, limited use of handbook – the MCH handbook was used only in the public health services. Efforts have been made to address these challenges by increasing community demand by making them understand the usefulness of the handbook through awareness programmes.
There were good discussions following the experience sharing from these countries. Dr Rajesh Mehta pointed out that postnatal care offered an opportunity to detect birth defects in the newborns and refer them for appropriate management. Another important issue was to provide special care for the babies who had been discharged from newborn care units following treatment of neonatal morbidities, since the mortality in such cases was quite high.

4.9 **Poster session: Postnatal care and referral pathways**

**Postnatal Care**

Countries prepared the posters for sharing the current status of PNC, number of visits, their timing and contents. In addition, professional associations presented the profile of PNC that is followed in the private sector. There were posters on PNC checklists used by health workers in Pakistan and on safe birth checklist being piloted in India.

Common observations from the country posters on PNC services are listed below.

- Countries have taken maternal and newborn care together in the PNC, but synchronization of maternal and newborn issues has not been adequate.
- Timing of postnatal visits varies between countries.
- The service package and contents of PNC are not standardized, vary across countries and are not always evidence-based.
- Thailand offers universal newborn screening for congenital hypothyroidism and phenylketonuria.
- Sri Lanka practises clinical screening of all newborns by paediatricians before the mother and baby are discharged from the hospital after delivery.
- Quality of care and M & E issues is inadequate.
- PNC indicators are not integrated into HMIS.
Professional bodies are supporting the government action plans. There is a plan to map the private sector resources available for maternal and newborn care including PNC, in India.

There was a consensus that the gaps in care around childbirth including immediate postnatal period should be identified and given a high priority in the country ENAP.

**Referral Pathways**

Country posters were presented to provide information on the referral pathways practiced during the PNC. Following are the highlights from these posters:

- All countries have identified referral pathways at various points in service delivery.
- Free of charge ambulance services are provided in several countries.
- Quality of referral has not received adequate attention.
- Referrals of mother and baby together are not emphasized.
- In Sri Lanka, clinical screening of newborns is carried out at postnatal clinics and the referral pathway for morbidities and congenital anomalies is well-defined.
- Thailand has introduced selective metabolic screening for newborns with referral linkages.

### 4.10 Clinical examination of the newborn

Dr Rajesh Mehta, WHO-SEARO informed that Regional Strategic Framework for prevention and control of birth defects has been developed. Based on which, countries have prepared national plans for prevention and control of birth defects. This was in response to the situation that birth defects were becoming responsible for higher proportion of child mortality, as other causes like infections and asphyxia declined, especially in countries that had achieved lower rates of child mortality. The Regional Office also convened expert groups to develop guidelines for newborn screening.
(clinical and metabolic), and for prevention and management of Down’s syndrome and thalassaemia.

Dr Ramesh Agarwal, WHO Collaborative Center (WHOCC) at AIIMS, New Delhi presented guidelines for clinical examination of newborns to be conducted before discharge from hospital after delivery. This was drafted by the Regional expert group convened by the WHOCC with support of WHO-SEARO. The checklist included parameters of clinical wellbeing, abnormalities including birth defects, status of breastfeeding and danger signs.

Some participants expressed concern that the checklist was too comprehensive for application at smaller facilities where only non-specialist health workers were available. It might take quite a bit of time. However, participants from Sri Lanka pointed out that all babies were examined by a paediatrician or a trained medical officer soon after birth and “top to toe” clinical examination was carried out. It was pointed out that the time taken for such a clinical screening reduced as health-care providers gained experience.

In India and Bangladesh, nurses and midwives were taught examination of newborns and are expected to carry out the physical examination of newborns to detect abnormalities as a routine procedure. The proposed standard checklist could be adopted in the current practice.

In Thailand, universal newborn screening was offered for congenital hypothyroidism, phenylketonuria, hearing defects and G-6-P-D deficiency. It was mentioned that although health-care providers had knowledge of common birth defects and their diagnosis, but clinical examination was not universally practiced. A standard guideline would help in improving clinical practice.

Participants agreed to provide suggestions to strengthen the proposed newborn clinical examination guidelines, so that countries could adopt / adapt to suit their needs and implement it.
4.11 Panel discussion: Specific issues of PNC

Dr Severin Xylander, moderated a panel discussion with experts representing the countries and organizations. The discussions focused on the following issues of PNC.

*How long should a newborn stay in a facility after delivery?*

The WHO recommendation is that healthy women and their babies should stay at the health facility at least 24 hours following delivery and should not be discharged earlier than this.

India and Indonesia follow the policy of discharge after 48 hours for normal delivery, while Bangladesh and Sri Lanka discharge after 24 hours in cases of uncomplicated vaginal delivery, and after three days in case of caesarian section. This practice is followed even in the private sector.

Although several countries have the policy of discharging mothers and babies after more than 24 hours of delivery, but mothers usually choose to go back home earlier for various reasons including economic and sociocultural reasons.

The duration of stay in hospital depends on the individual situation, ranging from less than 24 hours to seven days in case of complications. Discharge earlier than 24 hours takes place because of overcrowding in hospitals, non-availability of basic amenities like water, electricity and toilets in the hospitals. There are extraneous factors such as transport facilities, family needs like husband and family needing the woman back for cooking food. Such factors vary from country to country and place to place within the country. The confidence the family has in the services at the facility plays an important role. If the mother and family finds care provided at the institution comfortable and useful, the family would be willing to stay in the hospital for the stipulated time. They should also be properly counseled for the benefits of staying at the health facility for 24 hours. It is observed that health conscious patients do not insist on an early discharge and are likely to stay for the recommended period.
**What kinds of health workers conduct the post-delivery home visits?**

Various types of health workers conduct home visits to provide PNC in the countries of the Region. Countries have different cadres of health workers with different levels of skills.

In Sri Lanka, it is conducted by highly trained public health midwives who have 13 years of school education followed by 18 months of midwifery training. One PHM per 3000 population is the standard coverage, but at times, the population is too large for one person to cover. PHMs are professionally trained, especially in providing promotive, preventive and basic curative and referral services in maternal and child health including family planning methods and have the ability to identify danger signs in the antenatal and postnatal period. They have the knowledge and skills to recognize the danger signs and make timely referrals. Sri Lanka has strategically increased the number of postnatal visits and reduced the number of antenatal home visits, since antenatal clinic visits, on an average, have increased up to five visits during the whole pregnancy period. There are structured guidelines and checklists for PNC visits. Additional visits are provided for the mother and newborn who have had complications.

In Indonesia also, midwives conduct the PNC home visits. It is not a policy but is an accepted standard of care.

In India, trained village level volunteers, ASHA, conduct the postnatal visits. ASHA worker undertakes 6–7 visits per baby and gets an incentive of Rs. 250.00 (about USD 4). Rural areas are better covered than the urban poor living in the slums. Some other countries also use community health workers or volunteers for providing PNC.

**Home visits for PNC to everyone or targeted to high risk groups?**

Targeted or universal visits depend on the country situations. Lack of trained staff may be a constraint for universal PNC and good quality care. In India, a large proportion of deliveries takes place in private sector, and may not get PNC from the public health system. Countries expressed the need to provide PNC universally by trained health workers as per the WHO guidelines.
**PNC at 42 days: where should it take place – at home or health facility?**

This timing coincides with the first vaccination visit for the baby to the health facility. Hence the mother and baby could easily receive PNC in the health facility. In Bangladesh, Bhutan and Nepal, the 42-day visit is to the health facility. In Nepal, postpartum family planning services are also provided at this visit. Training programmes are adapted to that. In Sri Lanka, the PHM is mandated to visit the mother at six weeks and the mother also has the option of attending the postnatal well baby clinic.

**How do you ensure good quality of care around childbirth and postnatal period?**

Ensuring good quality of PNC was reported as a challenge by most countries. In a quality of care survey in seven countries the providers were not doing what they were supposed to do. Professional bodies should act as pressure groups for advocacy for quality care, as they are active in both government and private sectors.

### 4.12 Development partners’ forum

Dr Rajesh Mehta, WHO-SEARO moderated a panel discussion with representatives of partner organizations to share their priority activities in the area of maternal and newborn health.

**USAID**

Dr Lily Kak, Senior Maternal and Newborn Health Adviser, USAID shared that the US government was committed to MNCH. Ending preventable maternal and newborn mortality was one of the approaches that USAID is supporting and for which the President is strongly committed.

A global initiative “Ending preventable child and maternal deaths focusing in 24 high burden countries” had been put in place. USAID had participated in the partners’ forum held in South Africa and supported rolling out ENAP. It is funding several projects, including “Helping Babies Breathe” for neonatal resuscitation, “Every Premie” for addressing care of preterm babies and “Chlorhexidine programme” around the world. USAID also works in promoting public–private partnership.
**MCSP/MCHIP JHPIEGO**

Dr Koki Agarwal, Director, Maternal and Child Health shared that these entities together supported MNCH in 24 countries with a grant of US$ 500 million for five years. They could provide technical assistance to countries in the SEA Region.

**Save the Children**

Mr Stephen Richard Hodgins informed that Save the Children was currently implementing newborn programmes through SNL in Bangladesh, India and Nepal. SC/SNL was funded by USAID and other donors. They would be active partners in the ENAP process in the SEAR countries.

**John Snow International**

Dr Penny Dawson, Senior Technical Adviser shared that JSI was currently working in Bangladesh, India, Myanmar and Nepal in SEAR and several countries in Africa. It provided support to programmes in countries such as the chlorhexidine cord care project in Nepal.

**Japan International Cooperation Agency**

Ms Keiko Osaki, Senior Adviser, shared the work carried out by JICA in Bangladesh, Guatemala, Sudan, Philippines and India in strengthening maternal and child care including training of health-care workers, community mobilization, development of curricula for in-service training, addressing social barriers for access to services and other social determinants, advocacy, introducing information systems.

**Professional associations:**

Dr C P Bansal, representing South Asia Paediatric Association (SAPA), Dr Malik Goonewardene, representing South Asia Confederation of Obstetrics and Gynaecology (SAFOG), Dr Mohammed Shahidullah, representing Federation of Asia Oceana Perinatal Societies (FAOPS) expressed their support to MNCH programmes in the SEAR countries.
The SAPA representative conveyed that country level Paediatrics associations are extending support to ENAP in every country. The SAFOG representative informed that their member organizations in the countries work closely with all stakeholders to support RMNH programmes and focused on training, standards, and quality of care. The FAOPS representative shared that both maternal and newborn health agenda were taken up by its member organizations including obstetricians, paediatricians and neonatologists in 22 countries including countries of the SEA Region.

4.13 Resource materials for maternal and newborn care

Ms Fran McConville, WHO-HQ shared information on various WHO guidelines and tools related to newborn health and PNC. Partner organizations also displayed mannequins for training and other training and IEC materials.

**Strengthening education and training for newborn care:**

Dr Ashok Deorari, WHO Collaborating Center, AIIMS, New Delhi presented capacity building material of doctors and nurses to manage sick newborns. He informed that on-line training package has been developed. This uses a combination of self-reading materials and video-clips available on website or DVD and online mentoring by experts through email-chats. Standard treatment protocols (STPs) for managing common newborn conditions have been developed based on WHO evidence-based guidelines. These STPs are used as job-aids by the trained doctors and nurses and have also been made available as mobile apps for android and iOS mobile phones.

4.14 Revisiting evidence on newer newborn health interventions

Dr Kishwar Azad, Project Director – Perinatal Care Project, Bangladesh provided information on use of antenatal corticosteroids for management of preterm labour published recently in the Lancet. The cluster randomized
trial by Fernando Althabe and colleagues* that the use of antenatal corticosteroid treatment for preterm labour in low-resource settings, was associated with an increase in overall newborn mortality of 12%, perinatal mortality of 11%, and risk of suspected maternal infection of 45%. She also conveyed that the investigators had noted no significant effect on survival of preterm infants. She advised that caution must be exercised while introducing this intervention at a large scale public health programmes in low resource settings.

Dr Azad extended a similar advice for caution against the use of domiciliary simplified antibiotic treatment (oral amoxicillin and two doses of Inj gentamicin) for newborn sepsis. She emphasized that the clinical experience suggests that survival of newborns with septicemia may also be determined by good quality supportive treatment like homeostasis, oxygenation, management of hypothermia and hypoglycemia, in addition to antibiotics, that is possible only in hospitals.

It was also discussed that Nepal government was reconsidering the role of female community health volunteers in delivering community- based newborn care, following an evaluation that revealed some ineffective practices of such volunteers even after training.

The discussions emphasized that due diligence was required to evaluate the evidence in favour of public health interventions before adopting these for large scale implementation, so that no harm is done to newborns or their mothers.

5. **ENAP and PNC country action plans: from discussion to action**

- All countries have initiated the process of drafting ENAP or strengthening newborn plans within the RMNCAH programmes. At present, India is the first country to have endorsed and disseminated national ENAP. Countries are committed to endorsement of ENAP by ministries of health by the end of 2015. Countries requested technical assistance from WHO and UNICEF for costing of national ENAP.

- All countries are implementing PNC as per their own protocols. They would like to adapt new WHO PNC guidelines.

- While PNC visits are implemented nationwide, most countries reported that the coverage of PNC for mothers and newborn need to be enhanced through improved services at health facilities and linking community care to the health facilities.

- Low demand and inadequate health seeking behavior were commonly reported as bottlenecks to the scale-up of ENAP and PNC services. Dissemination of culturally tailored messages and involvement of women, families and the community in awareness campaigns are necessary to increase take up of newborn care and PNC.

- PNC visits should be linked with existing MNCH interventions including EPI to enhance their effective integration. Outreach for EPI could be a window of opportunity that service providers could tap into contact postnatal mothers for PNC for mothers and newborns.

- Newborn and PNC indicators are incorporated in HMIS to a varying degree. Countries committed to integrate core newborn and PNC indicators in their respective HMIS to appropriately measure and monitor service provision and its impact.

- Logistic and supply systems need to be strengthened to ensure an effective implementation of ENAP and PNC interventions.
6. **Recommendations**

(1) By June 2015, led by the national and subnational governments, with technical and financial support from partners and donors, all countries in South Asia, East Asia and the Pacific will have national/subnational Every Newborn Action Plans (ENAPs) and/or strengthened the newborn elements of their respective maternal, newborn and child health strategies and plans endorsed by respective Ministries of Health, followed by costing of the national plans by Dec 2015.

(2) All countries will develop plans to increase the access to and improve the quality of postnatal care (PNC) for mothers and newborns, following the principles of universal health coverage and equity; the WHO PNC guidelines should serve as minimum standard, and PNC improvement plans should be included in the national ENAP plans to be endorsed by June 2015.

(3) Countries should strengthen monitoring and evaluation of maternal-newborn health services, including introducing/strengthening quality improvement process for maternal-newborn care and perinatal death audits.

(4) Countries and partners should take action to improve the metrics of postnatal care by:

   (a) Advocating that the current widely used standard questionnaires for household surveys such as DHS and MICS align with WHO’s recommendations on postnatal care;

   (b) Ensuring that the key newborn and PNC Indicators are integrated in the current DHS/HMIS in line with the global ENAP metrics that is under development.

(5) WHO and UNICEF to support a joint stock taking of ENAP process and its roll out in countries by the end of 2015; to prepare an update on progress and identify the needs of
individual countries in terms of technical assistance; and support for planning and budgeting at national/sub-national levels.

(6) WHO to finalize and release updated guidelines on interventions to improve preterm birth outcomes, including the use of antenatal corticosteroids for premature labour and for kangaroo mother care; and recommendations on the use of chlorhexidine for cord care in high mortality settings should be updated as new evidence arises.

(7) WHO, in consultation with countries and collaborating centres, should provide more detailed guidance on the content of postnatal care contacts in the form of model standardized checklists that could be adapted to country needs.

(8) WHO, UNICEF and Partners should support countries for further generation and strengthening of evidence in some of the 17 priority areas identified as “Research Gap” by the PNC guidelines group.
Address by Dr Poonam Khetrapal Singh, Regional Director WHO South-East Asia

Distinguished participants, dear colleagues, ladies and gentlemen,

With only 415 days remaining to achieve MDGs, it is certainly unacceptable to note that an estimated 1.7 million deaths occurred in the under-five age group, with about 0.9 million newborn deaths in 2013. We acknowledge the decline in child mortality by more than 50% in the South-East Asia Region between 1990 and 2012 but recognize that newborn mortality has declined at a slower rate than under-five mortality. Maternal mortality ratio (MMR) has declined by more than half between 1990 and 2010 and is one of the most significant achievements over the past decade in the South-East Asia Region, but still 76,000 mothers died as a result of pregnancy and childbirth in 2012 in our Region.

In April 2014, the delegates from ministries of health and partner development agencies had raised concern about high number of preventable maternal, newborn and child deaths in the Region during the “Regional meeting on 2015 and beyond: the unfinished agenda of MDG4 and 5 organized by the WHO Regional Office. While overall achievements in relation to MDGs 4 and 5 have been positive, these are not uniform and progress is uneven both across the Region and within individual countries. Therefore, it is fair to state that maternal and neonatal survival is an unfinished agenda. This meeting, therefore, was an important milestone and was organized under the my flagship project on ‘Ending preventable maternal, newborn and child deaths in South-East Asia Region’ that has received unequivocal support from the Honourable Ministers of Health from Member States and that I personally consider this as an area of immediate and urgent focus.

The evidence indicates that most of the maternal and newborn deaths occur around the time of childbirth or within first few days after that. Many of these deaths can be prevented by interventions that are well known. Timely availability of good quality care during this period is of extreme importance and can result in significant reduction in maternal and newborn mortality and morbidity as well as prevention of stillbirths. This clearly emphasizes the need for a continuum of care.
to deliver evidence-based interventions for maternal care during pregnancy and child birth as well as newborn care.

Ladies and gentlemen,

You are aware that, in response to this situation, the Sixty-seventh World Health Assembly in May 2014 has adopted global Every Newborn Action Plan (ENAP) to ensure triple gains – reduction in maternal mortality, stillbirths and newborn mortality. Also, the efforts to ending preventable maternal mortality has brought the convergence of these two approaches in the form of ‘every mother every new-born’.

In preparation for the ENAP, several countries in the Region had participated in bottleneck analysis to identify challenges and gaps in the continuum of care that result in preventable maternal and newborn deaths. At present, UN agencies and partners are supporting Bangladesh, India, Indonesia, Myanmar and Nepal to develop nation ENAPs in line with the global action plan. Also, through a consultative process with Member countries, targets for ending preventable maternal mortality by 2030 have been established and countries are gearing for refining their strategies to achieve them.

In addition, WHO has recently published guidance on postnatal care visits for mothers and new-born. The days and weeks following the childbirth – the postnatal period – is a critical phase in the lives of the mothers and newborn babies. Most maternal and newborn deaths occur during this time. Yet, this is the most neglected period for the provision of quality care. Lack of appropriate care during this period could result in significant ill-health and even death. Rates for provision of skilled care are lower after childbirth when compared to rates before and during childbirth. This provides the basis for strengthening postnatal care, whose coverage has been reported to be low in many countries of the Region. As mentioned above, the postnatal period, especially during the first week of life, is a particularly vulnerable time period.

I am pleased to note that this regional meeting will review country progress on the Every Newborn Action Plan (ENAP) and WHO Postnatal Care Guidelines will be discussed and disseminated. The meeting also provides an opportunity to develop strategies and action plans for ensuring higher coverage with newborn and related maternal interventions including postnatal care in the countries of the Region.
Advocacy has a key role to play in mobilizing political will and resources for ending preventable maternal and newborn deaths. For this, we recognize that many different stakeholders must come together under the leadership of national governments for ensuring that every pregnancy is wanted and healthy, every pregnant woman survives, and every newborn survives and makes a healthy start in life to become a thriving child who can fulfil his/her full development potential.

WHO, along with UN agencies and other partners have constantly worked with ministries of health for accelerating progress towards achieving MDGs 4 and 5 and progressing beyond. I must reiterate the commitment expressed by WHO, UNICEF and UNFPA at the highest level in the Region in the first ever regional Joint UN Statement on Women’s and Children’s Health that was released during the Regional Meeting in Kathmandu earlier this year. The statement emphasized the need for expanding coverage of evidence-based interventions along the continuum of care; reaching the unreached populations; improving the quality of care at all levels of care; ensuring efficient use of precious resources and promoting innovations; addressing social determinants and upholding the national commitments on accountability for tracking results and resources towards women’s and children’s health.

I firmly believe in working together and partnerships as these have succeeded in drawing attention to the problems as well as in generating new resources for such areas in health. Such platforms also raise the visibility of the health agenda and provided common platforms for working together by combining the strengths of public and non-state organizations and the civil society. I also acknowledge the presence and participation of several development and donor partners such as USAID and JICA and international agencies, Save the Children, Jhpiego and several others. These collaborations will help expand interventions in a rapid, flexible and focused way; mobilize new and significant resources; develop and introduce innovative technological solutions where public, academic and market forces fail to mobilize the necessary research and development.

Ladies and gentlemen,

Let me thank the Government of Sri Lanka for collaboration in hosting this important meeting and all of you for your participation. I am sure the presence of senior-level representatives from national governments and partners will ensure the achievement of the objectives of the meeting. I sincerely hope that the deliberations are able to help forge accelerated actions in countries to improve the health of women and newborns in our Region.
Annex 2

Status of newborn health programmes in countries

Bangladesh

National ENAP draft has been prepared. A detailed scale-up plan for the ENAP and costing will be undertaken soon. ENAP will be finalized, endorsed and launched in 2015. This will be adequately reflected in the next phase of national health sector plan due from 2016.

Process and outcome indicators for newborn health will be identified in line with global indicators and incorporated in routine HMIS as well as in national health surveys.

National quality improvement and accountability framework will be finalized and operationalized to ensure effective coverage of priority MNH services in public and private sectors. Perinatal audits have been initiated in selected areas.

Postnatal guidelines will be strengthened by adaptation of WHO guidelines. Bangladesh will need support to develop and cost the ENAP, and develop the national monitoring and evaluation framework.

Bhutan

The ENAP is not yet developed, but there are plans to develop one.

Perinatal audit system is in place as a move towards improving quality of care.

PNC protocol will be revised, taking into consideration the WHO guidelines. The main constraints for PNC include lack of manpower, poor health-seeking behaviours, long distance travel to health centres, and cultural beliefs. Inadequate supplies of equipment such as baby warmers, incubators etc is also a constraint.

Demand generation activities as well as new indenting procurement system would also be included in the new plan.
Technical assistance is needed for developing ENAP, revising the essential newborn care guidelines with additions such as KMC, quality improvement and developing M & E framework.

**Democratic People's Republic of Korea**

ENAP would be developed in 2015 taking into account the renewal of national Medium Term Strategic Plan 2010–2015. There was no need to have sub-national plans. Evidence-based interventions for newborn care included in Improving maternal and child health project (Republic of Korea funded project) will be included in the ENAP. Clinical guidelines on CEmONC and BEmONC, Guidelines on RH, Postpartum haemorrhage, pre-eclampsia and safe abortion were developed in 2010. Newborn indicators are not included in the HMIS. Perinatal audits are taking place but need strengthening.

Absence of guidelines on PNC, capacity of doctors, lack of essential drugs, timely access to referral units due to transport problems are some of the bottlenecks.

Plans for 2015 are as follows:

- training of health workers on intensive newborn care at central and provincial hospitals;
- training of household doctors in essential newborn care and PNC;
- development of guidelines on newborn care;
- strengthening of referral systems (early referral for complicated delivery and low birth weight); and
- strengthening health facilities by providing medical equipment and supplies for neonatal health at different levels.

Technical assistance is required for developing guidelines, capacity-building, and developing M&E framework

**India**

ENAP has been developed with the participation of several stakeholders and would be costed shortly. There is need to have sub-national ENAP. Three out of the four
newer newborn specific interventions (except chlorhexidine application on cord) have been included in the ENAP package.

Currently, newborn specific indicators are included in HMIS and priority will be given to improve the quality of data; however, proportion of newborn resuscitated is not included in MIS.

The Maternal and child death reviews are included in the perinatal audits. Stillbirth reviews would be added in future.

The Government of India has established a quality assurance cell in every state with QA teams to ensure the improvement of quality of care including newborn care. Accreditation of hospitals is voluntary, at present. Quality standards for district hospitals and sub-district health facilities have been developed that would be implemented soon. Clinical guidelines are yet to be developed.

Technical assistance is required to strengthen the protocols for quality PNC and monitoring and evaluation.

**Indonesia**

ENAP has been developed, but is yet to be costed. Sub-national plans for provinces are being developed. All newborn specific interventions have been included in existing service/care packages.

Monitoring includes post natal visits, skilled care at birth, number of facility births and exclusive breastfeeding. M & E framework is being strengthened.

Perinatal audits are taking place and guidelines are in place. Standards and criteria have been identified for hospital accreditation.

- Plans for 2015 are as follows:
  - costing of the national action plans for newborn and child health;
  - integration of the newborn action plan into the next maternal action plan 2015–2030
  - facilitation of the development of sub-national plans in all districts in the next five years; and
  - adapting WHO guidelines for PNC.
Maldives

At present, there is no plan for ENAP and newborn health is covered in the national reproductive health strategy. Newborn specific indicators are included in the HMIS. Perinatal audits had been initiated, but needed strengthening.

National guidelines for sick newborn care and IMCI would be developed and endorsed. Thereafter, newborn care training would commence.

National PNC guidelines would be adapted, based on WHO guidelines and translated into the local language.

Development of 19 newborn stabilization units and 136 newborn corners has been planned. It is planned to establish a national hospital-based birth defects surveillance system.

Myanmar

National newborn and child health plan has been drafted and there is no plan for developing sub-national plans. The plan is not yet costed, but indicative budget was available. All newborn specific interventions have been included except KMC and antenatal corticosteroids for preterm labour.

Newborn specific indicators are not included in the HMIS. M&E framework is being developed. Perinatal audits are carried out in some hospitals. There is no health institution accreditation system at present.

At the moment, there are no specific guidelines for PNC but plans are there to develop one. Lack of trained staff is also a constraint.

Scaling up neonatal resuscitation (helping baby breathe) and care of preterm/LBW (KMC including breastfeeding support) packages would be developed soon. Referral pathways would be identified and established.

Technical assistance is required to cost the newborn and child health action plans and quality improvement.
Nepal

National ENAP has been drafted but is yet to be finalized. After its endorsement, costing would be done. Sub-national plans are not considered necessary. However, in 2015, districts would develop district-specific implementation plans in line with the national ENAP.

Interventions that need to be initiated are KMC and antenatal corticosteroids (to be reviewed in light of new global evidence).

The following four indicators would be included in the new HMIS:

- still births rate
- neonatal mortality rate
- antenatal corticosteroid use (in case implemented)
- newborn resuscitation.

A process for perinatal audits with maternal–perinatal death reviews has been established in 36 hospitals. Maternal death surveillance and response guidelines have been drafted and a pilot project for two districts has been planned.

There is accreditation system for private hospitals, but not implemented properly. It is planned to strengthen the national steering committee on QI and, in due course, assess all hospitals for accreditation on newborn and PNC.

An M & E framework is already available, but it would be strengthened with the inclusion of ENAP core indicators.

A representative national survey would be conducted to investigate the causes of maternal, perinatal and neonatal deaths.

KMC guidelines would be developed and PNC guidelines revised in line with the WHO guidelines. A workshop would be organized to share experiences in the use of antenatal corticosteroid and guidelines developed subsequently. Standard treatment protocols for newborn care would also be prepared to improve the quality of care.
Sri Lanka

ENAP has not yet been developed. Newborn health is included in the existing MNH strategic Plan (2012–2016). This would be updated to include specific ENAP. Thereafter, ENAP would be costed. All evidence-based interventions have been included. Pulse oximetry screening for newborn examination to detect congenital heart defects would be included. The plan is to improve effective coverage and ensure equity.

Newborn specific indicators are being included into the eIMMR – the electronic data system for indoor care in hospitals. Perinatal audits are conducted in 68 out of the 72 health-care institutions in the country. QA system has been established; clinical quality assurance would be established soon.

The following obstetric guidelines were available:

- management of labour
- management of hypertensive disease during pregnancy
- management of diabetes in pregnancy
- management of postpartum haemorrhage.

Obstetric standards for ANC, intranatal care and PNC are being developed. Newborn care standards are available. Newborn guidelines are being developed for institutional and field care. It is planned to include newborn specific indicators of the ENAP in the routine M & E system.

Research priorities:

- detailed analysis of etiology of deaths due to asphyxia;
- etiology of birth defects;
- quality of institutional and field PNC;
- long-term outcome of surviving preterm babies.

Challenges included implementation of monitoring newborn checklist in the labour room and referral of high risk mothers and newborns to the field midwife after discharge from hospital for comprehensive care.
Future plans include provision of a structured model/tools for care for high-risk mothers and newborns and establishment of a quality assurance system for maternal and neonatal health, improving and scale up Feto – infant mortality surveillance, and scaling up birth defects surveillance.

Technical assistance is needed for a BNA for newborn health, adoption of WHO quality assessment tools and framework, pilot test and incorporation of clinical quality assurance to the existing QA system.

**Thailand**

Thailand has achieved low mortality rates and would like to further strengthen the MNH services in 2015–2016.

Coverage and quality of ANC would be further improved. Guidelines for management of labour would be disseminated and implemented and a standard check-list used for monitoring. Training of doctors and nurses in newborn care would be strengthened through pre-service and in-service programmes.

A national database and registry would be established for newborn health, initially in selected hospitals based on the South-East Asia Region-Newborn and Birth Defects database developed by WHO-SEARO. Birth defects surveillance mechanism will be strengthened in 2015–2016 with assistance from WHO-SEARO.

**Timor-Leste**

A costed ENAP is available within the national reproductive, maternal, newborn, child and adolescent health strategy and the operational plan. Sub-national plans are not required. All newborn specific interventions are included in the care packages.

Newborn-specific indicators are included in the national M & E framework. Guidelines, reporting forms; and SMS-based reporting system had been developed. Implementation of updated HMIS includes a) training of care-providers and HMIS focal points; b) IT equipment procurement; c) printing and distribution of forms; and d) periodic reviews and evaluation.
Perinatal audits (maternal and child death reviews) have been initiated and personnel would be trained. An accreditation system would be established. Shortage of midwives and inadequate skills of medical officers in newborn care are the main constraints.

Technical assistance is needed for development of a newborn and child health policy, operational guidelines, a communication strategy, capacity for perinatal audits, and training in newborn care.
Annex 3

Agenda

(1) Opening

(2) Setting the scene:
   (a) Global and regional situation and recent developments
   (b) Bottleneck analysis and metrics for ENAP

(3) Updates: ENAP and innovations from selected countries

(4) Group discussions: Sharing of experiences and lessons learnt.

(5) WHO postnatal care guidelines: highlights and issues of implementation

(6) Existing postnatal care programme

(7) Poster session: Progress in ENAP and PNC

(8) Panel discussion: postnatal care practices

(9) Partners’ forum: current priorities for reduction in newborn mortality

(10) Group discussion: bottlenecks in postnatal care and solutions

(11) Technical updates: newborn screening and clinical examination, new evidence on antenatal corticosteroids for preterm labour

(12) Action plans for ENAP and PNC
## Annex 4

### List of participants

<table>
<thead>
<tr>
<th>Member States</th>
<th>Participants</th>
</tr>
</thead>
</table>
| **Bangladesh** | Dr Nasiruddin Mahmood  
Associate Professor  
Department of Paediatrics  
CMCH Dhaka  
Dr Md. Alamgir Ahmed  
DD & PM (Maternal and Newborn Health)  
Directorate General Health Services Dhaka  
Dr Altaf Hossain  
Programme Manager  
Directorate General Health Services |
| **Bhutan** | Ms Ugyen Zangmo  
Senior Programme Officer  
Reproductive Health Programme  
Department of Public Health  
Ministry of Health Thimphu  
Dr Tashi Choden  
Pediatrician  
Jigme Dorji Wangchuk National Referral Hospital  
Ministry of Health Thimphu |
| **DPR Korea** | Dr So Won Gun  
National Programme Officer for Women’s Health  
Ministry of Public Health Pyongyang |
| **India** | Dr Yu Hyang Suk  
Doctor of Women’s Health Management Section  
Pyongyang Maternity Hospital Pyongyang  
Ms Ri Hye Ran  
Interpreter  
Ministry of Public Health Official Pyongyang  
Dr Rakesh Kumar  
Joint Secretary  
Ministry of Health and Family Welfare New Delhi India  
Dr Kamala Kannan Ellangovan  
Secretary  
Department of Health & Family Welfare Government of Kerala Secretariat Annexe Thiruananthapuram-1 Kerala  
Dr Palakkad K Prabhakar  
Deputy Commissioner (Child Health)  
Department of Family Welfare Ministry of Health and Family Welfare New Delhi  
Mr Naveen Jain  
Mission Director  
National Rural Health Mission Jaipur, Rajasthan  
Dr Sushma Nangia  
Professor, Neonatology Division Lady Hardinge Medical College and Kalawati Saran Children’s Hospital New Delhi |

---

Report of a regional meeting
Indonesia

Dr Lovely Daisy
Head,
Section of Standardization
Subdirectorat of Child Survival,
Directorate of Child Health
Ministry of Health
Jakarta

Dr Rima Damayanti
Staff in Subdirectorat of Maternal Health
with Pregnancy Complications,
Directorate of Maternal Health
Ministry of Health
Jakarta

Dr Rosalina Dewi Roeslani, Sp.AK
Staff of Perinatology Division,
Faculty of Medicine
University of Indonesia
Cipto Mangunkusumo Hospital
Jakarta

Nepal

Dr Pushpa Chaudhary
Director
Family Health Division
DHS
Kathmandu

Dr Krishna Prasad Paudel
Chief Consultant Paediatrician
Kanti Childrens’ Hospital
Kathmandu

Myanmar

Dr (Mrs) Hnin Hnin Lwin
Assistant Director
Maternal and Reproductive Health
Department of Health
Naypyitaw

Dr (Mrs) Aye Aye Thin
Senior Consultant (Neonate)
Mandalay Children Hospital
Mandalay

Dr Khaing Zan Mya (Mrs)
Senior Consultant
Obstetrics and Gynaecology
Women and Children Hospital
South Okkalapa
Yangon

Dr Myint Myint Than
Director
Programm Manager (WCHD)-
Department of Health
Yangon

Maldives

Dr Mariyam Jenyfa
Senior Medical Officer
Health Protection Agency
Male’
Republic of Maldives

Ms Hafsa Ali
Deputy Director of Nursing
Indira Gandhi Memorial Hospital
Male

Sri Lanka

Dr Nilmini Hemachandra
Consultant Community Physician
National Program Manager for Medical Care
Family Health Bureau
Ministry of Health
Colombo

Dr Dhammika Rowel
Consultant Community Physician
National Programme Manager for Intranatal care for Newborn Care
Family Health Bureau
Ministry of Health
Colombo
Dr Dulani Gunasekara  
Associate Professor  
University of Sri Jayayuudinupune  
Kottei  

Thailand  
Dr Uraiwan Chotigeat  
Medical Officer, Advisory Level  
Queen Sirikit National Institute of Child Health  
Department of Medical Services  
Ministry of Public Health  
Bangkok  

Mrs Chaweewan Tonputsa  
Public Health Technical Officer  
Professional Level  
Bureau of Health Promotion  
Department of Health  
Ministry of Public Health  
Bangkok  

Timor-Leste  
Dra Benedita Marques de Araujo  
Child Health Programme Officer  
Ministry of Health  
Dili  

Ms Florenca Corte-Real Tilman  
Maternal Health Program Manager  
Ministry of Health  
Dili  

WHO collaborating centre  
Dr Ramesh Agarwal  
Associate Professor  
Division of Neonatology  
Department of Paediatrics  
All India Institute of Medical Sciences  
New Delhi  

Dr Lakhbir Dhaliwal  
Director, WHO-Collaborating Centre for Human Reproduction at the Department of Obstetrics and Gynaecology  
Postgraduate Institute of Medical Education and Research (PGIMER)  
Chandigarh, India  

Dr B S Garg  
Dean  
Mahatma Gandhi Institute of Medical Sciences  
Head, WHO Collaborating Centre for Research & Training in Community Based Maternal, Newborn and Child Health  
Wardha, Maharashtra, India  

Professor Surasak Angsuwathan  
Siriraj Reproductive Health Research Centre  
Department of Obstetrics and Gynaecology  
Faculty of Medicine  
Mahidol University  
Bangkok, Thailand  

Resource persons  
Professor Kishwar Azad  
Project Director – Perinatal Care Project  
Bangladesh Institute of Research and Rehabilitation in Diabetes, Endocrine and Metabolic Disorders (BIRDEM)  
Dhaka  
Bangladesh  

Dr Ashok Deorari  
Professor  
Division of Neonatology  
Department of Paediatrics  
All India Institute of Medical Sciences  
New Delhi, India  

Dr Ari Kusuma Januarto  
Secretary- General  
Perkumpulan Obstreti Dan Ginekologi Indonesia (Indonesian Society of Obstetrics & Gynaecology)  
Central Jakarta  
Indonesia
Every new-born action plan and postnatal care for mother and newborn

Dr Laxman Shrestha  
Professor of Paediatrics  
President  
Nepal Paediatric Society  
Kathmandu, Nepal

Dr Sujeewa Amarasena  
President  
Sri Lanka College of Paediatricians  
Colombo, Sri Lanka

Professional associations

Dr Iffat Ara  
Professor of Obstetrics and Gynaecology  
Dhaka Medical College and Hospital  
Dhaka, Bangladesh

Professor Mohammad Shahidullah  
President  
Bangladesh Neonatal Forum (BNF)  
Pro-Vice Chancellor (Administration)  
Dhaka, Bangladesh

Ms Halima Akhter  
President  
Bangladesh Midwifery Society  
Lecturer,  
Dhaka Nursing College  
Dhaka, Bangladesh

Dr KP Tshering  
President  
University of Medical Sciences  
Thimpu, Bhutan

Dr C.P. Bansal  
President  
South Asia Pediatric Association;  
Gwalior, Madhya Pradesh, India

Dr Ajay Gambhir  
President-Elect  
National Neonatology Forum of India  
New Delhi, India

Dr Sadhana Gupta  
Vice President Elect 2016  
Federation of Obstetric and Gynaecological Societies of India  
Mumbai, Maharashtra  
India

Ms Sureka Sama  
Secretary  
Indian Nursing Council  
Combined Council Building  
New Delhi

Dr Nurdadi Saleh  
President  
Perkumpulan Obstetri Dan Ginekologi Indonesia (Indonesian Society of Obstetrics & Gynecology)  
Central Jakarta  
Indonesia

Dr Emi Nurjasmi, MKes  
President of The Indonesian Midwives Association (IBI)  
Jakarta, Indonesia

Dr Muhammad Baharuddin, Sp.OG  
MARS Director of Budi Kemuliaan Hospital  
Jakarta, Indonesia

Professor Mya Thi Da  
Head  
Department of Obstetrics and Gynaecology  
University of Medicine  
Yangon, Myanmar

Professor Dr Nang Htawn Hla  
President,  
Myanmar Nurses and Midwife Association  
Yangon, Myanmar

Dr Aruna Karki  
Vice President  
Nepal Society of Obstetricians and Gynaecologists (NESOG)  
C/o Maternity Hospital, Thapathali  
Kathmandu, Nepal
Ms Kiran Bajracharya  
President  
Midwifery Society of Nepal (MIDSON)  
Kathmandu, Nepal  

Dr Ramya Pathiraja  
Secretary  
Sri Lanka College of Obstetricians and Gynaecologists  
Colombo, Sri Lanka  

Professor Malik Goonewardene  
Vice President  
South Asian Federation of Obstetrics and Gynaecology  
Colombo, Sri Lanka  

Development partners  

**JHPIEGO, Baltimore, Maryland, USA**  
Dr Koki Agarwal  
Director, Maternal and Child Health Integrated Programme (MCHIP)  
JHPIEGO  

Dr Neena Khadka  
Newborn Team Leader, Maternal and Child Survival Programme (USAID)  

**JICA, Tokyo, Japan**  
Ms Keiko Osaki  
Senior Adviser  
Japan International Cooperation Agency (JICA)  
Human Development Department  

Ms Omachi Mayumi  
Human Development Department  
Japan International Cooperation Agency  

**John Snow Inc., Kathmandu, Nepal**  
Ms Leela Kumari Khanal  
Project Manager  
Cord Care Project  

Dr Penny Dowson  
Sr Technical Advisor  

**UNICEF**  
Dr Deepika Attygale  
MNCH Specialist,  
UNICEF Country Office  
Kabul, Afghanistan  

Dr Lianne Kuppens  
Chief of Health and Nutrition  
UNICEF Country Office  
Dhaka, Bangladesh  

Dr Ziaul Matin  
MNCH Specialist,  
Health Section,  
UNICEF Country Office  
Dhaka, Bangladesh  

Mr Chandralal Mongar  
Health and Nutrition Officer  
UNICEF Country Office  
Thimphu, Bhutan  

Dr Mohammad Younus  
Health Specialist  
UNICEF Country Office  
Pyongyang  
DPR Korea  

Dr Ajay Trakroo  
Health Specialist  
UNICEF  
Raipur, Chhattisgarh  
India  

Dr Karina Widowati  
UNICEF Country Office  
Jakarta, Indonesia  

Dr Muthu Maharajan  
UNICEF Country Office  
Yangon, Myanmar  

Dr. Hendrikus Raaijmakers  
Chief of Health  
UNICEF  
Kathmandu, Nepal
Every new-born action plan and postnatal care for mother and newborn

Dr Asha Pun
MNCH Specialist,
UNICEF
Kathmandu, Nepal

Dr Douglas Noble
Regional Health Adviser
UNICEF Regional Office for South Asia
Kathmandu, Nepal

Dr Nuzhat Rafique
Regional Maternal Newborn Health Specialist
United Nations Children's Fund
Regional Office for South Asia (ROSA), Nepal, Kathmandu

Ms Lalita Gurung
Programme Assistant
UNICEF Regional Office for South Asia
Kathmandu, Nepal

Mr Kazutaka Sekine
Health Officer
Health Section
UNICEF
Kathmandu, Nepal

Dr Samia Rizwan
MNCH Specialist,
UNICEF Country Office
Islamabad, Pakistan

Dr Nadarajah Sutharman
Health & Nutrition Officer,
UNICEF Country Office
Colombo, Sri Lanka

Dr Nabila Zaka
Maternal and Child Health Specialist
Young Survival & Development Section(YCSD)
UNICEF East Asia Pacific Regional Office, EAPRO
Bangkok 10200
Thailand

USAID
Dr Lily Kak
Senior Maternal & Newborn Health Adviser
USAID Global Health
Washington, DC
USA

Save the children
Dr Sayed Rubayet
Project Director
Saving Newborn Lives
Dhaka, Bangladesh

Dr Michael Foley
Saving Newborn Lives
Dhaka, Bangladesh

Dr Bharat Ban
National Programme Manager
Save the Children
Saving Newborn Lives
Kathmandu, Nepal

Mr Stephen Richard Hodgins
Save the Children/US
Washington DC, USA

Observers
Dr Chithramalee de Silva
Deputy Director,
Maternal Child Health
Family Health Bureau
Colombo, Sri Lanka

Dr Kapila Jayarathne
Consultant Community Physician
National Programme Manager
Maternal Morbidity and Morbidity Surveillance
Family Health Bureau
Colombo, Sri Lanka

Dr Nirosha Lansakara
Consultant Community Physician
Planning, Monitoring and Evolution
Family Health Bureau
Ministry of Health
Colombo, Sri Lanka
Report of a regional meeting

Dr Nalin Gamaathige
Neonatologist
De Soyza Maternity Hospital
Colombo, Sri Lanka

Dr Sandiya Bandara
Neonatologist Teaching Hospital
Peradeniya
Colombo, Sri Lanka

Dr R. D. S. Ranasinghe
Consultant Community Physician
Sabaragamuwa Province
Sabaragamuwa
Sri Lanka

Dr U.D.P. Rathnasiri
Consultant Obstetrician and Gynaecologist
Colombo, Sri Lanka

Dr Gamini Jayakody
Consultant Community Physician
Central Province
Kandy, Sri Lanka

WHO Country Office
Dr Mamadou Hady Diallo
Medical Officer-MCH
WHO Country Office
Dhaka, Bangladesh

Mr Kinley Dorji
National Programme Officer
WHO Country Office, Bhutan
Thimphu, Bhutan

Dr Long Chhun
Medical Officer
WHO Country Office
Jakarta, Indonesia

Dr Meera Thapa Upadhyay
National Programme Officer
WHO Country Office
Kathmandu, Nepal

Dr Arturo Pesigan
Ag. WHO Representative
Colombo, Sri Lanka

Dr Anoma Jayathilake
National Programme Officer (MNCAH)
WHO Country Office, Sri Lanka

Dr Domingas Angela Da Silva Sarmento
National Programme Officer
WHO Country Office, Dili, Timor-Leste

WHO Headquarters, Geneva, Switzerland
Ms Frances Emma Mcconville
Technical Officer, Midwifery
Department of Maternal, Newborn, Child and Adolescent Health

Dr Severin Ritter Von Xylander
Medical Officer
Department of Maternal, Newborn, Child and Adolescent Health

WHO Regional Office for South East Asia, New Delhi, India
Dr Martin Weber
Regional Adviser
Maternal and Reproductive Health

Dr Rajesh Mehta
Medical Officer, Child and Adolescent Health
## Annex 5

### List of posters from countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Title</th>
</tr>
</thead>
</table>
| **Bangladesh** | 1. Country updates of Newborn Action Plan – Bangladesh experiences of quality improvement for MNCH services in Bangladesh  
2. Country update on postnatal care  
3. Experiences of scaling up SCANU with Technical support of UNICEF  
4. Measuring the quality and coverage of newborn health indicators through HMIS  
5. Maternal and perinatal death review (MPDR): an effective approach in planning, monitoring for quality maternal and neonatal health services through strengthening of health system |
| **Bhutan** | 1. Update on postnatal care for Bhutan  
2. Mother and child health handbook |
| **India** | 6. National collaborative centre for facility-based newborn care at Kalawati Saran Children’s Hospital & LHMC, New Delhi  
7. Role of Indian Nursing Council in promoting ENAP/INAP and postnatal care,  
8. Country update on postnatal care  
9. Mapping of private health facility and role of NNF (PPP)  
10. Postnatal care  
11. *Rashtriya Bal Swasthya Karyakram*  
12. Kangaroo mother care at AIIMS, New Delhi: An enriching experience of 15 years  
13. still birth surveillance: hospital-based |
| **Indonesia** | 1. Postnatal care visit for mother and neonates  
2. Management of preterm baby in Indonesia, especially in Cipto Mangunkusumo Hospital  
3. Country update on newborn action plan – Indonesia  
4. Progress of MCH handbook utilization in Indonesia, MoH of Indonesia |
<table>
<thead>
<tr>
<th>Country</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Myanmar</td>
<td>1. Myanmar newborn action plan</td>
</tr>
<tr>
<td></td>
<td>2. Myanmar newborn action plan – take best care</td>
</tr>
<tr>
<td></td>
<td>3. Home visit for newborn care by health volunteers (Community-based Newborn Care, CNBC)</td>
</tr>
<tr>
<td></td>
<td>4. Cord care with 7.1% chlorhexidine</td>
</tr>
<tr>
<td></td>
<td>5. Seven things this year initiative in Myanmar, Department of Health – UNICEF – Myanmar Maternal and Child Welfare Association</td>
</tr>
<tr>
<td></td>
<td>6. Postnatal Care</td>
</tr>
<tr>
<td></td>
<td>7. Maternal death review (MDR)</td>
</tr>
<tr>
<td></td>
<td>8. Myanmar Nurse and Midwife Association – Every Newborn Action Plan and postnatal care for mother and newborn</td>
</tr>
<tr>
<td></td>
<td>9. Postnatal care guideline in hospital setting</td>
</tr>
<tr>
<td></td>
<td>10. Maternal and neonatal care in remote and hard to reach areas in Myanmar – Coordination effort of Myanmar Medical Association &amp; the Nippon Foundation Mobile Medical Service in Myanmar</td>
</tr>
<tr>
<td>Nepal</td>
<td>1. Better cord care saves babies’ lives</td>
</tr>
<tr>
<td></td>
<td>2. Scaling up use of 7.1% chlorhexidine digluconate</td>
</tr>
<tr>
<td></td>
<td>3. Child Mortality</td>
</tr>
<tr>
<td></td>
<td>4. Evidence</td>
</tr>
<tr>
<td></td>
<td>5. Chlorhexidine in Nepal: A timeline</td>
</tr>
<tr>
<td></td>
<td>6. Implementation through integration and partnership</td>
</tr>
<tr>
<td></td>
<td>7. Implementation approach</td>
</tr>
<tr>
<td></td>
<td>8. Supply of 7.1% w/v chlorhexidine in Nepal</td>
</tr>
<tr>
<td></td>
<td>9. What data on CHX implementation strength are available now?</td>
</tr>
<tr>
<td></td>
<td>10. What data on CHX effective coverage are available now?</td>
</tr>
<tr>
<td></td>
<td>11. Ensuring sustainability</td>
</tr>
<tr>
<td></td>
<td>12. Challenges</td>
</tr>
<tr>
<td></td>
<td>13. Saving lives with CHX</td>
</tr>
<tr>
<td></td>
<td>14. NESOG</td>
</tr>
<tr>
<td></td>
<td>15. Midwifery Society of Nepal: 2010 (MIDSON)</td>
</tr>
<tr>
<td></td>
<td>16. Role of Nepal Paediatric Society in newborn activities</td>
</tr>
<tr>
<td>Country</td>
<td>Title</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Pakistan</td>
<td>1. Pakistan update on postnatal Care</td>
</tr>
<tr>
<td></td>
<td>– Pakistan is not on track to achieve MDG 4 &amp; 5</td>
</tr>
<tr>
<td></td>
<td>– 40 year track in infant and neonatal mortality in Pakistan</td>
</tr>
<tr>
<td></td>
<td>– three causes account for 90% of all newborn deaths</td>
</tr>
<tr>
<td></td>
<td>– timing of maternal and newborn deaths</td>
</tr>
<tr>
<td></td>
<td>– According to PDHS 2012– 2013</td>
</tr>
<tr>
<td></td>
<td>– Postnatal care</td>
</tr>
<tr>
<td></td>
<td>– Content of postnatal care</td>
</tr>
<tr>
<td></td>
<td>– Provider for maternal and newborn care</td>
</tr>
<tr>
<td></td>
<td>– Delivery of post natal care</td>
</tr>
<tr>
<td></td>
<td>– Programmatic components</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>1. Improving neonatal care in Sri Lanka – Sri Lanka College of</td>
</tr>
<tr>
<td></td>
<td>Paediatricians</td>
</tr>
<tr>
<td></td>
<td>2. Country update on newborn action plan</td>
</tr>
<tr>
<td></td>
<td>3. Postnatal care</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>• Country Update on Newborn Action Plan</td>
</tr>
<tr>
<td>JICA</td>
<td>1. Implementation of new birth records in a district of Burundi</td>
</tr>
<tr>
<td></td>
<td>2. Maternal and child health handbook (MCHHB) as the tool for</td>
</tr>
<tr>
<td></td>
<td>universal MNCH coverage in Vietnam</td>
</tr>
<tr>
<td></td>
<td>3. Posters</td>
</tr>
<tr>
<td></td>
<td>4. Overview of MCHHB in Palestine</td>
</tr>
<tr>
<td></td>
<td>– About JICA’s support for MCHHB</td>
</tr>
<tr>
<td></td>
<td>– The MCHHB in Palestine</td>
</tr>
<tr>
<td></td>
<td>– How MCHHB functions as portable medical record</td>
</tr>
<tr>
<td></td>
<td>– Opinions and experiences of health providers</td>
</tr>
<tr>
<td></td>
<td>– How MCHHB functions as health education tool</td>
</tr>
<tr>
<td></td>
<td>– Statistics about the MCHHB in Palestine</td>
</tr>
<tr>
<td></td>
<td>5. Maternal and child health handbook as the tool for universal MNCH</td>
</tr>
<tr>
<td></td>
<td>coverage in Viet Nam</td>
</tr>
<tr>
<td></td>
<td>6. Technical brief – Self-monitoring nutrition status through MCH</td>
</tr>
<tr>
<td></td>
<td>Handbook</td>
</tr>
<tr>
<td>Country</td>
<td>Title</td>
</tr>
<tr>
<td>---------</td>
<td>-------</td>
</tr>
<tr>
<td></td>
<td>7. Technical brief – A quick systematic review of existing MCH home-based records</td>
</tr>
<tr>
<td></td>
<td>8. Technical brief – What is the MCHHB?</td>
</tr>
<tr>
<td></td>
<td>9. Technical brief – Behaviour changes on ANC through the MCHHB</td>
</tr>
<tr>
<td></td>
<td>10. Technical brief – Increase in child health service coverage through MCHHHB</td>
</tr>
</tbody>
</table>
Every new-born action plan and postnatal care for mother and newborn
Member States have made significant progress towards reducing maternal and child mortality, but still a woman dies every seven minutes in pregnancy and child birth, every hour more than two hundred under-five children die in this Region including more than one hundred newborns. Slow neonatal mortality reduction has retarded progress to MDG4 in SEAR, and tackling the first few days' neonatal mortality is the real challenge.

Global Every Newborn Action Plan (ENAP) was developed following a systematic review of the progress in addressing newborn survival and extensive expert consultations. ENAP was endorsed at the Sixty-seventh World Health Assembly in May 2014. WHO has recently released guidelines for postnatal care (PNC) for mothers and children to be addressed.

The regional meeting on ENAP and PNC was organized to review the national newborn action plans and share successful experiences for scaling up. WHO technical guidelines on PNC for mothers and newborns were shared for ensuring uniform and universal implementation of these in Member Countries of the Region. Country teams prepared action plans for implementation of newborn action plans and postnatal care to accelerate reduction in newborn mortality. The meeting report provides highlights of the proceedings from the regional meeting.