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Newborn health: draft action plan

Every newborn: an action plan to end preventable deaths

Report by the Secretariat

1. Although remarkable progress has been made in recent decades to reduce the number of child deaths worldwide, the neonatal mortality rate globally has declined at a slower pace despite a large proportion of newborn deaths being preventable. Opportunities for improving newborn health are unprecedented as, today, much more is known about effective interventions and service delivery channels, and approaches to accelerating coverage and raising quality of care. Recently, renewed commitments to saving the lives of newborn infants have been made by many governments and partners, in response to the United Nations Secretary-General's Global Strategy for Women's and Children's Health and its accompanying Every Woman, Every Child initiative and to recommendations made by the Commission on Information and Accountability for Women's and Children's Health[1] and the United Nations Commission on Life-Saving Commodities.[2] This response has triggered an initiative by multiple stakeholders to propose to the global health community the development of a draft global action plan.

PREPARATION OF THE DRAFT ACTION PLAN

2. The preparation of the newborn health draft action plan has been guided by the advice of experts and partners, led by WHO and UNICEF, and by the outcome of several multi-stakeholder consultations at different global and regional forums.

3. A further consultative process followed with Member States, in particular regarding the goals and actions being proposed for the five strategic directions of the draft action plan and their related targets, through one global and two regional meetings of stakeholders. In addition a draft of the action plan was posted on the WHO website in December 2013 for consultation by Member States and other stakeholders before the 134th session of the Executive Board. At that session, the Board noted the proposed process for the further development of the draft action plan.[3]

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[1] Commission on information and accountability for Women's and Children's Health. Keeping promises, measuring results. Geneva: World Health Organization; 2011.

[2] United Nations Commission on Life-Saving Commodities. Commissioners' report: September 2012. New York: United Nations; 2012.

[3] See the summary records of the fourth (section 4) and seventh meeting of the Executive Board at its 134th session (document EB134/2014/REC/2).

4. The subsequent web-based consultation was conducted, as outlined in document EB134/17 Add.1. A Note Verbale was sent to Member States on 4 February 2014, describing the process and inviting feedback. In addition, information about the web consultation was widely disseminated through social media and networks on reproductive, maternal, newborn and child health to encourage as broad a response as possible.

5. By the deadline of 28 February 2014, more than 300 comments had been received, including responses from 43 State actors, 23 professional associations, 102 nongovernmental organizations, and many individuals. The Secretariat took these comments into account in revising the draft action plan.

6. The proposed "Every newborn: an action plan to end preventable deaths", provides clear objectives and actions for Member States and other stakeholders. It also proposes indicators that can be used to evaluate both progress in implementation and the impact of the action plan.

BACKGROUND

7. The number of child deaths worldwide has declined markedly in recent decades, largely through interventions to lower mortality after the first month of life. The mortality rate among children under five years of age has fallen globally by almost 50% (from 90 deaths per 1000 live births in 1990 to 48 deaths per 1000 live births in 2012), but the neonatal mortality rate decreased only 37% (from 33 deaths per 1000 live births to 21 deaths per 1000 live births) over the same period and represented, in 2012, 44% of the total child mortality.[1]

8. Many newborn deaths are preventable and could be avoided if the actions in this plan were implemented and its goals and targets achieved. The draft action plan is based on evidence of what works. It recognizes that survival of a newborn 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, health care for women and newborns within the continuum of care that spans pre-conception, pregnancy, childhood and adolescence.

9. The draft action plan sets out a vision of a world in which there are no preventable deaths of newborns or stillbirths, where every pregnancy is wanted, every birth celebrated, and women, babies and children survive, thrive and reach their full potential. To realize this vision, the plan proposes strategic objectives, mortality-related goals, and coverage and quality of care targets by 2035, with intermediate goals for 2020, 2025 and 2030. Mortality goals are related to targeted coverage of quality care for women and babies around the time of birth, care of sick and small newborns and postnatal care. The action plan includes an impact framework, milestones (Annex 1) and indicators to measure progress (Annex 2).

10. Developed within the framework for the Every Woman, Every Child initiative, the plan aims to enhance and support coordinated, comprehensive planning and implementation of newborn-specific actions within the context of national reproductive, maternal, newborn, child and adolescent health strategies and action plans. The goal is to achieve equitable and high-quality coverage of essential, referral and emergency care for women and newborns in every country through links with other global and national plans, measurement and accountability.

[1] UNICEF, WHO, The World Bank, United Nations. Levels and trends in child mortality: report 2013. New York: United Nations Children's Fund; 2013.

11. The focus is primarily on newborn survival and health and the prevention of stillbirths. These targets were not included in the Millennium Development Goal framework and consequently received less attention and investment, resulting in slower reductions in mortality.

12. Stillbirths, newborn survival and health are intrinsically linked with the survival, health and nutrition of women before conception and during and between pregnancies. The periods of greatest risk for morbidity and mortality for woman and child are the hours that precede and the hours and days that follow birth. The draft action plan therefore emphasizes the need to reach every woman and newborn baby when they are most vulnerable – in labour, during birth and in the first days of life. Intervention in this critical time period provides the greatest potential for ending preventable neonatal deaths, stillbirths and maternal deaths, and would result in a triple return on investment. The plan is part of the broader initiative to end preventable maternal and newborn deaths; a comprehensive maternal action plan is also needed to provide guidance on care before conception and during pregnancy.

13. The action plan has been drafted in close consultation with stakeholders; the draft version uploaded on the WHO website in February 2014 elicited more than 300 formal comments. The plan takes into account all inputs, the findings from an analysis of obstacles to scaling up effective interventions to improve newborn health, a comprehensive epidemiological analysis and a review of the evidence of the effectiveness of the proposed interventions.

EXISTING COMMITMENTS

14. Putting the action plan into practice will strengthen existing commitments, such as the pledge made in the Family Planning 2020 initiative "A promise renewed"[1] (which calls for an end to preventable child deaths) and strong regional and global undertakings to ending preventable maternal deaths. Given the large proportion of deaths of under-5-year olds that occur in the neonatal period and the close link between maternal and neonatal mortality, these commitments will not be fulfilled without specific efforts to reduce neonatal mortality and stillbirths. The plan builds on, and links to, other global action plans, such as those on nutrition, vaccines, malaria, pneumonia, diarrhoea, water and sanitation, and elimination of mother-to-child transmission of HIV, syphilis and neonatal tetanus, and takes into consideration multiple timeframes for achievement of these existing commitments' targets and goals.

15. 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 accompanying initiative Every woman, every child, and to the recommendations from the Commission on Information and Accountability for Women's and Children's Health[2] and the United Nations Commission on Life-Saving Commodities for Women and Children.[3] Recognizing that progress in newborn health has lagged behind advances in maternal and child health, the action plan takes forward the Global Strategy's mission, supporting the call by the World Health Assembly in resolution WHA58.31, Working towards universal coverage of maternal,

[1] UNICEF. Committing to child survival: a promise renewed – progress report 2013. New York United Nations Children's Fund; 2013.

[2] Commission on information and accountability for Women's and Children's Health. Keeping promises, measuring results. Geneva: World Health Organization; 2011.

[3] United Nations Commission on Life-Saving Commodities. Commissioners' report: September 2012. New York: United Nations; 2012.

newborn and child health interventions, to commit resources and to accelerate national action to build a seamless continuum of care for reproductive, maternal, newborn and child health. These initiatives also affirm women's and children's health as matters of fundamental human rights.

16. The Global Investment Framework for Women's and Children's Health[1] estimates that additional investment of US$ 5 per person per year on reproductive, maternal, newborn and child health across the continuum of care would produce a nine-fold return on investment in social and economic benefits in the highest-burden countries.

17. The Sixty-fourth World Health Assembly in 2011, in resolution WHA64.12 on WHO's role in the follow-up to the United Nations High-level Plenary Meeting of the General Assembly on the Millennium Development Goals (New York, September 2010), expressed deep concern at the slow and uneven progress towards Millennium Development Goals 4 and 5. In resolution WHA64.13 on working towards the reduction of perinatal and neonatal mortality the Health Assembly observed that movement towards reducing perinatal and neonatal mortality had stagnated and requested the Director-General to promote targeted plans to increase access to high-quality and safe health services that prevent and treat perinatal and neonatal conditions. The draft action plan responds to that request and also reflects the Health Assembly's decisions in resolution WHA64.9 on sustainable financing structures and universal coverage.

RIGHTS

18. Under Articles 6 and 24 of the Convention on the Rights of the Child, every newborn child has the inherent right to life, survival and development, the highest attainable standard of health and access to health care services for treatment and rehabilitation. The notion of legal obligations is reinforced in General Comment No. 15 by the Committee on the Rights of the Child on the child's right to the highest attainable standard of health and health care,[2] which specifies that States have an obligation to reduce child mortality and that particular attention should be paid to neonatal mortality.

19. The United Nations Human Rights Council welcomed the technical guidance on the application of a human-rights based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality in September 2012,[3] reinforcing women's rights to access quality, appropriate and affordable services and support across the continuum of care. The Council's resolution A/HRC/22/L.27/Rev.1 on the right of the child to the enjoyment of the highest attainable standard of health 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 take action to address the main causes of mortality and morbidity.

[1] Stenberg K, Axelson H, Sheehan P, Anderson I, Gülmezoglu AM, Temmerman M et al. Advancing social and economic development by investing in women's and children's health: a new Global Investment Framework. Lancet 2013; early online publication, 19 November. doi:10.1016/S0140-6736(13)62231-X.

[2] Convention on the Rights of the Child, document CRC/C/GC/15.

[3] Office of the High Commissioner for Human Rights, resolution A/HRC/21/L.10.

CURRENT SITUATION

20. In addition to 2.9 million babies who die in the first month of life, it is estimated that 2.6 million babies are stillborn (die in the last three months of pregnancy or during childbirth) and some 287 000 women die each year from complications of pregnancy and childbirth. The global annual average rate of reduction in neonatal mortality since 1990 has been 2.0%, lower than that of maternal mortality (3.1%) and under-5-year old mortality (2.9%).[1]

21. Most newborn deaths occur in low- and middle-income countries. Two thirds of all neonatal mortality is reported from 12 countries,[2] six of which are in sub-Saharan Africa. Countries with a rate of 30 or more deaths per 1000 live births account for 60% of all newborn deaths.[3]

22. Many countries with a high burden of newborn deaths have experienced recent conflict or humanitarian emergencies. Others have weak health systems with limited infrastructure and low density of skilled health workers and the population faces high out-of-pocket expenditures. Inequitable access to quality health services for women and children results in stark disparities in mortality rates and intervention coverage between and within countries. Nevertheless, 11 low- and lower-middle-income countries have reduced their neonatal mortality rate by more than 40% since 2000,[4] showing that it is possible to make rapid progress.

23. Three causes accounted for more than 80% of neonatal mortality in 2012 (Figure 1): complications of prematurity, intrapartum-related neonatal deaths (including birth asphyxia) and neonatal infections. Complications of prematurity are also the second leading cause of all deaths of children aged under 5 years. Annually, 15 million babies are born prematurely and 32.4 million with a weight below the tenth percentile for their gestational age; 10 million do not breathe at birth, of which 6 million require basic neonatal resuscitation (bag and mask ventilation).

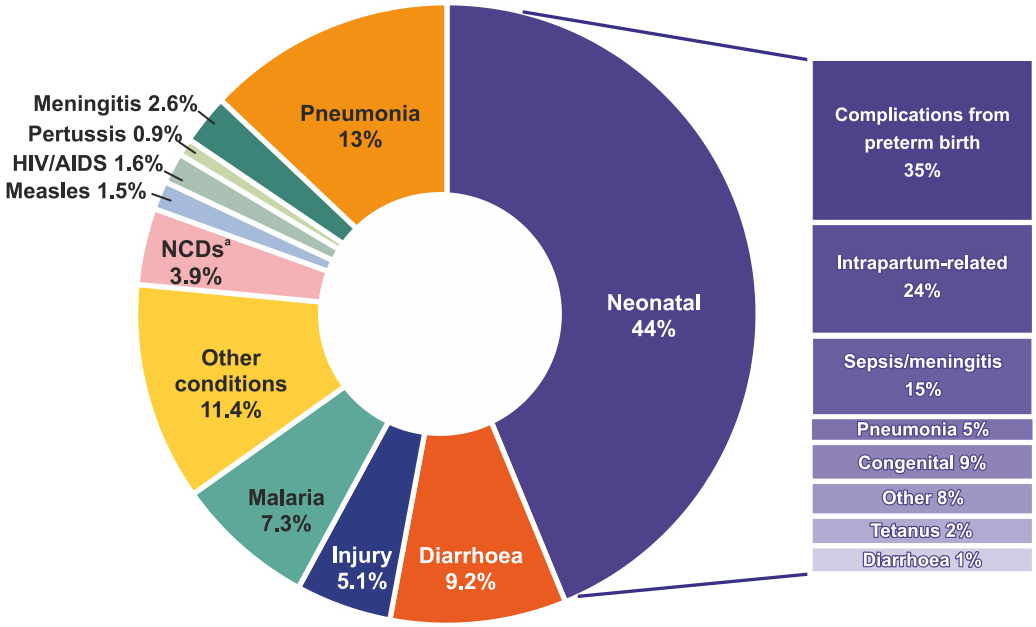
[1] WHO, UNICEF, UNFPA, The World Bank. Trends in maternal mortality: 1990 to 2010. Geneva: World Health Organization; 2012, and http://www.childinfo.org/files/Child_Mortality_Report_2013.pdf, respectively.

[2] In descending order of annual number of newborn deaths: India, Nigeria, Pakistan, China, Democratic Republic of the Congo, Ethiopia, Bangladesh, Indonesia, Angola, Kenya, United Republic of Tanzania, Afghanistan.

[3] 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.

[4] Bangladesh, Cambodia, Democratic People's Republic of Korea, Egypt, El Salvador, Malawi, Mongolia, Rwanda, Senegal, Sri Lanka and United Republic of Tanzania.

Figure 1. Causes of deaths in children under 5 years of age, 2012



[a] NCDs = noncommunicable diseases.

Source: WHO Global Health Observatory, 2014.

24. The highest risks of death in utero, in the neonatal period and throughout infancy and early childhood, are faced by small and low-birth-weight babies, that is, those who are born preterm or small for gestational age, or both. More than 80% of all newborn deaths occur among small babies in southern Asia and sub-Saharan Africa.

25. Disabilities remain an important issue. Many could be prevented by adequate care during labour and childbirth and in the neonatal period. Preterm babies who survive the first month of life face higher risks of post-neonatal mortality, long-term neurodevelopmental impairment, stunting and noncommunicable disease. Babies who are small for gestational age face risks of stunting and adult-onset metabolic conditions. Four million term or near-term neonates have other life-threatening conditions, including intrapartum-related brain injury, severe bacterial infection and pathological jaundice, which result in life-long impairments. More than a million neonates survive each year with long-term neurodevelopmental impairment. It is therefore important to look beyond survival and provide appropriate follow-up care for children affected by these conditions to ensure early detection and appropriate care and rehabilitation. As Article 23 of the Convention on the Rights of the Child stresses, it is also important to meet the needs of mentally or physically disabled children.

26. Some 10% of the entire global burden of disease is related to neonatal and congenital conditions. As the Health Assembly recognized in resolution WHA63.17 on birth defects, factors leading to birth defects and congenital abnormalities can affect health outcomes for babies who survive the neonatal period, as do many of the diverse causes and determinants of congenital disorders. Prevention of birth defects and provision of care for affected children need to be integrated into existing maternal, reproductive and child health services, with social welfare provision for all who need it.

27. Social determinants are an important factor in the health of women and newborns. Poverty, inequality and societal unrest undermine maternal and newborn care in numerous ways, such as poor nutritional status of girls and women (including during pregnancy) and inadequate housing and sanitation. Complex humanitarian emergencies cause 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 their own and their children's health, resulting in perilous delays and unnecessary deaths. This action plan acknowledges the inherent links between contextual factors and maternal and newborn health and focuses primarily on health system solutions.

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

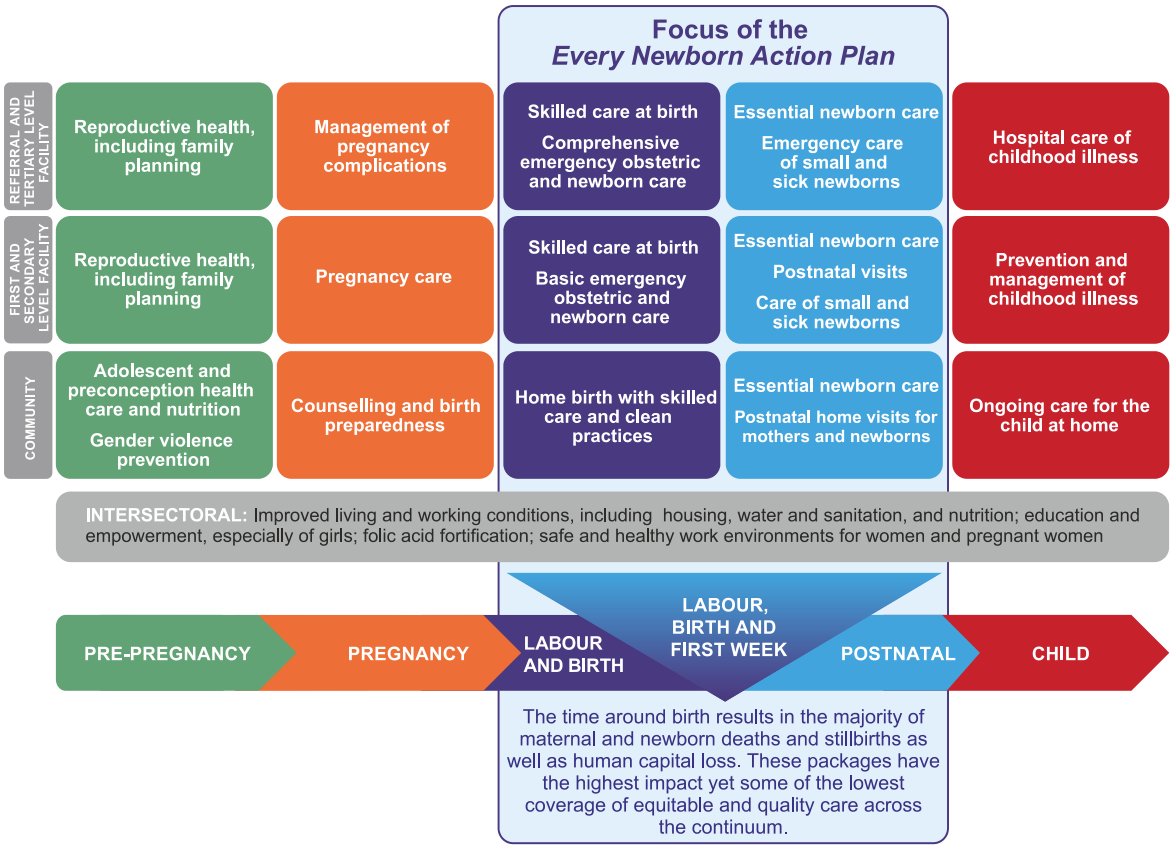
28. Unprecedented opportunities for improving newborn health now exist after decades of analysis and research that have generated information on the burden and causes of neonatal mortality, demonstrated effective interventions and service delivery channels, and identified ways to accelerate progress in extending the coverage of interventions to reduce mortality.[1]

29. Effective interventions for improving survival and health of newborns form one component of integrated health services for reproductive, maternal, newborn and child and adolescent health (Figure 2). These are well documented across the life course and have been packaged for levels of service delivery.[2] 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.

[1] Compilation of WHO recommendations on maternal, newborn, child and adolescent health (http://www.who.int/maternal_child_adolescent/documents/mnca-recommendations/en/, accessed 27 March 2014).

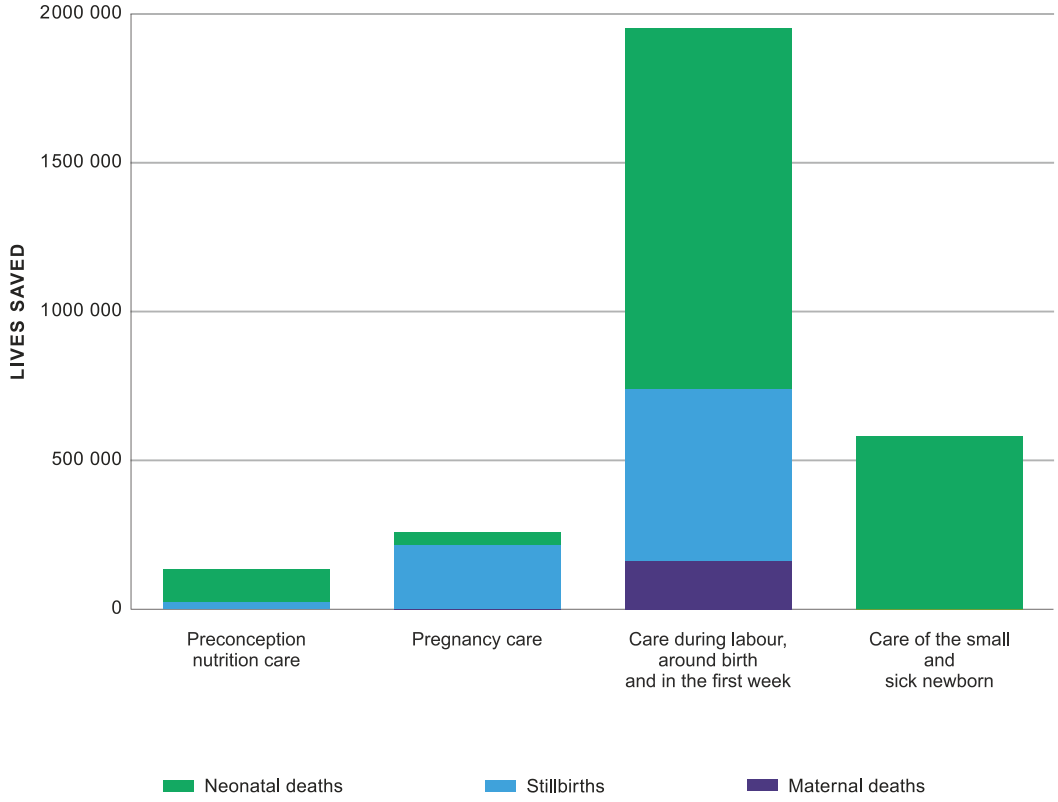
[2] A global review of the key interventions related to reproductive, maternal, newborn and child health. Geneva: The Partnership for Maternal, Newborn and Child Health; 2011.

Figure 2. Packages in the continuum of care



30. The packages of care with greatest impact on ending preventable neonatal deaths and stillbirths include: care during labour, childbirth and the first week of life; and care for the small and sick newborn. Figure 3 outlines preliminary results of the estimated impact of these interventions if universal coverage of care was to be achieved by 2025. Since these packages would save the most newborn lives as well as prevent maternal deaths and stillbirths, these are the focus of the Every newborn action plan.

Figure 3. Lives that could be saved by 2025 with universal coverage of care (preliminary results)



Source: Special analysis detailed in *The Lancet* Every newborn series, in press.

31. Interventions in the package of "care during labour, around childbirth and in the first week after birth" include (but are not limited to) skilled care at birth, basic and comprehensive obstetric care, management of preterm births (including the use of antenatal corticosteroids), and essential newborn care (hygienic care, thermal control, support for breastfeeding and, if required, newborn resuscitation). It is important that the interventions for mother and newborn are seen as a functional unit delivered in a narrow time window by the same health care provider (or team) and in the same place, with referral for management of complications including mother and baby together.

32. The package of "care of small and sick newborns" comprises interventions to deal with complications arising from preterm birth and/or small for gestational age, and neonatal infections (sepsis, meningitis, pneumonia and those causing diarrhoea). Appropriate management of small and sick newborns includes extra thermal care and support for feeding for small or preterm babies, including kangaroo mother care, antibiotic treatment for infections and full supportive facility care. The last encapsulates additional feeding support (including cup and nasogastric tube feeding and intravenous fluids), infection prevention and management, safe oxygen therapy, case management of jaundice and possibly surfactant and respiratory support.

33. Postnatal care provides the delivery platform for care of the normal newborn, including the promotion of healthy practices and detection of problems requiring additional care. It is provided in a different time window, often by different providers in different places. Care of the normal newborn includes early initiation of (exclusive) breastfeeding, prevention of hypothermia, clean postnatal care practices and appropriate cord care. Close observation for 24 hours and at least three additional postnatal contacts (on day 3 (48–72 hours), between days 7 and 14, and at six weeks after birth) is

recommended for all mothers and newborns to establish good care-giving practices and detect any life-threatening conditions.[1]

34. Other interventions across the continuum of care are also vital for the survival and health of women and their babies. For example, antenatal care provides an opportunity for integrated service delivery for pregnant women, including obstetric services, but also covers infections, such as preventing, detecting and treating malaria and syphilis in pregnancy, caring for women with tuberculosis and HIV infection, preventing mother-to-child transmission of HIV and reducing harmful lifestyle practices such as smoking and alcohol use. According to WHO's *World health statistics* (2013), the coverage rate of some interventions, such as vaccination with tetanus toxoid, is already high in many settings (82% of all newborns are now protected at birth against neonatal tetanus); there is therefore less potential for averting deaths (see Figure 3), but coverage rates must remain high. Some 81% of women receive antenatal care at least once during pregnancy, but only 55% receive the recommended minimum of four visits or more, and the quality of care is often suboptimal.

35. Care before and between pregnancies affects the survival and health of women and their babies. Contraception is a vital contributor through delaying, spacing and limiting births, all of which can reduce newborn mortality and boost the health of mothers, their babies and their other children. Access to family planning and the right to control if, when and how frequently to become pregnant empower women and girls and improves babies' health and survival. Investments in family planning will contribute significantly to an overall reduction in maternal and neonatal mortality: reducing the number of unintended pregnancies could avert 60% of maternal and 57% of child deaths.

36. Additional components of care before and between pregnancy that affect newborn health include life-skills education, nutrition, prevention and management of harmful practices (including smoking and alcohol use), identification and treatment of conditions such as sexually transmitted infections and mental illness, and tackling intimate partner violence. The nutritional status of women is of particular importance, as a woman undernourished before pregnancy is more likely to give birth to babies who are preterm or small for gestational age at birth, or both. This risk is determined partly by undernutrition of a woman in her own first 1000 days and during her adolescence. It is essential to break the intergenerational cycle of ill health and undernutrition, especially given increasing evidence about links between low birth weight and undernutrition in the first 1000 days of life and the rise of noncommunicable diseases in adulthood.

37. Preventing early unintended pregnancy in adolescent girls is a major component of efforts to improve newborn health.[2] Very young mothers and their babies face greater risks from pregnancy and birth.[3] Delaying pregnancy in adolescent girls is a powerful means of saving maternal and newborn lives and empowering girls to finish their education.

38. Care for women before and during pregnancy, childbirth and the postnatal period and between pregnancies[4] and for the newborn is best provided by a dedicated health professional qualified in

[1] WHO recommendations on postnatal care of the mother and newborn. Geneva: World Health Organization; 2013.

[2] Preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries. Geneva: World Health Organization; 2011.

[3] Motherhood in childhood. Facing the challenge of adolescent pregnancy. UNFPA state of world population 2013. New York: United Nations Population Fund; 2013.

[4] The term postnatal care is used to denote care for mothers and babies during the six-week period after birth, in line with WHO recommendations on postnatal care of the mother and newborn (Geneva: World Health Organization; 2013).

midwifery. Care should be respectful and should optimize normal biological processes. In most cases, the person providing care will be a professional midwife, who will need support from a team composed of other health professionals, such as nurses, obstetricians and paediatricians, when complications arise. The team could provide all aspects of care in settings where there are no professional midwives: for these settings, the term "midwifery personnel" is used.

39. Community health workers, especially in rural areas, 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 neonatal mortality rates. They are also effective in detecting and referring mothers with postpartum complications and offering family-planning counselling. Other community agents, such as traditional leaders, influential family members and traditional birth attendants, also influence the demand for, and access to, skilled care.

40. The provision of a continuum of care throughout the life course requires seamless, functional coordination between levels of health services and the public and private sectors. Delivering health care to women and newborns requires coordination between technical programmes and initiatives and collaboration among all concerned stakeholders: governments, professional associations, civil society, academic and research institutions, the business community, development partners and families.

ACTION PLAN: VISION AND GOALS

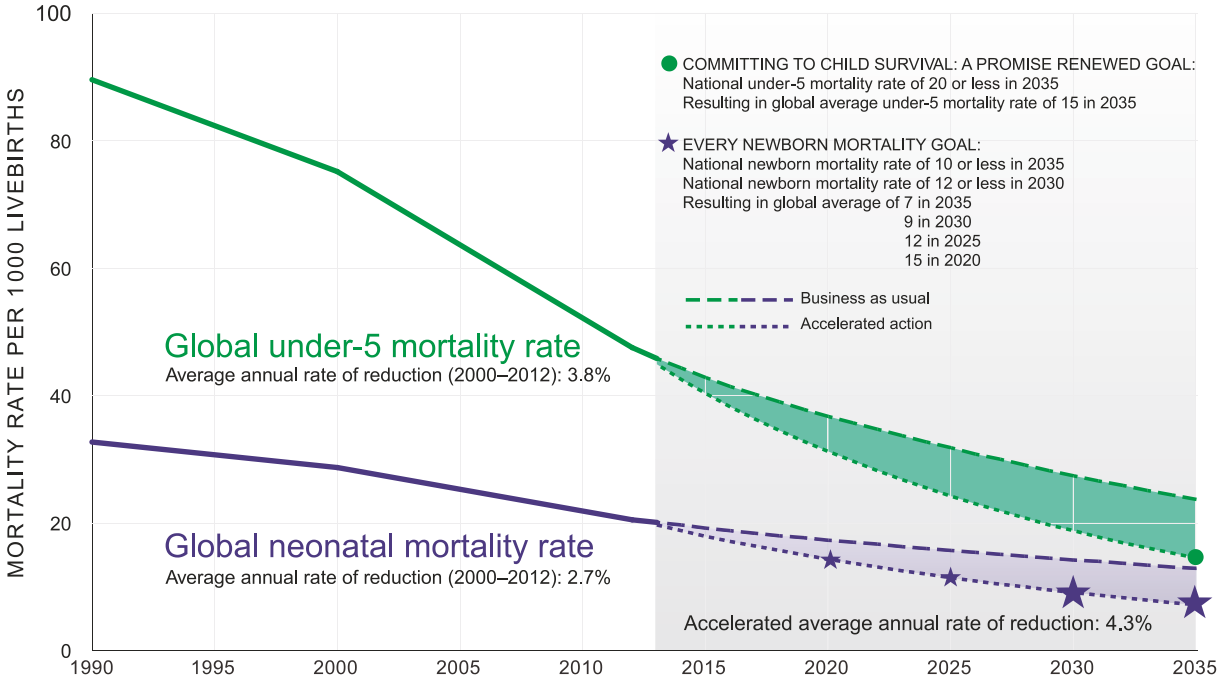
41. The **vision** of the Every newborn action plan is of a world in which there are no preventable deaths of newborns or stillbirths, where every pregnancy is wanted, every birth celebrated, and women, babies and children survive, thrive and reach their full potential.

42. **Goal 1 – ending preventable newborn deaths**:[1] all countries will reach the goal of fewer than 10 newborn deaths per 1000 live births by 2035 and continue to reduce death and disability, ensuring that no newborn is left behind. Achievement of this goal will result in an average global neonatal mortality rate of 7 deaths per 1000 live births, a figure that is consistent with, and necessary to the achievement of, the goal set in Committing to child survival: a promise renewed[2] of ending preventable child deaths. By 2030, all countries will reach 12 newborn deaths or less per 1000 live births resulting in an average global neonatal mortality rate of 9 deaths per 1000 live births (other interim goals are shown in Figure 4). It is intended that these goals will also link to forthcoming proposed goals for ending preventable maternal deaths. All countries should ensure this goal is also achieved for underserved populations, maximizing human capital. The goal may be considered a continuation of Millennium Development Goal 4 to cover the unfinished business of reducing newborn deaths.

[1] A newborn death is defined as the death within 28 days of birth of any live-born baby regardless of weight or gestational age.

[2] UNICEF. Committing to child survival: a promise renewed progress report 2013. New York: United Nations Children's Fund; 2013.

Figure 4. Ending preventable newborn and child deaths

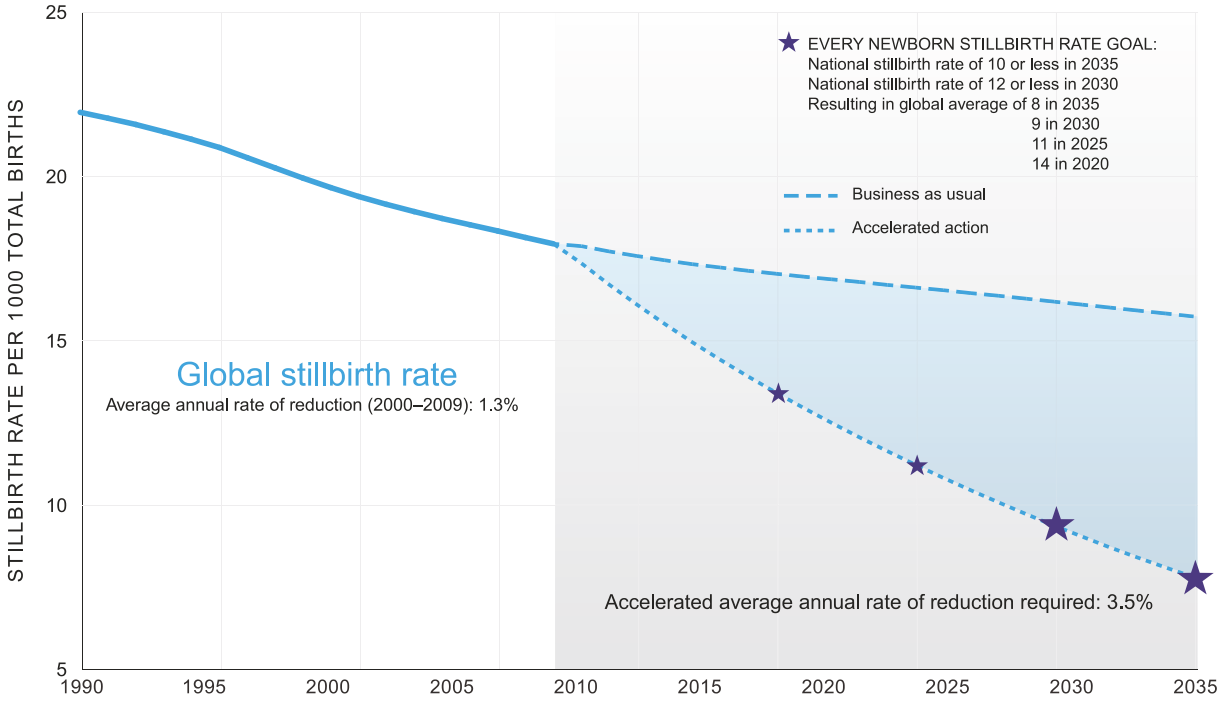


Sources: Country and official online consultations and neonatal mortality rate data from the United Nations Inter-Agency Group for Child Mortality Estimation, 2013.

43. **Goal 2 – ending preventable stillbirths**:[1] all countries will reach the goal stillbirth rate of less than 10 per 1000 total births by 2035 and continue to close equity gaps. Achieving this goal will result in an average global stillbirth rate of 8 per 1000 total births. By 2030, all countries will reach 12 stillbirths or less per 1000 total births resulting in an average global stillbirth rate of 9 deaths per 1000 total births (other interim goals are shown in Figure 5). All countries should focus on addressing inequalities and use audit data to track and prevent stillbirths.

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

Figure 5. Ending preventable stillbirths



Sources: Country and official online consultations and stillbirth rate data from *The Lancet* stillbirth series.[1]

44. The ambitious goals proposed in this action plan of ending preventable newborn deaths and stillbirths by 2035 – with intermediate goals for 2030, 2025 and 2020 – require universal, equitable and high-quality coverage of essential, referral and emergency care for every woman and newborn in every country. This demands measurement, accountability and linkages with other global and national plans.

ACTION PLAN STRATEGIC OBJECTIVES AND PRINCIPLES

45. To achieve the vision and mortality goals, the Every newborn action plan proposes five strategic objectives.

Strategic objective 1: strengthen and invest in care during labour, birth and the first day and week of life. A large proportion of maternal and newborn deaths and stillbirths occur within this period. Many deaths and complications can be prevented by ensuring provision of high-quality essential care for every pregnant woman and 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's and children's health. Women and newborns in many settings do not receive the care they need even when they have

[1] Cousens S, Blencowe H, Stanton C, Chou D, Ahmed S, Steinhardt L et al. National, regional, and worldwide estimates of stillbirth rates in 2009 with trends since 1995: a systematic analysis. Lancet 2011;377(9774):1319–30. doi:10.1016/S0140-6736(10)62310-0.

contact with the health system before, during or after pregnancy. Introducing high-quality care with high-impact, cost-effective interventions for mother and baby together – delivered, in most cases, by the same health providers with midwifery skills at the same time – is the key to improving the quality of care.

Strategic objective 3: reach every woman and newborn to reduce inequities. Having access to high-quality health care based on need without suffering financial hardship is a human right. Robust evidence of approaches for ending preventable newborn deaths that effectively accelerate the coverage of essential interventions through innovations such as task-sharing, improved access to life-saving commodities, health insurance and financing mechanisms, and use of information technology and social and knowledge networks is increasing.

Strategic objective 4: harness the power of parents, families and communities. Engaged community leaders, women's groups and community workers turn the tide for better health outcomes for newborns, particularly in poor rural communities. Education and information are crucial for empowering parents, families and their communities to demand quality care and to improve care practices in the home.

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 metrics globally and nationally, especially for birth outcomes and quality of care around the time of birth. Every newborn needs to be registered, and newborn and maternal deaths and stillbirths need to be counted.

46. The action plan is based on six guiding principles.

(1) **Country leadership.** Countries have primary ownership and responsibility for establishing good governance and providing effective and good-quality reproductive, maternal and newborn health services. Communities' participation in the planning, implementation and monitoring of policies and programmes that affect them is a central feature of such leadership and is one of the most effective transformational mechanisms for action and accountability for newborn health. Development partners should align their contributions and harmonize actions.

(2) **Human rights.** Principles and standards derived from international human rights treaties should guide all planning and programming for reproductive, maternal and newborn health and all phases of the programming process. Evidence and practice show the vital importance to health and development of many human rights outcomes.

(3) **Integration.** Providing every woman and newborn with good-quality care that is available without discrimination and is accessible and acceptable requires integrated service delivery. Coordinated health system approaches involving multiple programmes, stakeholders and initiatives across the continuum of reproductive, maternal, newborn and child health and nutrition are therefore essential, without losing visibility for newborn-specific content.

(4) **Equity.** Equitable and universal coverage of high-impact interventions and a focus on reaching excluded, vulnerable and poorest population groups are central to realizing the rights of every woman and newborn to life, survival, health and development.

(5) **Accountability.** Effective, accessible, inclusive and transparent programme-coverage and impact-monitoring mechanisms, independent review and action by all relevant actors are

prerequisites for equitable coverage, quality of care and optimal use of resources. Accountability also includes access to processes and mechanisms for remedies, be they legal, administrative or other.

(6) **Innovation.** Best practice evidence of strategies that broaden the coverage of interventions for newborns and reduce mortality has been accumulating over recent decades. Innovative thinking about ways to increase the participation of all stakeholders and reach the poorest and most underserved populations is nevertheless needed. More research and development is required to optimize the application of knowledge of which interventions and strategies are most effective.

ACTIONS TO ACHIEVE THE STRATEGIC OBJECTIVES

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

Rationale for strategic objective 1

47. The period occurring after 28 weeks of gestation to the first month after birth is especially important not just for survival, but also for early childhood interaction and development, when the foundations for the evolution of cognitive and psychosocial skills are created. It is during this period that 44% (1.2 million) of stillbirths, 73% (2 million) of newborn deaths and 61% (206 250) of maternal deaths occur.

48. Every pregnant woman should receive essential care provided by a skilled attendant who is proficient to monitor labour and assist the birth, able promptly to detect and manage complications competently, and capable of arranging for immediate referral when needed. Every 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.

49. Although globally the proportion of women giving birth with a skilled attendant (physician, nurse or midwife) has increased to 70%, great disparities in coverage and quality of care exist between and within countries. Coverage of skilled care at birth in sub-Saharan Africa reaches only half the population. Skilled care around childbirth is most efficiently provided in many countries in public or private health facilities, as immediate access to emergency obstetric and newborn services when complications occur is crucial to the survival of mother and child.

50. Packages of proven interventions should ensure the provision of basic and additional care for women and newborns to prevent or treat the main causes of mortality. Providing extra care to small (either small for gestational age and/or preterm) and sick babies is particularly important in reducing neonatal mortality. Health personnel need to be sufficiently competent and equipped to support women and these babies, many of whom do not need advanced or intensive care and can be managed in a lower-level health facility or possibly in the community. Inpatient care facilities can play a vital role for babies who need full supportive facility care (see paragraph 32). Recent research indicates that simplified antibiotic regimens for treatment of possible serious bacterial infections delivered through outreach services from primary health facilities might save additional lives in settings where referral is not possible.

51. Research is an important element of investing in care around the time of birth and an integral part of the actions proposed in this plan. Research priorities include understanding the factors that

impede or facilitate extending coverage of proven interventions in low- and middle-income countries, ways to fill existing gaps (such as the need for greater understanding of the biological basis of term and preterm labour and new ways of preventing preterm birth) and investigation of the long-term effects, later in life, of morbidities occurring before and around conception, during pregnancy and in the first month of life. Improving data collection and fostering innovation and collaboration are also essential.

Proposed actions

Key actions for strategic objective 1

Governments, in collaboration with stakeholders, should:

(a) conduct a systematic situational analysis and agree a core set of interventions and packages for the local context;

(b) institute measures to increase the coverage of skilled care at birth in health facilities;

(c) raise community awareness of the importance of the period around birth and the first week of life for preventing maternal and newborn deaths and stillbirths;

(d) increase accountability of all relevant stakeholders;

(e) develop or sharpen national plans for newborn health within the continuum of reproductive, maternal, newborn and child health and nutrition;

(f) allocate adequate financial resources to implement the national plan.

52. Governments and all concerned stakeholders should raise awareness and foster recognition in communities that the time around childbirth and the first week of life is vital to saving maternal and newborn lives and assume accountability for creating the conditions in which every woman and newborn can realize their right to health and health care.

53. All countries are encouraged to develop or re-focus national strategies and action plans in line with the principles, goals, targets and strategic objectives of the action plan. Each government should conduct a systematic situational analysis and agree a set of core interventions and packages that match the local context, are relevant to the burden of neonatal 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 emphasized in all relevant country action plans.

54. Comprehensive maternal and newborn health packages must be a part of core entitlements under existing and emerging universal health systems in all countries. 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, a simple tool for monitoring labour and anticipating complications, and increase the number of postnatal visits to women and their babies. Where necessary, more midwives, auxiliary staff and community health workers should be trained and retained.

55. National authorities, supported by 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 partners should ensure that investments in maternal and newborn health are sustained beyond 2015 and increased where needed.

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

Rationale for strategic objective 2

56. Skilled care at birth is provided by midwives, nurses and physicians in many countries, but women who give birth with a skilled attendant may receive suboptimal or poor-quality, non-respectful care. The partograph is still not commonly used, and infection-prevention and newborn care practices immediately after birth are often harmful and do not adhere to the principles of the Baby-friendly Hospital Initiative, which include 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. Increasing the number of births in health facilities is therefore not sufficient to reduce neonatal mortality, particularly early neonatal deaths. Quality care for mothers and newborns should be assured, even in natural calamities, disasters or emergencies.

57. It is estimated that one in three pregnant women needs some intervention during birth and between 5% and 15% require a Caesarean section.[1] Many women and babies in higher-mortality settings will not have access to emergency obstetric, or even basic neonatal, care. The incidence of birth complications, intrapartum-related death and neonatal encephalopathy rises with increasing neonatal mortality, reflecting lack of quality obstetric and neonatal emergency care. Though high Caesarean section rates are not desirable, rates of less than 5% are usually a marker of unavailability of maternal and neonatal emergency and intensive care.

58. Quality and equity of care affect health outcomes in lower-mortality settings. As it is difficult to predict need for emergency obstetric services, every maternity service should be able to provide basic life-saving interventions for women and newborns and have uninterrupted access to transport for referral when serious complications arise.

59. Quality of care is particularly important for reducing risks of disabilities or impairments. For example, preterm babies are vulnerable to eye complications. Blindness from retinopathy of prematurity is preventable by improving quality of neonatal care, including safer use of oxygen, and by detecting retinopathy early. Preterm infants must be followed up and their eyes must be checked.

60. A seamless continuum between primary care and referral-level facilities saves lives. Community-based skilled birth attendants may be common in low- and intermediate-mortality settings where human resources and capacity for training exist, but about one third of births globally (mainly in higher neonatal mortality settings) occur at home without care from a health professional. Effective community-based approaches require a functioning continuum of care and effective linkages to health facilities with comprehensive emergency obstetric care.

61. There is overwhelming evidence that the standard of education of physicians, nurses and midwives is low in many countries. Midwifery curricula in some do not meet global standards, with students not acquiring 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, lead to poor motivation and low quality of care.

[1] WHO, UNFPA, UNICEF and Mailman School of Public Health. Averting maternal death and disability: monitoring emergency obstetric care. A handbook. Geneva: World Health Organization; 2009.

62. Health services need to deal with risk factors for poor neonatal outcomes, such as adolescent pregnancy, short birth intervals, malnutrition (underweight and obesity), chronic disease (such as diabetes), infectious diseases (like tuberculosis and HIV disease), substance abuse (tobacco and alcohol use, for instance), domestic violence and poor psychological health. Workplace policies are important in supporting women during pregnancy and in the postnatal period and should include regulations to protect pregnant and lactating women from physically demanding work.[1] Behavioural and community interventions to reduce exposure to potentially harmful pollutants, such as from traditional cook-stoves and second-hand tobacco smoke, are also necessary. Prevention, screening and management of sexually transmitted infections (such as 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.

63. Existing programme platforms can provide specific links to improved newborn survival and health and will contribute to strengthening the quality of provided health services, including those for family planning, HIV infection and tuberculosis, syphilis, malaria, water and sanitation, nutrition, integrated management of childhood illness, home visits in the postnatal period and immunizations.

64. Adolescent-friendly health services offering sexual and reproductive health need to be available to young people, as data show that adolescents are not reached by health services and HIV infection is increasing among them. Prevention of early and unintended pregnancy, along with care for girls and young women during pregnancy, birth and in the postnatal period, are vital to supporting their own and their babies' mental and physical health.

65. Many health facilities, particularly those in remote areas, do not have life-saving commodities for women and newborns, as identified by the United Nations Commission on Life-Saving Commodities. Challenges include unregistered new formulations of medicines, major supply-chain bottlenecks, stock-outs, costs in settings where services are not free, and carers and health care providers being uneducated about commodities and their effectiveness. The private sector's considerable expertise in developing, manufacturing and distributing medicines, medical devices and technologies must be harnessed to increase availability, especially in resource-poor settings.

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

[1] International Labour Organization. C183 – Maternity Protection Convention, 2000 (no. 183) (http://www.ilo.org/dyn/normlex/en/f?p=1000:12100:0::NO::P12100_ILO_CODE:C183, accessed 27 March 2014).

Proposed actions

Key actions for strategic objective 2

Governments, in collaboration with stakeholders, should:

(a) update national policies, guidelines, norms and standards for maternal and newborn care;

(b) operationalize effective quality improvement systems for respectful, high-quality maternal and newborn care;

(c) adopt competence-based curricula for training of health care workers, and put in place regulatory frameworks for midwifery and other health care personnel;

(d) ensure postnatal care visits in the first week; and provision of quality extra care for small and sick newborns;

(e) consider and evaluate innovative approaches to motivate staff and to improve access and quality of care; further investigate cost–effectiveness and associated risks of performance-based financing, as has been introduced in some countries;

(f) ensure that all facilities are adequately staffed with multidisciplinary teams, are able to manage maternal and neonatal complications at referral-facility level, and have basic optimum infrastructure;

(g) ensure life-saving commodities for women's and children's health are included in every national essential medicines list;

(h) develop strategies to engage private-sector providers in increasing their advocacy for action on newborn and maternal deaths and stillbirths, and develop innovative technologies to improve newborn and maternal health outcomes;

(i) institute maternal and perinatal death surveillance and response, including notification of maternal and perinatal deaths (preferably within 24 hours);

(j) enhance public oversight of the quality of maternal and newborn care through raising public awareness and increasing community involvement.

67. Governments, in collaboration with professional associations, academia, training institutions and other stakeholders, should regularly update national policies and guidelines for interventions around the continuum of care for women's and children's health relative to global evidence-based guidelines and locally defined strategies. Additionally, they should operationalize effective quality improvement systems and adopt and enforce the implementation of norms and standards for respectful and high-quality maternal and newborn care.

68. Governments should adopt competency-based curricula for training of health care workers and put in place regulatory frameworks defining the scope and practice of midwifery and nursing, including specific skills of caring for small-for-gestational-age or sick newborns, lactation counselling and support training, and the minimum standards of educational requirement needed. Rectifying the shortage of specialists, such as neonatologists and breastfeeding counsellors, should also be considered, where appropriate.

69. 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: teams in first- and second-level referral hospitals should be multidisciplinary and

include specialized obstetric, paediatric and anaesthetic staff to manage maternal and neonatal complications.

70. Maternity facilities must have appropriate infrastructure and be adequately equipped to provide the care needed by mothers and babies. The norms of infection prevention and biosafety must be respected. Electricity, water, sanitation and hand-washing facilities, clean toilets, appropriate spaces for women to give birth with privacy and dedicated areas to manage sick newborns safely must be in place.

71. After birth, women and newborns in health facilities should receive all essential services before discharge. Mother and baby should be routinely accommodated in the same room with provision made for mothers to provide kangaroo mother care comfortably. Expression and storage of breast-milk should be encouraged in health facilities that care for preterm, small-for-gestational-age and/or sick babies, 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 be linked to primary care facilities through a well-functioning referral system. The required postnatal care visits in the first week after birth are necessary for counselling on health-seeking behaviours and for detection of any complications.

72. 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, should be ensured.

73. Monitoring and improvement of quality of care must be instituted in all public and private maternity care services through, for example, maternal and perinatal death surveillance and response, birth and death registration (including fetal deaths or stillbirths) and periodic surveys of health facilities' availability and readiness. Information technology can assist in real-time monitoring: mobile phones, for example, are valuable in increasing communication and sharing data among health providers and communities. Community and service links aiming to improve care quality require investment; audit meetings and accountability are also key elements of the process of improving quality of care.

74. Motivation of staff is an important determinant for the quality of care. Innovative approaches should also be applied as appropriate, such as coaching, mentoring, accreditation and continuous education to improve access and quality of care. National authorities may consider incentives such as financial payments, bonuses and public recognition. Performance-based financing is being introduced in several countries, but further investigation of its cost–effectiveness and associated risks are needed.

75. 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. Civil society and local leaders, including business leaders, can strengthen political will and help to increase public awareness and community ownership of problems and solutions. A free flow of data and information is needed to enable this, with results from annual health sector reviews being made publicly available in line with recommendations made by the Commission on Information and Accountability for Women's and Children's Health.

76. Engaging the private sector through public–private partnerships can bring multiple benefits, including: high-level advocacy; technology transfer to low-income countries; lower costs and increased availability of quality-certified essential medicines and medical devices; improved quality of care and the provision of evidence-based services by private practitioners; improved stewardship and

regulatory function of governments; transport provision for emergency cases; stronger employer-based health services and workplace policies and programmes that support pregnant women and new mothers; and development of innovative technologies with the potential to reduce newborn and maternal deaths and prevent stillbirths and disability.

Strategic objective 3: reach every woman and newborn to reduce inequities

Rationale for strategic objective 3

77. Every woman and newborn has the right to good-quality health care in line with the principles of universal health coverage and human rights. 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, inequitable access to health professionals, particularly in rural areas, is one of the main factors behind persistent high mortality rates for women and newborns.

78. Currently, fewer than one in six countries with the highest burden of maternal and neonatal mortality reaches the minimum benchmark of 23 doctors, midwives and nurses per 10 000 population necessary to provide a basic package of care.[1] Severe shortages of midwives exist in at least 38 countries.[2] These factors, combined with poor 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 in countries with a high and inequitable burden of newborn deaths.

79. Costs of health services can present an important barrier to families seeking care during pregnancy and childbirth and in the postnatal period. Direct costs, such as over-the-counter payments for medicines and fees for consultations and procedures, and indirect costs on, for example, transport and lost income have led to sharp inequities in coverage, most notably for women who give birth with a skilled attendant. Up to 11% of the population in some countries incur high costs in paying for health care, with as many as 5% forced into poverty because of health care-related expenditure, including costs associated with essential maternal and newborn care.[3] 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, particularly for women and children.

80. Special measures are necessary in health service and community settings to overcome violations of human rights where there is gender bias against the girl child.

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

[1] Global atlas of the health workforce, http://apps.who.int/globalatlas/default.asp, accessed 27 March 2014.

[2] UNFPA. State of the world's midwifery report 2011: delivering health, saving lives. New York: United Nations Population Fund; 2011.

[3] The world health report 2010. Health systems financing: the path to universal coverage. Geneva: World Health Organization; 2010.

82. Private sector enterprises should take special measures to promote community and workplace support for mothers in relation to pregnancy and breastfeeding and feasible and affordable child-care services, in compliance with the provisions of ILO's Maternity Protection Convention, 2000 (No. 183). The private sector can and should contribute to the promotion, protection and support of early and exclusive breastfeeding by ensuring that marketing and promotional practices fully conform to the provisions of the International Code of Marketing of Breast-Milk Substitutes and subsequent relevant World Health Assembly resolutions and by complying with national legal and regulatory provisions aimed at giving effect to them.

83. Reaching all women and newborns requires investment in every aspect of the health system, including leadership and governance, the workforce, infrastructure, commodities and supplies, service delivery, information systems and financing. Different contexts require tailored approaches, with specific attention to preparedness for, and rapid response to, complex humanitarian emergencies.

Proposed actions

Key actions for strategic objective 3

Governments, in collaboration with stakeholders, should:

(a) conduct a systematic analysis of obstacles to achieving full-scale, high rates of coverage of effective intervention packages for quality care within the health system and community and take action to remove those obstacles;

(b) ensure the integration of actions for newborn health into existing reproductive, maternal, newborn and child health initiatives and service delivery platforms so that no opportunity to reach mothers and newborns is missed;

(c) prepare and implement a development plan for the health workforce to ensure competency and respectful behaviour, improve the density, and increase motivation and retention of relevant health worker cadres as needed;

(d) optimize performance of available staff by considering delegation of tasks to mid-level health personnel with appropriate training and support and the role of community health workers in bridging gaps between families and health services;

(e) adopt and enforce laws and policies on equity of access and quality of maternal and newborn care in public and private sectors;

(f) plan maternal and newborn health services on the basis of an evidence-based agenda, and staffing required for its delivery;

(g) ensure elimination of barriers (social and financial) that limit access to care by mothers and newborns, including girls in some populations who are especially vulnerable;

(h) track national health expenditures, including those for maternal and newborn health, and mobilize additional domestic resources;

(i) develop targeted programmes in and out of school to expand adolescents' and young adults' access to, and use of, modern contraceptive methods and give pregnant adolescents the full support they need;

(j) consider community strategies to improve demand for services, birth preparedness and essential newborn care practices, including home visits by community health workers and participatory women's groups.

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

85. 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 to ensuring that no opportunities to reach mothers and newborns are missed. 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.

86. Every country should have a comprehensive development plan for the health workforce that covers education and training, the distribution, motivation and retention of skilled personnel, and redresses the mismatch between available health care workers and positions through a system that tracks from pre-service training through to posting and retention. It is essential that health workers have respectful attitudes and behaviours towards women and newborns, and working conditions should allow health workers to 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 salary supplements has been effective in motivating health workers to serve in remote and underserved areas.

87. Optimizing performance of available staff is a priority. Evidence that life-saving interventions can safely be delegated to mid-level health workers is strong, but only if they are appropriately trained. Midwifery personnel, for example, should be able to provide the full range of emergency obstetric care where referral possibilities are limited.

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

89. Plans for extending maternal and newborn health services should be based on objective information and evidence. Countries need to estimate requirements for the number of pregnancies and births within a given setting and build and equip the necessary infrastructure. They need to define a standard package of maternal and newborn care for each level of health provision and determine the number of staff and constitution of teams, including midwives and midwifery personnel and, where needed, specialists such as obstetricians, neonatal nurses and paediatricians. Geographical mapping of access points has been successful in several countries in supporting decision-making on the number and location of maternity facilities to reach the greatest number of families and communities. Sound planning should inform increased investment in care quality around childbirth.

90. Targeted programmes in and out of school are needed to expand adolescents and young adults' access to, and use of, modern contraceptive methods. Measures taken to prevent early pregnancies should include legislation to prevent or lower the number of girls who marry under the age of 18 years and life-skills education (for boys and girls) to help to keep girls in school, reduce rates of coerced

sex, prevent early and unintended pregnancy before 20 years and inculcate positive cultural norms and traditions. Young people should be able to access contraceptives and comprehensive sexual education that is empowering and which is designed to enable them to make sexual and reproductive decisions freely and responsibly. Countries should provide the enabling environment for this to happen. Youth-friendly health services should be available to give pregnant adolescents the full support they need to be well prepared for birth and parenthood, regardless of marital status.

91. Policies are needed to eliminate disparities in health care access, including subsidizing the cost of care and focusing on the most vulnerable population groups to ensure that good-quality maternal and newborn health services are available at an affordable cost at the point of use (which would mean free to many people). Countries should reduce reliance on out-of-pocket payments by increasing forms of prepayment with pooling of funds to share financial risks across the population. Prepayment typically involves taxes and other government charges and/or insurance. 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 through, for instance, taxes on tobacco and alcohol.

92. Countries 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). All major development partners should report their assistance for maternal and newborn health against their commitments and make covenants that would enable national authorities to establish predictable budgets and reinforce mutual accountability.

93. Community strategies to improve demand for services, birth preparedness and essential newborn care practices, including participatory women's groups and home visits supported by community health workers, volunteers or lay facilitators, have a critical role to play in reducing inequalities in mortality and access to care. Evidence suggests that participatory women's groups have the largest impacts on mortality among the poorest.

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

Rationale for strategic objective 4

94. It is vitally important to overcome barriers to accessing skilled care at birth and to harness the power of parents, families and communities, engaging them to seek care throughout pregnancy, birth and the first days and weeks of their children's lives. This is particularly important in low-income countries, where almost half of mothers do not receive skilled care during childbirth, more than 70% of babies born outside facilities receive no postnatal care[1] and most maternal and newborn deaths and stillbirths occur. Many newborns die at home without any care having been sought.

95. It is essential to empower women, parents, families and communities to seek health care services when needed and to ensure they can provide recommended care in the home by themselves. Health outcomes, both positive and negative, are determined by decisions made within the household, the families' ability to reach care when needed and the quality of the services received when they arrive. Unfortunately, many actors outside of health services are often not engaged in discussions and efforts to improve their health and to increase the coverage of essential interventions.

[1] WHO, UNICEF. Accountability for maternal, newborn and child survival: the 2013 update. Countdown to 2015: maternal, newborn and child survival. Geneva: World Health Organization; 2013.

96. Programmes that seek to strengthen health services through mobilizing community members to adopt healthy practices, shifting social norms to increase social support and addressing barriers to access have demonstrated the effects of such approaches. The resulting changes are particularly evident for maternal and newborn health. A woman's right to make decisions is crucial for her health and the health of her family.

97. Community-oriented activities can be broadly categorized in four areas: (i) increasing awareness of rights, needs, responsibilities and potential problems related to maternal and newborn health; (ii) developing capacities to stay healthy, make healthy decisions and respond to obstetric and neonatal emergencies; (iii) strengthening social support networks among women, families and communities and links with the health services; and (iv) improving quality of care through strengthening health services' interactions with women, families and communities and responses to their needs.[1] Investment is necessary in each of these areas, particularly in settings where maternal and neonatal mortality rates are high and access to health services is limited. Actions need to be taken collectively by multiple parties alongside efforts to improve the quality of health services. Civil society can play a catalytic role through existing and strengthened coalitions and networks.

98. Families, especially parents, are at the forefront of providing newborn care. They can and should ensure certain aspects of care for the healthy baby after birth, including keeping the baby clean and warm, initiating early and exclusive breastfeeding and performing proper cord care (including the use of chlorhexidine, if appropriate). This is particularly important for babies born at home or discharged a few hours after birth. Even though practices like breastfeeding are often considered as natural behaviours, many women require skilled support.

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

100. Men can play an important role in maternal and newborn health as partners, fathers and community members. Men are often key decision-makers in maternal and newborn care-seeking behaviour and need to understand the needs, risks and danger signs of pregnancy, childbirth and postnatal periods. Health programmes that are traditionally designed to interact with women need to broaden their understanding of men's needs and perspectives (without compromising women's rights), working with men and women (adolescents and adults) and positioning gender perspectives and reproductive rights as pertinent to both. Health care workers need to make it convenient for men to accompany their partners and attend births, supporting them to enhance couples' communication and decision-making.

101. In 2009 WHO and UNICEF issued a joint statement on home visits for newborn children based on research showing that visits conducted by community health workers improved newborn survival rates.[2] Extensive studies in Africa and Asia since then have shown that home visits during pregnancy and in the first week after birth increase the number of women seeking antenatal care and receiving skilled care during birth. Visits by community health workers also help families to take better care of

[1] Working with individuals, families and communities to improve maternal and newborn health. Geneva: World Health Organization; 2003.

[2] WHO, UNICEF. Home visits for the newborn: a strategy to improve survival. Geneva: World Health Organization; 2009.

the newborn and lead to improved practices, such as delayed bathing and early initiation of exclusive breastfeeding, resulting in significant reductions in neonatal mortality.

102. Community leaders, family members, traditional birth attendants and other influential people can also be positive agents for support. Depending on the context, elder family members, such as grandmothers and mothers-in-law, have a strong, culturally sanctioned power for decision-making and care, influencing, for example, the diet of pregnant women, workload and household responsibilities and use of emergency services.

103. Community mobilization through facilitated participatory learning and action with women's groups is recommended to improve maternal and newborn health, particularly in rural settings with low access to health services. The intervention can have a positive effect on newborn mortality, and further research may improve understanding of the effects on maternal health and care-seeking. Implementation of facilitated participatory learning and action with women's groups should focus on enabling discussions in which women can identify priority problems and advocate for local solutions for maternal and newborn health. In order to ensure quality, this intervention should be implemented with close monitoring and evaluation as well as prior adaptation to the local context.

104. Lay health workers, including traditional birth attendants, have successfully performed functions related to health care delivery for women and newborns and can be important members of the health team. They are not intended to replace a health professional in attending births, but can effectively promote maternal, newborn and reproductive health interventions such as, but not limited to, appropriate care-seeking, preparedness for birth and complications, and support for breastfeeding. Traditional birth attendants are often valued and respected community resources and finding new roles for them in areas such as providing continuous support for women during labour (in the presence of a skilled attendant) and serving as a link between communities and health services is important.[1]

105. In conjunction with other actions, 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, early initiation and exclusive breastfeeding, and other interventions. Multi-pronged approaches enhance the reach of messages.

106. The private sector's considerable expertise in strategic communications can be harnessed to change social norms (such as acceptance that maternal and newborn deaths are inevitable), promote optimal health behaviours and increase demand for good-quality care. Many private corporations have capacity for conducting research and mining diverse sources of data to create understanding of what motivates behaviours, an extremely valuable asset that has not yet been tapped to its full potential. Public–private partnerships are especially amenable to multimedia advocacy campaigns through existing private sector communications platforms, television, radio, social media and e-health and mobile-telephone technologies.

107. Civil society organizations can contribute significantly to social mobilization, creating political will and policy design, and can help to hold governments and health services accountable for implementing their programmes and plans.

[1] WHO recommendations. Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting. Geneva: World Health Organization; 2012; WHO, ICM, FIGO. Making pregnancy safer: the critical role of the skilled attendant. Geneva: World Health Organization; 2004.

108. Systematic reviews of the results of evidence-based approaches designed to harness the power of women, parents and communities are being conducted in areas such as: preparedness for birth and complications; transport schemes; maternity waiting homes; community participation in programme planning and quality improvement; alleviation of financial barriers and cash transfers; integrated case management of newborn and childhood illnesses; the use of mobile telephone technology; maternal and perinatal deaths audits; and results-based financing. Findings will inform future policy on these approaches.

Proposed actions

Key actions for strategic objective 4

Governments, in collaboration with stakeholders, should:

(a) promote zero tolerance for preventable maternal and newborn deaths;

(b) maximize the power of parents' voices, civil society, mass media and social media to provide information and change norms;

(c) conduct a systematic analysis of obstacles to accessing quality maternal and newborn services and uptake of essential home care practices by women, families and communities and actively involve communities in determining priorities and planning appropriate actions;

(d) equip families, including men, with the knowledge and capacities to provide good home care;

(e) strengthen links between community and health facilities through applying innovative approaches to reach remote areas;

(f) adopt combined approaches to improving care quality within the home and from health services;

(g) evaluate the utility of community-based organizations such as participatory women's groups to foster community mobilization, particularly among rural populations with limited access to care;

(h) adopt evidence-based strategies to generate and sustain demand for services using community-oriented actions;

(i) engage, enable and support in-country civil society organizations to demand transparency and oversight and improve access to, and quality of, care;

(j) engage the private sector to support multi-media communication campaigns to change social norms, promote zero tolerance for preventable mortality and advocate for optimal behaviours.

109. Maternal and newborn deaths and stillbirths need to be recognized by communities, families and individuals as avoidable and not inevitable. To ensure zero tolerance of preventable deaths, there has to be a change in social norms and expectations surrounding childbirth and newborn survival, and parents affected by stillbirths or newborn deaths need to be given a voice. Peer-to-peer strategies of using parents' voices to mobilize civil society, mass media and social media can be used to spread information and change norms.

110. The analysis of obstacles proposed under strategic objective 3 should also focus on factors that determine the demand for maternal and newborn health services and affect the provision of recommended self-care in the home in countries with a high burden of neonatal mortality.

Understanding the motivational, cultural, structural and financial elements that support 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. Programmes should include activities to give women and families a voice and allow their participation in prioritizing problems and solutions.

111. Where access to health services is inequitable or low, countries should consider investing in community health workers as a powerful resource for improving maternal and newborn care, particularly in hard-to-reach areas, and ensure their integration as an important human resource alongside health professionals for maternal and child health matters. Appropriate training, supportive supervision, deployment and compensation are necessary.

112. Consideration should be given to strengthening community-based organizations such as women's groups to foster community mobilization through dialogue-based approaches such as facilitated cycles of participatory learning and action. This is particularly relevant among rural populations for whom access to care is limited. Further evaluation of the utility of this approach in poor urban areas and with other actors, including men and grandmothers, is urgently needed.

113. Families, particularly men and fathers, also have important roles. They should be involved in individual household-level and community activities to enhance their contribution to supporting family health. Various channels can build capacity to provide good home care, such as health education, media campaigns and home visits by trained community health workers.

114. Strengthening linkages between communities and health facilities improves health outcomes for women and their babies, especially where referral services are provided. Mobile phone technology, which is now widely available and can reach remote areas in many countries, provides one approach for improving these linkages. It has been successfully used to supply health messages, establish help lines and facilitate real-time monitoring of births and deaths and can be linked with community mobilization interventions to create greater synergy.

115. Creating demand for services for underserved communities requires innovative approaches based on evidenced-based strategies. For example, conditional cash transfers to families and communities can be considered where financial circumstances impede access to health care, with careful monitoring to demonstrate cost–effectiveness.

116. 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 planning and monitoring health services and the quality of care received by mothers and children. Countries should pursue these recommendations. Similarly, all concerned stakeholders should accept independent accountability for implementing this action plan at global level as part of their commitment to saving the lives of newborns.

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

Rationale for strategic objective 5

117. Vital statistics provide indispensable information, in this case making policies more effective and responsive to the needs of women and children. In 2010, however, about one third of 135 million births globally and two thirds of deaths went unregistered. Half the countries in the WHO African and South-East Asia regions do not record cause of death in their vital statistics, and serious deficiencies

are present within existing systems.[1] The vital registration systems in some countries do not follow global recommendations about which child to count and often function for only part of the country. In others, 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. The United Nations Human Rights Council's resolution A/HRC/19/L.24, on birth registration and the right of everyone to recognition everywhere as a person before the law, is entirely dedicated to birth registration and legal identification for all, without discrimination.

118. 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 and stillbirths.

119. 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, including resuscitation equipment and antenatal corticosteroids. Many challenges remain, however, in gathering these data. Population-based household surveys, including demographic and health surveys and multiple indicator cluster surveys, have long collected data on indicators on family planning, antenatal care and attendance at birth. More information on postnatal contacts for newborns has recently been incorporated into these surveys and the number of countries with available data is steadily increasing. A process for generating indicators that can be considered for addition to household surveys to measure newborn care practices and the content of postnatal care is a milestone proposed in this plan.

120. Major gaps persist in the collection of data on outcomes, coverage and quality of care around the time of birth, and much more rigorous attention needs to be paid to the development and testing of indicators 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 data for improving quality. A set of core and additional indicators for tracking not only population-based coverage of effective interventions, but also the quality of care in health services, needs to be agreed for use in varying contexts, including complex humanitarian emergencies. Managers at all levels need to know to what degree the system can deliver essential maternal and newborn services and identify performance weaknesses that can be rectified through better planning, budgeting and service delivery. Many of the indicators can be integrated in routine health information systems, with results validated periodically through specific surveys.

121. Many countries have accepted maternal death surveillance and response as an effective means of identifying deaths, investigating their determinants and taking remedial action on preventable causes. Perinatal deaths should be considered 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.[2] New guidance from WHO and its partners provides clear recommendations on how

[1] Oomman N, Mehl G, Berg M, Silverman R. Modernising vital registration systems: why now? Lancet 2013;381(9875):1336–7.

[2] Pattinson R, Kerber K, Waiswa P, Day LT, Mussell F, Asiruddin SK et al. Perinatal mortality audit: counting, accountability, and overcoming challenges in scaling up in low- and middle-income countries. Int J Gynaecol Obstet. 2009;107 (Suppl. 1):S113–21, S121–2.

to implement maternal death surveillance successfully at full scale.[1] The guidance promotes a phased approach and suggests a focus on strengthening maternal death surveillance and response in health facilities before expanding it to communities. 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. Legal protection mechanisms that would facilitate full enquiries are nevertheless inadequate in many countries, meaning the full potential of the approach often remains untapped.

Proposed actions

Key actions for strategic objective 5

Governments, in collaboration with stakeholders, should:

(a) invest in birth and death registration coverage and quality, promoting recording of every birth, live or stillbirth, and recording stillbirths and neonatal deaths;

(b) consider the use of specific perinatal death certificates that capture additional data on stillbirths, gestational age and birth weight in addition to maternal complications;

(c) develop a minimum perinatal dataset and ensure that all birth outcomes are collected, with consistent definitions and cross-links to databases for vital registration;

(d) institutionalize maternal and perinatal death surveillance and response, linking this with perinatal death reviews and taking action to address avoidable factors identified through such reviews;

(e) track morbidity and disability outcomes especially when neonatal intensive care is being expanded;

(f) evaluate and define national indicators of service delivery for maternal and newborn health (based on the global indicators proposed in Annex 2) and integrate them into routine data collection systems and instruments;

(g) urge parliamentarians, community leaders, civil society and the general population to demand information and participate actively in planning and monitoring of access to quality health services received by women and children;

(h) develop strategies to engage the private sector in improving the collection and quality of birth and death registration systems and in investing, developing and executing innovative mechanisms for gathering data.

122. Countries should introduce and invest in improving 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. Additional data (such as gestational age and birth weight) and consideration of the social determinants of mortality should be included. The quality and completeness of data need to be monitored continuously and the data should be disseminated as the basis for planning.

[1] Maternal death surveillance and response: technical guidance. Information for action to prevent maternal death. Geneva: World Health Organization; 2013.

123. Investment and technical support are needed 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 vital registration and data derived from health facilities. Countries should strengthen mechanisms for maternal death surveillance and response and surveillance of perinatal mortality, linking this with perinatal death reviews and taking action to address avoidable factors identified through such reviews. It is also important to track disability outcomes (such as retinopathy of prematurity, deafness and cerebral palsy), particularly for countries expanding neonatal intensive care.

124. The global core indicators proposed as part of the action plan (Annex 2) should be evaluated by stakeholders and, after assessment, integrated into national health information management systems. The set of indicators proposed will be further developed as part of the operationalization of the action plan (referred to in paragraph 135), covering the domains of service readiness, outcomes, service use, intervention coverage and quality of care.

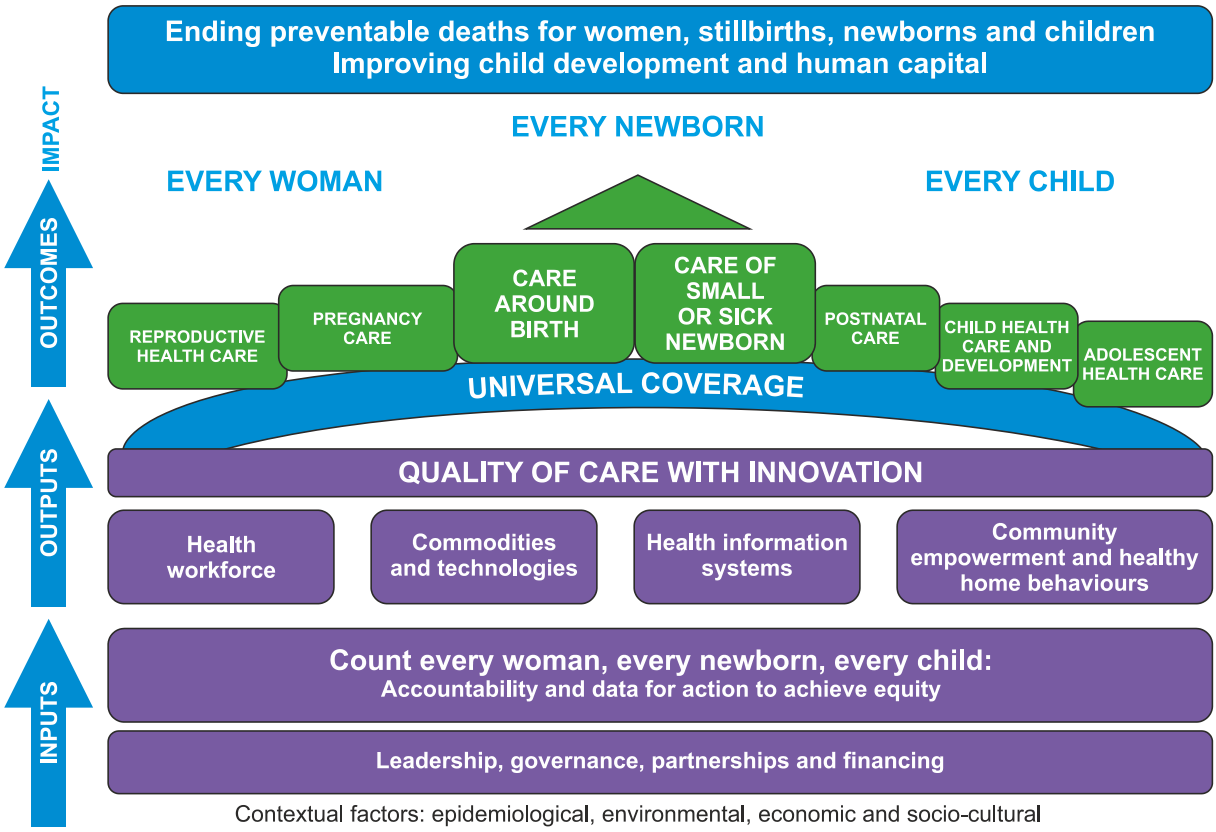
125. All stakeholders, from parliamentarians and community leaders to civil society and the general population, need to demand information and participate in planning and monitoring access to quality health services received by women and children, possibly through use of scorecards, to increase accountability for implementing this action plan.

126. While routine systems are being strengthened, countries and development partners should undertake periodic household surveys to obtain data on mortality, intervention coverage and use of services. The private sector should also be engaged in improving the collection and quality of birth and death registration systems and in investing, developing and executing innovative mechanisms for gathering data, especially through the use of mobile phones.

FRAMEWORK FOR SUCCESS

127. The impact framework shown in Figure 6 inserts “every newborn” into the “Every woman, every child” concept and broadens the goals to include ending preventable deaths for women, *stillbirths*, *newborns* and children, and improving child development and human capital. The outcome level of the framework includes all packages for reproductive, maternal, newborn and child health. This places the action plan’s particular emphasis on care of women and babies in labour, birth and the first week of life but also on care of small and sick newborns, with the objective of universal health coverage for all packages. Increased coverage of quality of care requires programme change to be expanded within the health system and community. Inputs to a strengthened health system require rigorous measurement, strong programme tracking and accountability. Finally, the socio-political, economic, environmental, biological and legal contexts affect all levels of change.

Figure 6. Every newborn impact framework



128. Mortality goals will only be achieved through improvements in coverage and quality of care for women and babies at birth and care of small and sick newborns. Interim targets of evidence-based interventions for coverage and quality of care around birth, care for newborns at risk, home visits and participatory group support for women and newborns are therefore proposed (Annex 1).

129. **Coverage targets by 2020**

(a) **Coverage and quality of care around birth:** 90% of women giving birth and 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 death surveillance, timely response and regular monitoring of quality of care will be an integral part of maternal and newborn health services.

(b) **Coverage and quality of care for small and sick newborns:** at least half of babies who do not breathe spontaneously at birth after thorough drying and stimulation will be resuscitated with bag and mask ventilation; at least half of stable preterm newborns or babies weighing less than 2000 g will receive kangaroo mother care and other supportive care; and at least half of newborns with possible serious bacterial infection will receive antibiotic therapy. Country-specific targets for comprehensive neonatal intensive care will be set, including tracking of disability.

(c) **Home visits and participatory group support for women and newborns:** each country will achieve at least a 20% increase (or an increase to 90% if their baseline is above 70%) of

early postnatal care for women and newborns within two days of birth to promote breastfeeding, counselling and screening for maternal and newborn complications, and postnatal family planning. Linking to community participatory approaches and parent groups is an important component of this strategy.

130. **Coverage targets by 2025**

(a) **Coverage and quality of care around birth:** 95% of women will give birth with a skilled attendant, and every woman and her newborn will receive effective high-quality and respectful care (see paragraph 129).

(b) **Coverage and quality of care for newborns at risk:** at least 75% of babies who do not breathe spontaneously at birth after thorough drying and stimulation will be resuscitated with bag and mask ventilation; at least 75% of stable preterm newborns or babies weighing less than 2000 g will receive kangaroo mother care and other supportive care; and at least 75% of newborns with possible serious bacterial infection will receive antibiotic therapy.

(c) **Home visits and participatory group support for women and newborns:** 90% of women and newborns will receive early postnatal care of high quality within two days of birth. The 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. Linking to community participatory approaches and parent groups is an important component of this strategy.

MEASURES OF SUCCESS

131. The Every newborn action plan is about taking action to achieve ambitious mortality goals and coverage targets to end preventable newborn deaths and stillbirths. The pathway to impact will be marked by milestones, which are defined at global and national levels for the period 2014–2020 (Annex 1). The milestones will form the starting point for accountability and independent oversight and the basis for monitoring progress in implementation. Monitoring and evaluation coincide with the reviews of progress towards the Millennium Development Goals in 2015 and will be ready for the prospective post-2015 sustainable development goals, linking to the new accountability mechanism.

132. A more detailed monitoring plan, with coverage and outcome metrics to track progress, is a milestone at global level. These indicators will need to be collected and used for national programme action within countries. Clearly delineating stillbirth interventions and strategies represents another milestone.

133. The real change for women and their babies will take place within countries. National milestones include (but are not limited to) ensuring that: commodities are included in national essential medicine lists and tracked; the community voice, especially of women, is heard; national health plans are sharpened and costed so as to deal appropriately with newborn health and stillbirths; and national expenditure for reproductive, maternal, newborn and child health is tracked and reported.

134. Considering a woman and her baby together forms a core concept of the action plan, so a package of interventions is needed for both: they are distinct yet interdependent, and the interdependence is vital to both. As a complement to this action plan, WHO, UNICEF and partners will develop a mother–baby friendly initiative that will focus on improving quality of care for mothers and newborns in facilities, linked to community actions and district health system strengthening. A set of norms and standards for quality of care around birth and the immediate postnatal period will be

defined and, once established in consultation with countries and technical experts, will need to be adapted and adopted within countries.

135. Achieving the vision, mortality goals and coverage targets outlined in the plan require measurable indicators to track progress and inform health policy and programmes. The selection of the core indicators (Annex 2) involved a grading process for direct relevance to the action plan framework, targets and goals and review of current data availability. Core indicators in some cases are agreed and tracked, but some need to be further tested and integrated into national measurement systems. Urgent work is required to improve the metrics for these and other supporting indicators and increase the number of countries routinely tracking them. The operationalization of these core indicators and a wide list of additional necessary indicators forms part of the short-term milestones listed in Annex 1.

RESEARCH PRIORITIES

136. Research into delivery, development and discovery needs to be placed at the forefront of efforts to reduce neonatal mortality. Research priorities for newborn health were identified by a global exercise for 2013–2025: nine out of 10 priorities related to improving delivery of known interventions.

137. 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; identifying and managing newborn infection at community level; removing barriers to the extension of exclusive breastfeeding and facility-based kangaroo mother care; evaluating the use of chlorhexidine for cord care in neonates born in health facilities; and developing strategies to improve the quality of facility-based care provided during labour and childbirth.

138. Development research priorities identified included: adapting kangaroo mother care to make it deliverable at community level; detecting early high-risk women in pregnancy and labour in the community; improving and simplifying intrapartum monitoring; evaluating appropriate oral antibiotics for treatment of neonatal sepsis; defining 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.

139. Discovery research priorities highlighted: science and technology in order to understand 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 better to identify and treat neonatal sepsis; better ways to detect fetal distress; and identification of biomarkers for intrauterine growth retardation and antepartum stillbirths.

COORDINATION

140. Putting the action plan into practice will require participation of many stakeholders, ranging from governments and policy-makers, donor countries, the United Nations and other multilateral organizations and global philanthropic institutions to civil society, health care workers and their professional associations, the business community, and academic and research institutions (see Annex 3).

141. The plan defines priority actions to provide a healthy start for every newborn within the context of integrated reproductive, maternal, newborn, child and adolescent health programmes. Maternal and child health services are an ideal platform for delivering integrated packages that include a range of

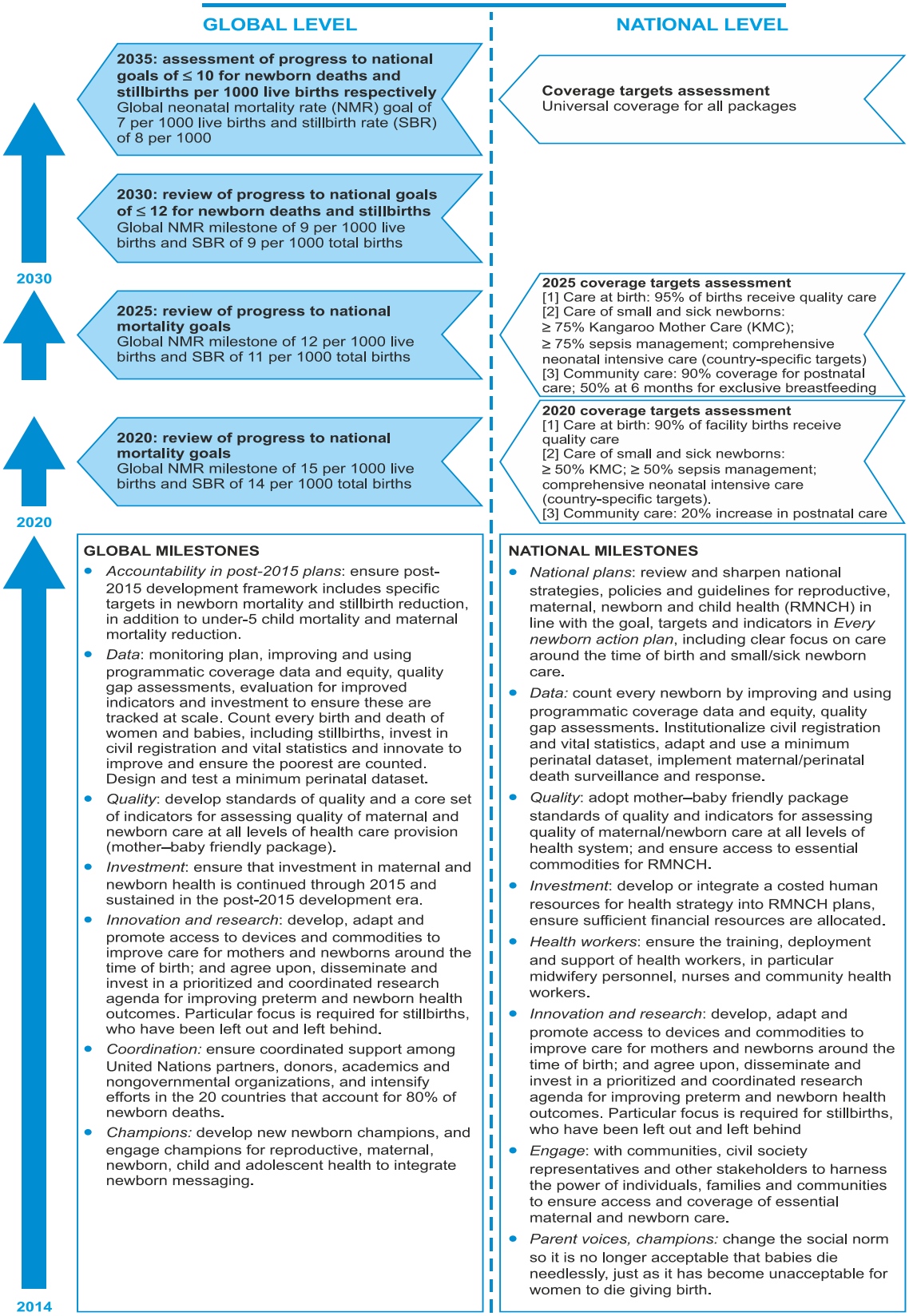
interventions, including those for malaria, HIV infection, nutrition and immunization. It is vital that post-2015 development goals include the vision of healthy societies in which women and adolescent girls, newborns and children survive and thrive. Coordination for implementation of this vision will rely on a strong, secure continuum of care to reduce dramatically preventable maternal, newborn and child deaths, and which has the potential to build more equitable societies and transform human development.

ACTION BY THE HEALTH ASSEMBLY

142. The Health Assembly is invited to adopt the draft action plan.

ANNEX 1

GLOBAL AND NATIONAL GOALS, TARGETS AND MILESTONES 2014–2035



ANNEX 2

PROPOSED GLOBAL INDICATORS FOR THE EVERY NEWBORN ACTION PLAN[1]

	Core Every newborn indicators	Additional indicators
Impact	1. Maternal mortality ratio*	
	2. Stillbirth rate	**Intrapartum stillbirth rate**
	3. Neonatal mortality rate*	Low birth weight rate*
		Preterm birth rate
		Small for gestational age
		Neonatal morbidity rates, such as infection
		Rates of long-term disability after neonatal conditions
Coverage: care for all mothers and newborns	4. Skilled attendant at birth*	
	5. Early postnatal care for mothers and babies*	
	6. Exclusive breastfeeding to 6 months*	
Coverage: complications and extra care	**7. Antenatal corticosteroid use**	Caesarean section rate*
	8. Newborn resuscitation	
	9. Kangaroo mother care and feeding support	
	10. Treatment of neonatal sepsis	
Input: counting	Birth registration*	Death registration, including cause of death
Input: Every newborn *service delivery packages*	*Mother–baby friendly measurable norms and standards* *Care of small and sick newborn*	

[1] * = indicator as defined and tracked in World Health Statistics 2013; Grey = not currently routinely tracked; **Bold** = indicator requiring additional evaluation for consistent measurement and linked to milestones in Annex 1.

Italics = input package requiring norms and standards to be defined and linked to milestones in Annex 1.

All indicators are to be tracked in such a way that they can be broken down to assess equity by, for instance, urban/rural, regional, wealth quintile.

ANNEX 3

ACTIONS BY CONSTITUENCY

Everyone has a role to play

Actors	Actions
Governments and policy-makers at national, regional and global levels	• *National plans*: review and revise national strategies, policies and guidelines for reproductive, maternal, newborn and child health in line with the goal, targets and indicators defined in the Every newborn action plan, including a clear focus on care around the time of birth. • *Budgets*: allocate sufficient financial resources to maternal and newborn health, and ensure adequate investment to improve quality of care. • *Legislation*: adopt appropriate legislation on birth registration, maternal deaths notification, maternity protection and the International Code of Marketing of Breast-Milk Substitutes. • *Health workers*: develop or integrate a costed strategy on human resources for health into reproductive, maternal, newborn and child health plans to ensure the training, deployment and support of health workers, particularly midwifery personnel, skilled birth attendants, nurses and community health workers. • *Quality*: adopt standards of quality and core set of indicators for assessing quality of maternal and newborn care at all levels of health care provision. • *Commodities*: include essential commodities for maternal and newborn health in national essential medicines list and ensure an uninterrupted supply at all levels of the health system. • *Engage*: engage with communities, civil society representatives and other stakeholders to harness the power of individuals, families and communities to ensure access and coverage of essential maternal and newborn care. • *Accountability*: count every newborn by institutionalizing civil registration and vital statistics maternal, perinatal and neonatal death surveillance and response.

Actors	Actions
Organizations in the United Nations system and other multilateral agencies	• *Policy*: ensure post-2015 development framework includes specific targets in newborn mortality reduction and stillbirth reduction, in addition to under-5 year old child mortality and maternal mortality reduction. • *Technical assistance*: provide technical assistance and support to government planning, implementation and accountability efforts. • *Coordination*: ensure coordinated support among United Nations partners and intensify efforts in the 20 countries that account for 80% of all newborn deaths. • *Quality*: develop standards of quality and core set of indicators for assessing quality of maternal and newborn care at all levels of health care provision. • *Investment*: ensure that multilateral investment in maternal and newborn health is continued through 2015 and sustained in the post-2015 development era. • *Champions*: engage champions for reproductive, maternal, newborn, child and adolescent health in order to provide coherent and coordinated massages about newborn health.
Donors and foundations	• *Funding*: mobilize funds to fill gaps and support the implementation of costed, evidence-based, country-owned reproductive, maternal, newborn and child health plans that include a focus on birth. • *Health worker training*: support the training and deployment of health workers, including investing in midwifery personnel, skilled birth attendants, nurses and community health workers that can deliver quality essential interventions focused on birth. • *Commodities*: support access to quality commodities by investing in innovative financing, creating incentives for producers and purchasers, supporting quality assurance and regulation, and research and development efforts to improve products. • *Accountability*: engage in country compacts and enhance accountability around financial flows.
Private business	• *Innovation*: invest in developing and adapting devices and commodities to care for mothers and newborns around the time of birth; invest in social and behavioural change campaigns, including those that reach the poorest and most vulnerable.

Actors	Actions
	• *Implement*: scale-up best practices and partner with the public sector to improve service delivery.
Nongovernmental organizations, communities and/or parent groups	• *Community health workers:* support preventive care before and after the period around birth and referrals to basic and comprehensive facilities as appropriate. • *Community leadership and accountability*: foster community leadership and accountability to remove barriers (in relation to, for instance, transport), hold health providers accountable for providing quality services and strengthen links between communities and facilities. • *Champions*: identify and support local champions, including parliamentarians, parent groups, professionals, community health volunteers and community leaders; engage and link champions for reproductive, maternal, newborn, child and adolescent health in order to provide coherent and coordinated messages about newborn health. • *Demand*: generate and sustain demand for services using community-owned actions (for instance incentives such as conditional cash transfers, insurance, transport, social mobilization, savings credit schemes and cooperatives). • *Adolescents*: give special attention to adolescent girls and implement approaches to help to prevent early and unintended pregnancies. • *Seek care*: use community health workers, skilled birth attendants and midwives in order to obtain essential maternal and newborn care that saves the lives of babies and women. • *Quality and accountability*: be a voice for change; demand quality, affordable, accessible services; report poor services through government and nongovernment mechanisms.
Academics and research institutions	• *Prioritize research needs*: agree upon and disseminate a prioritized and coordinated research agenda for improving preterm and newborn health outcomes. • *Invest in research*: encourage increased budget allocation for research into innovative interventions. • *Build research capacity*: build capacity at research institutions, especially in low- and middle-income countries, and train professionals. • *Disseminate findings*: disseminate research findings and best practices.

Actors	Actions
	• *Build partnerships*: strengthen global networks of academic providers, researchers and trainers.
Health professionals	• *Essential interventions*: prioritize essential interventions around the time of birth and care of small and sick newborns as part of an integrated package of reproductive, maternal, newborn and child health services. • *Health workers*: provide quality integrated services to babies and women through accelerated training, retention and motivation approaches. • *Commodities*: work with local and national bodies to ensure consistent availability of commodities and supplies essential for key interventions around the period of birth. • *Quality*: monitor quality of care including through use of maternal and perinatal death surveillance and response.

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