SECTION 1
Premise for open global consultation on coverage targets (2020-2025)

Purpose of updating Every Newborn targets 2020-2025
To provide a clear vision that helps countries to accelerate progress to reach coverage targets (2020-2025) and measure our collective progress to end preventable newborn deaths and preventable stillbirth on the path to 2030 Universal Health Coverage goals and the Sustainable Development Goals.

Purpose of global open consultation on proposed Every Newborn targets 2020-2025
The Every Newborn Action Plan was endorsed by 194 countries at the World Health Assembly in 2014 (WHA 67.10). In the development phase, an inclusive consultation process was undertaken. The original Every Newborn Action Plan included coverage targets and milestones only until 2020 and this global consultation on coverage targets for 2020-2025 aims to have the same inclusiveness and transparency.

Coverage targets are being developed now in order to provide a clear vision for countries to help accelerate and measure our collective progress on the path towards 2030 Universal Health Coverage goals and the Sustainable Development Goals, to end preventable deaths of mothers, of stillbirths and newborn mortality and morbidity.

The target audience are country and global level policymakers who will undertake the necessary actions and investments. By setting and ensuring progress to collectively agree coverage targets, we...
can hold each other to account to end these preventable deaths. Our hope is that all of us will input to shape these targets and will also be part of working to help accelerate progress.

**Background information:**

There are now more than 90 countries working to implement the recommendation of the Every Newborn Action Plan (ENAP), a roadmap for action to end preventable newborn mortality and preventable stillbirth. With recommendations of what countries can do better to reduce mortality and morbidity and close equity gaps, the Every Newborn Action Plan included the following: Newborn mortality and stillbirth reduction targets by 2030 with progress review in 2020 and 2025. Coverage targets for universal health coverage by 2030 with progress review in 2020 and 2025 Country and global milestones or actions by 2020.

Since the Every Newborn resolution WHA 67.10 was adopted, the Sustainable Development Goals and Global Strategy for Women, Children’s and Adolescents Health, have been developed and endorsed; the newborn mortality target is in both and the stillbirth target is in the Global Strategy. Universal Health Coverage targets also prioritize the importance of a life-course approach and a healthy start. The target year is now clearly 2030, whereas in 2014 we were uncertain between 2030 and 2035, so ENAP included both years. Therefore, no change is needed for the mortality targets, other than leaving out the 2035 one.

Countries are actively implementing the recommendation set out in the Every Newborn Action Plan and tracking progress. Many countries are making steady progress and more than 78 have set neonatal mortality reduction targets, but there remain crucial challenges. Humanitarian and fragile settings are the most left behind. Stillbirth targets have been set in more than 30 countries with attention and progress still lacking. New opportunities have arisen with a major focus and innovation for hospital care of small and sick newborns, which is essential to reach the NMR target of 12, meaning a crucial need for systematic implementation learning between countries. Improving and using routine data to drive coverage and quality is crucial over the next decade.

To accelerate progress to reach mortality targets by 2030, it is important that the coverage targets for key aspects of newborn health to achieve Universal Health Coverage (UHC) are set. Hence, in order to provide this clearer vision to countries, the Every Newborn Management Team, chaired by WHO and UNICEF, have reviewed evidence and data in order to propose coverage targets to achieve by 2025.

**Principles**

1. Alignment: Join with other relevant goals and targets rather than develop new ones as much as possible.
2. Analyses: Careful data analyses of trends to inform proposed targets and select indicators that are measurable.
3. Ambition: Appropriate balance between ambition to push change, yet not impossible to achieve.
4. Equity: Ensure attention to equity.
5. Integration: Keep the mother and baby together: ensure integrated woman and baby and where possible one joint indicator; which this is feasible for ANC and SBA and aimed for with early PNC indicators.
6. Indicators: Use contact point indicators. Although it is well recognized that contact point of care alone (for example ANC contact, or skilled attendance or PNC) is not sufficient for quality care, the focus of these targets is coverage given data availability and feasibility of measurement. For small and sick newborn care, we do not yet have a measure of contact point and hence need to utilize other measures such as service readiness.
SECTION 2
Background and technical notes on the Proposed 2025 coverage targets

**Target 1: Every Pregnant Woman**

**Indicator:** Complete antenatal care visits (4 or more) during pregnancy (ANC4+)

- Related global 2030 target: The 2030 Universal Health Coverage aspirational goal is 95% or higher
- Target sets by others: unable to find other targets for ANC4+ or ANC8
- Women to be reached each year: approximately 160 million * (number based on 2019 population projections from UNPOP)

**BACKGROUND**

**Metrics**

Although the 2016 WHO Guidelines for a Positive Pregnancy Experience recommend 8 ANC visits, the recommendation is relatively new and there are limited available data at this point with no reliable trend data. As a result, we will monitor ANC4+ but ensure that we promote the new recommendation.

**Trends**

Current average global coverage level of ANC4+ is 60% with 2025 projection to be over 70%
Target 2: Every Birth

Indicator: Births attended by skilled health personnel
- Related global 2030 target: The 2030 Universal Health Coverage aspirational goal is 95% and higher
- Target sets by others: MDG target by 2015 was 90% coverage
- Women and baby pairs to be reached each year: approx. 140 million total births **

BACKGROUND

Metrics
90% of countries are currently recording data for this indicator, which is also included in the Sustainable Development Goals

Trends
Current global average coverage of skilled attendance at birth is estimated at 81% and projection for 2025 is about 90%

Definition of Skilled Health Personnel
The definition of skilled health personnel used in this consultation is that posited by WHO in 2018.

Skilled health personnel, as referenced by SDG indicator 3.1.2, are competent maternal and newborn health (MNH) professionals educated, trained and regulated to national and international standards. They are competent to:
(i) provide and promote evidence-based, human-rights-based, quality, socio-culturally sensitive and dignified care to women and newborns;
(ii) facilitate physiological processes during labour and delivery to ensure a clean and positive childbirth experience; and
(iii) identify and manage or refer women and/or newborns with complications.
In addition, as part of an integrated team of MNH professionals (including midwives, nurses, obstetricians, paediatricians and anaesthetists), they perform all signal functions of emergency maternal and newborn care to optimize the health and well-being of women and newborns.

Within an enabling environment, midwives trained to International Confederation of Midwives (ICM) standards can provide nearly all of the essential care needed for women and newborns.* (In different countries, these competencies are held by professionals with varying occupational titles.)
(See: https://www.who.int/reproductivehealth/publications/statement-competent-mnh-professionals/en/)
**Target 3: Every woman and newborn**

Indicator: Early routine postnatal care (PNC) for every mother and baby (within 2 days)
- Related global 2030 target: The 2030 UHC aspiration goal is 95% and higher
- Target sets by others: none found
- Women and newborn pairs to be reached each year: approx. 145 million

**BACKGROUND**

**Metrics**
Indicators on early routine postnatal care are relatively new, with more countries having data over time on PNC within 2 days for women and few countries having trend data for PNC within 2 days for newborns. In addition, there are measurement challenges around accurately classifying routine PNC from routine intrapartum care.

Although PNC package is for integrated care of mother and newborn after discharge, the PNC contact point is currently measured separately. Given these measurement challenges, the trend data used to develop the targets for routine early PNC is based on PNC data for women.

**Trends**
Current global average for PNC for women is over 55% and projected by 2025 to be between 65% and 70% but with wider uncertainty intervals.
**Target 4: Every small and sick newborn**

**Indicator:** Care for both small and sick newborns

- 2030 target/Universal Health Coverage: both small or sick newborns are part of Universal Health Coverage, so the assumed target is 95% or higher
- Target sets by others: Every Newborn Action Plan (2014) previous target for 2025 was “75% coverage of Kangaroo Mother Care and inpatient sepsis case management; Comprehensive newborn care country specific targets.”
- Number of both small or sick newborns to be reached each year: approx. 30 million newborns

**BACKGROUND**

**Metrics**

Coverage data are lacking, but may be possible in the next 5 years, e.g. total admissions to neonatal ward, total admissions to Kangaroo Mother Care ward. In the meantime, a pragmatic approach is to use service readiness

- Definitions from WHO/UNICEF report “Survive and Thrive; Transforming care for small and sick newborns” and based on a global survey (Moxon et al 2019).
  - Level 1 is expected to be available in health facilities equivalent to Basic Emergency Obstetric Care (BEmOC) health facilities.
  - Level 2 is expected to be available in Comprehensive Emergency Obstetric Care (CEmOC) health facilities.
  - Level 3 is for tertiary care (selected CEMONC health facilities). Level 3 is for tertiary care, but over time should be available for all small and sick newborns as part of UHC (see Table 1).

<table>
<thead>
<tr>
<th>Table 1: Levels of newborn care with interventions per level</th>
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<tbody>
<tr>
<td><strong>Level 1</strong> (immediate and essential newborn care)</td>
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<tr>
<td>Immediate newborn care (delayed cord clamping, drying, skin to skin etc)</td>
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<tr>
<td>Neonatal resuscitation for those who need it</td>
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<tr>
<td>Breastfeeding early initiation and support</td>
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<tr>
<td>Essential newborn care R ongoing</td>
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<tr>
<td>Identification and referral of complications</td>
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<td>Targeted care as needed e.g. PMTCT of HIV</td>
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<td><strong>Level 2</strong> (special newborn care)</td>
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<tr>
<td>Thermal care including KMC for all stable neonates &lt;2000gms</td>
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<tr>
<td>Assisted feeding and IV fluids</td>
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<tr>
<td>Safe administration of oxygen</td>
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<tr>
<td>Detection and management of neonatal sepsis with injection antibiotics</td>
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<td>Detection and management of neonatal jaundice with phototherapy</td>
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<tr>
<td>Detection and management of neonatal encephalopathy</td>
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<tr>
<td>Detection and referral/management of congenital abnormalities</td>
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<tr>
<td><strong>Transition</strong></td>
</tr>
<tr>
<td>Management of preterm respiratory distress with Continuous Positive Airway Pressure (CPAP)</td>
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<tr>
<td>Follow up of at risk newborns</td>
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<tr>
<td>Exchange transfusion</td>
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<tr>
<td><strong>Level 3</strong> (intensive newborn care)</td>
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<tr>
<td>Mechanical/assisted ventilation</td>
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<tr>
<td>Advanced feeding support (e.g. parenteral nutrition)</td>
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<tr>
<td>Paediatric surveys for congenital conditions</td>
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<tr>
<td>Screening and treatment for Retinopathy of Prematurity</td>
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Refs WHO/UNICEF report “Survive and Thrive; Transforming care for small and sick newborns” and based on a global survey (Moxon et al 2019).
• **Denominator for calculation**: Could be total number of districts or equivalent sub-national units from ENAP reporting countries.

• **Tools**: There are several Health Facility Assessment tools including one combining the others that is now fully comprehensive and also covers floor plans, hospital acquired infections etc.

• **Reporting process**: Could be based on the national ENAP progress reporting with an additional review or data verification process.

**Trends**

There are limited national data for coverage of both small or sick newborn care and no reliable trend data. All the fastest progressing countries for NMR reduction have had a major scale up of neonatal intensive care and most are middle income countries. Most low-income countries (apart from humanitarian settings) now have facility birth coverage over 60% and district hospitals with many components of Level 2 newborn care, although often gaps exist on quality. Learning from India, it took 10 years from 1 pilot site to >840 Level 2 units and 90% of districts having a Level 2 unit. There is now major focus on both small or sick newborn care. Countries will need support to achieve high coverage. There is major innovation and impetus and countries need to be more ambitious.

**Technical note on option 3: travel time-based target**

The increased use of geographic information systems (GIS) tools and growing availability high-resolution geographical data provide opportunities to reflect real-life travel challenges still faced by women and newborns to access emergency care in many countries with a high burden of maternal and newborn mortality and morbidity. Input data required to measure the population covered by emergency care within 2 hours travel-time (the estimated maximum time between onset of untreated severe postpartum hemorrhage and death) include: (1) the geographtical coordinates (latitude, longitude) of health facilities, (2) spatial distribution of the population, (3) road and hydrographic networks, (4) digital elevation model, (5) land cover, and (6) administrative boundaries. Many of these data sets are freely available globally at high resolution, with the exception of the exhaustive set of facility coordinates that are usually available at the Ministry of Health. Spatial distribution of the population are available from census or from free database, such as WorldPop (https://www.worldpop.org/) or Columbia University/Facebook (https://www.ciesin.columbia.edu/data/hrsl/).

Since 2015, 12 countries in sub-Saharan Africa and South East Asia have used travel time-based targets for planning their national network of health facilities providing Emergency Obstetric and Newborn Care (EmONC). Using a free open source geographical modelling tool developed by WHO and the University of Geneva (AccessMod - https://www.accessmod.org), these countries are focusing their efforts and resources on ensuring that a selected number of referral health facilities provide quality emergency care for women and newborns (EmONC) 24h/7d and are accessible within two hours of travel time by most of the population - more information are available on https://www.unfpa.org/sites/default/files/pub-pdf/013_MHTF_Annual_report_15-online.pdf and on https://gh.bmj.com/content/bmjgh/4/Suppl_5/e000778.full.pdf.