Remarkable progress has been made in recent decades to reduce the number of child deaths worldwide, but neonatal mortality rate declined at a slower pace. Yet a large proportion of newborn deaths are preventable. Currently, 2.9 million babies die within the first month of life accounting for 44% of under-five mortality, and an additional 2.6 million babies are stillborn. In order to reduce child mortality and end preventable deaths, intensified action and guidance are needed to ensure newborn survival.

The Every Newborn: an action plan to end preventable deaths is a roadmap for change. It sets out a vision and proposes a goal and targets to end newborn deaths from preventable causes. Five guiding principles and five strategic objectives are at the core of the plan.

The action plan is based on evidence and considers the main causes on newborn mortality and effective interventions to prevent and manage these. It builds on the intrinsic links between maternal and newborn health and promotes state-of-the-art knowledge of effective delivery approaches for the interventions and innovations to accelerate progress towards universal health coverage. The plan is also informed by a systematic review of the progress in addressing newborn survival globally in the last decade.

Development of this plan has been guided by the advice of countries and experts, and was coordinated by a core group of partners, led by WHO and UNICEF. The process included several multi-stakeholder consultations in which country teams presented and discussed results from a bottleneck analysis towards scaling up of newborn interventions that they had conducted in their countries.

The Every Newborn Action Plan is situated in the continuum of care for Reproductive, Maternal, Newborn and Child Health. It will be a useful resource to guide the design of national plans to accelerate progress towards MDGs 4 and 5 and work towards the longer term goal of ending preventable deaths among women and children.
Every newborn: a draft action plan to end preventable deaths

1. Remarkable progress has been made in recent decades in reducing the number of child deaths worldwide, largely due to interventions to lower child mortality after the first month of life. Even though the mortality rate among children under the age of five years has declined globally by almost 50% (from 90 deaths/1000 live births in 1990 to 48 deaths/1000 live births in 2012), the neonatal mortality rate decreased only 36%, from 33 deaths/1000 live births to 21 deaths/1000 live births over the same period. As a result, the proportion of deaths in children under five years of age that occur in the neonatal period increased from 37% in 1990 to 44% in 2012 when 2.9 million children died within the first month of their life, mostly of preventable causes. These deaths are closely linked to 2.6 million babies who die in the last 3 months of pregnancy or during childbirth (stillbirths).

2. Many governments and partners have renewed their commitments to saving the lives of women and newborns, in response to the United Nations Secretary-General’s Global Strategy for Women’s and Children’s Health (launched in 2010) and its accompanying Every Woman, Every Child initiative and to recommendations made by the Commission on Information and Accountability (2011) and the United Nations Commission on Life-Saving Commodities for Women and Children (2012). The Every Newborn Action Plan takes forward the Global Strategy’s mission and is part of the Every Woman, Every Child movement, thus contributing to integrated actions across the reproductive, maternal, newborn and child health continuum of care.

3. World-wide, national and global leaders have endorsed the goals set out in Committing to Child Survival: A Promise Renewed (APR), which calls for ending preventable child deaths by 2035. Similarly, there are strong regional and global commitments to ending preventable maternal deaths. Given the significance of neonatal mortality in under-five mortality, the APR target that every country reduces under-five mortality to 20 or less per 1000 live births by 2035 will not be attained without specific efforts to reduce newborn mortality.

4. This draft action plan is a response to the urgent need to intensify action to end preventable neonatal deaths. It is based on evidence of what works and provides clear strategic objectives. It recognizes that survival of newborns is a sensitive marker of a health system’s response to its most vulnerable citizens and calls upon all stakeholders to improve access to and quality of care for women and newborns, within the continuum of care that spans pregnancy, childhood and adolescence. The draft action plan emphasizes reaching every woman and every newborn baby, in particular when they are most vulnerable, namely in labour, during childbirth and in the first days of

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a newborn’s life. Effective care for mother and baby at this time also reduces maternal mortality and intrapartum stillbirths, resulting in a triple return on investment.

5. The opportunities for improving newborn health are unprecedented. Over a decade of analysis and research has generated information on the burden and causes of newborn mortality, demonstrated effective interventions and service delivery channels, and identified ways to accelerate progress in extending the coverage of interventions and to reduce that mortality. The intrinsic link between the survival, health and nutrition of newborns and the survival, health and well-being of the mother has been corroborated, and the period of greatest risk of morbidity and mortality of both mother and child confirmed as the hours that precede and follow childbirth.

6. At the Sixty-fourth World Health Assembly, in resolution WHA64.12 and discussions in Committee A, Member States noted the insufficient and uneven progress towards achieving Millennium Development Goals 4 and 5, and observed that progress towards reducing perinatal and neonatal mortality had stagnated. They expressed concern over the high number of stillbirths and neonatal deaths and the large contribution of neonatal mortality to under-five mortality. The Health Assembly, in resolution WHA64.13, Working towards the reduction of perinatal and neonatal mortality, requested the Director-General to promote targeted plans to increase access to high quality and safe health services to prevent and treat perinatal and neonatal conditions. The present draft action plan responds to that request and is also in line with the provisions of resolution WHA64.9, Sustainable financing structures and universal coverage.

7. Newborn health is a human right as specified in the Convention on the Rights of the Child. The United Nations Human Rights Council, in resolution A/HRC/22/32, affirmed the importance of applying a human-rights-based approach to eliminating preventable maternal and child mortality and morbidity, and requested States to renew their political commitment and to take action to address the main causes of maternal and child mortality and morbidity. The General Comment No. 15 made by the Committee on the Rights of the Child in April 2013 specifies that 'States have an obligation to reduce child mortality', and the Committee urged particular attention be paid to neonatal mortality.

8. The Global Investment Framework for Women’s and Children’s Health estimates the effects of investment on reproductive, maternal, newborn and child health across the continuum of care. The package of 50 effective interventions considered includes those related to newborn health. The Framework estimated that, with the right investment of US$ 5 per person per year, the deaths of

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3 See also document WHA64/2011/REC/1, summary records of the ninth, tenth and eleventh meetings of Committee A.
147 million children (including 60 million newborns), 32 million stillbirths and 5 million maternal deaths can be avoided by 2035. The investment would yield a return of close to nine-fold in the form of social and economic benefits over the 23-year period, 2012-2035, considered by the Framework for a group of 74 countries with the highest burden of maternal, newborn and child deaths.

CURRENT SITUATION

9. It is estimated that every year 287,000 women die from complications of pregnancy and childbirth, 2.6 million babies are stillborn and 2.9 million babies die in the first months of life. The global annual average rate of decline in newborn deaths since 1990 has been 2.1%, lower than that of maternal mortality (3.1%) and mortality of children aged 1–59 months (3.5%) and far less than the 4.4% required to achieve Millennium Development Goal 4 and the 5.2% required to achieve the goal set in Committing to Child Survival: A Promise Renewed. Appendix 1 sets out the targets of the draft action plan for rectifying that situation.

10. Most newborn deaths occur in low- and middle-income countries. Two-thirds of all newborn mortality occurs in 12 countries, six of which are in sub-Saharan Africa. Countries with a neonatal mortality rate of 30 or more deaths/1000 live births account for 60% of all newborn deaths. Many countries with a high burden of newborn mortality have experienced recent conflict or humanitarian emergencies. Others have weak health systems with limited infrastructure and low density of skilled health workers; in addition, out-of-pocket expenditures are high. Access to quality health services for women and children is not guaranteed, resulting in stark disparities in coverage of interventions, between and within countries. In the past decade, however, at least 77 countries, including 13 low-income countries, have shown that it is possible to make rapid progress, as they reduced their newborn mortality rate by more than 25%.

11. Three causes account for more than 85% of newborn mortality (Figure 1): complications of prematurity, intrapartum-related neonatal deaths (including birth asphyxia) and neonatal infections. Complications of prematurity are currently the second leading cause of under-five deaths. Annually 15 million babies are born prematurely and 32.4 million are born with a weight below the tenth percentile for their gestational age. More than 60% of all newborn deaths occur

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5 India, Nigeria, Pakistan, China, Democratic Republic of the Congo, Ethiopia, Bangladesh, Indonesia, Angola, Kenya, United Republic of Tanzania, Afghanistan (in descending order of annual number of newborn deaths).
6 Afghanistan, Angola, Burundi, Central African Republic, Chad, Comoros, Congo, Côte d’Ivoire, Democratic Republic of the Congo, Djibouti, Equatorial Guinea, Ethiopia, Guinea, Guinea-Bissau, India, Lesotho, Mali, Mauritania, Mozambique, Nigeria, Pakistan, Sierra Leone, Somalia, South Sudan, Swaziland, Togo and Zimbabwe.
7 Bangladesh, Bolivia (Plurinational State of), Eritrea, Guatemala, Indonesia, Madagascar, Malawi, Morocco, Nepal, Senegal, Rwanda, United Republic of Tanzania and Viet Nam.
among babies who have a low birth weight due to prematurity or are small for gestational age or both.\textsuperscript{10} Among infants born prematurely, 2.7\% (or 345 000) suffer a moderate or severe impairment and 4.4\% (or 567 000) have a mild impairment.\textsuperscript{11} The life-time risk of developing a noncommunicable disease is also increased in people who were born prematurely. Moderate and severe prematurity carries the greatest risk of disability and long-term morbidity.

**Fig 1: Causes of death in children under five years of age**

Over 60\% of neonatal deaths are associated with low birth weight*


\textsuperscript{11} Lawn JE, Blencowe H, Darmstadt GL, Bhatta ZA. Beyond newborn survival: the world you are born into determines your risk of disability-free survival. Pediatric Research. 2013.
12. The impact of social determinants of health on newborn mortality should not be underestimated. Poverty, inequality and societal unrest undermine maternal and newborn care through numerous pathways, including poor maternal diets, inadequate housing and sanitation. Complex humanitarian emergencies catalyse dramatic movements of people, including pregnant women and newborns, and compromise access to functional health systems. Low education levels, gender discrimination and a lack of empowerment prevent women from seeking health care and making the best choices for themselves and their children’s health, thereby resulting in perilous delays and unnecessary deaths. The gap between those with highest and lowest coverage of effective interventions can be closed in a generation through intersectoral actions such as expanding educational programmes, improving living and working conditions, increasing access to clean water and adequate sanitation, and progress towards universal health coverage.

EFFECTIVE INTERVENTIONS FOR IMPROVING THE HEALTH OF NEWBORNS ALONG THE CONTINUUM OF CARE

13. Effective interventions for improving survival and health of newborn babies form one component of integrated health services for reproductive, maternal, newborn and child and adolescent health. These interventions have been well documented across the life course and have been packaged for levels of service delivery. Many are delivered from common platforms for health care delivery; integrated planning and delivery can ensure efficient and effective health services for women and children.

14. Interventions around the time of birth have the greatest effect on reducing neonatal mortality, as low coverage and poor quality of health care at that time account for high rates of newborn mortality as well as maternal mortality and intrapartum stillbirths. Good-quality care during labour, birth and in the immediate postnatal period not only prevents the onset of complications but enables their early detection and prompt management. Although globally the proportion of women giving birth with a skilled attendant (physician, nurse or midwife) has increased to 66%, great disparities exist between and within countries. In sub-Saharan Africa in particular, coverage of skilled care at birth remains low at just under 50%.

15. Recognizing the importance of reaching every women and every newborn with quality care around the time of childbirth and the days immediately after birth, interventions during pregnancy and before conception also have a critical role to play. Interventions include those essential for all pregnant women who are in labour as well as essential newborn care. Additional care may be required for small and/or sick babies such as neonatal resuscitation, antibiotics and Kangaroo

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Mother Care. However, care before pregnancy, between pregnancies and during pregnancy also affects the survival and health of newborns. Pregnant women who are malnourished are more likely to give birth to low birth weight babies, as are women who were undernourished during their own first 1,000 days of life. Very young mothers not only face more pregnancy-related problems but are also prone to obstructed labour. Inadequately-spaced pregnancies are closely linked with newborn health outcomes and mortality. Access to family planning and the right to control when and how frequently they become pregnant is a vital part of empowering women and girls but also to the survival and health of their babies. Figure 2 present the packages of interventions that are essential for newborn survival and that also have an impact on maternal mortality and stillbirths.

**Figure 2: Packages of essential interventions for ending preventable newborn mortality**

![Packages of essential interventions for ending preventable newborn mortality](image)

The time around childbirth and the first day of life: a critical window of opportunity to prevent and manage complications

16. Low access to effective interventions continues in the postnatal period, with less than half of women and their newborn babies receiving postnatal care within the first two days after birth. Early postnatal care is particularly important for reducing the large percentage of newborn mortality that occurs on the first day of life, as good-quality postnatal care within 24 hours, on day 3, and between day 7 and 14 has a major impact on maternal and newborn health. Postnatal care enables carers to institute good care practices such as exclusive breastfeeding and seeking care

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when a newborn develops signs of illness. Globally, only 38% of infants younger than six months of age are exclusively breastfed, often owing to inadequate care that starts in the first week of a baby’s life and in spite of the fact that optimal breastfeeding practices can save the lives of up to 800,000 children under five years of age each year.16

17. Interventions should start well before conception. Every pregnancy should be wanted and, in this connection, intensified efforts are needed to reach an estimated 222 million women in developing countries who would like to delay or stop childbearing but are not using any modern method of contraception.17 Investments in family planning will also contribute significantly to an overall reduction in maternal and neonatal mortality. Reducing the number of unintended pregnancies could avert 60% of maternal deaths and 57% of the child deaths.18

18. No girl should marry or become a mother before having had a chance to reach an age of maturity. About 16 million adolescent girls between 15 and 19 years of age give birth each year, roughly 11% of all births worldwide. Complications in pregnancy and childbirth are some of the leading causes of death for adolescent girls, and perinatal deaths among babies born to mothers under 20 years of age are 50% higher than among those born to mothers between 20 and 29 years of age; adolescent mothers’ babies are also more likely to have low birth weight and/or be born prematurely. Preventing early pregnancy in adolescent girls has to be a major component of efforts to improve the health of newborns.19

19. Efforts and resources to prevent adolescent pregnancy have typically been focused on girls aged between 15 and 19 years, yet the most vulnerable girls, and those who face the greatest risk of complications and dying as a result of pregnancy and childbirth, are 14 years old or younger. Their needs are immense, and governments, civil society, communities and the international community must do much more to protect them and support their safe and healthy transition from childhood and adolescence to adulthood.20

20. Providing care to women and couples before and between pregnancies improves the chances of mothers and babies being healthy. Preconception care has, until recently, been a weak link in the continuum of care. In addition to family planning, it includes life-skills education; interventions to improve nutrition, prevent and manage harmful practices, such as smoking or alcohol use;

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identification and treatment of conditions such as sexually transmitted infections and mental illness; and tackling intimate partner violence.

21. Antenatal care is an important channel for delivery of a set of interventions that have a direct impact on the health of the mother and the fetus. In low-income countries, only an estimated 37% of women attend the recommended minimum four visits to antenatal clinics, and often the quality of care available is sub-optimal. An even lower proportion receives essential interventions such as screening for and treatment of anaemia and hypertension, counselling and testing for HIV and syphilis, or prevention and treatment of malaria.

22. The provision of a continuum of care throughout the life course needs seamless, functional coordination between levels of health services. In many countries, skilled care at birth is most efficiently provided in health facilities, as immediate access to emergency obstetric and newborn services when complications occur is crucial for survival. Community health workers can play an important role in supporting families to adopt good home care practices, encouraging delivery in a health care facility when quality services are accessible, and ensuring timely referral of newborns showing signs of illness.

23. Delivering health care to mothers and newborns requires coordination between technical programmes and initiatives, and collaboration among all concerned stakeholders led by governments, with professional associations, civil society, academic and research institutions, the business community, development partners and families.

THE ACTION PLAN

24. This draft action plan aims to enhance and support coordinated, comprehensive planning and implementation of newborn-specific actions within the context of national health strategies and action plans. It has been drafted in close consultation with stakeholders and takes into account the findings of analyses of bottlenecks to scaling up.

25. Putting the action plan into practice will build upon and strengthen existing commitments, such as those referred to in paragraphs 2 and 3 above. The plan also builds upon goals and targets included in other global actions plans, such as those for elimination of mother-to-child transmission of HIV and syphilis; control of malaria; improving maternal, infant and young child nutrition; reaching universal coverage of immunization; and the Integrated Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea.

26. The action plan relies on five guiding principles:

(a) **Country leadership**: Countries have the primary ownership and responsibility for establishing good governance and providing effective and good-quality reproductive, maternal and newborn health services. Community participation is a key feature of such leadership as it is one of the most effective transformational mechanisms for action and
accountability for newborn health. Development partners should align their contributions and harmonize action.

(b) **Integration**: Providing every woman and every newborn with good-quality care requires integrated service delivery with coordinated health system approaches between multiple programmes, stakeholders and initiatives across the continuum of reproductive, maternal, newborn and child health are essential, without losing visibility for newborn specific content.

(c) **Equity**: Equitable and universal coverage of high-impact interventions, and a focus on reaching the most vulnerable and poorest population groups are central to realizing the right of every woman and every newborn, girl and boy, to health.

(d) **Accountability**: Transparency, oversight and accountability are prerequisites for equitable coverage, quality of care and optimal use of resources.

(e) **Innovation**: Evidence has been accumulating over the past decade of strategies that broaden the coverage of interventions for newborns and reduce mortality. Nevertheless, innovative thinking is needed about ways to reach the poorest and most underserved populations. Optimizing the application of knowledge of which interventions and strategies are most effective still needs more research and development.

**VISION, GOALS AND TARGETS**

27. The action plan sets out a vision, and proposes a goal and targets for neonatal mortality reduction and reduction by 2035, with intermediate mortality targets for 2020 and 2025. The mortality targets are related to targets of coverage and quality of care for mothers and babies in health care facilities, postnatal care and care of sick newborns. More targets are shown in Appendix 1. Figure 3 shows the current trajectory for under-five and neonatal mortality along with the targets for under-five mortality reduction as proposed by *A Promise Renewed* and matching targets for newborn mortality reduction as proposed by this *Every Newborn* action plan. Figure 4 outlines the vision, goals and targets proposed by this draft plan.

28. The draft action plan supports the goals of Family Planning 2020 initiative to reach 120 million new users with modern contraception, specifically through services providing postnatal care. Specific linkages with other goals are included in the respective section of the document.
Figure 3: Trajectory of under-five and neonatal mortality to 2035

**Proposed neonatal mortality rate target for 2035**
Linked to A Promise Renewed target for preventable child deaths

<table>
<thead>
<tr>
<th>Scenario</th>
<th>2035 neonatal deaths</th>
<th>2035 global NMR (weighted)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business as usual</td>
<td>1.8 million</td>
<td>13</td>
</tr>
<tr>
<td>Every country reaches NMR of 10 per 1,000</td>
<td>1 million</td>
<td>7</td>
</tr>
</tbody>
</table>

Involves >2/3 reduction in NMR for every country, as if a continuation of MDG4.

Data sources: Trajectory calculated using mortality date from the UN Inter-agency Group for Child Mortality Estimation, Levels and Trends in Child Mortality: Report 2013
Figure 4. Outline of the vision, goals and targets of the Every Newborn action plan

**Vision**
The action plan envisages a world in which there are no preventable deaths of newborns or stillbirths, where every pregnancy is wanted, every birth is celebrated, and mothers, babies and children thrive and reach their social and economic potential.

**Global targets**

**Ending preventable newborn deaths:** All countries have less than 10 neonatal deaths/1000 live births by 2035, with a resultant average global neonatal mortality rate of 7 deaths/1000 live births, with interim global targets as shown below. This target is consistent with and supports that in *Committing to child survival: A Promise Renewed* for ending preventable child deaths and with proposed targets for ending preventable maternal deaths. Member States should ensure this target is also achieved for all their underserved populations.

<table>
<thead>
<tr>
<th>Year</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
<th>2035</th>
<th>Number neonatal deaths in 2035</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal mortality rate (global weighted average)</td>
<td>15</td>
<td>12</td>
<td>9</td>
<td>7</td>
<td>About 1 million</td>
</tr>
</tbody>
</table>

A neonatal death is defined as the death within 28 days of birth of any liveborn baby regardless of weight or gestational age. Note that these figures take into account the targets set in *Committing to child survival: A Promise Renewed* for every country to reach a mortality rate for children under 5 years of age of 20 deaths/1000 live births, which will result in a global average of 15 deaths/1000 live births.

To achieve an average global neonatal mortality rate of 7 deaths/1000 live births, all countries will have to reduce neonatal mortality by at least two-thirds from a baseline in 2012, which may be considered a continuation of Millennium Development Goal 4 applied to the unfinished agenda for the reduction in the number of newborn deaths.

**Ending all preventable stillbirths:**
All countries reduce their stillbirth rate to less than 10/1000 total births by 2035, with a resultant average global stillbirth rate of 8/1000 total births. Those countries with a stillbirth rate under 10/1000 total births should focus on addressing inequalities and using audit data to track and prevent all avoidable stillbirths.

For international comparison purposes, a stillbirth is defined as a baby born with no signs of life, weighing more than 1000 g or at 28 weeks gestation.

**Goals**
The overall goal is to achieve equitable and high-quality coverage of essential, referral and emergency care for every woman and every newborn within every country.

**Linkage with other global and national plans:**
The action plan will support the goals of Family Planning 2020 to reach 120 million new users with modern contraception, specifically through linkages with provision of postnatal care. It also builds on and links with other global action plans, such as those on nutrition, vaccines, pneumonia, diarrhoea, and water and sanitation, elimination of mother-to-child transmission of HIV, syphilis and tetanus.
Measurement and accountability:
Within 12 months of the launch of the action plan, an operational plan will be developed for defining and measuring coverage and quality of effective interventions and intervention packages promoted in this action plan, in association with the organizations and institutions with a global mandate for improving such metrics, as well as linking to other global plans, and accountability frameworks. Annex 2 lists key indicators for newborn health.

### Goals for coverage by 2020

**Goal 1: Coverage and quality of care at birth**
Ninety percent of women giving birth and of babies born in facilities will receive effective high-quality and respectful care that includes essential care during pregnancy, labour and following birth, with preventive care and appropriate management of complications for the mother and newborn. Maternal and perinatal deaths surveillance and response, and regular monitoring of quality of care will be an integral part of maternal and newborn health services.

**Goal 2: Coverage and quality of care for newborns at risk** At least half of babies not breathing spontaneously after birth are resuscitated with bag and mask ventilation; at least half of stable preterm newborns or babies weighing less than 2000 g receive kangaroo mother care and other supportive care; and at least half of newborns with possible serious bacterial infection receive antibiotic therapy.

**Goal 3: Home visits and participatory group support for women and newborns**
Each country will have achieved a 20% increase (or an increase to 90% if their baseline is above 70%), in the delivery of early postnatal care to mothers and newborns within two days of birth, in order to promote breastfeeding, counselling and screening for maternal and newborn complications, and postnatal family planning. In addition, each country will have an increase of 20% in the number of pregnant women having access to a participatory group.

### Goals for coverage by 2025

**Goal 1: Coverage and quality of care at birth**
95% of women will give birth with a skilled attendant, and every woman and her newborn with a skilled attendant will receive effective high-quality and respectful care outlined in coverage target 1.

**Goal 2: Coverage and quality of care for newborns at risk**
At least 75% of babies not breathing spontaneously after birth are resuscitated with bag and mask ventilation; at least 75% of stable preterm newborns or babies weighing less than 2000 g receive kangaroo mother care and other supportive care; and at least 75% of newborns with possible serious bacterial infection receive antibiotic therapy.

**Goal 3: Home visits and participatory group support for women and newborns**
90% of mothers and newborns receive early postnatal care of high quality within two days of birth and access to a participatory group. Quality of postnatal care will be tracked with improved metrics to assess content and longer term outcomes such as the nutrition goal of 50% exclusive breastfeeding in all countries by 2025.
STRATEGIC OBJECTIVES

29. The Every Newborn action plan proposes five strategic objectives.

**Strategic objective 1: Strengthen and invest in care during labour, childbirth, and the first day and week of life.** More than one-third of stillbirths (1.2 million), 75% of newborn deaths (2 million) and 72% of maternal deaths (206 250) occur within this period. Many deaths and complications can be prevented by ensuring provision of high-quality, essential care for every pregnant woman and every baby around the time of labour, childbirth and in the first 24 hours and week after birth.

**Strategic objective 2: Improve the quality of maternal and newborn care.** Substantial gaps in the quality of care exist across the continuum of care for women and children’s health. In many settings women and newborns do not receive the care that they need even when they have a contact with the health system whether before, during or after pregnancy. The key to success in improving is introducing high-quality care with high-impact, cost-effective interventions for mother and baby together – in most cases, by the same health providers at the same time.

**Strategic objective 3: Reach every woman and every newborn to reduce inequities.** Access to high-quality health care that people need without suffering financial hardship when paying for them is a human right. There is increasingly robust evidence of approaches for ending preventable newborn deaths that effectively accelerate the coverage of essential interventions, through innovations that include task sharing, improved access to life-saving commodities, health insurance and financing mechanisms, and use of information technology and social and knowledge networks.

**Strategic objective 4: Harness the power of parents, families and communities.** Education and information are crucial for empowering parents, families and their communities to demand quality care. Evidence has shown the power of engaged community leaders, women’s groups, and community workers in turning the tide for better health outcomes for newborns. Participatory learning and action in poor rural communities is a core intervention that requires investment and expansion.

**Strategic objective 5: Count every newborn - measurement, programme tracking and accountability.** Measurement enables managers to improve performance and adapt actions as needed. Assessing outcomes and financial flows with standardized indicators improves accountability. There is an urgent need to improve the metrics globally and nationally, especially for birth outcomes and quality of care. Every newborn needs to be registered and newborn deaths need to be counted. Counting every maternal death and stillbirth is of equal importance.
ACTIONS TO ACHIEVE THE STRATEGIC OBJECTIVES

Strategic objective 1: Strengthen and invest in care during labour, childbirth, and the first day and week of life

Why?

30. The time around labour, childbirth and the first days thereafter is when newborns are most vulnerable. Not only are they at risk of mortality due to complications, they may also acquire long-term disabilities. Skilled care during labour and childbirth with prompt management of complications alone can prevent about 50% of newborn mortality and 45% of intra-partum stillbirths. Combined with adequate newborn care in the postnatal period, 75% of current newborn deaths can be prevented as well as thousands of stillbirths and maternal deaths. This period is especially important not just for survival but for early childhood interaction and development, when the foundations for the evolution of cognitive and psychosocial skills are created.

31. Every pregnant woman should receive essential care provided by a skilled attendant who is proficient to monitor labour and assist the birth, and who is able to promptly detect and competently manage complications and arrange for immediate referral when needed. Similarly, every newborn baby should receive essential newborn care starting immediately after birth, during the first day, and continued at critical intervals in the first week of life and beyond.

32. Packages of proven interventions are available that should ensure provision of the basic and additional care for women and newborns in order to prevent or treat the main causes of neonatal mortality. These interventions include: (i) management of preterm birth, including the antenatal use of corticosteroids; (ii) skilled care at birth; (iii) basic obstetric care; (iv) comprehensive obstetric care; (v) essential newborn care including warmth, hygiene and feeding; (vi) neonatal resuscitation; (vii) kangaroo mother care; (viii) treatment of possible severe neonatal infections; and (ix) supportive care for sick newborns. A summary of essential interventions is attached as Appendix 2.

33. Providing extra care to babies with low birth weight is particularly important to reduce newborn mortality, and health personnel need to be competent and equipped to support mothers and these babies, many of whom do not need advanced or intensive care and can be well managed in a lower-level health facility or possibly in the community. For those babies that need intensive care, primary referral health facilities can play a vital role by providing interventions such as oxygen therapy, continuous positive airway pressure, intravenous fluids and life-saving medicines.

34. Many newborns with possible serious bacterial infection who cannot be referred for inpatient care can now be treated with simplified antibiotic regimens. That development strengthens the potential of home-based care visits in the first week after childbirth to be effective, as newborns with signs of severe illness may be identified by a trained community health worker, referred to a primary health
care facility, and treated as outpatients with standard protocols of management of newborn illnesses.

35. Research is an important element of investing in care around the time of birth. Nobody can predict when a pregnant woman will go into labour, yet timing of birth can determine the survival and health outcomes of a newborn. There is a need for greater understanding of the biological basis of term and preterm labour; devising new ways to prevent preterm birth; extending proven interventions in low- and middle-income countries; improving data collection; and fostering innovation and collaboration.

Proposed actions

36. All countries are encouraged to develop or re-focus national strategies and action plans in line with the principles, goal, targets and strategic objectives of the draft action plan. Governments should conduct a systematic situation analysis and agree on a set of core interventions and packages that match the local context, are relevant to the burden of newborn morbidity and mortality, and fit within the continuum of care. Equitable access to high-quality care during labour, childbirth and the first week of the postnatal period should be prioritized in all relevant country action plans.

37. National authorities, supported by interested stakeholders, should cost plans and allocate sufficient funding for women’s and children’s health, with due emphasis on care around the time of birth and the first week of life. Governments and all concerned stakeholders should ensure that investments in maternal and newborn health are sustained beyond 2015 and increased where needed.

38. National authorities should institute measures to increase coverage of skilled care at birth in health facilities. They should support the implementation of guidelines and policies to improve management during labour and childbirth, including the use of the partograph, and to increase the number of postnatal visits to mothers and their babies. Where necessary, more midwives, auxiliary staff and community health workers should be trained.

39. Governments and all concerned stakeholders must raise awareness and foster the realization in communities that the time around childbirth and the first week of life is vital to saving maternal and newborn lives, and be accountable for creating the conditions in which every mother and newborn can realize their right to health and health care.
Summary of key actions for strategic objective 1

- Instil a realization among the population about the uniqueness of the time around childbirth and the first week after birth in order to save lives.
- Develop or sharpen national plans for newborn health within the continuum of reproductive, maternal, newborn and child health in line with the principles, goal, targets and strategic objectives of the Every Newborn action plan.
- Allocate adequate financial resources to implement the national plan and ensure high levels of access to health services for women and newborns.
- Increase accountability of all relevant stakeholders to create the conditions in which the right to health and health care is realized for every mother and every newborn.

Strategic objective 2: Improve the quality of maternal and newborn care

Why?

40. More skilled care at birth is being provided by physicians, nurses and midwives in many countries, but many women who give birth with an attendant receive suboptimal or poor-quality, non-respectful care, for herself and her newborn. The partograph is still not commonly used and infection prevention and newborn care practices immediately after birth are often harmful and not in line with the principles of the Baby-friendly Hospital Initiative, such as keeping the baby warm, keeping mother and baby together, initiating breastfeeding early, and promoting exclusive breastfeeding. Creation of appropriate areas for newborn care is often overlooked. Too few countries have embraced the principles of the Baby-friendly Hospital Initiative and care in many facilities is neither mother- nor baby-friendly. Simple indicators, such as the rate of early initiation of breastfeeding rate, clearly illustrate the discrepancy between coverage of skilled care at birth and the quality of care received. Thus, increasing the number of births in health facilities is not commensurate with the expected declines in neonatal mortality, in particular early neonatal deaths.

41. Reasons for inadequate and inequitable quality of care are multiple and include constraints related to the density of health workers in the population, their knowledge, competences, motivation and work load, and availability of commodities. There is overwhelming evidence that the standard of education of physicians, nurses and midwives is low in many countries. For example, curricula in midwifery in some countries do not meet global standards, and students do not acquire the competences necessary to provide good-quality services with confidence. Limitations in regulation and professional association capacity mean that midwifery personnel have little legal protection and lack an organized voice to represent their interests. These factors, combined with staff shortages,
poorly equipped facilities and low remuneration, easily lead to poor motivation and low quality of care.

42. Health services also need to deal with risk factors for poor neonatal outcomes, such as adolescent pregnancy, short birth intervals, malnutrition (underweight or obesity), chronic disease (e.g., diabetes), infectious diseases (e.g., HIV), substance abuse (e.g., tobacco and alcohol use) and poor psychological health. Workplace policies are important to support women during pregnancy and in the postnatal period and should include regulations to protect pregnant women from physically-demanding work. Employment and community interventions to reduce exposure to potentially harmful pollutants, such as those from traditional cook-stoves and second-hand tobacco smoke, are also necessary. Prevention, screening and management of sexually transmitted infections (e.g. HIV and syphilis), malaria and noncommunicable diseases are often implemented through specific programmes but have to be well integrated with maternal and newborn health services. Figure 5 provides examples of specific platforms and how they can contribute to strengthening the quality of the health services provided to improve newborn health and survival outcomes.

Figure 5: Specific action for newborns in existing programme platforms

<table>
<thead>
<tr>
<th>PLATFORM</th>
<th>SPECIFIC LINK TO IMPROVED NEWBORN HEALTH AND SURVIVAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Planning</td>
<td>Prevention of pregnancy in adolescence, prevention of unintended pregnancies for all women and promotion of birth spacing</td>
</tr>
<tr>
<td>HIV</td>
<td>Prevention of mother-to-child transmission of HIV and the elimination of new HIV infections in children</td>
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<tr>
<td>Syphilis</td>
<td>Screening and treatment of syphilis</td>
</tr>
<tr>
<td>Malaria</td>
<td>Prevention, identification and intermittent treatment of malaria in pregnancy (IPTp)</td>
</tr>
<tr>
<td>Water, sanitation, and hygiene</td>
<td>Promotion of handwashing</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Early initiation and exclusive breastfeeding, promotion of healthy nutrition before and during pregnancy including supplementation or fortification of essential foods with micronutrients</td>
</tr>
<tr>
<td>Integrated management of childhood illnesses (IMCI)</td>
<td>Identification, treatment and timely referral of sick newborns; support for exclusive breastfeeding and counseling for feeding problems</td>
</tr>
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</table>

**Home visits in the postnatal period**

- Postnatal care for all newborns. Support for good home care practices, identification and referral of sick newborns to health facilities, and follow-up support upon discharge

**Immunization**

- Promotion of vaccination, especially for adolescent girls; elimination efforts for maternal and neonatal tetanus and rubella/congenital rubella syndrome; provision of BCG, OPV and Hep B at birth

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43. Adolescents require specific attention. Increasingly data are becoming available that show that they are not reached by health services. While globally the incidence of HIV infection is declining, HIV infection rates are increasing among adolescents. Adolescent friendly health services need to be available for young people and offer sexual and reproductive health services. Prevention of early pregnancy is key but it also important to give special attention to girls and young women during pregnancy, childbirth and in the postnatal period, both for her own mental and physical health as well as the health of the baby.

44. Availability of life-saving commodities - such as uterotonic medicines (oxytocin or misoprostol), resuscitation devices, injectable antibiotics or antenatal corticosteroids, and chlorhexidine for cord care in home births in high mortality settings - is not secured in many health facilities, in particular in remote areas. New formulations of medicines may not have been registered and major supply chain bottlenecks exist. In many settings, essential commodities are frequently out of stock because of supply-chain deficiencies. In addition, carers and health care providers often lack awareness of a commodity and its effectiveness. In settings where services are not free to the user at the point of use, costs may be prohibitive.

45. There are few global indicators to monitor quality of maternal and newborn care exist but in many countries mechanisms for monitoring and evaluation are non-existent. Maternal and perinatal death surveillance and response can be a powerful approach to improve the quality of care. Many countries have adopted legislation requiring notification of maternal deaths, which can provide an entry point for a confidential enquiry into the causes that led to a maternal death and for planning remedial action to improve the quality of care. A similar approach could be taken for perinatal mortality.

**Proposed actions**

46. In collaboration with professional associations, academia and training institutions, and other stakeholders, governments should regularly update national policies and guidelines for interventions around the continuum of care for women’s and children’s health, on the basis of global evidence-based guidelines, and locally defined strategies. They should adopt norms and standards for respectful and high-quality maternal and newborn care and enforce their implementation.
47. Governments should adopt competency-based curricula and put in place regulatory frameworks defining the scope and practice of midwifery as well as nursing, including specific skills to take care of newborns that are small for gestational age or sick, lactation counselling and support training, and the minimum standards of educational requirement needed. Rectifying the shortage of specialists, such as neonatologists or breastfeeding counsellors, should also be considered, where appropriate.

48. Staffing levels for each facility providing maternal and newborn care need to be planned in such a way that services can be provided on a continuous basis, 24 hours a day, seven days a week. Team work is essential. In first-level and second-level referral hospitals, teams should be multidisciplinary and include specialized obstetric and paediatric staff in order to manage maternal and neonatal complications.

49. Maternity facilities must have appropriate infrastructure and be adequately equipped to provide the care needed by mothers and their babies. The norms of infection prevention and biosafety must be respected. Electricity, water, sanitation and hand-washing facilities, and clean toilets, appropriate spaces for women to give birth with privacy, and dedicated areas to manage sick newborns safely must be in place. Mother and baby should be routinely accommodated in the same room and provisions made available for mothers to provide kangaroo mother care comfortably. Expression and storage of breast milk should be encouraged in health facilities that care for babies that are small for gestational age or sick, complemented by milk banks in selected referral care facilities. Secondary and tertiary care facilities should have suitably equipped and staffed neonatal units and nurseries and linked to primary care facilities through a well-functioning referral system.

50. Life-saving commodities, including essential technologies, for women’s and children’s health should be included in every national essential medicines list and an uninterrupted supply chain to all facilities, especially the most peripheral health facilities, should be ensured. Medicines need to be appropriate for newborns, and investments need to be made by manufacturers to increase the availability of low-cost commodities that can be easily supplied and used in resource-poor settings.

51. A seamless continuum between primary care and referral level facilities saves lives. It is estimated that one in three pregnant women requires an intervention during childbirth and between 5% and 15% of women require a caesarean section delivery. It is sometimes difficult to predict risk and therefore every maternity service should be able to provide basic life-saving interventions for mothers and their newborns and have uninterrupted access to transport for referral when serious complications arise.

52. Monitoring and improvement of quality of care must be instituted in all public and private maternity care services, for instance through maternal and perinatal death surveillance and response, birth and death registration as well as periodic surveys of availability and readiness of health facilities. Information technology can assist in real-time monitoring and mobile phones are valuable for
increasing communication between health providers and with the community, for example in the sharing of data. Links between communities and services to improve the quality of care require investment as well as evaluation. Audit meetings and accountability are other key elements of the process of improving quality of care.

53. Motivation of staff is important for determining the quality of care, and national authorities may consider incentives, such as financial payments, bonuses and public recognition. A particular form of incentive is performance-based financing, which is being introduced in several countries, although further investigation of its cost-effectiveness and any associated risks is needed.

54. Raising public awareness and increasing community involvement can accelerate improvements in quality of care. Parliamentarians, who represent voters, legislate, scrutinize and approve budgets and oversee government actions, are therefore seminal in determining women’s and children’s well-being. Similarly, civil society and local leaders can strengthen crucial political will and help to increase public awareness and community ownership of the problems and solutions. For this to happen, there needs to be a free flow of data and information, and results from annual health sector reviews should be made publicly available, in line with recommendations made by the Commission on Information and Accountability for Women’s and Children’s Health.

55. Engaging the private sector through public–private partnerships can bring multiple benefits, including technology transfer to low-income countries, lower costs and increased availability of affordable and quality-certified essential medicines and commodities, improved quality of care and the provision of evidence-based services by private practitioners, stewardship and regulatory function of governments, provision of transport for emergency cases, stronger employer-based health services, and development of innovative technologies.

<table>
<thead>
<tr>
<th>Summary of key actions for strategic objective 2</th>
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<tbody>
<tr>
<td>• Update national policies, guidelines, norms and standards for maternal and newborn care in line with globally agreed evidence-based guidelines, and local conditions.</td>
</tr>
<tr>
<td>• Adopt competence-based curricula and put in place regulatory frameworks for midwifery and other health care personnel.</td>
</tr>
<tr>
<td>• Ensure that all facilities providing maternal and newborn care are adequately staffed, have basic optimum infrastructure, allow for mother and baby to remain together, have a steady supply of life-saving key commodities and are able to provide uninterrupted services.</td>
</tr>
<tr>
<td>• Ensure that all newborns that are born in health facilities and their mothers receive all essential services before discharge.</td>
</tr>
<tr>
<td>• Develop strategies for how to engage private-sector providers to assess and ensure the</td>
</tr>
</tbody>
</table>
quality of their services, increase the supply of affordable essential commodities, and develop innovative technologies to overcome barriers.

- Institute maternal and perinatal death surveillance and response, including notification of maternal and perinatal deaths, preferably within 24 h in order to elicit rapid action.
- Consider and evaluate innovative approaches such as coaching, mentoring, accreditation and continuous education to improve access and quality of care.
- Enhance public oversight of quality of maternal and newborn care, make available relevant information, and facilitate the power of communities to hold concerned stakeholders to account.

**Strategic objective 3: Reach every woman and every newborn to reduce inequities**

**Why?**

56. Every woman and every newborn has the right to good-quality health care, in line with the principles of universal health coverage and human rights. Despite significant increases in the number of births in health care facilities over the past decade, the quality of care in many is not uniform. Moreover, about one third of births globally occur at home without care from a health professional. Countries with highest rates of neonatal mortality have vastly lower rates of caesarean sections than those with lower mortality rates. Though high caesarean section rates are not desirable, rates of less than 5% are usually a marker the unavailability of maternal and neonatal emergency and intensive care. There are few universal indicators of intervention coverage around the time of childbirth but small-scale analyses and studies reveal that coverage of potentially life-saving interventions, such as antenatal therapy with corticosteroids for preterm labour and early initiation of and exclusive breastfeeding, kangaroo mother care, and breastfeeding for babies that are premature and have low birth weight, and treatment of newborns with serious neonatal infections with antibiotics is still very low in many settings.

57. Access to high-quality maternal and newborn care depends, among other factors, on the availability of skilled health workers who are motivated, adequately equipped and equitably distributed. In many countries, the low density of health professionals, particularly in rural areas, is one of the main factors that explains persistent high mortality rates for mothers and newborns. Currently less than one in six countries with the highest burden of maternal and newborn mortality reaches the minimum benchmark of 23 doctors, midwives and nurses per 10 000 population that is necessary to provide a basic package of care.\(^{22}\) Severe shortages of midwives exist in at least 38 countries.\(^{23}\) In countries with a high and inequitable burden of newborn deaths, these factors, combined with poor

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working conditions and few incentives for staff to live and work in remote areas or among disadvantaged populations, lead to unequal distribution of health workers and great inequities in access to care for mothers and newborns.

58. Cost of health services can present an important barrier to families seeking care during pregnancy and childbirth and in the postnatal period. Over-reliance on direct payments, for instance over-the-counter payments for medicines and fees for consultations and procedures, as well as indirect costs, such as transport and lost income, have led to sharp inequities in coverage, most notably for those women who give birth with a skilled attendant. Families who use maternal health services can incur high, sometimes catastrophic, costs in paying for their care. In some countries, up to 11% of the population suffers this type of hardship and up to 5% are forced into poverty because of health care-related expenditure, including costs associated with essential maternal and newborn care. The goal of universal health coverage stipulates that everybody should be able to access health services and not be subject to financial hardship in doing so, but the world is falling short on both counts, in particular for women and children.

59. The absence of information on budgets limits transparency and oversight for maternal and newborn health. Few countries have conducted national health accounts with specific subaccounts for maternal and newborn health, and tracking of development assistance has become prominent in the public domain only recently.

60. Reaching every woman and every newborn requires investment in every aspect of the all health system, including leadership and governance, the work force, infrastructure, commodities and supplies, service delivery, information systems, and financing. There is increasing evidence of effective approaches to accelerating coverage of effective interventions and reducing inequities, through, for instance, innovative ways to removing barriers in the health system. Different contexts require tailored approaches, with specific attention to preparedness and rapid response for complex humanitarian emergencies.

Proposed actions

61. For countries to move towards universal coverage of maternal and newborn care, a first proposed step is to conduct a systematic analysis of the barriers to extending provision of the intervention packages necessary for provision of good-quality care. These obstructions can be found within the health system itself but gaps in family and community knowledge, misperceptions and lack of resources can contribute. Results of such analyses should be taken into consideration in the design of national newborn action plans.

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62. A central component of national newborn action plans usually relates to the health workforce. Every country should have a comprehensive development plan for the health workforce that covers addresses not only its education and training but the distribution, motivation and retention of skilled personnel. It is essential that health workers’ attitudes and behaviours towards women and newborns are respectful. At the same time, working conditions need to be such that health workers themselves operate in a safe and respectful environment. Plans should include actions to expand and/or more equitably redistribute the workforce and, where needed, implement immediate remedial measures including appropriate remuneration. Provision of housing, electricity, and supplements to salaries has been effective in motivating health workers to serve in remote and underserved areas.

63. Optimizing performance of available staff is a priority. Evidence is strong that life-saving interventions can well be delegated to mid-level health workers, but only if they are appropriately trained. For example, where possibilities for referral are limited, midwifery personnel should be best able to provide the full range of emergency obstetric care. Community health workers can play an important role in bridging the gap between health services and families, and home visits made by them during pregnancy and in the first week after childbirth have been shown to have a positive impact on newborn care practices and to reduce newborn mortality rates by about 20%. They are also effective in detecting and referring mothers with postpartum complications and counselling on family planning.

64. Governments should adopt and enforce laws and policies on equity of access and quality of maternal and newborn care, in both the public and private sectors. Policies should include: ensuring universal access by women and children to health care services without enduring financial hardship; notification of maternal and perinatal deaths; context-specific approaches to HIV and infant feeding; ratification of the ILO’s Maternity Protection Convention, 2000 (No. 183); and legislation to implement the International Code of Marketing of Breast-milk Substitutes.

65. Plans for extending maternal and newborn health services should be based on objective information and evidence. Countries need to estimate requirements for and build and equip the infrastructure that is required for the number of pregnancies and births within a given setting. They need to define a standard package of maternal and newborn care for each level of health provision. In addition they need to determine the number of staff and the role of teams that include midwives and midwifery personnel, and where needed, specialized cadres such as obstetricians, neonatal nurses and paediatricians. Geographical mapping of access points has been successfully used in several countries for decision-making on the number and location of maternity facilities in order to

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reach the greatest number of families and communities. Sound planning should inform increased investment in quality of care around childbirth.

66. In settings where adolescent pregnancies are common, deliberate efforts have to be made to prevent teenage and unintended pregnancies and to expand services to teenagers and young adults. Preventive measures, health education and good service delivery promote health and are cost-saving. Targeted programmes are needed to expand availability and use of modern contraceptive methods by adolescents and young adults. In order to prevent early pregnancies, measures should be taken, including: introduce legislation to prevent or lower the number of girls who marry under the age of 18 years; keep girls in school; reduce rates of coerced sex; prevent early pregnancy before 20 years, and inculcate positive cultural norms and traditions, through life-skills education for both boys and girls. Young people should be able to access sexuality education and contraceptives, and girls should be empowered to resist coerced sex. Youth-friendly health services should be available to give pregnant adolescents the full support they need so that they may be well prepared for birth and becoming a parent, regardless of marital status.

67. Closing the gap in coverage of maternal and newborn interventions between rich and poor will save lives. Policies are needed to eliminate disparities in health care access, including subsidizing the cost of care and focusing on the most vulnerable population groups, in order to ensure that maternal and newborn health services are available, of good quality and at an affordable cost at the point of use (which would mean free to many people). To do this, countries should reduce reliance on out-of-pocket payments by increasing forms of prepayment with subsequent pooling of funds to share financial risks across the population. Prepayment typically involves taxes and other government charges and/or insurance. In order to mobilize resources, governments must prioritize the health sector in domestic budgets, increase efficiency in collection of national revenue, and adopt innovative ways of raising funds, for instance through taxes on tobacco and alcohol. Development assistance for reproductive, maternal, newborn and child health will continue to fill funding gaps in many low-income countries. Investments should be used efficiently, well targeted and respond to priority needs.

68. In order to increase transparency in funding and resource allocation, all countries must develop capacity for regularly account for health expenditure, matched to commitments, goals and targets. They must track total health expenditure by financial source (and per capita), and total expenditure on reproductive, maternal, newborn and, child health by financing source (and per capita). Similarly all major development partners should report their assistance for women’s and newborn health against their commitments and make covenants that would enable national authorities to establish predictable budgets and reinforce mutual accountability.

69. Providing every woman and every newborn with essential interventions not only requires financial investment but also will improve efficiency in the functioning of the health system as a whole and at every point of contact in the health system. Integration of actions on the health of newborns into existing reproductive, maternal, newborn and child health initiatives and service delivery platforms
(including those for HIV, malaria and immunization) will be crucial for ensuring that no opportunities to reach mothers and their newborns are missed (Figure 5). Countries must critically assess what services are needed, motivate health workers, improve hospitals’ efficiency, eliminate waste and corruption, and optimize the use of technologies and health services.

70. Investment in creating demand for newborn care through participatory community approaches is an essential cross-sectoral activity. In settings where there is gender bias against the girl child, special measures are necessary to overcome this violation of human rights, in health services and communities.

Summary of recommended actions for strategic objective 3

- Conduct a systematic analysis of obstacles to achieving full-scale, high rates of coverage of effective intervention packages.
- Prepare and implement a development plan for the health workforce in order to increase motivation and retention of skilled personnel and thus broaden access to good-quality maternal and newborn care at community, primary and referral health care levels.
- Consider task delegation to mid-level health personnel and the role of community health workers in providing maternal and newborn health services and bridging the gaps between families and health services.
- Ensure elimination of barriers (social and financial) that limit access to care by mothers and newborns, including girls who are especially vulnerable in some populations.
- Track national health expenditures including for maternal and newborn health and mobilize additional resources including from domestic and external sources.
- Invest in community participatory interventions in rural areas in collaboration with local leaders and development organizations.
- Engage in compacts of government and partners on the basis of a common agenda that is evidence-based and prioritizes high-impact interventions and good quality of care for women and children, to maximize the use of available resources.

Strategic objective 4: Harness the power of parents, families and communities

Why?

71. Almost half of all mothers in low-income countries do not receive skilled care during birth, and more than 70% of all babies born outside hospitals do not receive any postnatal care.\(^\text{26}\) Many newborns

\(^{26}\) Requejo JH, Bryce J, Victora C, Deixel A. Accountability for maternal, newborn and child survival: The 2013
deaths occur at home without any care having been sought. Health outcomes, both positive and negative, are determined largely by decisions made within the household. Families and communities, however, are often not seen as major parties in efforts to improve their health and to increase the coverage of essential interventions.

72. Programmes that seek to strengthen health services through integration with community mobilization, education and empowerment of all community members in order to adopt healthy practices and shift social norms have demonstrated the power of such an approach. The resulting changes are particularly evident for maternal and newborn health where a decade of research and large-scale projects have provided evidence of effective approaches to strengthen the capacities of individuals, families and communities.

73. Community-based activities can be broadly categorized into four areas, namely: (i) to develop capacities to stay healthy, make healthy decisions and respond to obstetric and neonatal emergencies; (ii) to increase awareness of the rights, needs and potential problems related to maternal and newborn health; (iii) to strengthen social support networks between women, families and communities and with the health system; and (iv) to improve quality of care, health services and interactions with women and communities. Investment in each of these areas is necessary, particularly in settings where maternal and newborn mortality rates are high. Actions need to be taken in concert by multiple actors and, in this area, civil society can play a particular catalytic role through existing and strengthened coalitions and networks.

74. In 2009, WHO and UNICEF issued a joint statement on home visits for the newborn child as a strategy to improve newborn survival on the basis of research studies that demonstrated that home visits by community health workers improved newborn survival rates. Since then, extensive studies in Africa and Asia have shown that home visits during pregnancy and in the first week after birth do increase the number of women who seek antenatal care and who receive skilled care during birth. These visits also lead to improved practices, such as delayed bathing and early initiation of and exclusive breastfeeding, resulting in significant reductions in newborn mortality rates.

75. The work of women’s groups and peer or lay counsellors has been effective in many countries. Women’s groups in particular have led to better home care practices, social support, enhanced decision-making skills, gender empowerment, increased care-seeking, and stronger community organization in order to tackle major barriers, such as transport or financing of emergency care.

76. Families, especially mothers and fathers, are at the forefront of providing newborn care. Building their capacities to nurture the newborn is essential. Even though practices like breastfeeding are often considered as natural behaviours, many women require skilled support. The same is true for

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the interactions between carer and child that are crucial for psychosocial and cognitive development and should start from the day of birth. Simple actions of communication and stimulation are relevant for term and preterm babies alike as they catalyse the maturation of neurological pathways. Support for early child development is an essential component of newborn care.

77. In addition to individually-targeted approaches, social and mass media can be influential in imparting knowledge, changing behaviour and instilling social accountability for newborn health services. Advocacy campaigns using radio and television have contributed to increasing the number of births in health facilities, exclusive breastfeeding and other interventions. Multi-pronged approaches enhance the reach of messages.

78. Systematic reviews of the results of evidence-based approaches designed to harness the power of parents and communities are being conducted in the following areas: transport to referral centres, alleviation of financial barriers and cash transfers, home visits by community health workers, community mobilization and engagement, the role of women’s groups, integrated case management of newborn and childhood illness, the use of mobile telephone technology (m-health), maternal and perinatal deaths audits, and results-based financing.

79. Governments hold the final responsibility for ensuring access to good-quality health services, but civil society organizations are necessary partners for developing equitable health systems that respond to the needs of all families. The nature of such organizations varies greatly from country to country, but they often have a vital role in providing health services, as well as being an effective and efficient means for hearing people’s views. They can contribute significantly to social mobilization, creating political will, and policy design, and can help to hold governments and health providers to account. Strengthening partnerships with such bodies is essential.

80. The private sector’s considerable expertise in strategic communications can be harnessed to change social norms, promote optimal health behaviours, and increase demand for good-quality care. The capacity of many private corporations to conduct research and mine diverse sources of data in order to understand what motivates behavioural change is an extremely valuable asset that has not yet been tapped to its full potential. Public-private partnerships are especially amenable to multi-media advocacy campaigns by using existing private sector communications platforms, television, radio, social media, and e-and m-health technologies.

Proposed actions

81. In countries with a high burden of newborn mortality, the analysis of obstacles proposed under strategic objective 1 should also focus on factors that determine the demand for maternal and

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newborn health services. Understanding the motivational, cultural, structural and financial aspects that cause families and communities to implement good home care practices and seek appropriate care for mothers and their newborns is essential for devising an appropriate response.

82. Where access to health services is inequitable or poor, countries should consider investing in training and deployment of community health workers as a powerful resource for improving maternal and newborn care, in particular in hard-to-reach areas. Community health workers can fulfil multiple tasks, including home visits during pregnancy and after childbirth, facilitation of women’s groups, and mobilization of community leaders and structures to act for the health of newborns.

83. In order to foster community mobilization through participatory learning and action, the establishment of community-based organizations such as women’s groups should be considered, in particular in rural populations. Further evaluation of the utility of these approaches in poor urban areas is urgently needed. The role of men and fathers is also important, and they should be involved in individual household-level and community activities.

84. Where individual and family financial circumstances impede access to health care, conditional cash transfers to families and communities can be considered, with careful monitoring in order to demonstrate cost-effectiveness.

85. Mobile phone technology is now widely available, and can reach remote areas in many countries. It has been successfully used to provide health messages, establish help lines, and facilitate real-time monitoring of births and deaths. It can be linked with community mobilization interventions for greater synergy.

86. The Commission on Information and Accountability for Women’s and Children’s Health has called for improved oversight and transparency, urging parliamentarians, community leaders, civil society and the general population to demand information and participate actively in both the planning and monitoring of health services and the quality of care received by mothers and their children. Countries should follow-up on these recommendations. Similarly, there should be independent accountability for the implementation of this action plan at the global level, of all concerned stakeholders towards their commitments to saving newborn lives.

Summary of key actions for strategic objective 4

- Promote zero tolerance for preventable maternal and newborn deaths by changing social norms and expectations surrounding childbirth and newborn survival, and also giving a voice to parents affected by stillbirths or newborn deaths.
- Include a systematic analysis of obstacles to demand for good-quality maternal and
newborn services by families and communities and implement essential home care practices, as a basis for planning appropriate actions.

- Equip families, including men, with the knowledge and the capacities to provide good home care including through women’s empowerment and groups, media campaigns, and home visits by trained community health workers.
- Strengthen links between community and health facilities, and adopt combined approaches to improve quality of care within the home and within health services.
- Use the power of parent’s voices, civil society, mass media and social media to provide information and change norms.
- Adopt evidence-based strategies to generate and sustain demand for services using community-owned actions (for example, conditional cash transfers, health insurance, transport, social mobilization, savings credit schemes and cooperatives).
- Engage, enable and support in-country civil society organizations to demand transparency and oversight and improve the access and quality of care.
- Engage the private sector to support multi-media communications campaigns through radio, television, social media, and e-and m-health technologies to change social norms, promote zero tolerance for preventable mortality, and advocate for optimal behaviours.

### Strategic objective 5: Count every newborn – measurement, programme tracking and accountability

**Why?**

87. Vital statistics provide indispensable information, in this case making policies more effective and responsive to the needs of women and children. However, in 2010, about one-third of 135 million births globally and two-thirds of all deaths went unregistered. Half the countries in the African and South-east Asia regions do not record cause of death in their vital statistics, and serious deficiencies are present within existing systems. In some countries, the vital registration system does not follow global recommendations about which child to count, and the system often functions for only part of the country. In other countries, not all deaths are registered. Failure to collect high-quality data on registration of births and deaths, including cause of death, results in an absence of crucial information for policy-making, planning and evaluation across all development sectors including health and health services. In 2012, the United Nations Human Rights Council for the first time adopted a resolution entirely dedicated to birth registration and legal identification for all, without discrimination.

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30 See for example resolutions WHA20.19 and WHA43.20.
31 Resolution A/HRC/19/L.24 Birth registration and the right of everyone to recognition everywhere as a person before the law.
88. Modelled estimates of newborn mortality and causes of deaths at global, regional and national levels exist, with more infrequent estimates of rates of preterm births, stillbirths, babies born with low birth weight or that are small-for-gestational age as well as neonatal morbidity and subsequent disability. As governments and partners establish and expand access to interventions related to newborn health, more and better information is needed for monitoring and assessing progress towards achieving the commitments made to ending preventable newborn deaths.

89. Few universal indicators are available for monitoring equity of access and quality of maternal and newborn care. Some steps to improve measurement have been initiated, such as adding questions to household survey instruments on postnatal care for mothers and newborns and to facility-assessment tools about the availability of commodities specifically for newborns, such as resuscitation equipment and antenatal corticosteroids. However, many challenges remain in gathering these data.

90. Major gaps remain in the collection of routine data on outcomes, coverage and quality of care around the time of birth. Much more rigorous attention needs to be paid to the development and testing of indicators for the time period, and their inclusion in health management information systems. Few indicators related to the health of newborns are currently included in routine health management information systems, with limited use of the actual data for improving quality. A set of core and additional indicators for tracking not only population-based coverage of effective interventions but the quality of care in health services needs to be agreed for use in varying contexts, including complex humanitarian emergencies.

91. Many countries have embraced maternal death surveillance and response as an effective means to identify deaths, investigate their determinants and take remedial action on preventable causes of death. Perinatal deaths should be considered as an important component of these initiatives. A meta-analysis of the impact associated with the introduction of perinatal audits in low- and middle-income countries demonstrated a 30% reduction in mortality when solutions identified from the audit process were linked to action. Auditing maternal and perinatal deaths and linking the results to a national process has the potential to strengthen capacity to avoid preventable causes of mortality. Nevertheless, legal protection mechanisms that would facilitate full enquiries are inadequate in many countries and therefore the full potential of the approach often remains untapped.

Proposed actions

92. Countries should invest in improving the collection and quality of birth and death registration systems and consider innovative mechanisms for gathering data, such as through community health

workers and use of mobile phones. Registration of stillbirths and newborn deaths should be accompanied by programmatically-relevant categorization of the causes of deaths. Quality and completeness of data need to be monitored continuously and the data should be disseminated as the basis for planning. Investment and technical support are also needed in order to improve the quantity, consistency and frequency of national input data for all maternal and birth outcomes, as part of a minimum perinatal dataset linked to both vital registration and data derived from health facilities. It is also important to track disability outcomes (such as retinopathy of prematurity, deafness and cerebral palsy) particularly for countries expanding neonatal intensive care.

93. The service delivery indicators that are being proposed as part of the draft action plan should be evaluated by stakeholders and, after assessment, integrated into national health systems management. A set of core indicators will be further developed as part of the operational plan referred to in paragraph 101 and cover the domains of service readiness, outcomes, service utilization, intervention coverage, and quality of care. Managers at all levels need to know to what degree the system can deliver essential maternal and newborn services and identify weaknesses in performance that can be rectified through better planning, budgeting and service delivery. Many of these indicators can be integrated in routine health information systems and results periodically validated through specific surveys.

94. Countries should strengthen mechanisms for maternal death surveillance and response (MDSR) and surveillance of perinatal mortality. New guidance from WHO and its partners provides clear recommendations on how to implement maternal deaths surveillance successfully at full scale. The guidance promotes a phased approach and suggests a focus on strengthening MDSR in health facilities prior to expanding it to communities.

95. While routine systems are being strengthened, countries and development partners should invest in periodic household surveys in order to obtain data on mortality, intervention coverage and use of services. Population-based household surveys, including the Demographic and Health Surveys and the Multiple Indicator Cluster Surveys have long collected data on indicators on family planning, antenatal care, and attendance at birth. Recently, more information on postnatal contacts for newborns have been incorporated into these two surveys and the number of countries with available data is steadily increasing. A list of proposed indicators that can be added to household surveys to measure newborn care practices and the content of postnatal care will be presented in the final action plan.

Summary of key actions for strategic objective 5

- Invest in birth and death registration coverage and quality: promote recording of every birth, live or stillbirth, and record deaths using correct attribution of the causes of stillbirths and neonatal deaths on death certificates and improved codes of the International Statistical Classification of Diseases and Related Health Problems (10th Revision). Consider the use of specific perinatal death certificates as recommended in that Classification that capture additional data on stillbirths, gestational age and birth weight as well as maternal complications.
- Develop a minimum perinatal dataset and ensure all birth outcomes are collected, with consistent definitions and crosslink databases for vital registration, routine health information system and other sources of facility and community data. Triangulate with intermittent periodic household surveys and censuses.
- Track morbidity and disability outcomes, especially once neonatal intensive care is being expanded.
- Institutionalize maternal deaths surveillance and response, and link this with perinatal death reviews, and take action to address avoidable factors identified through such reviews.
- Define indicators of service delivery for mothers and babies and integrate them into routine data collection systems and instruments, if necessary conducting periodic health facility assessments to evaluate the quality of care.

RESEARCH PRIORITIES

96. Health research in the three domains of delivery, development and discovery needs to be placed at the forefront of efforts to reduce newborn mortality. Research priorities for newborn health were identified by a global exercise for 2013-2025. Nine out of 10 priorities identified related to improving delivery of known interventions.

97. The top research priorities for the delivery of interventions include finding approaches to scale-up simplified newborn resuscitation at lower levels of the health system; identification and management of newborn infection at community level; addressing barriers in the scaling up of exclusive breastfeeding and facility-based Kangaroo Mother Care; evaluating chlorhexidine cord care for neonates born in health facilities; and developing strategies to improve quality of facility-based care provided during labour and childbirth.

98. Development research priorities identified included adapting Kangaroo Mother Care to make it deliverable at the community level; early detection of high-risk women in pregnancy and labour in the community; improving and simplifying intrapartum monitoring; evaluating appropriate oral antibiotics for treatment of neonatal sepsis; the role of perinatal audits in improving quality of care.
during labour and childbirth; and developing lower cost surfactant and devices for use in low- and middle-income countries.

99. Discovery research priorities highlighted the need to invest in science and technology to discover the causal pathways of preterm labour; new tocolytics to delay preterm birth; stable surfactant with easier mode of delivery; effective maternal vaccines to prevent neonatal sepsis; point of care diagnostics and new biological agents to better identify and treat neonatal sepsis; ways to better detect fetal distress; and to identify biomarkers for intrauterine growth retardation and antepartum stillbirths.

COORDINATION

100. Putting the draft action plan in practice will need the participation of many stakeholders. These range from governments and policy makers, donor countries and global philanthropic institutions, and the United Nations and other multilateral organizations to civil society, health care workers and their professional associations, the business community, academic and research institutions.

101. Integration is a main driver behind the implementation of this action plan which requires multiple programmes within the health sector to collaborate and integrate essential newborn interventions in the various delivery platforms that they use. Maternal and child health services are an ideal platform for delivering integrated packages that include a range of interventions, including for malaria, HIV, nutrition and immunization. The conceptual framework for the Every Newborn action plan is shown in Figure 6 and includes some examples of specific linkages.

Figure 6: Conceptual Framework for the Every Newborn Action Plan
MONITORING FRAMEWORK AND MILESTONES

102. Within 12 months of the adoption of the plan, a monitoring framework for the *Every Newborn* action plan will be elaborated, in line with other global plans, in terms of defining and measuring coverage and quality of the target packages of care, and more robust and frequent measurements of impact, through collaboration with expert metric organizations and institutions. This monitoring and evaluation plan will coincide with the reviews of progress towards the Millennium Development Goals in 2015 and be ready for the post-2015 era. A draft list of indicators for assessing coverage of essential newborn interventions and quality of care in health services is attached as Appendix 3.

103. The pathway to the overall goal and targets of this action plan will be marked by certain milestones. These will be defined for the period 2014–2020. They will form the starting point for accountability and independent oversight and will be the basis for monitoring progress in implementation.
### Appendix 1

**GLOBAL AND NATIONAL TARGETS 2020-2035**

FOR THE EVERY NEWBORN ACTION PLAN

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Impact global level</strong></td>
<td></td>
</tr>
<tr>
<td>Neonatal mortality rate per 1000 live births</td>
<td>15 12 9 7</td>
</tr>
<tr>
<td>A neonatal death is defined as a death within 28 days of birth of any liveborn baby regardless of weight or gestational age</td>
<td>Equivalent to 66% reduction in neonatal mortality rate for all countries by 2035, from the baseline of 2012</td>
</tr>
<tr>
<td>Rate of stillbirths per 1000 total births</td>
<td>11 8</td>
</tr>
<tr>
<td><strong>Coverage and quality of care at national level</strong></td>
<td></td>
</tr>
<tr>
<td>Proportion of births attended by skilled health personnel</td>
<td>Universal  Universal</td>
</tr>
<tr>
<td>Percentage of women and newborns who receive high quality care at birth*</td>
<td>90% of all facility births receive this care</td>
</tr>
<tr>
<td>Percentage of small and/or sick newborns who receive high quality care*</td>
<td>&gt;50% &gt;75%</td>
</tr>
<tr>
<td>a. Number of babies not breathing after birth receiving bag and mask resuscitation</td>
<td></td>
</tr>
<tr>
<td>b. Preterm babies weighing less than 2000 g who receive kangaroo mother care and other supportive care</td>
<td></td>
</tr>
<tr>
<td>c. Newborns with possible serious bacterial infection who receive appropriate antibiotic therapy</td>
<td></td>
</tr>
<tr>
<td>Percentage of women and newborns who receive early postnatal care (within two days of birth)*</td>
<td>20% increase on baseline from 2012 (or 90% if nat. baseline &gt; 70%)</td>
</tr>
<tr>
<td>Linkages</td>
<td></td>
</tr>
<tr>
<td>The Action Plan will complement other global and national plans, and support the linked goals. Some examples are shown.</td>
<td>Family Planning 2020</td>
</tr>
</tbody>
</table>

**Metrics and accountability**

* A full plan for defining and measuring coverage and quality of the above packages, with more robust and frequent measures of impact measurement will be developed within 12 months of the endorsement of the action plan, through collaboration with other global plans, expert metric organizations.
### Effective intervention packages for newborn health across the lifecycle

<table>
<thead>
<tr>
<th>Reproductive health care including preconception care and adolescent health care</th>
<th>Nutrition, immunisation, reduction in harmful practices (tobacco, alcohol), family planning, prevention of adolescent pregnancy, prevention and treatment of STIs, improvements in environmental health, support for mental health, mitigation of interpersonal violence, life skill education</th>
</tr>
</thead>
</table>
| Pregnancy care | Care for EVERY pregnant woman  
- Examination including blood pressure  
- Adequate nutrition; Use of iodized salt  
- Screen for anaemia; Iron and folic acid and calcium supplementation  
- Tetanus toxoid vaccination  
- Insecticide-treated bed nets and intermittent preventive treatment of malaria  
- Identification and management of HIV, syphilis and STIs  
- Management of infections such as UTI and vaginitis  
- Preparing for birth |
| Management of complications |  
- Management of eclampsia and severe pre-eclampsia including magnesium sulfate (and with antihypertensives, if needed)  
- Management of prolonged premature rupture of membranes with antibiotics  
- Management of preterm labour with antenatal tocolytics and corticosteroids( if gestation < 34 weeks) |
| Care around birth | Care for EVERY woman  
- Maternal and fetal monitoring during labour, with appropriate and timely response in the event of complications  
- Safety precautions and hygiene, and infection prevention |
| Management of complications |  
- Basic emergency obstetric care  
- Comprehensive emergency obstetric care |
| Immediate care for EVERY newborn |  
- Immediate and thorough drying, skin-to-skin contact, delayed bathing  
- Appropriately timed cord clamping, clean cord care (including use of chlorhexidine for home births in countries with NMR of 30 or above)  
- Early initiation of exclusive breastfeeding  
- Routine care (e.g. eye care, Vitamin K, immunization)  
- Postnatal examination and periodic checks  
- Counselling on essential newborn care practices (thermal care, breastfeeding, hygiene and cord care) and care seeking |
| Management of complications |  
- Management of newborn who does not breathe with tactile stimulation and if needed bag and mask ventilation |
<table>
<thead>
<tr>
<th>Postnatal care</th>
<th>Care for EVERY newborn</th>
<th>Care for the preterm and low birth weight baby</th>
<th>Management of newborn infections</th>
</tr>
</thead>
</table>
|                | • Exclusive breastfeeding and Warmth  
  • Hygiene including dry cord care, chlorhexidine for home births in settings countries with high NMR of 30 or above  
  • Prevention of mother to child transmission of HIV  
  • Communication and play for development  
  • Counselling on recognition of newborn danger signs and appropriate care seeking  | • Support for exclusive breastfeeding or breast milk feeding  
  • Kangaroo mother care for extended periods.  
  • Additional feeding support for very low birth weight babies  
  • Extra home visits to assess baby and support mother  
  • Oxygen and/or continuous positive airway pressure for babies with respiratory distress (using use of pulse oxymeters) where appropriate | • Antibiotic treatment of newborns with signs of possible serious bacterial infection  
  • Increased breastfeeding during illness to promote recovery. |
# Appendix 3

## Indicators for newborn survival, health and quality of care

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Utility and limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ROUTINE CARE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Skilled attendant at birth</td>
<td>Number of birth attended by a doctor/nurse/midwife</td>
<td>All births</td>
<td></td>
</tr>
<tr>
<td>2 Birth companion of choice and skilled attendant at birth</td>
<td>Number of births attended by a doctor/nurse/midwife and where the mother had a birth companion of choice</td>
<td>All births</td>
<td>Respectful care during childbirth</td>
</tr>
<tr>
<td>3 Early postnatal care</td>
<td>Number of babies receiving care within 2 days of birth</td>
<td>All live births</td>
<td></td>
</tr>
<tr>
<td>4 Early initiation of breast feeding</td>
<td>Number of babies breast fed within 1 h of birth</td>
<td>All live births</td>
<td></td>
</tr>
<tr>
<td>5 Proportion of newborns who received all four elements of essential newborn care</td>
<td>Number of newborns who received all four elements of essential newborn care</td>
<td>Total number of live births in the health facility</td>
<td>Sensitive indicator to capture quality of essential newborn care in health facilities (more) comprehensively</td>
</tr>
<tr>
<td>6 Exclusive breast feeding at 1 month</td>
<td>Number of newborn babies exclusively breast fed till first 30 days of life</td>
<td>All live births in the reference period/year where babies survived first 30 days of life</td>
<td></td>
</tr>
<tr>
<td><strong>COMPLICATIONS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Newborn resuscitation</td>
<td>Number of babies not breathing after birth receiving bag and mask resuscitation</td>
<td>Number of babies not breathing after birth</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Indicator</strong></td>
<td><strong>Definition</strong></td>
<td><strong>Population</strong></td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>8</td>
<td><strong>Fresh still birth rate</strong></td>
<td>Number of babies not showing signs of life at birth and no signs of maceration</td>
<td>All births</td>
</tr>
<tr>
<td>9</td>
<td><strong>Intra-partum stillbirth rate</strong></td>
<td>Number of still born infants weighing &gt;2500 g with no known major congenital anomalies and fetal heart rate documented on admission</td>
<td>Total number of births that took place in the facility</td>
</tr>
<tr>
<td>10</td>
<td><strong>Antenatal corticosteroid use</strong></td>
<td>Number of babies born before 34 weeks (ultrasound confirmed) whose mothers received antenatal corticosteroids</td>
<td>All newborn babies with ultrasound confirmed gestational age of less than 34 weeks</td>
</tr>
<tr>
<td>11</td>
<td><strong>Kangaroo mother care</strong></td>
<td>Number of babies with birthweight less than 2000 g receiving skin to skin contact for at least 3 hours per diem for at least 1 week</td>
<td>All live born babies with birthweight less than 2000 g</td>
</tr>
<tr>
<td>12</td>
<td><strong>Neonatal sepsis</strong></td>
<td>Number of babies with suspected severe bacterial infection (infant reportedly stopped feeding well and/or stopped moving on its own) receiving injectable antibiotics</td>
<td>All babies with suspected severe bacterial infection (infant reportedly stopped feeding well and/or stopped moving on its own)</td>
</tr>
</tbody>
</table>

**POLICY AND SYSTEMS**

<table>
<thead>
<tr>
<th></th>
<th><strong>Indicator</strong></th>
<th><strong>Definition</strong></th>
<th><strong>Population</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td><strong>Birth registration</strong></td>
<td>Percentage of children &lt;1 year with a birth certificate</td>
<td>All births in last one year</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Number of babies</td>
<td>All live births</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>------------------------------------------------------------------------------</td>
<td>------------------</td>
<td>-----------------</td>
<td>---</td>
</tr>
<tr>
<td>14</td>
<td>Birth weight recording</td>
<td>Number of babies</td>
<td>With birthweight</td>
<td>recorded within 24 hours of birth</td>
</tr>
<tr>
<td>15</td>
<td>Facility neonatal mortality rate disaggregated by birth weight: &gt;4000 g, 2500-3999 g, 2000-2499 g, 1500-1999 g, &lt; 1500 g</td>
<td>Number of neonatal deaths by categories of birth weight: &gt;4000 g, 2500-3999 g, 2000-2499 g, 1500-1999 g, &lt; 1500 g</td>
<td>Total number of live births in the health facility segregated by birth weight</td>
<td>Sensitive indicator to capture quality of care in health facilities (ICD-10 requirement)</td>
</tr>
<tr>
<td>16</td>
<td>Policy on special care for low birth weight babies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Policy on payment for maternal and newborn care services/free maternity and newborn services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Perinatal death reviews</td>
<td>Number of perinatal deaths reviewed</td>
<td>All perinatal deaths</td>
<td>Frequency every month/3 months</td>
</tr>
<tr>
<td>19</td>
<td>Neonatal death reviews</td>
<td>Number of neonatal deaths reviewed</td>
<td>All neonatal deaths</td>
<td>Frequency every month/3 months</td>
</tr>
<tr>
<td></td>
<td><strong>Human resources</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Availability of community health worker for newborn care</td>
<td>Number of community health workers providing newborn care in population</td>
<td>All births in population</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Availability of midwives</td>
<td>Number of midwives in population</td>
<td>All births in population</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Infrastructure</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Proportion of health facilities with availability of soap, running water or alcohol based rub in labour and childbirth, neonatal and paediatric wards</td>
<td>Number of health facilities with availability of soap, running water or alcohol based rub in labour and childbirth, neonatal and paediatric wards</td>
<td>Total number of health facilities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Availability of newborn resuscitation in facilities</td>
<td>No of facilities in population where trained staff are available to perform newborn resuscitation 24/7</td>
<td>All facilities providing maternity services</td>
<td>Assessed through SARA</td>
</tr>
<tr>
<td>---</td>
<td>----------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>23</td>
<td>Proportion of health facilities with safe uninterrupted oxygen supply in the childbirth, neonatal and paediatric wards</td>
<td># of health facilities with safe uninterrupted oxygen supply in the childbirth, neonatal and paediatric wards</td>
<td>Total # of health facilities</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Proportion of health facilities offering maternity services that have BFHI(^{34}) certification and recertification not older than two years</td>
<td>Number of health facilities offering maternity services that have BFHI certification and recertification not older than two years</td>
<td>Total # of health facilities with maternity services</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Proportion of health facilities where Kangaroo Mother Care is operational(^{35}), by level of facility</td>
<td>Number of health facilities where Kangaroo Mother Care is operational, by level of facility</td>
<td>Total # of health facilities with maternity services or inpatient care for newborn infants</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Availability of Caesarean section in population</td>
<td>No of facilities in population where caesarean section was performed in preceding 3 months</td>
<td>All facilities providing maternity services</td>
<td>Assessed through SARA</td>
</tr>
<tr>
<td>27</td>
<td>Proportion of health facilities that had a stock out of essential life savings medicines (oxytocin, magnesium sulphate, dexamethasone, vaccines, oral rehydration salt (ORS),</td>
<td>Number of health facilities that had a stock out of essential life savings medicines (oxytocin, magnesium)</td>
<td>Total number of health facilities</td>
<td>Assessed through SARA</td>
</tr>
</tbody>
</table>

\(^{34}\) BFHI - Baby Friendly Hospital Initiative
\(^{35}\) Operational here indicates that Kangaroo Mother Care is provided as per recommended standards
<table>
<thead>
<tr>
<th>Code</th>
<th>Question</th>
<th>Reference</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>29</td>
<td>Proportion of health facilities with maternity services that have functional bag &amp; masks (2 neonatal mask sizes) in the delivery areas</td>
<td>Sulphate, dexamethasone, vaccines, oral rehydration salt (ORS), zinc, oral amoxicillin, injectable gentamicin, (MRDT/antimalarial and ARVs context specific) in a specified period of time</td>
<td>Facility surveys / self-assessments</td>
</tr>
</tbody>
</table>
## Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal death</td>
<td>The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes</td>
</tr>
<tr>
<td>Maternal Mortality Ratio</td>
<td>Number of maternal deaths per 100,000 live births during a specified time period, usually 1 year</td>
</tr>
<tr>
<td>Neonatal – Early Neonatal Deaths</td>
<td>Deaths that occur in the first seven days of a baby’s life</td>
</tr>
<tr>
<td>Neonatal – Late Neonatal Deaths</td>
<td>Deaths occurring after 7th day but before the 28th completed day of life</td>
</tr>
<tr>
<td>Neonatal Mortality Rate</td>
<td>Probability of dying during the first 28 completed days of life, expressed per 1,000 live births.</td>
</tr>
<tr>
<td>Perinatal mortality</td>
<td><em>Perinatal mortality</em> is death in the perinatal period which includes late pregnancy, birth and the first week of life, and thus includes stillbirths and early neonatal mortality</td>
</tr>
<tr>
<td>Preterm – extremely preterm</td>
<td>A baby born at &lt;28 completed weeks gestation. Differing lower cut off for preterm birth definition from 20 to 28 weeks</td>
</tr>
<tr>
<td>Preterm – moderate or late preterm birth</td>
<td>A baby born at 32 - &lt;37 completed weeks gestation</td>
</tr>
<tr>
<td>Preterm – very preterm</td>
<td>A baby born at 28 - &lt;32 completed weeks gestation</td>
</tr>
<tr>
<td>Preterm birth</td>
<td>A baby born &lt; 37 completed weeks gestation</td>
</tr>
<tr>
<td>Small for Gestational Age (SGA)</td>
<td>Infant below the 10th percentile of birth weight for gestational age, gender-specific reference population. An SGA baby may be preterm or full-term</td>
</tr>
<tr>
<td>Low birth weight</td>
<td>Weight of less than 2500 g, irrespective of gestational age</td>
</tr>
<tr>
<td>Very low birth weight</td>
<td>Weight of less than 1500 g</td>
</tr>
<tr>
<td>Extremely low birth weight</td>
<td>Weight less than 1000 g</td>
</tr>
<tr>
<td>Stillbirth</td>
<td>The birth of a dead baby with a birth weight of 500 g or more, 22 or more completed weeks of gestation, or a body length of 25 cm or more, who died before or during labour and birth. For international comparisons, WHO recommends reporting of stillbirths with birth weight of 1000 g or more, 28 weeks’ gestation or more, or a body length of 35 cm or more, often reported as third-trimester stillbirths</td>
</tr>
<tr>
<td>Stillbirth – fresh stillbirth</td>
<td>Baby born dead without signs of skin disintegration or maceration and the death is assumed to have occurred after the onset of labour and before birth</td>
</tr>
<tr>
<td>Stillbirth Rate (for international comparison)</td>
<td>Stillbirth relates to the fetus of 28 weeks gestation that at birth shows no sign of life. Stillbirth rates are calculated per 1000 total births (live and stillbirths)</td>
</tr>
<tr>
<td>Under-five Mortality Rate</td>
<td>Probability of dying between birth and exactly 5 years of age, expressed per 1,000 live births.</td>
</tr>
</tbody>
</table>