Under the Regional Flagship project on ending preventable maternal and child mortality with a focus on reducing newborn mortality, the WHO Regional Director for South-East Asia has appointed the Technical Advisory Group (SEAR-TAG) to provide guidance to national governments, implementing partners and other stakeholders on how best to accelerate implementation of strategies, and monitor these. The inaugural meeting of SEAR-TAG was organized on 15–18 December 2015 to evolve a shared understanding of priorities, challenges and high impact approaches for reducing newborn mortality. The focus on addressing the issue of high newborn mortality through the global approach of every newborn action plan will have additional benefits of reduction in maternal mortality and stillbirths.

All twelve SEAR-TAG members, RMNCAH nodal persons from the ministries of health from Member States, representatives of UN agencies and other partners, INGOS and NGOs, representatives of Professional associations (Pediatrics, Neonatology and Obstetrics) and WHO Collaborating Centres participated in the meeting.

There were deliberations to examine and identify ways to address three areas: coverage and equity gap in terms of low and uneven coverage of evidence-based interventions; quality gap in terms of inadequate quality of care; and an accountability gap in terms incomplete registration of births and deaths of mothers and newborns as well as stillbirths. The report provides the summary of proceedings of the SEAR-TAG meeting and the recommendations.
Ending preventable maternal, newborn and child mortality

Regional Technical Advisory Group Meeting

Recommendations and Report
December 2015

World Health Organization
Regional Office for South-East Asia
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Acronyms

AIIMS  All India Institute of Medical Sciences, New Delhi
ANC   antenatal care
ASEAN Association of Southeast Asian Nations
BD    birth defect(s)
CDC   United States Centers for Disease Control and Prevention, USA
CEDAW The Convention on the Elimination of all Forms of Discrimination against Women
CoIA  Commission on Information and Accountability for Women’s and Children’s health
CRVS  civil registration and vital statistics
EmOC  emergency obstetric care
GFF   Global Financing Facility
HMIS  health management information system
ICDDR, B International Centre for Diarrhoeal Disease Research, Bangladesh
ICM   International Confederation of Midwives
ICT   information and communication technology
JICA  Japan International Cooperation Agency
KMC   kangaroo mother care
MDG   Millennium Development Goal(s)
MMR   maternal mortality ratio
MoH   Ministry/ministries of health
NICU  neonatal intensive-care unit
NMR   neonatal mortality rate
PHM   public health midwives
PPH   postpartum haemorrhage
QI    quality improvement
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>QoC</td>
<td>quality of care</td>
</tr>
<tr>
<td>RMNCAH</td>
<td>reproductive, maternal, neonatal, child and adolescent health</td>
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<tr>
<td>SAARC</td>
<td>South Asian Association for Regional Cooperation</td>
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<tr>
<td>SBR</td>
<td>stillbirth rate</td>
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<tr>
<td>SDG</td>
<td>Sustainable Development Goal(s)</td>
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<td>SEAR</td>
<td>WHO South-East Asia Region</td>
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<tr>
<td>SNCU</td>
<td>special newborn care unit</td>
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<tr>
<td>SRS</td>
<td>sample registration system</td>
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<tr>
<td>U5MR</td>
<td>under-five mortality rate</td>
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<td>UHC</td>
<td>universal health coverage</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>WASH</td>
<td>Water, sanitation and hygiene</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Introduction

The World Health Organization (WHO) South-East Asia Region (SEAR) accounts for 26% of the world’s population with more than 37 million births annually and about 36% of total births globally. In 1990, the baseline year for the Millennium Development Goals (MDGs), eight of the 11 countries had maternal mortality ratios (MMR) greater than 400 per 100 000 live births and child mortality rates higher than 80 per 1000 live births. The situation has greatly improved. By 2015 only two countries\(^1\) had a MMR of 200 or above, with the Regional MMR falling from 525 to 164 per 100 000 live births in the same period. This represents an overall reduction of 69% with an annual rate of reduction of 4.7%. Similarly by 2015 only three countries\(^2\) had a child mortality rate of 40 or above, with the regional rate falling from 118 to 43 per 1000 live births between 1990 and 2015.

This still falls short of the anticipated 75% reduction in maternal mortality and 67% reduction in child mortality. Furthermore, the rate of decline in the newborn mortality rate (NMR) is slower than overall child mortality rate and needs to be accelerated. The adoption of the Sustainable Development Goals (SDGs) and the launch of the United Nations (UN) Secretary-General’s Global Strategy for Women’s, Children’s and Adolescents’ Health 2016–2030 provide new impetus for increased attention to the crucial issues and barriers to improving the health of women, children and adolescents.

The overall remit of the Technical Advisory Group (TAG) is reproductive, maternal, newborn, child and adolescent health (RMNCAH). Recognizing that the rate of reduction of newborn mortality is slower than that of maternal and post-neonatal child mortality, and that the interventions to save newborn lives will also prevent stillbirths and contribute to further reduction in maternal mortality, this first meeting of the TAG focused on newborn health, with particular attention to care around the time of birth and care of the preterm and sick newborn.

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\(^1\) Nepal and Timor-Leste.

\(^2\) India, Myanmar and Timor-Leste.
The South-East Asia Region-Technical Advisory Group (SEAR-TAG) meeting provided a forum to understand and respond to the need for accelerated reductions in newborn mortality in the Region. Five countries in the Region (Bangladesh, India, Indonesia, Myanmar and Nepal) have prepared a national Every Newborn Action Plan (ENAP). Timor-Leste strengthened attention to the newborn within the national RMNCAH strategy in 2014. The Democratic Peoples’ Republic of Korea, Maldives and Sri Lanka are considering or have initiated the development and strengthening of national newborn plans.

Three common gaps were prioritized based on the bottleneck analysis for maternal and newborn health undertaken by countries. The meeting was organized around these main themes:

- **Coverage and equity gap**: low general coverage combined with socioeconomic disparities in coverage of life-saving interventions for maternal and newborn health (MNH) are largely determined by challenges related to the health system, primarily health financing and human resources (specifically midwives).

- **Quality gap**: the national ENAPs identified issues to resolve in improving quality of MNH services, focusing on the time around childbirth.

- **Accountability gap**: counting maternal and newborn deaths and stillbirths and coverage of key interventions needs to be part of national accountability.

Discussions focused on the time around childbirth since this is the most dangerous period for mothers and newborns. Attention was also paid to prematurity and low birth weight since these problems are common in some of the countries in the Region.

Bangladesh, India, Indonesia, Myanmar, Nepal and Timor-Leste have been identified as high-priority countries in the Region for accelerating reductions in newborn mortality. The first five are among the “Countdown to 2015” countries due to the high burden of maternal, newborn and child mortality. Timor-Leste is included since it still has a high level of maternal, newborn and child mortality despite approaching the middle-income level of development.
1. **Objectives of the meeting**

- review progress in developing and implementing national every newborn action plans;
- provide technical updates on maternal and newborn health;
- share experiences, best practices and high-impact approaches for reduction in newborn mortality;
- develop shared understanding on strategic regional actions to accelerate reduction in newborn mortality along the RMNCAH continuum; and
- develop recommendations for action and identify technical assistance required from WHO and partners.

The recommendations to guide the work of the South-East Asia Region as it supports country efforts to reduce maternal and newborn mortality are presented in the following section. Progress will be followed regularly and reported to the next meeting of the TAG.
2. **Recommendations**

The South-East Asia Regional Technical Advisory Group recognized the ground-breaking regional H4+ joint statement on ending preventable maternal, newborn and child mortality in the South-East Asian Region signed by all regional heads of WHO, United Nations Children’s Fund (UNICEF), United Nations Population Fund (UNFPA), World Bank, United States Agency for International Development (UNAIDS) and UN WOMEN on 14 December 2015.

The TAG acknowledged the historic transition from MDGs to SDGs, and the launch of the landmark Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030). Aligned with the SDGs, the overarching objectives of the Global Strategy, namely, *survive, thrive and transform*, aim at ending preventable deaths, ensuring health and well-being, and expanding enabling environments.

The TAG members congratulated the countries on significant progress made on the health MDGs in the SEAR countries. Although the Region has missed MDGs 4 and 5 targets overall, there is no doubt that recent years witnessed the fastest declines in maternal, child and newborn mortality in human history.

The deliberations of the present meeting of the SEAR-TAG focused on neonatal health. In particular, the aim was to agree on actions required to further accelerate reductions in neonatal mortality in the member countries. Issues of coverage and quality of services, equity and national accountability were discussed at length. Specifically, the TAG crystallized priority steps on how WHO along with partners could support countries to reach the SDG and Global Strategy’s neonatal mortality target of 12 per 1000 live births or less in every country by 2030.

The TAG was particularly impressed by the formulation of national newborn action plans in several countries to further reduce newborn mortality and prevent stillbirths in the post-2015 decades. In addition, the various innovations at all levels of the health system, including those for the community, have been impressive.
The TAG members recognized that further acceleration in neonatal mortality reduction would require impact on early neonatal survival, which is dependent on continuum of care of the mother-baby dyad.

Based on the regional situation analysis, presentations and discussions in the regional meeting, key recommendations for action have been formulated; these are directed to the Secretariat, the UN H4+ partnership and to the member countries themselves.
Overarching recommendations

(1) WHO to secure the buy-in to the recommendations from all the national governments through the Regional Committee deliberations on Women’s, Children’s and Adolescents Health, with a focus on reduction in newborn mortality in September 2016. **Action:** WHO-SEARO to report progress.

(2) To facilitate dissemination, buy-in and adoption of the recommendations in countries, countries should be encouraged to replicate the Regional TAG, through national processes, e.g. multi-speciality National Task Force. Each country is encouraged to undertake a strategic consultation with the support of H4+ and partners in the country. **Action:** Countries to create/strengthen National Task Force or similar mechanism and share progress at the next SEAR-TAG meeting.

(3) Countries to focus on expansion of good quality care for mothers and newborns around the time of childbirth (including late antenatal care) and first few days thereafter including facility-based and home-based care of small and sick babies. **Action:** Countries to prioritize this and operationalize plans e.g. within ENAP immediately and share progress at the next SEAR-TAG meeting.

(4) WHO to inform the intervention packages that will be required for reducing the NMR to low levels of 12 per 1000 live births or less (secondary and tertiary care and other interventions). **Action:** WHO-HQ to inform by third quarter 2016.

(5) WHO, UNH4+ and partners to support high priority countries for development of investment cases, to engage with Global Finance Facility and mobilise domestic resources for RMNCAH. **Action:** WHO, UNH4+ and partners to prepare a strategic approach and support country level dialogue for development of investment cases in 2-3 priority countries in 2016

(6) WHO with H4+ to create a SEAR web-based repository of best practices in RMNCAH and increase opportunities for cross-learning and share innovative experiences. **Action:** WHO with UNH4+ to create SEAR repository and inform of progress.
Specific recommendations

Addressing the coverage and equity gap

(1) High-priority countries to develop and refine implementation plans (national and subnational) for their national ENAPs, including standards and guidance for strengthening facility-based newborn care, with special attention to reaching currently unreached populations including robust equity-sensitive indicators of coverage and quality.  
**Action:** Prepare the plans immediately with support of UNH4+ and inform progress to SEAR-TAG.

(2) In order to increase in-facility deliveries with good quality intrapartum SBA care of mothers and babies and good quality care of small and sick newborns (facility-based and home-based):

   – WHO to provide updated guidance on place and person for skilled attendance at delivery and for care of the newborn. (Update the 2004 guidance, based on evidence and experience).
   **Action:** WHO-HQ by end 2016.

   – A landscape analysis of skilled attendance at birth/institutional delivery in the Region, specifically addressing midwifery skills and newborn care skills, including the scope of practice and autonomy of practice.
   **Action:** WHO and H4+ to provide by third quarter of 2016.

   – Countries should develop/update plan for skilled human resources to achieve the intermediate targets (2020, 2025, 2030) and address deployment and retention issues, specifically for the underserved areas, marginalized and vulnerable populations, including the role of the private sector (For profit and not for profit).
   **Action:** Countries to inform progress by end 2016.

(3) Countries to develop/expand innovative financing mechanisms in countries, particularly to reduce out-of-pocket expenditure for mothers and babies for care at birth, early postnatal period and management of complications.  
**Action:** Inform of progress by end 2016.
Based on the evidence that special care newborn services are beneficial for sick and small babies, champion and create newborn spaces at health facilities conducting deliveries as well as special newborn care units and intensive newborn care units for referral care at appropriate levels of care.

**Action:** WHO and UNH4+ to support development of demonstration sites in national/regional centres of excellence. Countries to create and inform progress by end 2016.

Countries to plan to rapidly scale-up postnatal care for the mother and newborn in the first week, including home visits, as per WHO guidelines (which includes postpartum FP) and define targets for coverage and quality. Undertake relevant implementation research to improve learning on delivering postnatal care at scale.

**Action:** Countries and WHO and H4+ to report progress by end 2016.

Develop action plan to increase community involvement, demand creation for access to quality services involvement of husband/partner, women’s empowerment, women’s groups, and young people; and civil society and community-based organizations.

**Action:** Countries to develop and report progress by end 2016.

**Addressing the quality gap**

Countries to adopt/adapt the Regional Framework for Improving Quality of Care of RMNCAH, and build capacity at the health facility level to improve quality of care as a part of an overall quality of healthcare improvement endeavour in the countries.

**Action:** Countries to report by end 2016.

Regarding the standards and guidelines for quality of care around childbirth and care of small and sick babies put together by WHO:

- Partners should agree to one set of guidelines and help countries to prepare scale-up plans for implementation.
- WHO, UNH4+ and partners to develop models/demonstration sites and support implementation research for further learning.

**Action:** WHO and UNH4+ to report progress by end 2016.

(3) Adopt the Mother/Baby/Family Friendly hospital initiative (for care of mothers, and normal and sick newborns) in the countries (or other brand) with WASH as one of the core indicators of quality of the facility.

- collaboration with professional associations, with consideration of accreditation as part of the process;

- liaise with stakeholders and actors in the non-health sector to strengthen WASH standards in health facilities and monitoring;

- involve community to generate demand for quality services.

**Action:** Countries to report progress by end 2016.

(4) Quality of care principles and pathways should be part of the pre-service curriculum for doctors and nurses/midwives. WHO, H4+ and professional associations to support the pre-service schools and national professional bodies in this endeavour.

**Action:** Countries to report progress by end 2016.

**Addressing accountability**

(1) WHO and H4+ partners should develop a Regional Monitoring Framework for RMNCAH, including specific indicators for newborn health, with milestones for regional and country progress in line with the Global Accountability Framework for Women’s, Children’s and Adolescents’ Health/SDG Monitoring Framework.

**Action:** WHO to report progress by end 2016.

Create equity sensitive targets for NMR at national and subnational levels to drive equitable progress. Specifically, all countries should have appropriate rural NMR targets for 2025 and 2030. In countries with significant gender differential in care seeking, WHO and UNH4+ to work with countries to find local solutions to overcome this.

**Action:** WHO and UNH4+ to report progress by end 2017.
(2) Strengthen quality of data collection (CRVS, HMIS, household and health facility surveys) and use of the data for action related to maternal and newborn health, including disaggregation to capture gender and equity and other disparities. Consider use of an on-line dash-board for reporting and feedback.
Action: Countries to inform of progress beyond 2016.

(3) WHO and UNH4+ to support countries to accelerate maternal death surveillance and response/maternal and perinatal death surveillance and response adoption and implementation, add perinatal death surveillance and response where appropriate/ready. Scale-up electronic databases on perinatal health.
Action: WHO and UNH4+ to inform progress by end 2016.

Future work


- Support countries to accelerate actions to reduce adolescent pregnancy.
Action: WHO and H4+ to undertake analytic work and prepare country-specific targets for consideration in the next meeting.

- Work on inclusion of the private sector towards progress on coverage, equity, quality and accountability given their current and growing role in provision of services in the Region.
Action: A landscaping/synthesis of models of public private partnership across the Region, including barriers and facilitators, and robust evaluation of effects.

- Support countries to develop national research priorities for maternal and child health, working with key national research bodies.
3. Inaugural session

In her inaugural speech, the WHO Regional Director, Dr Poonam Khetrapal Singh highlighted progress towards the MDGs in the countries of the Region, specifically congratulating the countries that achieved MDG 4. She noted that even in countries that have achieved MDG 4, there are geographical variations due largely to socioeconomic factors. Furthermore, the Region contributes to more than 30% of global newborn mortality. Regarding maternal mortality, the Region has achieved a 69% reduction since 1990; this, however, falls short of MDG 5 targets. To accelerate action towards and beyond the MDGs, a Technical Advisory Group was set up to provide technical advice to Member States and assist in monitoring progress in the Region. Dr Singh highlighted the successful summit of United Nations (UN) agencies held on 14 December, 2015 where agencies signed a joint statement and agreed to further their commitments to accelerating reduction of maternal, newborn and child deaths.

The representative of UNICEF signalled the importance of the cooperation and partnership among UN agencies in supporting the countries, particularly with South-South collaboration. While focus on the newborn is very important, there is still a need to continue addressing other causes of under-five deaths, particularly pneumonia and diarrhoea. Focus on equity is important because it is the right thing to do and because it makes economic sense. Concrete measures are needed to help governments to focus on the poorest. While the main focus has been on coverage, quality of care is also essential.

The representative of UNFPA spoke of the importance of family planning and comprehensive reproductive health information and services for adolescents. The continuum of care approach is critical to newborn care. Young women who finish their education are far more likely to delay pregnancy and have a healthy baby. The issue of good nutrition in adolescents, particularly the prevention of anaemia is very important. UNFPA believes strongly in the UNH4+ grouping of UN health agencies. SDGs include the important phrase “leaving no one behind”: no woman should die giving life.
The representative of the World Bank reiterated the Bank’s commitment to work towards smart evidence-based investments that are scalable over time, and with sustainable domestic finances.

UN Women expressed pleasure at being a co-signatory to the joint statement. They will work collaboratively to ensure that women’s rights are protected. Girls and young women’s rights are affected by early marriage, which is as high as 50% in some states in India. The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) strongly affirms the right to sexual and reproductive health (SRH), to girls’ right to be born and their right to education. The SDG framework includes goals on ending preventative maternal, newborn and child deaths, access to SRH and rights, gender and equity. The joint statement is an innovative approach; together UN agencies will work more effectively with governments to achieve the targets.
Joint Statement on Ending Preventable Maternal, Newborn and Child Mortality

New Delhi, India - 16 December 2015

We, the representatives of the H4+ agencies in South and East Asia, jointly commit our continuing support to the governments across our regions toward ending preventable maternal, newborn and child deaths by 2030. We are also committed to help our regions progress toward meeting the global targets as adopted in the Sustainable Development Goals (SDGs) and proposed in the second Global Strategy for Women's, Children's and Adolescents' Health.

We acknowledge that there has been significant progress in reducing maternal and child mortality in the South and East Asia Regions in pursuit of the Millennium Development Goals (MDGs). However, newborn mortality and stillbirths still remain high in many countries while in some these are under-reported. In addition, there is significant inequity between and within countries and quality of care remains a concern. We recognize that much morbidity and mortality among women, newborns and children is preventable using well-known, evidence-based solutions, several of which are not associated with high cost or technology. Likewise, we recognize the importance of empowerment of women, the attainment of gender equality and promoting adolescent health to ensure the sustainable future of all countries.

The regional H4+ leadership urges Member States to prioritize universal coverage of essential interventions and high-quality care urgently around the time of childbirth and the first days of life because of the dangerous implications during this period for women, their unborn babies and newborns. Evidence suggests that this strategy will accelerate reduction in newborn mortality and, at the same time, help reduce stillbirths and maternal mortality.

We pledge to work with governments to help strengthen their leadership and capacity to undertake time-bound actions to:

- Mobilize sufficient, sustainable and equity-focused financing, adequate and skilled human resources, and essential commodities and equipment for maternal and newborn health care.
- Improve management capacity to sustain strong health systems for high-quality service delivery, community participation to reach the unreached, and preparedness to maintain services in humanitarian emergencies and fragile settings.
- Assume national accountability for results and resources through harmonized monitoring, reporting and use of relevant disaggregated health data, indicators and information; and upholding rights of women and children.
- Enhance collaboration and coordination with donors and partners including civil society and the private sector.
- Expand coverage of services for family planning, preventing adolescent pregnancies, prevention of mother-to-child transmission of HIV and syphilis, prevention of birth defects; and enhance investment in early childhood development and adolescent health to ensure better chances of survival, good health and overall well-being.
- Address, over time, the wider determinants of health, including but not limited to socioeconomic status; education, especially for girls; nutrition; water, sanitation and hygiene; the empowerment of women and gender equality through a multi-sectoral approach.

Poornam Khetrapal Singh
WHO
Regional Office for South-East Asia

Karlin Hulsehoff
UNICEF
Regional Office for South-East Asia

Daniel Toole
UNICEF
East and Asia Pacific Regional Office

Yoriko Yasukawa
UNFPA
Asia and the Pacific Regional Office

Rahma Elarian
World Bank

Steven J Kraus
UNAIDS
Regional Support Team Asia and Pacific

Roberta Clarke
UN WOMEN
Asia and the Pacific Regional Office
4. **Proceedings**

The proceedings of the meeting are organized according to the agenda, with the presentations for each session followed by a summary of discussions. The group work that was undertaken as part of each session is summarized in Annex IV.

**Session 1: Overview and progress**

**SDG3 and Global Strategy for Women’s, Children’s and Adolescents’ Health**

Anthony Costello, WHO headquarters, gave an overview of achievements on the MDGs, the level of equity gaps within countries, SDG 3 and current priorities in the global health agenda. The cost of implementing the SDGs is estimated to be US$ 2 trillion to US$ 3 trillion per year. The returns on investments in women’s, children’s and adolescents’ health are likely to be high compared with other areas. Current factors that influence life and health, such as demographic and epidemiological transitions (e.g., an ageing population), urbanization, overweight/obesity and the growing importance of noncommunicable diseases (NCDs), combined with environmental changes and frequent emergencies mean that health interventions need to be redefined in the context of the new phase of sustainable development. The renewed UN Secretary-General’s Global Strategy for Women’s, Children’s and Adolescents’ Health responds to this need by promoting three main approaches: Survive, Thrive and Transform.

**Accelerating reduction of newborn mortality in SEAR: From knowledge to action**

Vinod Paul, Chair of the SEAR-TAG, presented highlights from the 2014 Lancet Every Newborn series. With 90% coverage of available interventions, nearly 71% of neonatal deaths, 33% of stillbirths and 54% of maternal deaths could be averted. Most neonatal deaths occur around the time of birth and in the early neonatal period. Large proportions of these deaths are due to prematurity, intra-partum asphyxia and sepsis, all of which require adequate hospital care.
Maternal and newborn health (MNH) is well covered under SDG 3. Universal health coverage (UHC) for mothers and newborns will be essential, as will a health systems approach and attention to emerging priority areas including NCDs. Research and learning, advocacy and resource mobilization are the keys to accelerating the reduction of MNH in the Region.

**Regional overview of newborn health**

Rajesh Mehta, WHO SEARO, suggested that countries in the Region fall into three groups based on the neonatal mortality rate (NMR) and the number of neonatal deaths per year. Five countries have high levels of mortality; three countries have moderate; and three more have low levels.\(^3\) Intervention coverage, quality and measurement are the key challenges for improving neonatal mortality in the Region.

The current evidence suggests that focusing on interventions during childbirth and the first week of life will lead to maximum gains. These interventions concern the quality of care, care for preterm and sick newborns, facility-based delivery and resuscitation of newborns. Approaches include health systems actions, financing, human resources and ensuring quality.

\(^3\) High NMR >20/1000 LB. Bangladesh, India, Myanmar, Nepal, Timor-Leste.
Moderate NMR 10-19/1000 LB. Bhutan, Democratic People’s Republic of Korea, Indonesia.
Low NMR <10/1000 LB  Maldives, Thailand, Sri Lanka.
Session 2: ENAP progress in countries

Bangladesh, India, Indonesia, Myanmar and Nepal have prepared national every newborn action plans based on the global ENAP framework, and Timor-Leste has strengthened newborn-specific activities within the National RMNCAH Plan. Each of these countries shared the main features and unique strengths of their plans for reducing newborn deaths, including progress in costing and implementation planning at the national and subnational levels.

<table>
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<tr>
<th>Country</th>
<th>ENAP launched/endorsed</th>
<th>Costing</th>
<th>Remarks</th>
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<tbody>
<tr>
<td>Bangladesh</td>
<td>Dec 2015 (planned)</td>
<td>Underway</td>
<td></td>
</tr>
<tr>
<td>India</td>
<td>2014</td>
<td>Underway</td>
<td>Targeting single digit NMR</td>
</tr>
<tr>
<td>Indonesia</td>
<td>2014</td>
<td>Completed</td>
<td>Targeting single digit NMR Planning merger of maternal and neonatal plans</td>
</tr>
<tr>
<td>Myanmar</td>
<td>Within the national strategic plan for newborn and child health and development</td>
<td></td>
<td>Planning RMNCAH++</td>
</tr>
<tr>
<td>Nepal</td>
<td>Not yet</td>
<td>Not yet</td>
<td>Draft plan being prepared</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>Within RMNCAH strategy 2014</td>
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During the discussion, participants posed technical questions on the practice of delayed cord clamping, the use of misoprostol in the field to prevent postpartum haemorrhage (PPH), and avoidance of misuse. It was
clarified that oxytocin injection is the preferred method of preventing and managing PPH, but misoprostol can be used when oxytocin is not available. In addition, the WHO recommendation for institutional delivery was clarified: the mother and infant should spend between 24 and 72 hours in hospital after delivery. The possibility of a regional target for institutional delivery was raised, for example 90% of deliveries should be institutional by 2020.

Implementation-related discussions centred on the role of the skilled birth attendant, whether one SBA is adequate to care for both the mother and the newborn, or whether there is a need for an additional SBA for exclusive attention to the newborn. The concern was also raised about low birth weight babies and home deliveries. WHO clarified that there are guidelines for the care of low birth weight babies and for postnatal care for mother and baby, irrespective of place of delivery.

Session 3: Overcoming constraints to coverage of priority interventions around time of childbirth

Achieving high MNH coverage with equity in the SDG phase in South-East Asia and the Pacific (EAP) Region

Kyoko Shimamoto, UNICEF EAPRO, outlined the key equity issues related to coverage of MNH interventions. Coverage may be up to seven times higher in high-income countries compared with low-income countries; there is also variation within countries. If coverage of interventions were scaled up nationally to the level of the wealthiest, nearly 1.3 million under-5 deaths could be averted in the EAP Region.

Evidence-based planning, which uses rigorous bottleneck and determinant analysis to inform policy and design programmes, was described with examples from Indonesia and Nepal. Enhanced accountability through routine decentralized/disaggregated monitoring and evaluation is essential.
Global Financing Facility: how will it work for countries?

Rekha Menon, World Bank, described the Global Financing Facility (GFF) as a platform to bridge current financing gaps for women’s and children’s health. The GFF aims to enhance alignment of financing and financial sustainability by focusing on results that are smart, scaled, and sustainable, on investment cases, mobilizing finances and financing strategies. It also looks to ensure long-term financial sustainability by increasing domestic resources allocated to women’s, children’s and adolescents’ health.

In the first phase, the GFF is being implemented in the Democratic Republic of the Congo, Ethiopia, Kenya and the United Republic of Tanzania. In the second phase it will expand to Bangladesh, Cameroon, India, Liberia, Mozambique, Nigeria, Senegal and Uganda. Investment cases describe the “best buys”, the service delivery and preventive interventions, health systems strengthening, multisectoral approaches and civil registration and vital statistics (CRVS). Currently US$ 875 million have been pledged by Canada, Norway, and the Bill & Melinda Gates Foundation. Each country will receive between US$ 10 million and US$ 60 million.

Increasing institutional deliveries in India: Janani Shishu Suraksha Karyakaram (JSSK) entitlement for free care for mothers and newborns in India

Veena Dhawan, MoH, stated that in India, JSSK (mother and newborn care scheme) aims to reduce maternal and infant mortality rates by eliminating out-of-pocket expenses for families of pregnant women and sick infants who seek care in government health facilities. It intends to reach those pregnant women who still deliver at home and to increase timely access to care for sick newborns and infants. JSSK will target low-performing states and marginalized populations in high-performing states.

Challenges faced include the variable use of resources and incentives, a weak monitoring and reporting system, deficiencies in public procurement policy and practice, as well as insufficiencies in routine laboratory and diagnostics, blood storage, and the referral and transportation system from state to state.
**Increasing institutional deliveries in Indonesia: health insurance for MNH services**

The Indonesia National Health Insurance (Jaminan Kesehatan Nasional, or JKN) for MNH aims to ensure the financial sustainability of health care and to protect the poor. It covers, among other interventions, antenatal care, delivery, caesarean section and family planning services. The key challenges faced by this programme are inequities in access particularly in the remote islands, assurance of quality of care and monitoring of out-of-pocket expenditure.

**Technical update**

Rajiv Bahl, WHO headquarters, presented highlights of recent WHO recommendations on MNH care. These include new guidelines for:

- managing preterm and low birth weight;
- managing newborn infections;
- labour and childbirth;
- community mobilization.

Ongoing research on MNH covers: The efficacy of antenatal corticosteroids in hospitals in resource-limited settings, the efficacy of community-initiated kangaroo mother care (KMC), and/or early KMC, better outcomes of difficult labour, improved labour monitoring and action, and demand for quality. There is a need for guidance in how to scale-up the quality of care around birth, KMC, simplified treatment of infections and social interventions.

**Universal health coverage for MNH**

Phyllida Travis, WHO SEARO, introduced the current global and regional situation on UHC and its relevance to MNH. Constraints of service delivery affect all levels of the health system. Resources and service provision for MNH must be monitored, and strengthening the health workforce will be imperative to improving access to quality services. The WHO global reference list includes 100 core health service indicators, of which 27 are related to MNH.
She proposed five main areas of action to achieve UHC for MNH in the Region:

1. Sector strategies, subsector plans, and policy briefs.
2. Service delivery, including community-based services and patient safety.
3. Health workforce strengthening: focus on rural retention, migration of health staff.
4. Affordable access to quality medicines; antimicrobial resistance; trade issues.
5. National monitoring of progress towards UHC.

Discussion

Concerns were raised about the timely utilization and dosages of antenatal corticosteroids and about health outcomes for the most vulnerable. More research is needed on the use of tocolytics. Improving the quality of MNH care requires financing and collaboration within health systems.

Addressing human resource gaps: global and regional perspectives on midwifery to strengthen care of mothers and newborns around childbirth

Hla Hla Aye, UNFPA, presented the finding of State of the World’s Midwifery Report 2014, which covers 73 of 75 low- and middle-income countries. These countries account for 78% of the world’s annual births, 96% of maternal mortality, 91% of stillbirths and 93% of neonatal mortality; at the same time they have only 42% of the world’s medical, midwifery and nursing personnel.

Midwifery plays an important role in maternal and newborn care by providing services close to mothers, their newborns, children and families. The continuous availability of personnel with high-quality training that meets international standards, such as that outlined by the International Confederation of Midwives (ICM) is essential. National recognition, appropriate remuneration and the support of professional associations are among the strategies to improve midwifery services. A major milestone in
the professional recognition of midwifery was the Midwifery Alliance of Asia, launched in Indonesia in 2015.

**Building skills of midwives in Thailand**

Bunyarit Sukrat, Ministry of Public Health, stated that Thailand has achieved certain MDG targets: 99% of births are in health facilities, and 32.5% are conducted by nurses. (Medical doctors also conduct deliveries and are recognized as SBA.) In lieu of a midwifery cadre, Thailand has a cadre of nurse midwives trained with a nursing and midwifery curriculum. The scope of midwifery practice in Thailand includes education and counselling, physical examination, delivery and family planning services, as well as assisting physicians in performing treatment.

The advantages to this system are a shorter training period and a rapidly increasing number of SBAs to provide services. At the same time, those nurses who end up working in the labour room still need additional training. Thailand is moving towards standardizing accreditation of skilled birth attendants with ASEAN guidance.

**The changing role of public health midwives in Sri Lanka**

Chiranthika Vithana, Ministry of Health, stated that health services in Sri Lanka have been free since 1930; free education began in 1944 and the decentralized health system was founded in 1989. At present, preventive health services are carried out in 329 health divisions with 7000 midwives. Antenatal care is provided to 99% of pregnant mothers, 99.9% of all pregnancies end in institutional delivery, and at least 74% receive one domiciliary postpartum care in the first 10 days. Public health midwives reside in the community catering to a population of 3100.

With the rapid reduction in home deliveries, the role of public health midwives (PHM) has evolved from providing skilled attendance at birth in the field to holistic care for the life-course approach. As the role changes, more technical skills are needed for targeted individualized interventions. Challenges include the reduced numbers of candidates for PHM training, and barriers to providing domiciliary care in urban settings.
Discussion

Moving from medically led to midwifery led care may be more effective, although ensuring quality is a long-term and costly effort. Questions were raised related to the role of the public health midwife in Sri Lanka and how this cadre could be made more “fit for purpose” with the change in epidemiology. In response to discussion around the need for an antenatal care visit between 36 and 40 weeks of pregnancy, participants were informed that the WHO guidelines on four ANC visits are being reviewed.

TAG members commented on the impressive use of data for quality improvement in Thailand, including managerial issues and creating demand from the community, as well as on the importance of combining coverage and quality, the need for countries to define the main provider of care, and the link between MMR and SBA. Integration with family planning services and creating demand are important, and the increasing rate of caesarean section particularly in the private sector in urban areas is of great concern.

Discussions also included suggestions as to possible regional targets for SBA at delivery, e.g., increasing by 10% annually to reach 90–100% coverage within five years. Investing in human resource is essential, with midwives being the most cost–effective investment. There is nonetheless a great need to define the qualification, education and training of this cadre. It would also be helpful to collect and share countrywide data on the current availability, status, numbers and roles of midwives.

WASH Symposium: strengthening basic amenities in hospitals to improve quality of care around the time of childbirth

Basic amenities and a clean environment are vital standards to be maintained at hospitals.

Water, sanitation and hygiene in health-care facilities

Rabin Lal Shrestha, WaterAid South Asia, stated that bacterial infections cause 5–15% of maternal deaths and 30–35% of child deaths. The risk of sepsis increases 34-fold in low-resource settings. Water, sanitation and hygiene (WASH) measures include the availability and quality of water and of sanitation and hand-washing facilities, as well as the management of
waste. Universal access to safely managed water, sanitation and hygiene is part of the SDGs.

The lack of water and sanitation discourages women from using the health facility for childbirth, thus showing the intrinsic link between quality of care and WASH. In SEAR countries, the lack of access to WASH is important: only 25% of health facilities have water and 20% have sanitation facilities. The gap in comprehensive and comparable national data makes it difficult to argue for policy reforms and effective programme delivery.

**Identifying actions for improving WASH in health-care facilities**

The results of the Bangladesh hospital hygiene survey, presented by Sufang Guo, UNICEF, Rabin Lal Shrestha, WaterAid, and Ms Payden, WHO SEARO, showed that hand-washing agents are available for 93% of doctors and 97% of nurses, but for only 23% of patients. The operation and maintenance of sanitation facilities are often partial or non-existent. In Bhutan, an assessment of 35 health facilities showed that 40% do not have sufficient water, access to toilets is low and other hospital waste disposal is not segregated.

**Discussion**

Participants recognized that WASH is a crucial part of health services. Lack of maintenance in health facilities is also an issue. The WHO hand-washing guideline is very useful, and hand hygiene should be included in MNH training. In maternity wards, WASH facilities are often inadequate; to improve this, mother- and baby-friendly hospital criteria must include WASH parameters. Participants also commented that demand creation is very important. Currently, in Bangladesh, 68% of households have mobile phones while the same proportion of households practice open defecation. The opportunity to change practice is there and needs to be acted upon.
Session 4: Addressing the quality gap in MNH care

While there has been improvement in the coverage of MNH services, there is evidence that life-saving interventions for mothers and newborns are often delivered with inadequate quality, especially during the most critical period around childbirth.

Improving quality of care for MNH in health facilities: standards of care around childbirth

Matthews Mathai, WHO headquarters, presented “Standards of care around childbirth” and described the quality of care (QoC) vision, framework and implementation strategy, strategic areas of work, current work and immediate and medium-term outputs. The QoC vision aims to ensure that all mothers and newborns have access to the health-care system. This is in alignment with two complementary global action agendas: Ending Preventable Maternal Mortality and the Every Newborn Action Plan.

WHO has identified six strategic areas in the collective efforts to realize the QoC vision: research, guideline development, standards of care, effective interventions, measurement indicators and capacity strengthening.

An important element in QoC is the development of standards of care that are universally applicable. A review process had been undertaken to develop the definition, taxonomy and structure of these standards. Eight standards exist (one for each WHO QoC framework domain); there are between two and 12 quality statements for each standard and measures for each quality statement (at least one each for input, output and outcome if applicable).

The standards, quality statements and measures will be finalized and published by December 2015. A technical consultation will be held and the implementation guidance and plan will be finalized by January 2016. A consultation for forerunner countries, pilot testing of implementation guidance and the launch of the learning platform will be completed by March 2016.
Regional framework for improving quality of care for RMNCAH

Neena Raina, WHO SEARO, highlighted the importance of QoC in effective coverage, essential to achieving the SDGs. At the same time, infrastructure, human resources, competencies, skills, and accountability are major gaps in the Region that influence effective coverage. QoC improvements also need a focus on demand creation.

Many tools are available at global and regional levels to improve QoC. These include the Integrated Management of Childhood Illness (IMCI) health facility survey, the assessment of quality of adolescent health services, service availability and readiness assessment (SARA), quality of maternal, neonatal and child care in hospitals, assessment of emergency obstetric care (EmOC services), mortality reviews, maternal and perinatal death surveillance and response, perinatal/neonatal/child death reviews and clinical audits.

The regional framework for improving quality of care proposes a quality improvement (QI) system that extends across the RMNCAH continuum and all levels of care and aims to achieve “effective coverage”, meaning high and equitable coverage of quality care. The vision of the framework is that all countries of the South-East Asia Region provide universal access to quality care for every woman, newborn, child and adolescent at all levels of care.

The framework recommends implementation of a systematic process at the country level with support from the regional and district level that will help to ensure that health-care interventions are delivered with adequate quality and that harmful practices are avoided. It provides guidance on actions required to be undertaken at national, subnational and health facility levels to ensure good quality of care.

Improving MNH care in Bangladesh

Pabitra Kumar Sikder, stated that the Bangladesh MNH initiative aimed to reduce maternal and neonatal mortality and morbidity through improved community MNH practices and services with an emphasis on equity. The initiative began in July 2007 and addressed antenatal care, SBA (facility births), newborn care (specifically thermal care), EmOC and postpartum
family planning. The major approaches employed were governance and leadership, decentralization with local level plans, local recruitment of human resources under local level plans (LLP) training and deploying private community skilled birth attendants (CSBA) in the most remote areas, and healthcare financing (pay for performance), awareness raising and demand creation.

Outputs included the development, implementation and monitoring of district and sub district MNH plans, increased availability and access to quality MNH care and increased demand for MNH care and services particularly by the poor and marginalized. Equity, participation and accountability in MNH interventions also improved.

Five composite indicators were used to monitor progress:

(1) Percent of women attending at least four ANC sessions from medically trained providers.
(2) Percent of deliveries assisted by medically trained providers.
(3) Percent of facility deliveries.
(4) Percent of women receiving postnatal care by medically trained providers within two days of delivery.
(5) Percent of newborns receiving postnatal care by medically trained providers within two days of delivery.

Assessments on quality and safety of health care in Indonesia

Three sets of data were presented: the findings of the assessment of QoC for mothers and newborns in 18 hospitals in 2009, the HAPIE (Hospital Accreditation Programme Impact Evaluation) study baseline results from 2012 and the review of quality and safety of healthcare. Common problems identified were lack of integration of policies into monitoring and evaluation mechanisms and poor coordination at organizational and institutional levels. Lessons learnt from these assessments are that QoC requires a systems approach, MNCAH should be a part of the national quality and safety framework, and evidence-based quality indicators for MNCAH need to be defined.
Improving care of sick and small newborns in hospitals: The SAARC experience

Harish Chellani, Consultant, South Asian Association for Regional Cooperation (SAARC) MCH Project, put forward a number of challenges faced in improving facility-based newborn care in the Region:

1. lack of skilled human resources;
2. availability of functional equipment at all times;
3. admission overload (lack of adherence to admission and discharge guidelines);
4. poor adherence to infection control practices;
5. delayed use of services and poor compliance;
6. poor referral transport and linkage.

To overcome these challenges, the SAARC maternal-child health project ensured the availability and adequacy of infrastructure and equipment at various districts and sub districts, improved the skills of doctors and nurses in applying standard treatment guidelines and established referral linkages.

Discussion

Several issues were raised: The need for guidelines for districts and sub-districts where the bulk of problems are located, the scientific methodology of listening to clients particularly in cases of deaths and near-miss (newborn and mothers) and monitoring the time taken on referral. The JHPIEGO representative announced the availability of a toolkit for private sector providers, which includes standards of care, capacity-building and accreditation. Other issues related to training included the need for inclusion of quality improvement (QI) processes in pre-service education and high-quality standards for training. What would be useful is an accountability framework for quality whereby all partners sit together to ensure uniformity of standards. Learning onsite (at the place of work) is considered to be more beneficial than offsite training.
It was also recognized that no countries have sustained improvement without demand for care with quality. Thus, this aspect needs to be addressed. In addition, attention should be paid to a supportive environment in which midwives can practice.

**Session 5: Community actions for maternal and newborn health**

Better health outcomes for women and newborns require close engagement with the community, in addition to improved home-care practices and the participation and empowerment of parents, families and communities to demand quality care.

**Evidence-based strategies for community-based care for MNH**

Anthony Costello, WHO headquarters, outlined evidence-based strategies for communities and their role in care for MNH. The list of community sectors and strategies that influence MNH includes traditional healers, volunteers and doulas, community health workers, women’s groups, health committees and mHealth (mobile health). As part of cooperative nurturing, community approaches require team-building, careful listening and local ownership.

Facilitated participatory learning and action cycles with women’s groups have been effective in rural settings with low access to services. A community action cycle follows the phases of identifying and prioritizing problems, planning strategies, putting strategies into practice and evaluating together. Five principles have been identified for transforming strategies into action:

1. build coalitions by leveraging groups with a shared vision;
2. focus on a few selected strategies and interventions;
3. build ownership at grassroots level;
4. continually innovate to maximize resources;
5. reinforce accountability by continuously measuring what matters.
Promoting facility births through participatory women’s groups on MNH in Nepal

Dharma Manadhar, Nepal, informed that in MIRA’s (maternal and infant research activity) mother and newborn care programme in Makwanpur district, health services were strengthened in control and in intervention areas. Community mobilization was conducted through participatory learning and action with women’s groups and village health committees. The first year focused on problem identification and planning together, and identifying and agreeing on strategies. Developing and implementing the strategies were done in the second year. The intervention led to a 30% reduction in neonatal mortality. Child survival was significantly higher in the intervention group; maternal mortality was also reduced but not significantly.

The involvement of civil society in MNH promotion in Myanmar

Daw Thazin Nwe stated that the Myanmar Maternal and Child Welfare Association (MMCWA) is a voluntary organization dedicated to improving quality of life by promoting the health and well-being of mothers and children. Activities span health, education, economy and the social sector. MMCWA has established antenatal care, maternity waiting homes and delivery care in some parts of the country and is supporting the Government’s MCH activities. The organization has 100 000 volunteers, each responsible for 10 households.

The organization also works with the Ministry of Health to build capacity, including the recruitment of midwives and auxiliary midwives, refresher training for midwives, and the provision of mobile clinic activities in hard-to-reach areas.

Home-based postnatal care in Bhutan

In Bhutan, nearly 40% of deliveries take place at home and postnatal care is inadequate. A report in 2011 indicated that PPH was the leading cause (40%) of maternal death. In three selected districts, postpartum mothers and newborns were visited within the first seven days after delivery, and assessed using a checklist. The three districts (Chukha, Samtse and Trashigang) were chosen based on geographic diversity, difficult terrain,
poor maternal and child health indicators and low institutional delivery. Both institutional delivery and postnatal care increased during the project, and MMR and NMR were reduced. The intervention will be expanded to other districts.

**Discussion**

Issues raised included the sustainability of project interventions, the pathway to reduced mortality, mortality reduction versus social cohesion, the need to train people to facilitate community processes and the different needs in urban and low-mortality settings. There is also the need to promote WHO guidelines on community mobilization and home visits, as these provide gains beyond mortality reduction. Other points raised included the need for community empowerment and accountability, particularly to empower people to hold government to account. In addition, it will be important to support implementation research studies at demonstration sites on community interventions on maternal and newborn health, and to share findings across the Region.

**Improving early childhood development**

Paul Francis, WHO India, presented an early childhood development project that used an integrated mother and child protection card to promote and monitor child stimulation, optimal feeding and other essential practices.

This project was implemented in two sites in the states of Haryana (Yamuna Nagar district) and Maharashtra (Wardha district). The community health workers (ASHAs) demonstrated capacity and interest to provide information on early childhood development during home visits. Parents were receptive and highly appreciative of this information, and other family members supported the new actions. Results are promising and showed improvement in all relevant practices as well as nutritional status. The project also confirmed that multiple channels for behaviour change are required for improving intervention coverage.
Use of information and communication technology (ICT) in training health workers in newborn care

Ashok Deorari, AIIMS New Delhi, outlined the need for disseminating knowledge and information in the Region and suggested the electronic media as an effective medium. This approach quickly communicates evidence-based practices to a wide population, and can transform training and education in the health sector. It provides opportunities for two-way interaction, discussions and self-evaluation. mHealth makes e-learning and education tools available on mobile phones. Any guideline or treatment protocol can be easily converted into a simple application; in addition, options are available to update and improve features of existing tools.

South-South collaboration for health

Deepika Attygalle, UNICEF-ROSA, presented experience on the South-South collaboration for health. During this process two or more developing countries pursue their objectives through exchanging knowledge, skills and technical resources. It supports partnerships involving governments, regional organizations, civil society, academia and the private sector for individual and/or mutual benefit within and across regions.

Examples include a team from Afghanistan visiting a hospital in Sri Lanka to observe quality of care protocols, implementation and quality assurance mechanisms, and a team from the Sri Lanka Ministry of Health and members of the College of Paediatricians visiting a district hospital in India to see the special newborn care unit and online data monitoring system. Challenges of South-South exchanges are sustainability, reporting, coordination, partnerships, and monitoring and evaluating the long-term effectiveness.

Strengthening country capacity for MNH

Ms Keiko Osaki, Japan International Cooperation Agency (JICA) Japan, presented that the Agency aims for universal health coverage by supporting the global health agenda. Priority is placed on health system strengthening with specific focus area, including MCH and infectious disease control.
Key priorities of the United States Agency for International Development (USAID) are AIDS-free generation, infectious diseases control and ending preventable child and maternal deaths, which includes investment in 24 priority countries. In the newborn health area, USAID catalyses action at global and local levels and promotes the ENAP platform. It also emphasizes innovation and public-private partnership. In the SEA Region, USAID has supported Bangladesh, India, Indonesia, Myanmar and Nepal to scale up high-impact interventions and to strengthen health systems, improving quality and costing.

**Discussion**

Concerns were raised about data security and patients’ information with the use of mobile phone applications. It was proposed to conduct studies, and to create models using mobile phones and ICT systems for education, monitoring, service delivery and reaching communities. Models may also be developed to integrate training packages in the pre-service education to complement existing textbooks. Discussion on South-South collaboration centred on exploring and establishing mechanisms taking into account essential elements such as planning, implementation, building networks and linkages, confirming roles, responsibilities and activities of various partners and stakeholders, monitoring, communication and promotion, sustainability and resources.

**Session 6: Strengthening accountability for MNH**

Measurement of agreed indicators is crucial for monitoring progress, and improves performance and accountability. This session presented global and regional perspectives on improving metrics for birth outcomes and quality of care around the time of birth.

**Maternal and perinatal death surveillance and response (MDSR)**

Matthews Mathai, WHO headquarters, explained that the unique features of MDSR are the elements of surveillance and response. Guidelines are available on the WHO website, and a survey was undertaken in 2015 to monitor MDSR implementation. Key findings for SEAR include a discrepancy between the number of deaths reported by the survey and the
numbers expected according to UN estimates. For example, India reported 1850 maternal deaths whereas estimates indicate 45 000. There is nonetheless progress in the proportion of deaths being reviewed; in Myanmar, for example, 863 deaths were reviewed out of 922 reported.

Perinatal death surveillance is a more recent step in the set-up of reliable and usable systems for death surveillance and response, and is appropriate to include once MDSR has been well established. Guidelines should be available in mid-2016.

**SDG 3 indicators and ENAP metrics for reviewing progress**

Anthony Costello, WHO headquarters, indicated that it will be crucial to have country voices to help with the design and implementation of monitoring, an important post-2015 issue.

Since “health” is an integral part of all 17 SDGs, having one specific health goal is sufficient. UHC is the core of SDG 3, and is linked to all goals and targets. It is important to be proactive in reducing fragmentation, and to use the SDGs as an opportunity to enhance actions with other sectors.

The targets to be achieved by 2030 under the UN Secretary-General’s global strategy for women’s, children’s and adolescents’ health, as well as the Survive, Thrive and Transform approaches are primarily drawn from the targets for the SDGs. Newborn and maternal mortality reduction strategies are well-aligned.

**Strengthening birth and death registration: regional perspective**

Rajesh Narwal, WHO India, pointed to the need for a robust CRVS system for health policy, planning and monitoring and evaluation. In addition to numbers, it is essential to record causes of death. The finding of the CRVS regional evaluation revealed insufficient priority, poor quality of reporting, low demand from civil society and patchy coverage. Overall, more births were registered than deaths and large regional disparities were found in the proportion of deaths covered.

An action framework for strengthening CRVS in the Asia-Pacific Region was launched with a multi-partner, multi-stakeholder initiative. This
framework, with the motto “Get everyone in the picture”, aims to improve birth and death registration with coverage and accuracy.

Regional initiatives and the SDGs provide great windows of opportunity to strengthen CRVS, which in turn could avert misdirection of funds and foster efficiency and accountability.

**Regional network to strengthen database for newborns, stillbirths and birth defects**

Neena Raina, WHO-SEARO, highlighted the World Health Assembly resolution on developing and strengthening surveillance systems for birth defects, and the findings of the 2011 situation analysis that pointed to the scarcity of relevant data.

In 2013, a regional strategic framework for the prevention and control of birth defects was developed. Since then, nine countries have developed their national strategic plans, a web-based regional surveillance system has been developed by WHO-SEARO in collaboration with CDC, USA, and manuals for programme managers and an atlas for detection of visible defects at birth were published.

The recently-released mobile application for birth defects surveillance was presented; it is expected to strengthen the expansion of the network for the newborns, stillbirths and birth defects database in resource-limited settings.

**Improving quality of care by using MPDSR in Sri Lanka**

Dr B V S H Benaragama, Ministry of health, stated that in Sri Lanka, all health facilities were required to conduct a maternal and perinatal review at monthly intervals, with a multi-professional team. With an emphasis on learning rather than fault-finding, each death was discussed in detail, and incidents were traced from field level health services to facility levels. Each event was assessed based on the three-delay model. The findings were widely disseminated to relevant sectors to take corrective actions, and later used to improve quality of care.
Major challenges faced were: irregular review periods, the lack of a designated officer at the institutional level, poor participation of clinicians, non-familiarity with procedures and timeliness of reporting. Examples of actions arising from the reviews include: the identification of human resource gaps, infrastructural developments, addressing gaps in drugs and supplies and streamlining of health information to avoid duplication.

Stillbirths surveillance in India

Anju Puri, WHO India, highlighted the global burden of stillbirths is 27.7/1000 births, most of which are antepartum (63%). The regional cause pattern is similar to the global picture with 16% of stillbirths unexplained. In line with ENAP, the India NAP was formulated. The initial action was to study the existing reporting systems for stillbirths through health management information systems and sample registration system, SRS, and to suggest ways of strengthening surveillance mechanisms. National guidelines are being developed to support hospital-based and community-based surveillance for stillbirths.

Discussion

Issues raised included the role of verbal autopsy in achieving community engagement. Tools are also now available on social autopsy. There is a need for stronger emphasis on disaggregated data to reveal inequities. Monitoring must relate directly with the accountability framework; the link is currently unclear. Quality of care data must be used to make a strong investment case for MNH service strengthening. There is a potential problem of name and blame in MDSR. MDSR must not be used for taking punitive action otherwise it will create a “wall of silence” – with great reluctance of professionals to report events and circumstances. It was also suggested that antenatal care be linked with birth defect prevention.

Other key points included the issuing of birth certificates, which should be done at the institution of delivery. Behavioural research is needed to understand cultural and health provider barriers to reporting deaths. MDSR must lead to system-level responses as well as those at the individual facility/district level. Regional progress is being made on the availability of a unique personal identifier (with appropriate data protection safeguards) to support monitoring of coverage, quality and outcomes.
Awareness of CVRS and MDSR needs to be introduced into pre-service curricula. Large-scale research and evaluation of implemented interventions is needed in the Region to understand barriers and facilitating factors. The UNH4+ could support country requests for South-South exchanges. Participants also commented that the SDG targets are very ambitious, especially with current inequities across countries, gaps in human resources, capacities, financing, etc. The Region needs a strategy to achieve the targets despite these inequities.

**Closing session**

Arun Thapa, Director of Programme Management, WHO-SEARO, closed the meeting and expressed his observations and remarks. He acknowledged the contribution of TAG members and country teams in proposing actionable recommendations. In this partnership, the Regional Office and the TAG will “walk together”, in support of Member States and hoped that TAG members would continue to provide inputs in an ongoing manner between the annual TAG meetings.
Annex 1

Address by
Dr Poonam Khetrapal Singh, Regional Director,
WHO South-East Asia Region

Distinguished participants,

Dear colleagues,

Ladies and Gentlemen,

As the phase of the Millennium Development Goals comes to an end and the world moves into the phase of sustainable development with a new set of goals, it is time to take stock of our achievements in reducing newborn, child and maternal mortality. As we look back, we see a mixed bag. We can derive satisfaction from substantial global progress in reducing child deaths since 1990 by more than 50%. The number of under-5 deaths has decreased from 12.7 million in 1990 to 5.9 million in 2015. The acceleration in decline of child mortality has been much faster during 2000–2015, with an annual rate of reduction of 3.9% compared with 1.8% in 1990–2000. However, progress remains insufficient to reach the MDG 4 target globally.

In the South-East Asia Region, decline in the under-5 mortality rate has been faster in the corresponding period – it has declined by about 64% from 118 per 1000 live births in 1990 to 43 per 1000 live births in 2015. The progress has been quite variable among countries of the Region. Based on the 1990 baseline, Bangladesh, Bhutan, Indonesia, Maldives, Nepal, Thailand and Timor-Leste have achieved the MDG 4 target of reduction in under-5 mortality by two thirds. However, Democratic People’s Republic of Korea, India, Myanmar and Sri Lanka have not achieved the MDG 4 target. We also know that even in countries that have achieved the MDG 4 target, there are some populations in which child mortality has remained high because of social, economic and geographic factors.
However, in comparison, the decline in newborn mortality has been slower—declining by 55% between 1990 and 2015. Newborn mortality presently contributes to about 56% of under-5 mortality in our Region compared with 44% globally. Without a rapid reduction in newborn mortality, further reduction in under-5 mortality would be a challenge. The South-East Asia Region contributed to about 30% of newborn deaths that occurred in the world in 2015. About 75% of the regional newborn deaths occurred in India alone (700 000 in a year), owing to its large population and a high newborn mortality rate. Other countries in our Region with a high burden of newborn deaths are Bangladesh (74 000 deaths), Indonesia (74 000 deaths), Myanmar (24 000 deaths) and Nepal (12 000 deaths).

There has also been significant progress towards reduction in maternal mortality. Globally, there has been a decline of 45% since 1990. In SEAR, there has been a decline of about 64% in maternal mortality between 1990 and 2013. However, progress is insufficient for the Region as a whole to have achieved the MDG 5 target of a reduction of maternal mortality ratio (MMR) by three fourths since 1990.

We, in consultation with Member States, have identified ending preventable maternal, newborn and child mortality with a focus on accelerating reduction in newborn mortality as a flagship priority area in the Region. To take forward the actions under this flagship programme, we have constituted a Technical Advisory Group (SEAR-TAG) comprising twelve members who are eminent scientists. The TAG members are independent experts of very high professional standing with considerable experience in the area of reproductive, maternal, newborn child and adolescent health (RMNCAH) including academic, clinical and public health and research for evidence and implementation. They have been requested to help provide technical guidance to Member States for accelerating reduction in maternal, newborn, child mortality and monitoring progress in the Region.

This is the first meeting of the SEAR-TAG for women’s and children’s health with a focus on reducing newborn mortality in the Region. I understand that all 12 TAG members are participating. Some of them have travelled a long way to participate in this important meeting. I thank them for their commitment and warmly welcome them.
Ladies and Gentlemen,

I must say that this meeting is taking place at an opportune time when the framework of Sustainable Development Goals (SDGs) has recently been launched by the UN Secretary-General in September 2015 along with the renewed and updated Global Strategy for Women’s, Children’s and Adolescents’ Health. These global initiatives provide new opportunities to undertake more strident actions towards ending preventable newborn, child and maternal mortality and to empower national governments to strengthen their leadership and assume accountability for ensuring adequate resources and achieving results. We also have better understanding of evidence on interventions and approaches to prevent mortality that has been presented in the Global Every Newborn Action Plan (ENAP) Framework and Strategies for Ending Preventable Maternal Mortality (EPMM). We know that two thirds of newborn mortality is preventable. Based on these opportunities, we all will need to work together towards achieving the new targets for a newborn mortality rate of 12 per 1000 live births, a child mortality rate of 25 per 1000 live births and a maternal mortality ratio of 70 per 100 000 live births by 2030 in each country of our Region.

As national governments assume and strengthen leadership to ensure that all mothers, newborns and children survive and thrive and in turn transform society, partner agencies would be required to strengthen collaboration and ensure coordination to harmonize their support to Member States. I am pleased to share that last evening, we had a very successful Summit meeting of the regional leadership of H4+ agencies including UNICEF, UNFPA, UNAIDS, UN WOMEN and the World Bank. Together, we express our joint commitment and support for ending preventable mortality in the Region. I welcome colleagues from sister organizations present here as well as colleagues from all partner agencies to come up to the stage.

It is also my pleasure to welcome national programme managers from ministries of health from all 11 Member States and representatives from academia and professional associations. I understand that country teams will have an opportunity for close interaction with TAG members to identify country-specific high impact evidence-based approaches for accelerating reduction in newborn mortality. I am sure all of you together will be able to deliberate on critical issues and chalk out a realistic way forward.
I express my best wishes for successful deliberations in this meeting and appeal you all for effective follow-up actions in your countries during the next year to make the difference based on agreed actions. Once again, I express our full support to Member States of the Region. Please do enjoy your stay in New Delhi that offers you an interesting mix of ancient and modern culture.

Thank you.
Annex 2

Agenda

(1) Regional overview and progress of newborn health
(2) Country progress - ENAP progress in countries
(3) Overcoming constraints of coverage of priority interventions around time of childbirth
(4) Achieving high MNH coverage with equity in the SDG phase
(5) Financing for maternal and newborn health
   – Global Financing Facility-How will it work for countries Rekha Menon, World Bank
   – Country experiences on increasing institutional deliveries
(6) Technical updates on MNH
(7) Addressing Human Resource gap (Skilled Birth Attendants-Midwives for care of mothers and newborns)
   – Skills building of midwives for caring of mothers and newborns: Thailand
   – Public Health Midwives - Is the role changing? - Sri Lanka
(8) Strengthening basic amenities in hospitals: Improving quality of care around time of childbirth - WASH in health-care facilities
(9) Addressing quality gap in MNH care
(10) Improving quality of care for MNH in health facilities
    – Standards of care around childbirth
    – Regional Framework for improving quality of care for RMNCAH
    – Improving MNH care - MNHI and other experiences
    – Improving care of sick and small newborns in hospitals-SAARC experience
(11) Community actions for maternal and newborn health
   - Women’s Groups for MNH in Nepal
   - CSO Experience (MWCA) for promoting MNH
   - Home-based postnatal care

(12) Strengthening capacity
   - Improving quality of survival: early childhood development
   - Use of ICT in training of health workers in newborn care: e-learning
   - South-South Collaboration for Health
   - Strengthening country capacity for MNH

(13) Strengthening accountability for MNH
   - Maternal and perinatal death surveillance and response – Global overview
   - SDG 3 Indicators and ENAP Metrics for reviewing progress
   - Strengthening birth and death registration-Regional perspective
   - Regional network to strengthen database for newborns-stillbirths-birth defects
   - Improving quality of care by using MPDSR
   - Stillbirths surveillance
Annex 3

List of participants

Members

Dr Vinod K. Paul
Professor and Head
Department of Paediatrics
All India Institute of Medical Sciences
New Delhi, India

Dr Tomris Türme
President
International Children’s Center
Ankara, Turkey

Dr Shams El Arifeen
Centre for Child and Adolescent Health
International Centre for Diarrhoeal Disease Research
Dhaka, Bangladesh

Dr Nozer Sheriar
Immediate Past Secretary General
The Federation of Obstetric and Gynaecological Societies of India (FOGSI)
Mumbai, India

Dr Mohammad Baharudin Hasanuddin
Director
Budi Kemuliaan Health Institution
Jakarta, Indonesia

Dr Katherine Ba-Thike
Independent Consultant-
Reproductive Health
Yangon, Myanmar

Dr Dharma Sharna Manandhar
President and Executive Director
Mother and Infant Research Activities
Kathmandu, Nepal

Dr Sujeewa Amarasena
Professor in Paediatrics
Department of Paediatrics, Faculty of Medicine,
University of Ruhuna
Galle, Sri Lanka

Dr Siraporn Sawasdivorn
Clinic Associate Professor
Queen Sirikit National Institute of Child Health
Bangkok, Thailand

Dr Peter von Dadelszen
Professor and Academic Head of Obstetrics and Gynaecology
St George’s University of London
London, United Kingdom

Dr Wendy Jane Graham
Professor of Obstetrics and Epidemiology
University of Aberdeen
United Kingdom

Dr Gary Darmstadt
Professor of Paediatrics
Stanford University
School of Medicine
United States of America

Country Participants

Bangladesh

Dr Pabitra Kumar Sikder
Deputy Director-Primary Health Care and Programme Manager-Maternal and Newborn Health
Directorate General of Health Services
Dhaka

Dr Md Abdul Ghani
Programme Manager (Admin & Finance) In-Service Training
Directorate General of Health Services
Dhaka

Dr K M Zahirul Hoque
Program Manager Adolescent & School Health Programme
Directorate General of Health Services
Dhaka
**Bhutan**

Dr Tashi Choden  
Paediatrician  
Jigme Dorji Wangchuk National Referral Hospital  
Thimphu

Ms Tashi Tshomo  
Asst. Program Officer  
Department of Public Health  
Ministry of Health  
Thimphu

Ms Chimmi Dem  
Program Officer  
Department of Public Health  
Ministry of Health  
Thimphu

**DPR Korea**

Dr Kim Kyong Chol  
Director  
Department of Prevention and Treatment  
Ministry of Public Health  
Pyongyang

Dr Ri Hye Jong  
Section Chief of the Neonatal Department  
Pyongyang Maternity Hospital  
Pyongyang

Ms Pang Sol Ran  
Official, Korea Association for Supporting the Children  
Pyongyang

**India**

Dr P. K. Prabhakar  
Deputy Commissioner (Child Health)  
Ministry of Health and Family Welfare  
New Delhi – 110011

Dr Zoya Ali Rizvi  
Assistant Commissioner (Reproductive & Child Health)  
Ministry of Health and Family Welfare  
New Delhi – 110011

Dr Veena Dhawan  
Assistant Commissioner (Maternal Health)  
Ministry of Health and Family Welfare  
New Delhi – 110011

Dr Ajay Khera  
DC Incharge (Child Health)  
Ministry of Health and Family Welfare  
New Delhi

**Indonesia**

Drg. Melly Juwitasari  
Head of Section of Infant Health  
Subdirectorate  
Directorate of Child Health  
Ministry of Health  
Jakarta

Mr Dhito Pemi Aprianto  
Health Administration Officer  
School-aged Children and Adolescents’ Quality of Life  
Directorate of Child Health  
Ministry of Health  
Jakarta

Dr Christina Manurung  
Family Planning Head of Subdirectorate  
Directorate of Maternal Health  
Ministry of Health  
Jakarta

**Maldives**

Ms Nazeera Najeeb  
Public Health Programme Coordinator  
Health Protection Agency  
Ministry of Health  
Malé

Dr Mariyam Jenyfa  
Senior Medical Officer  
Health Protection Agency  
Ministry of Health  
Malé

Ms Aminath Shahuza  
Social Service Officer  
Health Protection Agency  
Ministry of Health  
Malé
Myanmar
Dr Myint Myint Than
Director
Child Health Development Division
Department of Public Health
Ministry of Health
Naypyitaw
Dr Khin Myo Htike
Medical Officer
Maternal and Child School Health
Sagaing Region, Myinmu
Dr Aye Su Mon Win
Medical Officer
Maternal and Child School Health
Ayeyarwaddy Region, Raykyi

Nepal
Dr Pushpa Chaudhary
Director
Family Health Division
Ministry of Health and Population
Teku, Kathmandu

Mr Chuda Mani Bhandari
Senior Public Health Administrator
Child Health Division
Ministry of Health and Population
Teku, Kathmandu

Dr Jhalak Sharma Gautam
Senior Integrated Medical Officer
Family Health Division
Ministry of Health and Population
Teku, Kathmandu

Sri Lanka
Dr B. V. S. H. Benaragama
Director (MCH)
Family Health Bureau
Colombo 10

Dr Dhammica Rowel
Consultant Community Physician/NPM
(intranatal and newborn care)
Family Health Bureau
Colombo 10

Dr Chiranthika Vithana
Consultant, Community Physician/NPM
(adolescents and youth health)
Family Health Bureau
Colombo 10

Thailand
Dr Suthipong Pangkanon
Medical Officer
Queen Sirikit National Institute of Child
Health
Department of Medicines Services
Ministry of Public Health
Nonthaburi

Dr Bunyarit Sukrat
Medical Officer
Bureau of Reproductive Health
Department of Health
Ministry of Public Health
Nonthaburi

Timor-Leste
Dr Triana do Rosario Corte-Real de Oliveira
Head of Maternal and Child Health
Department
Ministry of Health
Dili

Mrs Fatima Isabel Gusmao
Programme Manager for Adolescent Health
Ministry of Health
Dili

Mrs Norberta Belo
Advisor for National Directorate of
Public Health
Ministry of Health
Dili

WHO Collaborating Centres and
National Institutions
Dr Ahmed Ehsanur Rahman
Senior Research Investigator
Centre for Child and Adolescent Health (CCAH)
International Centre for Diarrhoeal Disease
Research
Dhaka, Bangladesh
Ms Deki Pem  
Lecturer  
Faculty of Nursing and Public Health  
Khesar Gyalpo University of Medical Science of Bhutan  
Thimphu, Bhutan  

Dr Ashok Deorari MD FAMS  
Professor  
Department of Paediatrics  
WHO Collaborating Centre for Education and Research in Newborn Care  
All India Institute of Medical Sciences  
New Delhi, India  

Dr Ramesh Agarwal  
Additional Professor  
Division of Neonatology, Department of Paediatrics  
WHO Collaborating Centre for Newborn Training and Research  
All India Institute of Medical Sciences  
New Delhi, India  

Dr Anu Sachdeva  
Assistant Professor  
Division of Neonatology  
Department of Paediatrics  
WHO Collaborating Centre for Newborn Training and Research  
All India Institute of Medical Sciences  
New Delhi, India  

Dr B. S. Garg  
Director-Professor of Community Medicine  
Director, Dr Sushila Nayar School of Public Health  
Mahatma Gandhi Institute of Medical Sciences, Wardha, Maharashtra, India  

Dr Niyasha Ibrahim  
Paediatrics/Consultant  
Indira Gandhi Memorial Hospital  
Malé, Maldives  

Dr Korakot Sirimai  
Associate Professor  
WHO Collaborating Centre for Research in Human Reproduction  
Sririraj Reproductive Health Research Center  
Faculty of Medicine, Siriraj Hospital  
Mahidol University  
Bangkok, Thailand  

Dr Patcharaporn Aree  
Associate Professor  
WHO Collaborating Centre for Nursing and Midwifery Development  
The Faculty of Nursing  
Chiang Mai University  
Chiang Mai, Thailand  

Professional Organizations  

Bangladesh  

Prof Md. Mahbubul Hoque  
Secretary General  
Bangladesh Neonatal Forum (BNF)  
Dhaka, Bangladesh  

India  

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

Indonesia  

Dr Tunjung Wibowo  
Consultant of Neonatology  
Secretary of Neonatology Working Group of Indonesian Paediatric Society  
Yogyakarta, Indonesia  

Myanmar  

Professor Mya Thida  
President  
Obstetrical and Gynaecological Society  
Myanmar Medical Association  
Yangon, Myanmar  

Professor San San Myint  
Neonatologist  
Retired Professor and Head of Department of Neonatology  
University of Medicine (I)  
Yangon, Myanmar  

46
Nepal

Professor Dr Laxman Shrestha
President - Nepal Paediatric Society
Head - Department of Paediatrics
TU Teaching Hospital
Maharajgunj Medical Campus
Institute of Medicine, Maharajgunj
Kathmandu, Nepal

Dr Lata Bajracharya
President
Nepal Society of Obstetricians and Gynaecologists (NESOG)
Kathmandu, Nepal

Professor Ashma Rana
President
South Asian Federation of Obstetrics and Gynaecology (SAFOG)
Kathmandu, Nepal

Sri Lanka

Dr Kanishka Karunaratne
President
Sri Lanka College of Obstetricians and Gynaecologists
National Cancer Institute - Maharagama
Colombo, Sri Lanka

Dr Ramya de Silva
President
Sri Lanka College of Paediatricians
Colombo, Sri Lanka

UN Agencies

UNICEF

Mr Louis-Georges Arsenault
The Representative
United Nations Children's Fund (UNICEF)
New Delhi, India

Dr Karina Widowati
Maternal and Child Health Specialist
United Nations Children's Fund (UNICEF)
Jakarta, Indonesia

Dr Ni Ni Lwin
Health Officer, Maternal, Newborn and Child Health
United Nations Children's Fund (UNICEF)
Myanmar

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

Dr Sufang Guo
Health Specialist
UNICEF
Regional Office for South Asia (ROSA), Kathmandu, Nepal

Dr Deepika Attygalle
Programme Manager
Child Survival and Development and Regional Coordinator
South to South Cooperation
United Nations Children's Fund (UNICEF)
Colombo, Sri Lanka

Dr Basil Rodrigues
Regional Adviser – Child Survival
UNICEF - East Asia and Pacific Regional Office (EAPRO)
Bangkok, Thailand

Ms Kyoko Shimamoto
Health Specialist
Maternal, Newborn and Child UNICEF - East Asia and Pacific Regional Office (EAPRO)
Bangkok, Thailand

Dr Carla Quintao
Health Officer
United Nations Children's Fund (UNICEF)
Dili, Timor-Leste

UNFPA

Ms Frederika Meijer
Country Representative
United Nations Fund for Population Activities (UNFPA)
New Delhi 110003
Recommendations and Report

Ms Nam Suk
National Programme Officer
United Nations Population Fund
Pyongyang
Democratic People’s Republic of Korea

Dr Hla Hla Aye
Assistant Representative
United Nations Population Fund
Yangon, Myanmar

Ms Neera Thakur
RH Officer
United Nations Population Fund
Kathmandu, Nepal

Dr Domingas Bernardo
Assistant Country Representative
United Nations Population Fund
Dili, Timor-Leste

Dr Chandani Galwaduge
Programme Specialist
Maternal and Child Health/Reproductive Health
United Nations Population Fund
Dili, Timor-Leste

US AID

Dr Lily Kak
Senior Maternal and Newborn Advisor
United States Agency for International Development
Washington D.C., USA

Dr Sharmila Neogi
Maternal Health Adviser
United States Agency for International Development
New Delhi, India

World Bank

Ms Rekha Menon
Practice Manager, South Asia Region
Health, Nutrition & Population Global Practice
World Bank
New Delhi, India

Mr Jorge Coarasa
Health, Nutrition & Population Global Practice
World Bank
New Delhi, India

UNAIDS

Mr Steven John Kraus
Director
UNAIDS Regional Support Team for Asia and the Pacific
Regional Office for Asia-Pacific
Bangkok, Thailand

UN WOMEN

Dr Rebecca Tavares
Representative for India, Bhutan, Maldives and Sri Lanka, UN Women
Office for India, Bhutan, Maldives & Sri Lanka
New Delhi, India

Partners

Dr Assaye Nigussie
Deputy Director MNCH
The Bill and Melinda Gates Foundation
Seattle, USA

Dr Vijay Kumar
Executive Director (Hony)
SWACH Foundation
Panchkula, Haryana

Dr Ajitkumar Sudke
Senior Programme Officer - MNCH
The Bill and Melinda Gates Foundation
New Delhi, India

Dr Abhijeet Pathak
Programme Specialist Medical
International Planned Parenthood Federation
New Delhi, India

Ms Daw Thazin Nwe
President
Myanmar Maternal and Child Welfare Association
Nay Pyi Taw, Myanmar
Ms Yukie Yoshimura  
Chief Advisor  
Safe Motherhood Promotion Project  
Phase 2  
Japan International Cooperation Agency  
Dhaka, Bangladesh

Ms. Keiko Osaki  
Senior Advisor on Health  
Japan International Cooperation Agency  
Japan

Dr Ishtiaq Mannan  
Director - Health, Nutrition and HIV/AIDS  
Save the Children  
Dhaka, Bangladesh

Dr Rajesh Khanna  
Senior Technical Advisor - Newborn Health  
Save the Children  
Gurgaon, Haryana

Dr Harish Chellani  
Consultant  
SAARC Project on Newborn Health  
Safdarjung Hospital  
New Delhi, India

Dr Monowarul Aziz  
Senior Programme Manager  
Health, Nutrition and Population Programme  
BRAC, 75, Mohakhali  
Dhaka  
Bangladesh

Mr Rabin Lal Shrestha  
Regional Advocacy Manager for South Asia  
Water Aid, South Asia  
Kathmandu, Nepal

Dr Bulbul Sood  
Country Director / India  
Jhpiego - an affiliate of Johns Hopkins University  
221, Okhla Phase III  
New Delhi, India

Dr Sebanti Ghosh  
Senior Technical Advisor  
John Snow India Private Limited  
New Delhi, India

Dr Ardi Kaptiningsih  
Taman Permata Cikunir, Jl Koala I, Block A-8  
No 26, Bekasi 17146,  
West Java, Indonesia

Dr Meera Thapa Upadhyay  
Chief Consultant Gynaecologist  
Paropakar Maternity and Women Hospital  
Kathmandu, Nepal

WHO headquarters

Dr Anthony Mark Costello  
Director  
Department of Maternal, Newborn, Child and Adolescent Health  
Geneva, Switzerland

Dr Matthews Mathai  
Coordinator  
Epidemiology, Monitoring and Evaluation  
Department of Maternal, Newborn, Child and Adolescent Health  
Geneva, Switzerland

Dr Rajiv Bahl  
Coordinator, MNCAH Research and Development  
Department of Maternal, Newborn, Child and Adolescent Health  
Geneva, Switzerland

WHO Country Offices

Dr Mahbuba Khan  
National Professional Officer  
WHO Representative’s Office  
Dhaka, Bangladesh

Mr Tshering Dhendup  
National Professional Officer  
WHO Representative’s Office  
Thimphu, Bhutan
Dr Nazira Artykova  
MCH Technical Officer  
WHO Representative’s Office  
Pyongyang, DPR Korea  

Dr Rajesh Narwal  
National Professional Officer  
WHO Representative’s Office  
New Delhi, India  

Dr Paul Francis  
National Professional Officer  
WHO Representative’s Office  
New Delhi, India  

Dr Amrita Kansal  
WHO Representative’s Office  
New Delhi, India  

Dr Anju Puri  
National Professional Officer  
WHO Representative’s Office  
New Delhi, India  

Mrs Rustini Floranita  
National Professional Officer  
Maternal and Reproductive Health  
WHO Representative’s Office  
Jakarta, Indonesia  

Dr Dewi Indriani  
National Professional Officer  
Child Health  
WHO Representative’s Office  
Jakarta, Indonesia  

Dr Chandani Anoma Jayathilaka  
Technical Officer  
WHO Representative’s Office  
Yangon, Myanmar  

Dr Mukta Sharma  
Technical Officer  
WHO Representative’s Office  
Bangkok, Thailand  

Mr Crispin Araujo  
Programme Assistant  
Nutrition, Food Safety and RMNCH  
WHO Representative’s Office  
Dili, Timor-Leste  

WHO/SEARO

Dr Arun B. Thapa  
Ag. Director - Family Health, Gender and Life Course & Director, Programme Management  
New Delhi, India  

Dr Phyllida Travis, Director  
Health System Development  
New Delhi, India  

Dr Neena Raina  
Regional Adviser  
Child and Adolescent Health  
New Delhi, India  

Ms Payden  
Regional Adviser  
Water, Sanitation and Health  
New Delhi  

Dr Rajesh Mehta  
Medical Officer  
Child and Adolescent Health  
New Delhi, India  

Dr Elizabeth Mason  
Global Public Health Sarl  
62, Parc des Mayens, Le Grand Saconnex  
Geneva, Switzerland  

Dr Dinesh Jeyakumaran  
Junior Public Health Professional  
Child and Adolescent Health  
New Delhi, India
Annex 4

Session on country reflections: proposed priority actions

Key points:

**Bangladesh**

- Coverage
  - Development of new midwifery cadre
  - Implementing strategy for hard to reach areas
- Quality
  - CQI – need to create right mind-set
  - PDSA – make audit a routine practice
- Accountability
  - Accreditation of health facilities, including private and public
  - CS rate – need for monitoring of levels in private and public sector
  - Need for reliable and real time

**Bhutan**

- General observations on lessons learnt – key importance of research
- Commit to:
  - Implement ENAP
  - Adopt MDSR

**Democratic People’s Republic of Korea**

- No private sector
- Recognize more strongly the priority which must be given to QI of MNH services
India

- Strengthening monitoring of equity
- One thing to highlight: implementing pro-poor strategies in hard-to-reach populations to reduce inequities in identified high priority (low performing) districts.

Indonesia

- Request for TA to achieve higher profile for MNH at policy level for RMNCAH

Maldives

- Need for stronger recognition of nurse-midwives
- Re-start conduct of near miss reviews

Myanmar

- Specific mapping of neglected populations (remote)
- Accountability needs partner harmonization to jointly and openly monitor progress

Nepal

- Birthing and newborn care centres will be strengthened, as part of National Strategic Plan
- Free newborn care from 2015/16
- ENAP will reach out and ensure other partners in Ministry of health and beyond recognize this is an important cross-sectoral issue.
- Nepal faces many challenges owing to recent environmental disaster

Sri Lanka

- Timely moment for UHC as new Government
- TA needed on QI, health financing, and HR development plan
**Thailand**
- MNCH is acknowledged priority for Ministry of health

**Timor-Leste**
- Strengthening of outreach activities to reduce inequities
- Emphasis on data reliability being reviewed at the regional level and then give feedback to other levels
Annex 5

Summary of group work

*Actions for high and equitable coverage for interventions around childbirth*

<table>
<thead>
<tr>
<th>Health financing for scaling up institutional deliveries and newborn care (small and sick babies)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What are the present successful mechanisms to minimize out of pocket (OOP) expenses?</strong></td>
</tr>
<tr>
<td>Participants highlighted the mechanisms in their countries to reduce OOP expenses; these are summaries by country and by type of mechanism.</td>
</tr>
<tr>
<td><strong>Bangladesh</strong>: Services in the Public Health System are free, including for the sick newborn. DSF project in 1/3 districts, covers OOP for ANC, transport, delivery (including complications), normal newborn (sick newborn not included) and PNC. Where in place shows increased facility delivery. Provider gets performance incentive.</td>
</tr>
<tr>
<td><strong>Bhutan</strong>: Free health care – 100% coverage.</td>
</tr>
<tr>
<td><strong>India</strong>: JSY scheme 2005. Mother gets cash incentive of Rupees 1 400 for institutional delivery. Implementation is in all low performing states. In other states it is for the poorest. JSSK since 2011 – scheme to reduce OOP expenses, free transport between home and facility, plus inter-facility and food for 3-8 days. Sick newborn and infant to one year covered (2013). Challenge: SCNU not available in all states such as Bihar and UP. Scheme works very well for mothers, but not so well for newborns.</td>
</tr>
<tr>
<td><strong>Maldives</strong>: Since 2009 public health services free (up to 100 000). Since 2014 – limitless free health care.</td>
</tr>
<tr>
<td><strong>Myanmar</strong>: Free services ANC – five years. (Transport and food not included). Ministry of Labour – Social Security Insurance, reimburse money to working women who are members. Ministry of Social Welfare – trying to provide social protection.</td>
</tr>
<tr>
<td><strong>Nepal</strong>: Demand side financing for ANC, delivery. For caesarean section the hospital is reimbursed. Institutional delivery now 50%. Newborn care is not covered. Scheme under development for sick newborn care.</td>
</tr>
</tbody>
</table>
**Sri Lanka:** All services free including sick newborn. Public sector 96%, private sector 4%.

**Thailand:** UHC (public health insurance) – ANC, delivery, postpartum. But sick newborn care not covered and costs may be very high. Hospital can recover some but not all costs. (no OOP).

**Timor-Leste:** Free health services for mothers and children.

**Summary**

**Demand side financing schemes:** JSSK (India), DSF (Bangladesh), Amasuraksha (Nepal).

**Universal free care:** Bhutan, Timor-Leste, Nepal (defined population and packages).

**Public funded insurance schemes:** Agrahar (Sri Lanka), Indonesia (BPL), cross-subsidized.

**Social security schemes:** Thailand (public/private funded).

**What are the other feasible options for financing?**

Other options being tested or implemented in countries include:

- Corporate social responsibility towards maternal/newborn health.
- Tobacco, liquor tax for MNCH.
- Results-based financing, NGOs support.
- Social health Insurance can help existing national programme move towards universal health coverage for RMNCAH. For example, in Thailand, insurance covers private accredited providers.
- Regulation of private sector.
- Health insurance based scheme – pilot in three sub districts of Bangladesh. DFS scheme under discussion for newborns in Nepal.
- Donors, GFF, (need investment case for financing).

**What are the successful and possible approaches for reaching the unreached?**

Successful approaches being implemented in countries include:

- Special services for migrant populations will be included into the universal coverage.
- Outreach clinics in every village, using social mobilizers and community nurses – Nepal, Maldives.
• Mobilization through religious leaders and groups.
• Using the concept of barefoot doctors to reach the unreached – Indonesia.
• Using maternity waiting home – Bhutan, Maldives.
• Additional incentives, non-financial benefits for service providers working in remote areas.
• Home visit to reach the unreached areas – Timor-Leste.

Other possible options include:

• Improving access to quality MNH services to the underserved and vulnerable requires defining, and mapping the hard-to-reach areas, vulnerable population; not reinventing the wheel, use the census/surveys; polio programme, maternity homes.
• Use disaggregated data to design programmes.
• Increasing service facilities (population norms), mobile teams.
• Special financing for unreached areas.
• Bring women closer to the place of facility for birth.
• Deploy trained personnel in the rural areas - provide compensation, career ladder, incentives.
  Review has to be made by government and Indicators set to see the success and differences of different approaches.
• Strengthen referral.
• Pre-requisite: providing assured quality services.

### Addressing human resources issues

#### Categories/Cadres for which there is a shortage

Problems cited by countries include:

**Bhutan:** Shortages of nurses/midwives. Candidates sent to India for training. Shortage of specialized care such as sick neonates. Need to scale up SNCU and KMC.

**India:** There are not enough specialists leading to an unmet need for CeMONC. ANMs at sub-centre levels – Some states have bridge course, also considering upgrading of ayurvedic doctors.
**Indonesia**: Problem of distribution of health workers, also skills and competency.

Problem of accreditation of nursing and midwifery schools.

Shortage of specialists in neonatal health.

**Maldives**: Rely on expatriates – as there is no medical school. Most Maldives doctors want to stay in urban areas. Midwifery school exists.

**Sri Lanka**: Retention of public health nurses is a problem.

Approaches to retain specialists include:

- Multi-tasking.
  - Task shifting.
  - Lowering the basic recruitment criteria for public health midwives.
  - Higher incentives to attract service providers.
  - Standardized in curricula to accommodate foreign employees to the service.

- Local recruitment, mandatory services; incentives based deployment.

- Mentoring and enabling environment (availability of commodities, housing).

- Defining career paths; supportive supervision.

- Traditional systems of medicine to provide public health services.

- Midwifery cadre should be promoted.

- Strengthening pre-/in-service training.

- Promoting community participation.

- Move towards midwifery system.

- Task shifting for sick newborn care – District SCBU.

- To address the shortage of specialists in neonatal health, one year diploma course for Obstetrics/Gynaecology and Paediatrics.

**Key actions that the group recommends for managing the shortage**

- Production of health workers, especially midwives, should be increased.

- Review accreditation of midwives and their roles and responsibilities.
Successful and feasible approaches for retaining the health workers in rural and difficult areas:

- Retain - ensure to recruit from that local area.
- Strengthen pre-service training.
- Reward and incentivize health workers better and provide them career opportunities such as provide housing, transportation and incentives. Introduce career guidance and promotional scheme.

Ensuring appropriate skill mix to care for mothers and newborns

Recommendations for strengthening pre-service education and training

The groups discussed ways to strengthen pre-service education and actions that have been adopted in their countries:

- Scale up and improve quality of skill mix training through a national curriculum which is skill-based/guideline-integrated into the pre-service and on the job training. Include standards for pre-service education, consider the duration of curriculum.
- Standardized policy and implementation of this policy - governance issue.
- Establishing training hubs at country level, regional level, include competency based learning.
- Ownership and accountability.
- Creating separate cadre of midwives and providing higher status for midwives.
- Create cadre of neonatal nurses. Need specific course on this.
- Medical schools and larger hospitals should be accountable for the larger area
- Implementation of international curriculum
- Curricula need to be regularly updated for MBBS, nurses, midwives to reflect skills and responsibilities of their posting.
- Need to open up midwife career ladder (not necessarily to change to nursing).
- Strengthening medical and nursing/midwifery council.
### Recommendations for strengthening in-service training

Ways to strengthen in-service training that are being implemented in countries include:

- CME (continuing medical education), e-learning.
- QI initiative needed at the local level.
- Enhanced learning, process mapping needed.
- Quality of training should be monitored.
- Need continuous skills building – skills labs, mentoring or similar.
- WHO to look at integration of new sepsis and newborn care guidelines into IMNCI.
- Continuing professional development (CPD) – needs to be linked to annual registration. Competency, supervision, etc.

### Recommendations for strengthening supportive supervision and mentoring

Ways to strengthen supportive supervision that are being implemented in countries include:

- Supportive supervision is not common and becomes a challenge in the remote areas.
- There is need for competency based rewards; e-learning, use of mobile technology, multi-model approach.
- Supportive supervision – need guidelines, integrated team, accountability.
- Checklist should be standardized and be around key clinical behaviour and not focus only on instruments.
- Nepal moving towards on-site coaching and mentoring.
- Sri Lanka has developed supervisory tool – incorporated in the health system.
- PDSA approach for supervision?

### Demand generation for institutional deliveries and newborn care (small and sick babies)

### Key recommendations for engaging individuals, families and community

The participants recognized that many of the demand-creation interventions are implemented in few areas and not countrywide. Examples include:

- Special focus on the unreached even though the cost might be higher.
- Client’s feedback mechanism as a means to improve service. Analysis based on their feedback, the bottlenecks.
- Education and engagement such as classes for mothers during ANC and distribution of books.
- Use of MCH handbook, engaging both mother and husband, FGD.
- Seeking care: BCC strategies.
- Reaching care: inter-sectoral planning for transport; financial protection.
- Providing care: assured quality services.

**Specify the support required from WHO, UNICEF, UNFPA and other partners**

**Bangladesh:** Poor QoC. Need steps to improve QoC. Also moving towards midwifery-based system – need help to develop a model for this.

**Bhutan:** Enhancement of midwifery skills to provide QoC, plus research – how to reduce caesarean section rate.

**India:** Using technology to reach the unreached. Plus ASHAs efficiency of payments. Need support for routine monitoring, capacity-building and research.

**Indonesia:** High mortality districts with low coverage of health insurance.

**Myanmar:** Needs to review the financing of health services in the country, inter-ministerial planning (finance, health, SW, labour, etc.).

**Maldives:** How to incentivize midwives. Looking beyond usual causes of NM birth defects and prematurity.

**Nepal:** Support to get to 100% coverage. Midwifery training capacity.

**Thailand:** Monitoring of financing, especially for international comparison.

**Sri Lanka:** Need to fine-tune neonatal care. Super-specialization on regional basis.
### Actions for improving quality of care around the time of childbirth

#### Quality improvement mechanism at national and subnational level

The groups discussed key factors and actions for improving quality.

- Improving quality should be an ongoing process with Ministry of health in the driver seat.
- Accreditation and re-accreditation.
- Include key indicators in health information system that reflect the status and improvement of quality – input, process and output.
- In-service training at subnational level for healthcare professionals.
- Mentoring and facilitated supervision-post in-service training.
- Quality improvement has two separate components, i) Physical quality standards (developing standards, etc.) and ii) Motivation (work improvement, etc.).
- Checklists and guidelines (essential list, 24-hour electricity, water quality, etc.). Ensuring Supply chain management and inventory management.
- Local champions are required. A local leader must be selected such as a midwife.
- Policies and investments are needed.

#### Key recommended actions for strengthening the leadership for improving quality of care in Ministry of health (national and subnational)

The groups discussed key recommendations for strengthening leadership for QoC.

- Establishment of a committee at different levels (Ministry of health, and institutional level).
- National quality improvement bodies who are responsible to monitor the quality improvement cycle.
- Establish standard tools for each level of facility according to country needs. SOP’s to be displayed. Quality indicators to be displayed and also to be in the patient charter.
- A dedicated person as a leader at all levels - quality manager at Health facility to take the leadership, regular management.
- Key indicators in hospital level that reflect the status and improvement of quality and which can be reviewed (core indicators). Strengthen mechanism for better coordination between clinicians. Dashboard to be displayed at hospital facilities.

- Ensure skilled human resources.

- Ensuring medical audit at hospitals.

- Involve the professional organizations.

- Internalise the culture of quality from pre-service training and in-service training – ensure the quality in practice (for example use of partogram, reducing nosocomial infection).

- Promote community awareness and private sector to buy in.

Country examples include:

**Bangladesh**: Quality improvement secretariat in Ministry of health.

**Bhutan**: Quality assurance division in Ministry of health.

**India**: Already have – NHSRC.

**Indonesia**: No identified unit.

**Maldives**: Quality assurance division in Ministry of health.

**Myanmar**: RMNCAH – Technical Strategy group (TSG).

**Nepal**: Management division under Ministry of health.

**Sri Lanka**: Quality improvement secretariat at Ministry of health that take cares of the QoC.

**Thailand**: Mechanism of implementation for national and subnational level under MoPH.

### Recommendations to strengthen capacity for QI

The groups discussed ways to strengthen capacity for QI. They proposed the following solutions:

- Establishment of a simple user-friendly guideline for leaders; 2-3 days module (a request to WHO to develop).

- Capacity development as an ongoing process through technology, mobile application.
• Inter-sectorial partnership. For example, equipment in the hospital cannot be used without electricity.

• Utilization of periphery health facilities? Is it possible to assure quality assurance at all levels?

• Client feedback system should drive the quality improvement process compiled with audit process, exit interview, involvement of community members in quality improvement team.

• Improve HR – Need a dedicated cadre of neonatal and mother care nursing/midwife according to the birth numbers.

• Review and update the pre-service curriculum to improve the skills of the health staff. Coaching and mentoring in-service health staff to abide with the guidelines, including follow up after the training.

• Support services also need strengthening with QoC such as Transport service.

• Measurement indicator defined. Data should be analysed and used for the QoC improvement. Re-registration system to ensure the standard of service.

• Logistics: The equipment should be available; Essential drug list and equipment. Maintenance and regular check-up for the equipment. Regular audits on their use, etc.

• Ensure management of facilities including waste management, water and sanitation, etc.

• Develop and make available SOP and clinical guidelines - to develop a comprehensive handbook for at birth care.

• Share technology and experience at national and international level. Adaptation of global quality standards in country context. Formation of quality teams at hospital level.

## Specify the support required from WHO, UNICEF, UNFPA and other partners in all the identified areas

The groups identified the following support required:

- Evidence-based standard guideline on QoC.
- List of indicators (key performance indicators).
- Technical assistance based on the needs (assessments, review, bottle neck analysis, adaptation of guidelines, ToTs).
- Research and continuous studies to improve the input and output indicators.
- Demand creation – for seeking quality.
- TAG/ South-South Cooperation – learning from each other.

**Actions for improving national accountability for MNH**

<table>
<thead>
<tr>
<th>Key recommended actions for strengthening the leadership for improving collection and use of data in Ministry of health (national and subnational)</th>
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</thead>
<tbody>
<tr>
<td>Participants identified actions that are being taken in their countries, or that they propose as important to put in place.</td>
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<tr>
<td>- Policy guideline on surveillance, review, collection and use of data. Clear policy with well-defined mechanism of implementation - some countries need further improvement.</td>
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<tr>
<td>- Legislation to compel government and private sector to review and report.</td>
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<tr>
<td>- Sensitization of policy makers, managers, service providers, community health workers and the community about the importance data.</td>
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<tr>
<td>- Ministries maintain central repository – a nodal unit with identification of a single nodal person or a unit. (Thailand has best practice of Ministry of health receiving data from hospitals.)</td>
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<tr>
<td>- Mandatory notification of maternal death, stillbirth and neonatal death.</td>
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<tr>
<td>- Conduct regular reviews and make managers at each level accountable to conduct and report regularly with analysis and feedback to all levels.</td>
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<tr>
<td>- Capacity-building needed to strengthen collection and use of data.</td>
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<tr>
<td>- Clinicians (obstetricians, paediatricians) field health workers accountable for data collection, review and reporting.</td>
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<tr>
<td>- Regular dialogue with hospital and district level all stakeholders.</td>
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<td>- NGOs where available to link with Ministry of health and support Ministry of health.</td>
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<tr>
<td>- Having a scientific format for reporting uniformly used throughout the country, automation and real time use of data, also use of data for publication.</td>
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### Key recommended actions for strengthening birth and death registrations (civil registration and vital statistics)

Participants discussed and made recommendations on key actions to strengthen birth and death registration:

- Compulsory birth and death registration legislation and policy (database should be linked with other ministries for example, for vaccination, school admission, identity card, death). Link the birth notification and death notification data; identification numbers need to be linkable – unique identifier (such as Bhutan, India).
- Legislation making birth and death registration linked to social and educational benefits so people are encouraged to perform early registration.
- Governments should focus on completeness and standardization of the registration. Improve awareness to generate demand for registration of births and deaths, for example through social volunteers.
- Simple and international acceptable format for birth and death registration. Stillbirth is a neglected area and needs to be specifically included.
- All births, stillbirths and deaths should be documented and cause of all deaths should be inquired.
- For facility births: Provision of issuing birth certificate and registration within a stipulated time.
  - For home births: Demand generation for birth and death notification.
- Involvement of the private sector.

### Key recommended actions for strengthening maternal and perinatal death reviews

Participants discussed key actions and how to strengthen MDSR and perinatal death reviews.

- Start from MDSR and include PDSR when the country is ready.
- Reporting and review to be made compulsory by law and policy such as policy/legislation for MPDR and MDSR.
- Create a national task force and subnational task forces.
- MDSR should be made an integral part of QI process and have a simplified tool, possibly IT-based. Address improving clinical services and health systems barriers.
- Selective review of perinatal death.
• Limit to only necessary data collection, that is start small and expand. Start from the community and note the importance of listening to the community. For example demand generation and community sensitization: counselling, mass campaign. Include community feedback.

• Make sure that Response take place. (Response is more important than surveillance).

• Multisectoral involvement: Review and Response.

• Medical audit should be part of pre-service curriculum.

• Social autopsy for identifying the modifiable social actions to prevent deaths, through samples, surveillance through identified centres, stillbirths through verbal autopsies.

**Barriers include:**

• Transparency, under-reporting, limit the number (selective cases), universal for number, blame culture, looking at the piecemeal, budget.

• Lack of IT facilities.

• Large numbers.

**Actions to overcome the barriers:**

• Simplify the tasks/procedures, back with resources.

• Coordination between obstetricians and paediatricians.

• Bring the social aspect along with medical aspect.

• Make death registration a legal requirement.

• Engage the community, in rural settings in particular (For example, Nepal: social awareness).

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**Key recommended actions for integrating ENAP core and additional indicators in existing system**

Participants discussed how to integrate ENAP indicators into the existing system, recognizing that some of the indicators are already there.

• Learn from countries that are well ahead in incorporating ENAP indicators (such as Nepal).

• Review existing HMIS along with ENAP core and additional indicators; identify gaps in existing registers and HMIS.
- Integrate with health HMIS including facility (government and private).
- Process indicators should be introduced from a lower level.
- Demographic health survey, other regular surveys to capture data required for ENAP.
- Monthly reporting of data required for indicators from institutions. Automation at different levels.
- MPDSR key indicators to monitor accountability and make the indicators visible. Capacity development of service providers and managers – collect, report and use of data.
- Involvement of the private sector.
- Real time use of the data by national and subnational level stakeholders.
- Community feedback mechanism for accountability.

### Key recommended actions for strengthening surveillance of stillbirths

Participants recognized that stillbirth surveillance is very weak or non-existent. The main suggestions to strengthen surveillance were:

- Need for a standardized definition of stillbirth.
- All stillbirths should be reported with SOP on stillbirth detection and reporting.
- Sentinel hospital-based surveillance (integrated with newborn health and birth defects databases). Magnitude and trends.
- Start with the hospital data and track down to the community. With synchronization of community and hospital-based surveillance.
- Community-based – Improve the awareness of the community through community workers at mothers’ groups. Enhance demand generation activities for the community to report a stillbirth. Raising social awareness through community watch groups (such as Myanmar), local community.

Other suggestions included:

- Use of IT platforms.
- Involvement of the private sector.
- Report stillbirth cases by midwife.
Recommendations and Report

- Include in pre-service curriculum.
- Include in the HMIS.
- Monthly review to monitor and summarize outcomes.

Specify the support required from WHO, UNICEF, UNFPA, and other partners in all identified areas

Participants identified the following support required:

- Facilitation of South-South collaboration, including bi-regional collaboration – Asia Pacific.
- Technical assistance to set up system, and for advocacy, policy dialogue, plus TA for mobilisation of resources.
- Facilitate sharing of best practices.
- Sharing current information regularly.
- Regular technical assistance and follow-up for six high-burden countries.
- Make guidelines simple to develop SOPs, guidelines, information systems.
- Enhance coordination among the UN partners.
- Technical assistance towards large scale research and evaluation.
Under the Regional Flagship project on ending preventable maternal and child mortality with a focus on reducing newborn mortality, the WHO Regional Director for South-East Asia has appointed the Technical Advisory Group (SEAR-TAG) to provide guidance to national governments, implementing partners and other stakeholders on how best to accelerate implementation of strategies, and monitor these. The inaugural meeting of SEAR-TAG was organized on 15–18 December 2015 to evolve a shared understanding of priorities, challenges and high impact approaches for reducing newborn mortality. The focus on addressing the issue high newborn mortality through the global approach of every newborn action plan will have additional benefits of reduction in maternal mortality and stillbirths.

All twelve SEAR-TAG members, RMNCAH nodal persons from the ministries of health from Member States, representatives of UN agencies and other partners, INGOS and NGOs, representatives of Professional associations (Pediatrics, Neonatology and Obstetrics) and WHO Collaborating Centres participated in the meeting.

There were deliberations to examine and identify ways to address three areas: coverage and equity gap in terms of low and uneven coverage of evidence-based interventions; quality gap in terms of inadequate quality of care; and an accountability gap in terms incomplete registration of births and deaths of mothers and newborns as well as stillbirths. The report provides the summary of proceedings of the SEAR-TAG meeting and the recommendations.