Accelerate reduction in newborn and child mortality towards achieving SDG 2030 targets

Report of the Regional Meeting

15-17 October 2019, New Delhi, India
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BACKGROUND

There has been significant reduction in under-five mortality in the Region – 70% reduction between 1990 and 2017 yet an estimated 1.3 million under-five deaths happened in 2017. Reduction in newborn mortality has been relatively slower – a reduction of 60% in the same period, with an estimated 0.76 million newborn deaths in 2017.

WHO-SEARO has considered acceleration in ending preventable maternal and child mortality as a high priority action and has instituted Regional Flagship to drive the progress in the Region. Under the Flagship WHO-SEARO has considered Bangladesh, India, Indonesia, Myanmar, Nepal and Timor-Leste as high priority countries because of relatively high burden of child mortality. WHO, along with partners has provided focused support to these countries to analyze the situation and adopt country-specific high impact approaches to address causes of newborn and child mortality moving forwards towards achieving the SDG targets.

Over the last five years the support from WHO to countries has been effective in enabling countries to accelerate the reduction in newborn and child mortality as we move towards achieving the SDG 2030 targets for ending preventable child mortality – reduce under-five mortality rate to 25 per 1000 live births, or lower and newborn mortality rate to 12 per 1000 live births, or lower. In comparison, in 2017 the Regional U5MR was 36 per 1000 live births and NMR was 21 per 1000 live births.

To accelerate reduction in newborn and child mortality the emphasis has been on rapid and equitable expansion of evidence-based interventions addressing the common causes of mortality, improving the quality of care and strengthen monitoring of the implementation. The focus has been on good quality of care at the time of birth, facility-based and home-based care of small and sick babies to reduce neonatal mortality and strengthening pneumonia management to address post-neonatal child mortality.

At the same time DPR Korea, Maldives, Sri Lanka and Thailand have already achieved low rates of under-five and newborn mortality. They need different approach to further reduce child mortality by addressing new and emerging causes of death and improving the quality of care.

Concurrently, there have been global developments. The Global Strategy of Women’s, Children’s and Adolescent’s Health (Global Strategy 2016-2030) has recommended to move beyond survival and ensure wellbeing, development and protection of children. Globally, WHO and UNICEF have initiated work on redesigning child health initiative to address emerging health and development priorities and define the interventions and strategies to cover an extended age group of 0 – 18 years as well as support the survive, thrive and transform agenda of the Global Strategy. WHO-SEARO has prepared regional framework for improving quality of care and supported work on quality improvement in the countries.

WHO-SEARO along with Partner agencies has prepared Regional Strategic Framework for improving newborn and child health in consultation with Member States in 2018, which provides guidance to countries for strengthening the national newborn and child health programs.
In the run up to this meeting, new evidence from multicounty research studies on kangaroo mother care, simplified antibiotic treatment of newborn sepsis and strengthened treatment of childhood pneumonia has been shared with the countries and key actions identified. In this Regional meeting, we used these new recommendations and global and regional guidance to prepare action plans for implementing high impact approaches in the countries.

The meeting was attended by Ministry of Health officials from Bangladesh, Bhutan, India, Indonesia, Maldives, Sri Lanka, Thailand and Timor-Leste, experts from the WHO collaborating centre at AIIMS, Delhi, representatives from other agencies like United Nation Children Fund, Save the Children and USAID, renowned maternal and child health experts as special invitees, and technical staff from the WHO Headquarters, South-East Asia Regional and Country offices.

**OBJECTIVES**

The Regional meeting was organized to strengthen implementation of national programs towards acceleration in reduction in neonatal and child mortality. The specific objectives were:

1. To review progress and share experiences in implementation of newborn and child health programs in the countries
2. To share recent technical updates in the field of newborn and child health
3. To identify strategies and priority actions in the countries for scaling-up evidence-based interventions for accelerating reduction in newborn and child mortality
4. To consider broadening the agenda beyond child survival to identify actions for child development and wellbeing
At the inaugural session, Dr Neena Raina, Acting Director, Family Gender and Life Course (FGL), WHO-SEARO, welcomed the participants and delivered the message from the Regional Director of WHO-SEARO, Dr Poonam Khetrapal Singh.

The Regional Director commended the efforts of the Member States recognizing the Regions’ acceleration in reduction of child mortality during the last part of the MDGs phase, which has continued during the SDG phase subsequently. Considering the annual reduction rates between 2010 and 2018 the Region is likely to achieve the SDG targets for child mortality and newborn mortality by 2030. She urged the Member States to sustain the gains and further accelerate the progress in times to come, while ensuring equitable coverage of evidence-based interventions, such that “no one is left behind”. She emphasized the importance of the Regional meeting to help ensure the adoption of under-utilized evidence-based interventions at scale in high burden countries. She reiterated WHO’s support in better utilization of these interventions and approaches, and promotion of new priorities like improving the quality of care for mothers and children through the regional model of point of care quality improvement (POCQI) introduced in the countries of the Region, reproductive, maternal, newborn, child and adolescent health (RMNCAH) policy survey analysis to identify key gaps in policies and guidelines and provide support and focus on early childhood development.

Dr Neena Raina echoed the sentiments of Dr Khetrapal and emphasized the need to focus on the “thrive and transform” aspects in addition to the agenda of “survival”. She emphasized the need to focus on new priorities like the nurturing care framework, birth defects surveillance, quality of care etc., to ensure that those objectives are not lost while pursuing and ensuring better survival.

Dr. Rajesh Mehta, Regional Adviser for newborn, child and adolescent health, WHO-SEARO shared objectives of the regional meeting and introduced the participants. He acknowledged the presence of delegates from the Ministries of Health from SEAR countries, representatives from WHO Collaborating Centers, Academia and several Partner agencies.
PROCEEDINGS OF TECHNICAL SESSIONS

The technical sessions were planned to ensure maximum participation and discussion. Participants were encouraged to share their country situation and context-specific concerns and do collaborative thinking around evidence-based solutions to the key issues.

All sessions included an introductory presentation to share the regional and country situation on the theme of the session and outlined the key issues. Subsequently different countries shared their experiences for others to learn from them. This was followed by a discussions.

SETTING THE STAGE

Child health redesign: The first session focused on the global initiative of child health redesign in the context of SDGs and an overview of the regional situation and strategy for improving newborn and child health in the Region. The following key points emerged from the presentations and discussions thereof:

- The purpose of child health redesign is to redesign technical and program guidance to better support country programs to ensure that all children survive, remain healthy, and grow, develop and thrive to reach their full potential as adults.
- WHO’s role in this initiative will be to provide technical guidance with respect to the conceptual framework, package for care of well child, package for additional care for diseases detected in under-five children and recommend evidence-based interventions for children aged 5-9 years based on the current epidemiology.
- Besides reduction in NMR and U5MR, countries need to focus on:
  - Emerging and leading causes of mortality in children older than 5 years and adolescents and consider issue related to increasing urbanization.
  - Continued advocacy for sufficient resources for child health as this is facing competition with a shift of focus to the ageing population.
  - Reducing morbidity as part of the thrive agenda and strengthen health systems to provide integrated, comprehensive care to address disability.
  - Employ a multi-sectoral approach and coordinate across all health and related sectors for achieving the desired outcomes for health and wellbeing of children and adolescents.
  - Renewed focus on the double burden of childhood malnutrition through multisectoral response for prevention and management.
  - Undertake implementation research to identify context specific solutions.

Regional situation of newborn and child health

Regional progress in reduction of newborn mortality and current situation of coverage of evidence-based interventions for newborn health and quality of care were shared. The challenges and way forward were also presented.

- Globally and regionally, reduction in neonatal mortality rate (NMR) has been slower compared to reduction in under-five mortality rate (U5MR), though the SEA Region has done better in mortality reduction compared to the World (Global vs. SEAR, 1990-2018: NMR reduction 55% vs 62%; U5MR 58% vs 71.4%).
By 2030, SEAR will achieve SDG goals of U5MR ≤25 and NMR≤12 if average rate of reduction between 2010 and 2018 is maintained. Some countries of region have already achieved SDG goals for NMR- Thailand (NMR=5), Sri Lanka (NMR=4), Maldives (NMR=5) and DPR Korea (NMR=10) as of 2018, while others need to accelerate (India, Myanmar, Timor Leste).

While top causes of neonatal mortality, i.e., prematurity (41%), birth complications (20%), infections (14%) and birth defects (12%) need to be addressed on priority, the ongoing work on underlying causes like health and nutrition of girls and women, adolescent pregnancy, poverty, illiteracy and other adverse factors is equally important.

Addressing neonatal mortality requires interventions across the continuum of care (life course) and across the health system (Family and community level, outreach, and clinical care or facility level). Key packages include: intrapartum care (51% newborn saved) and care of small and sick newborns (30% newborns saved) (Lancet 2014).

WHO has recently completed a survey on national policies and guidelines for reproductive, newborn, child and adolescent health. The survey suggest that required policies are in place in most countries in the Region, but these are not translating into effective coverage. There are a few policy gaps that countries should consider addressing by adopting evidence-based recommendations.

Effective leadership, governance and accountability mechanisms are required to address implementation barriers and strengthen health systems for achieving effective coverage of key evidence-based interventions to reduce neonatal mortality:
- Ensure good healthcare infrastructure for maternal and newborn care with adequate provision of WASH facilities, electricity, essential supplies & equipment
- Ensure adequate human resource mix: Numbers, distribution and competencies
- Compliance with standards, protocols, patient safety
- Ensure adequate health financing
- Ensure good measurement system for monitoring progress and link with accountability

Country report on situation of newborn and child health - Poster Walk.

The objective of the poster walk was to have countries share their progress and experiences in implementation of newborn and child health programs, specifically on the status of newborn and child mortality, facility-based and home-based newborn care, pediatric care and emerging areas/priorities along with health system challenges and the inter-sectoral work. The countries also included the priority issues they would like to address in coming 1-2 years. This information was used during the meeting to use the context specific information to help the countries identify strategies and priority actions for accelerating reduction in newborn and child mortality.

ACCELERATING REDUCTION IN NEWBORN MORTALITY

The second session focused on specific actions for accelerating reduction in newborn mortality namely, strengthening of facility-based care with specific focus on good quality institutional deliveries and improving the quality of facility-based care for small and sick newborns. Maldives and Sri Lanka shared their experience on achieving high coverage of institutional deliveries whereas,
India and Bangladesh shared their experience of scaling up of facility-based newborn care through newborn care units - SNCUs and SCANUs respectively.

**Care around the time of birth:**

**WHO Standards and Guidelines for Newborn care:** The global standards for improving quality of maternal and newborn care in health facilities were presented. The standards of care cover the routine care women and their babies and management of complications occurring during labour, childbirth and the early postnatal period, including those of babies during the first week of life. They define priorities for improving the quality of maternal and newborn care for use by planners, managers and health care providers to:

- Prepare evidence-based national standards of care to ensure high-quality, effective maternal and neonatal health services around the time of childbirth at different levels of care;
- Specify the expected standards of care and delivery defining the quality of service;
- Use available resources to achieve optimal health care outcomes and satisfaction of individuals, families and communities;
- Ensure that high-quality maternal and newborn care or services are being provided and monitor service improvements; and
- Provide a benchmark for national health facility audits, accreditation and rewarding provider performance.

These standards should be adopted and mainstreamed within national quality of care strategies for the delivery of maternal and newborn healthcare services ensuring that the services provided are of high quality.

**Universalizing institutional deliveries:** Maldives and Sri Lanka that have achieved more than 95% coverage of institutional delivery presented how they achieved these and what are their next steps.

- **Maldives:** The main enablers for achieving high coverage and quality of MNH services are:
  - High public health spending on health, 3-4% of GDP
  - Country has invested in healthcare infrastructure with each island having a health facility manned by a complete health care team
  - Home visits are conducted by community health officers
  - There is universal health insurance coverage, wherein Government covers the entire health expenditure in public sector, and 50% of health expenditure in private sector
  - Facility-based newborn care and implementation of Point of Care Quality Improvement (POCQI) at all levels of care ensure good quality

- **Sri Lanka:** Public health system has evolved over decades supported by good governance, adequate investments and accountability. Free healthcare is provided to everyone by the Government. Main features that other countries could learn are:
  - Functional cadre of midwives: One midwife for about 5000 population. There are two types of midwives: public health midwife to provide community level care and facility midwife who is trained to provide maternal and newborn care at all levels.
  - There is a well-defined organizational structure for provision of care with links between preventive and curative care; and facility-based care is available close to home (network of small hospitals) with referral linkages with higher level facilities. Service delivery system is quite efficient.
- Reporting and accountability system is well defined and consistently followed.
- Supervision and monitoring system is functional at field level; supervisory tools have been developed and trainings of supervisors are provided. Regular review of performance is undertaken.
- Surveillance and death audits are undertaken regularly.
- Contribution from non-health sector has been ensured: Female education and empowerment, minimum gender discrimination, extensive roads network that have ensured that hospital services can be accessed within 30-45 minutes.

It was concluded that a systematic development of the health system, functional health facilities closer to the homes of people, functional referral linkages, an adequately trained health workforce who can provide quality care that inspires people’s trust, as well as ensuring that there are no financial barriers to access is important to achieve the targets of newborn mortality reduction.

**Facility-based care for small and sick babies**

**Newborn care units:** Country experience of scaling-up facility-based newborn care from India and Bangladesh was shared that other countries could consider replicating.

India described the progress in scaling up special newborn care units (SNCUs) over last 15 years initially supported by UNICEF and WHO and later supported by the state and central governments under the National Health Mission. By now India has established around 850 SNCUs, mostly in district hospitals and medical colleges. They also presented operational challenges related to insufficient numbers of doctors and nurses and non-functioning equipment that they are progressively addressing.

Bangladesh has similar plans for establishing newborn units in each district. They have already 40 SCANUs covering two-thirds of the country already. A level-2 neonatal care available in a district provides referral care for small and sick babies within reasonable distance for people to save precious lives.

**Strengthening Kangaroo mother care (KMC) for small babies**

**Kangaroo Mother Care: Recommendations from Research:**

Recent evidence from the WHO-led multi-country research studies on kangaroo mother care (KMC) was presented that has implication for more effective use of KMC for small babies (preterm and low birth weight) in hospitals and in the homes/community.

- Prematurity is the leading cause of neonatal mortality in the Region and KMC is one of the WHO’s key evidence-based recommendation to improve preterm birth outcomes. The global target for KMC in the global Every Newborn Action Plan (ENAP) is 50% coverage by 2020 and 75% by 2025. The current global coverage of KMC is abysmally low – less than even 5%.
- Till date, the evidence for KMC was limited to facility-based KMC, for stable infants. Therefore, a significant proportion of small babies in the most crucial hours immediately after birth, when mortality is highest, babies who are discharged soon after birth and those born at home did not get the benefit of this life-saving intervention package.
- WHO has supported research to understand additional approaches for KMC:
  1. Improve coverage of KMC in facilities and continuation in follow up after discharge from hospital (facility to community continuum)
2. Benefits of Community-initiated KMC
3. Immediate-KMC (i-KMC) that is initiated as soon after birth as possible even if baby is still not clinically stable.
   - Evidence from these research studies suggests following key actions that could help achieve high coverage of KMC:
     - Identification of all preterm and LBW babies to initiate KMC at homes or facilitate their referral to health services, as required.
     - Supportive environment in health facilities and homes for providing KMC.
     - Respectful care for mothers during their stay with babies in the hospitals – provision of a bed, food, toilet, bath etc.
     - Understanding and conviction among the staff in maternity and newborn units that KMC is the standard of care for small babies and must be practiced universally.
     - Link between hospital care and home visits for continued support to the mother and family at home after the baby and mother are discharged to go home.
     - KMC should be continued after facility-based initiation when they go home after discharge and for infants for whom KMC could not be started in a facility it should be initiated in community.
   - In the i-KMC trial, immediate-KMC was initiated soon after birth even if the baby was not clinically stable and needed medical care (like tube feeding and C-PAP). The neonatal unit was redesigned to accommodate the mother inside the neonatal unit with the baby (the concept of Mother-NICU). The experience confirmed that it is possible to keep mothers inside the neonatal unit with their preterm and low birth weight babies from soon after birth. So, the mothers and babies are kept together and not separated at all (Zero Separation). This may be operationalized by adopting the following ways:
     - Any new maternal-newborn units to be built should have adequate space to keep mothers inside the newborn units (NICU) with full sized bed for mother and baby, bathing/toilet facilities, mini kitchen/pantry and reclining chair for the surrogate caregiver etc.
     - The mother, father and family should be able to decide how much they can participate in such care. It was found that it was possible for mothers to stay with baby inside the newborn unit for the entire 24 hours, if necessary arrangements were made.
     - Allowing father and other family members to provide KMC when mother is tired, unable or not available.
     - Benefit of this arrangement was that the chances of complication for babies are reduced as parents are observant and immediately report issues to the nurse or doctor on duty.
   - Recommendations for Member States from an earlier Regional meeting on KMC in 2018 were shared once again with the country delegates in this meeting:
     - Accelerate efforts for rapid scale-up of facility-KMC as part of high-quality maternal and newborn health programmes
     - Re-design maternal and newborn care units in hospitals to achieve zero separation of mothers and newborns, even when newborns are preterm/LBW or sick
     - Consider community-KMC, both for continuing after facility-based initiation and for initiating for those where KMC could not be started in a health facility.
     - Strengthen supportive supervision mechanism as well as monitoring and evaluation framework for KMC programmes
Improving practice of KMC in the hospital - Using QI approach:
A project from All India Institute of Medical Sciences (AIIMS), New Delhi presented how they used the quality improvement approach (the Regional model of point of care quality improvement – POCQI) to improve the duration of KMC for small babies admitted in the NICU. It was emphasized that the healthcare team in the NICU can improve the practice without additional resources by effectively engaging with mothers and families, counselling them appropriately and providing them continuous support for KMC and breastfeeding. The team used local data and observations, undertook root-cause analysis to evolve a solution to improve compliance to KMC and use mother’s own milk as standard of care for small babies in the neonatal unit. It was explained that quality improvement is a continuous process and should be practiced at all levels of care.

Preterm Care - Innovative training package:
WHO Collaborating Center for Newborn Care at All India Institute of Medical Sciences, New Delhi has prepared a modern multi-modal training package for teams of doctors and nurses to better manage the small babies. The training package includes blended e-learning and simulation methodology including self-learning and facilitated-learning through hands-on training among hospital teams facilitated by experts. The course materials are available free of cost on their website (www.pretermcare-eliminatingrop). It is focused on competency-based learning using various methods to promote better learning and skill acquisition. It has 10 modules on different aspects of preterm care including KMC and includes short videos and simulation exercise for practice. A mobile app “Preterm Care - Do No Harm” is also available for free. The resources have been adapted on WHO guidelines and are being used by more than 125 institutions across the Region, with a high user satisfaction.

Home-based postnatal care:
Postnatal care that could potentially save many newborns by provision of essential newborn care and timely identification of sickness and timely referral care.

Regional situation of PNC: Current status of postnatal care in the countries of the SEAR was summarized using the RMNCH policy survey and a dedicated survey carried out by WHO-SEARO. The key learning points from this part of the session were:

- There is a clear gap between the existing policy on PNC services and its implementation in the SEAR countries. Only one-third of babies receive a home visit within 2 days of delivery. There is no reliable information on quality and content of PNC contacts / visits.
- A well-defined service delivery model with systematic scale up plan is not available in many countries. There appear to be critical gaps in terms of how home-based services are organized to deliver evidence-based interventions.
  - In some countries there are no identified cadre of health workers to visit homes.
  - Training of CHWs, supervisory support and monitoring mechanisms for PNC are key issues.

Country experience in PNC: Bhutan, India and Indonesia shared their experiences of scaling up home-based postnatal care. The key learning is that every country should review their key health policies and guidelines regularly to keep them updated with the most recent evidence-based recommendations to ensure optimal MCH outcomes. It is important to identify context-specific
cultural and other barriers that might affect coverage (E.g. prohibition of mother-newborn pair to leave home during initial 42 days after birth) and generate evidence to find context-specific solutions to address such issues.

**Bhutan** has a high postnatal care coverage of 83% in 2018. They conducted a pilot study in 2013, the learnings from which were applied to scale-up PNC home visits across the entire country. The key to high coverage required a focus on home visits for all home deliveries, a follow up visit within 3 days for all facility-based deliveries, and appropriate linkage between birthing centers and community health unit. Additionally, Bhutan has specified the roles and responsibilities for healthcare personnel at different levels to provide PNC and has a good monitoring mechanism in place. Community health workers examine the mothers and babies, do proper counseling and advocate for future facility-based delivery.

**India**: PNC is delivered through community-based frontline workers (ASHAs), with a provision of 6 home visits (on day 3, 7, 14, 21, 28 and 42) for institutional deliveries and 7 visits (an additional visit within 24 hours of birth) for home deliveries. ASHAs perform all tasks including caregiver counselling and newborn examination. They stressed the need for capacity building (proper training and regular refresher sessions), on-the-job mentoring and supportive supervision, encouragement of the workers and timely payments of incentive to them through direct beneficiary transfer.

**Indonesia**: Their postnatal care guidelines were reviewed and updated in 2017 and adopted to the WHO guidelines for integrated PNC for mother and newborn. These were tested through a pilot project in 7 districts and subsequently the package was finalized in 2019. They revised their MCH Handbook accordingly.

**IMPROVING QUALITY OF CARE**

This session focused on improving quality of maternal, newborn and child health care. There was a presentation on “Regional initiative on quality Improvement for MNCH”, followed by one on “Improving quality of newborn care”, “Maternal Perinatal Death Surveillance & Response (MPDSR) in the South-East Asia Region” and “Patient Safety and WASH at health facilities/hospitals”.

**Regional progress** in improvement of quality of care for maternal, newborn and child health was presented including the WHO vision for quality of care (QOC), regional quality of care (QOC) framework, adopting global standards of care that cover the well-known attributes of good quality of care - safe, people-centered, timely, effective, equitable and efficient. It was emphasized that in the LMIC settings of South Asia, more lives are lost due to poor-quality of services than due to non-utilization of health services (1.9 million vs. 1 million), as analyzed by the Lancet Commission. This is a manifestation of a broader systems failure, which needs to be strengthened systematically through system-wide actions at different levels of programme management and facility-level to improve quality of care.

WHO-SEARO along with partners has supported the countries to set up the system of quality improvement at national and sub-national levels by strengthening dedicated units for improving quality of healthcare, adopting global standards of care into national guidelines along with stewarding quality improvement work at health facilities and hospitals. By now, all Member States in the Region have national quality policies, strategies and plans. Several countries also have accreditation.
programs. For hospital / health level improvement of quality of care the Regional model of point of care quality improvement (POCQI) has been developed and introduced in nine countries of the region (except DPR Korea and Thailand). The training is on a four-step process for quality improvement by forming teams of healthcare workers in the health facilities, using local data to define quality gaps and setting aims of improvement, doing a root-cause analysis, identifying local solutions to address the quality gaps and undertake rapid PDSA (plan-do-study-act) cycles to see if the identified solutions work in their own settings. A regional learning platform has been created on a dedicated website (www.pocqi.org) that offers a forum for sharing experiences in QI, teaching-learning resources, and recent publications and technical resources on quality improvement.

It was emphasized that systematic actions are required - much more than just training workshops, to set up QI programmes in districts and states to effectively manage it. These important components are: Establishing district level units for managing QI programme, initial POCQI trainings to hospital teams followed by provision of onsite mentoring support, promoting sharing and learning of experience among QI teams within the district and across districts, monitoring of the programme and community engagement. Such work is already happening at scale in Bangladesh and India.

**Improving quality of newborn care: Neonatal units and Labour Rooms:**
Nationwide Quality of Care Network, India (NQOCN) is a network of QI experts from the professionals form the fields of pediatrics - neonatology, obstetrics and nursing-midwifery. The Network has been supporting multiple healthcare teams to practice quality improvement for maternal, newborn and child healthcare. The experience of supporting quality improvement programmes for mothers and newborns in the labour rooms and newborn care units in Indian hospitals was shared. The network experts undertake POCQI trainings followed by onsite QI coaching for healthcare teams to build their capacity in continuous practice of improving quality of care. NQOCN has also initiated pre-service model for POCQI training involving medical and nursing students in Lady Harding Medical College in New Delhi and have created a “Be the change” model. They are progressively expanding the pool of QI experts, documenting experience and results of on-ground improvements, disseminating learnings, and integrating QI topics in research in medical college hospitals.

**Maternal and perinatal death surveillance and response (MPDSR):**
Medical Officer-Maternal and Reproductive Health, WHO-SEARO shared the progress in implementation of maternal and perinatal death surveillance and response (MPDSR) that is closely linked to quality improvement in terms of the response that is decided after root-cause analysis of maternal death. She reminded that maternal mortality ratio (MMR) is high across SEAR (152 per 100,000 livebirths as of 2017), and the Region is not likely to achieve the SDG goal by 2030. Stillbirth rate is also high in the Region with only 6 out of 11 countries having achieved (Maldives, Sri Lanka, Thailand) or being on track (Bhutan, DPR Korea and Indonesia). She informed that all countries are implementing MPDSR, but the analysis of underlying modifiable and preventable factors leading to perinatal death is not adequate, and the processes of response (improving care practices) need to be improved. The process of MPDSR should be linked with quality improvement processes at all levels to ensure timely and adequate response at all levels of health system.
Six countries in the Region do not have a policy/guideline requiring stillbirths to be reviewed (Bangladesh, Bhutan, Indonesia, Myanmar, Thailand and Timor-Leste). Stillbirths surveillance can be linked to birth defects like the example of SEAR-NBBD.

The key issues that need to be addressed are:

- Slow scaling-up of MDSR in most countries and very limited implementation of PNDSR
- Limited country capacity to conduct action-oriented reviews even with supportive policies
- Inadequate capacity to use ICD MM/PM
- Weak implementation of response mechanisms/actions to improve care at all levels
- Poor linkage with CRVS, QOC etc.
- Low mortality country may consider reviewing on severe morbidity or near-miss

Factors for success of MPDSR are:

- Supportive political and policy environment at the national or the local level
- Proactive institutional ethos that promotes learning as a crucial part of improving QoC
- Leadership at all levels with individual responsibility and a sense of ownership- A skilled, independent and respected chairperson who is a champion for the process
- Meetings should be task oriented- Recommendations, suggested actions and focal person should be specified, starting with things under health worker control. Minutes of proceedings should be maintained and follow up should be ensured for items that have not been completed.
- Maintain good communication between departments and staff stability; and
- Progress should be celebrated as and when it occurs.

Patient Safety and WASH at health facilities/hospitals:

WHO-SEARO Regional Adviser for service delivery and safety presented on importance of patient safety and infection prevention as part of quality of care. She observed that countries need to improve water, sanitation and hygiene (WASH) provisions at the health facilities in line with global recommended standards. Most countries in the Region have initiated implementation of Infection Prevent and Control (IPC) and antimicrobial resistance (AMR) initiatives. National programs on healthcare associated infections are being established in Bangladesh, Bhutan and DPR Korea, while Maldives, Nepal and Timor-Leste are getting ready for the same. All Member States are implementing trainings on patient safety and quality of care. However, most routine health information systems lack indicators on quality and safety and more work is needed to establish a culture of safety, improve patient experience and involve patients as partners.

From the patient safety perspective, there is significant variation and gaps in basic amenities in frontline facilities of SEAR. WHO has guidance on essential environment health standards in healthcare (2008), which include water quality and quantity, water facilities and access to water, excreta and wastewater disposal, healthcare waste management and information and hygiene promotion. Additionally, it has knowledge portal on healthcare waste management (http://www.healthcare-waste.org/) and on WASH in healthcare facilities (http://www.washinhcf.org/home/). WHO has also developed a risk-based management tool through an iterative process to prioritize, implement and monitor actions. The WASH FIT Digital (https://washfit.org/#/) is a free, open-access digital tool, based on the WASH FIT guide developed by WHO and UNICEF. WASH FIT is designed to help health care facilities improve quality of care through improved WASH provisions. It includes a set of forms for implementing a risk-based management
approach developed by WHO and UNICEF. The site also includes a dashboard to visualize the progress and keep track of it. She emphasized that positioning primary health care as the cornerstone for accelerating progress on UHC requires certain transitions, including: re-examining ways to improve health care quality and safety, esp. of frontline services, and links to secondary care.

COUNTRY ACTIONS FOR ACCELERATING REDUCTION IN NEWBORN MORTALITY

This session comprised group work for all the country teams facilitated by the technical experts for improving the coverage and quality of institutional deliveries, facility based newborn care and home-based postnatal newborn care in their countries. The discussion focused on the country policy and programme status and identifying key actions based on an analysis of the gaps and available evidence on what works to reduce newborn mortality. The country teams identified key actions in the next 2 years to improve the coverage and quality of institutional deliveries, facility-based newborn care including preterm care and KMC, and home-based postnatal care.

ACCELERATING REDUCTION IN POST-NEONATAL CHILD MORTALITY

The situation of child health in the Region and evidence-based approaches to reduce mortality were presented followed by presentation on how to strengthen the management of childhood pneumonia and possible serious bacterial infection (PSBI) in young infants, the two common causes of child mortality. Country level experience was shared by Myanmar and Nepal on IMNCI implementation in context to the management of childhood pneumonia, and by India on the findings from implementation research on PSBI management in young infants where referral is not feasible.

Child Health - Situation and Evidence-based approaches:
WHO-SEARO Regional Adviser for newborn, child and adolescent health presented the situation of child health in the Region. He commended that the Region had recorded a 71.4% reduction in U5MR down from 119 / 1000 live births in 1990 to 34 / 1000 live births in 2018. The Region is on track to achieve the SDG goal of <25 by 2030 as per the annual reduction rate achieved between 2010 and 2018. Yet about 1.2 million children are dying before reaching their 5th birthday in one year. At least two countries, Myanmar and Timor-Leste are falling short of reaching the SDG target by 2030 given their current rate of reduction. Wide disparities by geography, education and wealth exist even for countries that have reached low mortality rates.

Pneumonia is the major cause of death among under-5 after preterm complications and contributes to as many as 28% post-neonatal deaths, followed by diarrhoea (20%). Burden of childhood pneumonia is also quite high in SEAR, with >9.5 million children having severe pneumonia episodes per year (2015). Age group of 5-9 years also needs attention which is currently not receiving as much attention. Low recognition of illness, low care seeking, low antibiotic coverage and low compliance with hospital referral along with poor quality of care contribute to the high case mortality due to pneumonia. WHO-UNICEF Framework for protection, prevention, and treatment of pneumonia and diarrhea to reduce morbidity and mortality recommends the essential package of interventions under three groups: Interventions for Protection (EBF for 6 months, adequate complementary feeding, vitamin A supplementation); interventions for Prevention (vaccination, handwashing, safe drinking water and sanitation, reducing household pollution, cotrimoxazole prophylaxis for HIV
exposed); and interventions for Treatment (improved care seeking and referral, improved case management in facility and community, adequate supplies of medicines and continued feeding). He recommended that the barriers to the implementation of these essential interventions should be addressed. Specifically, WHO updated guidance on outpatient treatment of pneumonia should be integrated into the country specific guidelines to improve access to life-saving treatment. In updated WHO IMCI guidelines, young infants of 7-59 days with fast breathing as the only sign of illness are now classified as pneumonia and not PSBI, therefore do not need referral, only outpatient treatment with oral amoxycillin for 7 days. Countries need to adapt such guidelines for management of childhood pneumonia so that the cases that were previously classified severe pneumonia could be safely and effectively managed near homes and not referred to higher level hospitals, which does not materialize in most cases anyway.

Research to practice - Strengthening management of childhood pneumonia and PSBI in young infants: Recent WHO recommendations for Young Infants with clinically severe infection (Possible Serious Bacterial Infection) who refuse referral or when referral is not feasible may also be treated on outpatient basis if they are not critically ill.

Childhood pneumonia management - IMNCI implementation: Myanmar and Nepal presented the status of implementation of Integrated Management of Childhood and Neonatal Illness (IMNCI). IMNCI is being scaled-up at community level, first level health facilities and at referral level hospitals. Some issues with implementation of IMNCI were highlighted - policy not allowing use of antibiotics by community health workers; need of integration of malaria, pneumonia, diarrhoea and malnutrition, need to update existing national guidelines, availability of paediatric formulations, safe oxygen delivery system and other equipment, and improving care seeking behaviour at community level. Adequate training of health personnel in IMNCI with regular refresher courses and follow up; and monitoring are also important issues.

Scaling up management of babies with PSBI in a district: India Clinical Epidemiological Network (INCLEN) shared the implementation research findings on management of young infants (0-59 days) with clinically severe infection (Possible Serious Bacterial Infection - PSBI) in situation when referral is not accepted or is not feasible. Implementation research suggested that systemic changes can help improve PSBI management in community for cases where referral is not possible, without many additional resources. It was pointed out that large-scale implementation of PSBI management in community settings when referral is not feasible is not simple and needs health system support. Moreover, it is likely to work differently in different health settings. Each country must go through the learning curve for translating research into practice. Following key findings were shared:
- With intensive social mobilization and awareness generation, mothers and families in the community can be empowered to identify young infants with signs of sickness and facilitate access and uptake of services for treatment and follow up. This can also strengthen social accountability in terms of motivating the community health workers to undertake home visits.
- Community health workers (CHWs) can be trained to identify danger signs suggestive of PSBI, who in turn teach mothers how to recognize these signs of sickness in their babies. They can convince the family to go to higher level hospital and help complete outdoor treatment if referral advice is not accepted.
- These providers (CHWs and MOs) need to be trained in simplified antibiotic treatment for PSBI and communication with mothers and families.
- As for supplies & logistics, there should be no stock outs at any level of healthcare services.
- The confidence of the medical officers at primary health centers (PHC) to manage young infants needs to be enhanced by the support from higher-level hospital in the region. This role of motivating MO-PHC was done by the technical resource center established for the research study at the district hospital. When the MO-PHC started treating PSBI in young infants as outdoor care the CHWs also became confident to take up this role considering that the MOs are there to provide back up support when needed.

**Pediatric Care Standards and Child Death Review Guidelines:**

The recently released WHO “Paediatric Care Standards” and “Child Death Review Guideline” were presented by an expert from WHO-HQ. Paediatric standards are similar in structure to the global maternal and newborn standards and should be adapted by the countries for implementation. These standards define the inputs and process for provision of good quality paediatric care and cover both the provision of care and experience of care by the family. There are eight standards that help setting up the infrastructure for pediatric care and recommended resources, standard protocols for treatment, care and counseling, data systems to monitor performance and quality of care, and community participation.

The child death review guidelines will help in standardizing the approach to investigate selected child deaths to understand the cause of death including underlying systemic and social factors. Child death review systems should build upon the experience of undertaking MPDSR in the countries and follow similar processes.

**PROGRESS BEYOND SURVIVAL**

WHO-SEARO Regional Adviser presented on the global framework for “Nurturing Care for Early Childhood Development”. This framework was released in 2018 at the time of the World Health Organization. The key points covered in the presentation are:

- The Framework focuses on health sector’s role during pregnancy and first three years of life that is the most crucial period of brain development.
- Health sector is the most common sector that meets families of 0-3 years children and has multiple opportunities of interaction during well child visits and visits for the treatment of sickness.
- The five components of ECD are: Good Health, Adequate Nutrition, Responsive Care, Security and Safety, and Opportunities for early learning.
- Responsive caregiving underpins all components of nurturing care and effective interventions for responsive care across life-course are well-recognized.
- It is important to provide universal support to all children in addition to special services for the children affected with developmental issues, delays and difficulties.
- WHO and UNICEF Training package “Care for Child Development” is an effective tool for building knowledge and skills of healthcare and nutrition workers.
- Countries of the Region have supportive national policies for supporting ECD and several sectors have been implementing different components of nurturing care in isolation, using diverse approaches. They must now undertake preparation of a comprehensive programme for nurturing care through inter-sectoral approaches to build human capital from an early age, starting during the antenatal period.
**India** shared the highlights of their nationwide programs- National Nutrition Mission (NNM) and Rashtriya Bal Swasthya Karyakram (RBSK), wherein opportunities at all levels from community to the facilities are used to promote early child development. ECD interventions are available alongside the nutritional interventions like food security and nutrition counseling across the life course. Simple pictorial messages on early child development and responsive parenting have been incorporated in the national mother-child protection (MCP) card provided to the mothers during pregnancy that is maintained during the postnatal period and until the child is three years old.

**Sri Lanka** presented their Early Childhood Care and Development (ECCD) program with the following highlights:
- The programme starts from preconception education and services for newly married couples by public health midwives.
- Antenatal care (ANC) counseling includes information on postnatal child health development.
- Child Health and Development Record Card carries age-specific instructions for mothers on all aspects of postnatal care including growth monitoring, thermal care, breastfeeding, immunization, alarming (danger) signs, nutrition advise etc.
- In pre-school settings, there are programmes of pre-school teachers, education and awareness of mothers on development of pre-school children.
- However, challenges of availability of adequately trained personnel able to detect affected children and provide required services have been identified, as well as data collection and analysis for monitoring progress are important concerns.

**Thailand** has strong focus on “thrive” agenda after having achieved very low levels of mortality characterized by:
- A universal health insurance scheme with coverage of 99.9% Thai population in 2011.
- National standards for MCH-related services in Thailand include child development checkup and nutrition along with parental education as part of postpartum care, with the goal of achieving normal child development for >85% children (currently reported to be 67.5%).
- Availability of maternal and child health personnel and services are available till the sub-district level, with huge number of village health volunteers (n=1,054,729).
- The Government of Thailand’s nationwide ECD project launched in 2018, “Miracle of the 1000 days of life”. The program focuses on promoting nutrition and development from pregnancy onset till two years of life of the child and seeks to provide integrated health care through joint investment by local government organizations and network participation and increased social activities. All related ministries participate for driving this program from national to local level, including the village health volunteer at the community level, with robust monitoring mechanisms in place.
- A team of Health Promoting Hospital / village health Volunteer makes monthly home visits to mothers and children to follow and counsel them about appropriate food, and food sanitation etc.
- An MCH handbook to be distributed to every pregnant woman who attends the antenatal care and a Facebook application for parental guidance “Early Moments matter on Mobile (EMMM)” to track development, automatic software used to sending customized message to chat box of participants The program will send text and links to pregnant women, mothers, or family according to the gestational ages or the age of their children.
Parents are trained to use Developmental Surveillance and Promotion Manual (DSPM) during the postpartum period before d/c home and in WCC. Nationwide screening and intervention Thai children at the age of 9-18-30-42 months once a year.

COUNTRY ACTIONS FOR CHILD HEALTH

In this group work session, the country teams worked together to identify and outline the key actions for improving coverage and quality based on information shared in the meeting. The presentations outlined the plan of action in the coming two years, in the following areas:

- Strengthening pneumonia and PSBI management
- Care of sick child at home, first level - IMNCI, iCCM
- Pediatric care at referral hospitals; and
- Strengthening implementation of Nurturing Care for Early Childhood Development

CROSS CUTTING AREAS

In this session, participants opted to join one of the parallel sessions to discuss three cross-cutting issues: Health system strengthening, improving quality of care and patient safety, and Multisectoral actions for strengthening newborn and child health. The discussions from the three sessions was shared in a plenary session to inform everyone.

HEALTH SYSTEMS STRENGTHENING

In this group, the discussion focused on human resources of health, health information systems, service delivery platforms and implementation research. Key discussion was:

- **Human resources for health (doctors, nurses and midwives).** These are inadequate in numbers (except DPR Korea and Maldives) and maldistribution is an issue in most countries of the Region. Usually, care is being provided by the LEAST TRAINED provider. Countries are using both merit and incentive- based models to improve the numbers and distribution in the rural, difficult and remote areas, but none are optimal. There is a need to identify and test innovative models, e.g., UK example where specialist training (medical) is regionalized.

- **Service delivery.** Service delivery was discussed specifically with reference to postnatal care. Sri Lanka and Bhutan have a systematic approach to provide postnatal care, but delivery platforms in other countries seem sub-optimal. The care is usually provided by different types of community-based workers who have variable competency. The clear understanding of the service provider (community health worker, midwife / nurse / doctor) and their roles as well as that of their supervisors appear to be an issue. There is need to have an adequately trained provider do the home visits and enhance the skills of existing personnel so that the interventions are delivered consistently with good quality at each contact with the family.

- **Health Information systems.** It is important that the indicators being collected be reviewed and updated periodically as per standard guidelines, e.g., KMC, delayed cord clamping, with data disaggregated to inform equity gaps. Latest data should be made available for critical indicators. Data collection methods are variable across settings- these are electronic at most
places, but feedback system is lacking at most places and there is limited data use to inform action at the local level. Health information systems should be enabled to support improved quality and safety of care

- **Implementation research** - Important areas identified for implementation research were how to increase coverage of postnatal care, institutional deliveries and duration of stay in the health facility following birth, how to re-organize MNCH service delivery to provide quality services at lower levels of care to ensure effectiveness and cost-effectiveness, and how to improve quality and effectiveness of data utilization and obtain timely data

**QUALITY OF CARE AND PATIENT SAFETY**

The WASHFIT dashboard prepared by WHO-SEARO was discussed to support and monitor the healthcare facilities towards improvement in water and sanitation provision.

Country teams shared the main features of quality of care programmes.

**Bangladesh**
- District QI programmes for maternal and newborn care is underway;
- Preterm care programmes are implemented all over the country but need support of the QI programmes.
- KMC national program underway in 110 centers.
- National recommendation of using 7.5% chlorhexidine for umbilical cord care to reduce neonatal sepsis is implemented countrywide for two years, but no data is available to understand coverage and quality; only experience case series are available.

**India**
- AIIMS at New Delhi had initiated QI projects; weekly meetings are being held to reinforce and check progress and sustenance; POCQI has become part of system in NICU and feedback from staff confirms that there has been no increase in work load.
- POCQI Model has diffused into other areas of healthcare in the AIIMS hospital like departments of obstetrics, cardiology, emergency medicine, traumatology, ophthalmology etc.
- AIIMS has spearheaded introduction of POCQI in NICU sand SNCUs in nine states of India
- POCQI is being integrated in the clinical trainings now.

**Indonesia**
- Hospital accreditation has been implemented across the country. All PHCs and 2383 hospitals have been accredited. MCH community is demanding more detailed QA benchmarks. It is recommended that after the accreditation is achieved the hospitals should conduct self-assessments periodically to ensure that the standards are sustained.
- Community empowerment in Indonesia is achieved by using MCH handbook. The schedule and items of MCH services are explained to mother in mothers’ classes which are separate for pregnant women and mothers with under-five children.
- POCQI model has been introduced in the country.
- UNICEF is supporting QI programme in 2 PHC and 19 hospitals in 12 provinces and is being requested to support QI for pediatric care using the Six Sigma approach.

**Maldives**
• Main challenge is that healthcare workers are not practicing the national guidelines for MNCH care.
• IGMH has a quality cell and has undertaken QI projects using the POCQI approach.
• Efforts are under way to improve clinical trainings for maternal-newborn care and practices of infection prevention and control.
• Needs better and regular monitoring
Nepal
• Cord care program underway; started in 2014 all over districts; successful drivers were a clear implementation plan, community health centers were given one-month supply to take care of home deliveries.
• POCQI model has been introduced in the country and 8 zonal hospitals have started implementing it.
• Country recently mapped all technical resources (policy documents, guidelines, training packages and protocols etc.) for improving quality of care so that a holistic approach could be designed.
• Preterm care and KMC guidelines are being drafted and MPDSR guidelines are being updated.
Sri Lanka
• Separate ministry in responsible for QA; MOH has a quality secretariat
• Country has implemented Six Sigma for 20 years; mentoring phase is now over; MOH closely monitors and the health system responds by maintaining standards; regular meetings are held for discussing gaps against the QA standards.
• WHO QA assessment tool in four MCH areas adopted
• Hospital staff trained, advised for Internal audit and subsequent meeting, medical officer quality in all regional hospital,
• POCQI has been introduced to strengthen the improvement component of the Six Sigma approach. POCQI training was initially provided to 7 hospitals in 2016 that has now spread to 25 hospitals.
• QI initiative has experienced bottlenecks on account of decreased motivation in the healthcare teams after training, in sufficient monitoring and lack of national mentoring group for QI.
Timor Leste
• Quality cabinet has been established in MOF that oversees QI in all facilities.
• One national and five peripheral hospitals, using 2014 IPC guidelines and have documented reduction in neonatal sepsis by 25%.
• There is a twinning partnership with Macau Government since 2018 that is supporting a Pilot on IPC and WASH in three districts through exchange of skills.
• Continuous QI approach has been introduced and 250 health workers trained. POCQI model has been introduced in the National Hospital.
• National hospital has started using electronic medical records in maternity wing.

MULTI SECTORAL COORDINATION

Discussions focused on engagement with WASH, Nutrition, Environmental health and private sectors. The benefits, mechanisms, facilitating factors and mechanisms for Intersectoral coordination were deliberated upon. Key points were:
General

- Foremost requirement for multisectoral coordination is leadership in the Government and presence of clear administrative structure for inter-sectoral work. In Myanmar, an independent national coordination committee is present which is autonomous and thus plays a critical role in intersectoral coordination.
- An SDG action plan should be drawn in consultation with different sectors to ensure their involvement.
- New sources of funding activities related to multisectoral coordination need to be identified. E.g., the corporate social responsibility funds in India wherein every company must spend 2% of their profit for socially relevant activities every year.

Newborn mortality reduction through inter-sectoral actions

- Involvement of nutrition sector, WASH in health facilities, communication and transport, and private sector are key to reducing NMR
- In India, the monthly Village Health and Nutrition Days provide platforms for the health and nutrition sectors to converge for service delivery. This serves as the platform for engaging with other sectors like women groups or self-help groups, WASH etc.
- It is critical to improve the supportive environment for breastfeeding and complementary feeding. Provision of facilities at workplaces would involve the labour department, agriculture (for nutritional component), social protection (for child abuse etc), and legal department (better implementation of IMS ACT- Infant Milk Substitute Act).
- To improve WASH in health facilities, Clean India Movement (Swach Bharat Abhiyaan) is an example of highest-level political commitment – at the level of the Prime Minister. Within this Kayakalp initiative aims to improve cleanliness in hospitals and incentives such as appreciation and cash award are offered. At school level, department of Education and WASH has been instrumental in improving hygiene and sanitation.
- Improvement in roadways helps timely referral and transport of sick infants that is a clear example of how multi-sectoral approach is helpful.

Involvement of Private sector

- Involving professional bodies that include members from private practice can help adoption of standard treatment protocols and better implementation of national programmes.
- Accreditation of private health facilities within the network of care can facilitate their involvement in universal health coverage.
- Multiple examples on how this can be done were shared. In India, private doctors must provide free treatment in government hospitals for 12 days in a year, their services are compensated by the government. In Myanmar, specialists and nurses from tertiary care centers are engaged to provide services at lower facilities 4 times in a year.
- Universal health assurance scheme in India is another opportunity to involve private health facilities in UHC.

Early Childhood development (0-3years)

- Provision of safe environment requires engagement of multiple stakeholders at various levels. E.g., creches in workplaces requires coordination with hiring companies, use of lead-free toys would require involvement of industries, prevention of pollution, use of safe fuels will require coordination with dept of environment and prevention of abuse requires involvement of social sector.
• Engaging fathers in care giving is critical for overall development of a child. This can get due attention provided there is involvement and coordination between health and education sector. Media could play an important role in the process.
CLOSING SESSION

In the last session, the participants shared their feedback about their learnings from the meeting, which was very positive. They were inspired and stimulated by the country examples of success and showed keen interest in replicating the same in their own contexts. Thereafter, the conclusions and recommendations from the meeting were presented and the countries were asked to share their feedback on the same.

Participants were congratulated for the hard work they put in preparation of the meeting and their close interactions during the meeting. The need to incorporate key learnings from the meeting in the country action plans was emphasized, along with the need to devising a clear strategy on how to implement the same, with the support of WHO and UNICEF country offices.

It was pointed out that the learnings from the meeting if implemented effectively, could help countries accelerate their achievement of the SGD targets for newborn and child mortality.
CONCLUSIONS

- South-East Asia Region has recorded significant reduction in newborn and child mortality over past two decades.
- Because of the acceleration in mortality reduction achieved since 2010, SEA Region, as a whole, is likely to achieve the SDG targets for newborn and child mortality reduction by 2030. Some countries need to further accelerate mortality reduction, especially newborn mortality reduction, to meet their individual 2030 targets. All countries need to pay attention to inequalities in newborn and child mortality.
- Some evidence-based interventions across life-course for newborn and child health have reached high coverage but others are at low level for impact on mortality reduction. In addition, there are wide disparities in the coverage based on economic and social parameters.
- Increasing coverage and quality of institutional deliveries, strengthening management of preterm, low birth weight and sick babies, treatment of sepsis in young infants, and childhood pneumonia need to be recognized as high priority areas in countries that have comparatively high child and newborn mortality.
- Several streams of work in quality of care are underway, including adoption of national standards, updated clinical guidelines and trainings, patient safety and infection control guidelines, accreditation/certification of health facilities, and MDSR. Quality Improvement component has been added recently in the countries and needs to be scaled-up in an institutionalized manner.
- Maternal, perinatal and child death reviews and response to avert future deaths should be expanded and linked with clear efforts in improving quality of care for ensuring good health outcomes.
- Community health workers led services for maternal, newborn and child health need to be reviewed for quality and redesigned for more effective implementation.
- Countries recognize the need to strengthen health sector’s contribution to nurturing care for early childhood development from pregnancy to first three years in collaboration with other sectors in order to further improve survival and holistic development.

RECOMMENDATIONS

For countries

For acceleration in newborn and child mortality reduction countries need to undertake rapid expansion of coverage of all evidence-based interventions with equity and good quality, that depends on strength of the health system and contribution from other relevant sectors.

- **Expand good quality facility-based care** for childbirth, management of small and sick babies including preterm care and kangaroo care and obstetric complications. Based on an **assessment of the availability and distribution** of such facilities across the districts countries should prepare strategies for the under-served areas.
- **Build capacity and practice of continuous quality improvement** for MNCH care. POCQI model needs to be scaled-up as it has shown promise in the introduction phase.
- Review the **implementation of home-based postnatal care** for mothers and newborns and strengthen the service delivery system to reach high coverage and good quality. This approach will be useful for other healthcare areas like care of sick children and implementation of ECD interventions by the community health workers.
• **Strengthen management of childhood pneumonia and PSBI** closer to homes including update of the national IMNCI and other guidelines and expand coverage of implementation with good quality.

• Review the policy environment and programme for **nurturing care for ECD** and strengthen universal implementation through healthcare system focusing on antenatal period and 0-3 years age using integrated approaches and in collaboration with different sectors.

• Consider preparing a **national framework for improving quality and safety** in MNCH care and an action plan to implement at scale and monitor actions at national, district and point of care levels as an institutionalized programme.

• Review and evaluate ongoing **community engagement** and **intersectoral approaches** and strengthen collaboration across relevant sectors including private sector.

• Identify **country-specific research priorities** to expand coverage and quality of high impact lifesaving interventions to ensure effectiveness.
ANNEXURES

1. Address by Dr Poonam Khetrapal Singh, WHO Regional Director for the South-East Asia Region
2. Programme of the meeting
3. List of participants
4. Group photograph
5. Summary of country actions for newborn and child health.
ANNEXURE I: Address by Dr Poonam Khetrapal Singh, WHO Regional Director for the South East Asia Region

Hon’ble representatives and distinguished participants,

Good morning and welcome to this regional meeting on accelerating reductions in newborn and child mortality towards achieving the SDG targets.

Although our Regional Director, Dr Poonam Khetrapal Singh, would have liked to attend this important meeting, she is unable to due to a prior commitment. I therefore take great pleasure in delivering this message on her behalf.

The Regional Director notes that the 2019 Child Mortality Report from the UN Inter-Agency Group has confirmed that DPR Korea, Maldives, Sri Lanka and Thailand have achieved the SDG targets for reducing under-five and newborn mortality, and that Indonesia has achieved the 2030 target for reducing under-five mortality. Moreover, she says, as per the current annual rate of reduction, the Region is expected to achieve the target for under-five mortality reduction and neonatal mortality by 2030 as per the projection based on the annual reduction rates between-2018.

The Regional Director is certain that with concerted efforts all Member States can achieve the targets. She commends countries on their hard work during the MDG era, because of which the Region achieved about 72% reduction in under-five mortality between 1990 and 2018, compared with the global reduction of 58%, and a 62% reduction in newborn mortality, compared with the global reduction of 51%.

In commending Member States on their progress, the Regional Director urges countries to sustain and accelerate their work to achieve the SDG targets.

To that end, she welcomes the Flagship Priority’s increased focus on newborn mortality.

Distinguished participants,

Much of the reduction in newborn and child mortality can be ascribed to investments made by countries to scale up the coverage of evidence-based interventions. The opposite is also true: Where progress has been inadequate we find that coverage has been uneven, or that interventions have been applied inconsistently throughout the life course. In addition, we find a significant disparity of coverage in relation to geographic location or social-economic parameters. We must work together so that no one is left behind.

A key part of making the necessary progress is achieving UHC, another of our Flagship Priorities and the defining mission of SDG 3. Meeting the health needs of women, children and adolescents is an important part of UHC, and continues to receive our attention. The Call to Action made by parliamentarians following a WHO-supported meeting last year was inspiring. Dr Khetrapal Singh looks forward to the progress it will drive.
To catalyze that progress, this Regional Meeting, which comes after consultations with high-burden countries to reduce newborn and child mortality, will help ensure under-utilized, evidence-based interventions are adopted at scale. This includes kangaroo mother care for pre-term and low birth weight babies, as well as simplified antibiotic treatment of newborn sepsis and strengthened treatment of childhood pneumonia.

The Regional Director reiterates WHO’s support in better utilizing these evidence-based life-saving interventions and other measures.

She says that following the development of the Regional Framework for improving the quality of care in RMNCAH, the Regional Office prepared a regional model to build capacity for continuous quality improvement in health facilities.

The Point of Care Quality Improvement model – or ‘POCQI’ – has been introduced in nine of the Region’s countries. Notably, it has also been introduced in the Global Quality-Equity-Dignity Network, and in countries in the Africa, European and Western Pacific regions.

Dr Khetrapal Singh is pleased that all 11 of the Region’s Member States recently completed a global survey on policies and guidelines on RMNCAH. The analysis will be used to identify specific policy gaps and the support needed for countries to address them.

The Regional Director also appreciates that the recently launched Nurturing Care Framework for Early Childhood Development will be discussed in this meeting. Alongside newborn mortality reduction, the Regional Office is increasingly focused on early childhood development.

Distinguished partners and participants,

The Regional Director says that the Regional Office is constantly reviewing the situation in countries and is focused on high-priority countries with a relatively higher burden of mortality. She is inspired by WHO’s collaboration with partner agencies, especially UNICEF. You may be aware that WHO-SEARO and UNICEF-ROSA jointly organized a training workshop on perinatal death review earlier this month.

Dr Khetrapal Singh notes that, as per WHO’s thirteenth GPW, the Regional Office is preparing work plans for the 2020-2021 biennium based on country needs. This will allow the Regional Office, along with our team from headquarters, to better provide strategic guidance and resources at the country level. Dr Khetrapal Singh is pleased that our three-level team will be working with you over the coming three days.

The Regional Director once again welcomes you to this meeting and urges you to make the most of the opportunity to drive progress where it matters most: at the country level. She wishes you successful deliberations and looks forward to being apprised of the outcomes.

I echo that sentiment and wish you a comfortable stay in New Delhi.

Thank you.
**ANNEXURE II: PROGRAM**

**Day 1: TUESDAY, 15 OCT 2019**

**Session 1: Setting the Stage**
- Child Health in SDGs: Global initiative of child health redesign
- Regional Situation and Strategy for improving newborn and child health
- Newborn and child health programme in countries

**Session 2: Accelerating reduction in Newborn Mortality**
- Newborn Health: Situation and Evidence-based approaches
- Facility-based care: Institutional deliveries
- Country Experience in achieving high coverage and good quality
  - Maldives: Discussions
  - Sri Lanka: Discussions
- Facility-based care: Newborn units for care of small and sick babies: Country experience of scaling-up with quality
  - India: Discussions
  - Bangladesh: Discussions
- Strengthening Preterm Care and Kangaroo care
- KMC: Recommendations from Research
- M-NICU: Changing structure and practices for KMC in hospitals
- Using QI approach: Improving practice of KMC in the hospital
- Preterm Care: Innovative training Package

**Day 2: WEDNESDAY, 16 OCT 2019**

**Session 2 (Contd.): Accelerating reduction in Newborn Mortality**
- Home-based postnatal care: Situation in the Region
  - Country experiences in scaling up HBPNC:
    - Bhutan
    - India
    - Indonesia

**Session 3: Improving quality of care**
- Regional initiative on Quality Improvement for MNCH
- Improving quality of newborn care: Neonatal units and Labour Rooms
- Maternal and Perinatal Death Surveillance and Response
- Patient Safety and WASH at health facilities/hospitals

**Session 4: Country actions for accelerating reduction in Newborn Mortality**
- Key actions for improving coverage and quality planned in next 2 years:
  - Institutional deliveries
  - Facility-based newborn care
  - Home-based postnatal care

**Session 5: Accelerating reduction in post-neonatal child mortality**
- Child Health: Situation and Evidence-based approaches
- Research to practice: Strengthening management of childhood pneumonia and PSBI in young infants
- Childhood pneumonia management: IMNCI implementation
  - Myanmar
- Nepal
  - Scaling up PSBI in a district
  - Pediatric Care standards
  - Child Death Review Guideline

**DAY 3: THURSDAY, 17 OCT 2019**

**Session 6: Progress beyond Survival**
- Nurturing Care for Early Childhood Development:
- Country experiences of ECD: 15 Min each
  - India: National Nutrition Mission and ECD
  - Sri Lanka: Including developmental delay
  - Thailand: Focusing on development of 0-3 years Children

**Session 7: Country actions for child health**
- Key actions for improving coverage and quality planned in next 2 years:
  - Strengthening pneumonia and PSBI management
  - Care of sick child at home, first level - IMNCI, iCCM
  - Pediatric care at referral hospitals
  - ECD

**Session 8: Cross-cutting areas**
- World Caffe
  - Health System strengthening
  - Quality of Care and Patient Safety
  - Multisectoral actions
- Plenary Feedback from work stations: 10 Min each

**Session 9: Conclusions and recommendations**
### ANNEXURE III: LIST OF PARTICIPANTS

#### Ministries of Health officials

**Bangladesh**

1. Dr Md. Jahurul Islam  
   Newborn Health, National Newborn Health Program & Integrated Management of Children Illness (NNHP & IMCI)  
   Directorate General of Health Services (DGHS)  
   Ministry of Health & Family Welfare

2. Prof. Dr Manisha Banerjee  
   Professor and Head  
   Department of Neonatology  
   Dhaka Medical College  
   Ministry of Health & Family Welfare

**Bhutan**

3. Mr Tshedar  
   Senior Program Officer  
   Communicable Diseases Division  
   Department of Public Health

4. Mr Karma Tenzin  
   Program Officer  
   Non-Communicable Diseases Division  
   Department of Public Health

**India**

5. Dr Ajay Khera  
   Commissioner (MCH)  
   Ministry of Health and Family Welfare

6. Dr Sheetal Rahi  
   Assistant Commissioner (AH)  
   Ministry of Health and Family Welfare

7. Dr Renu Srivastav  
   Adviser, Maternal, Newborn and Child Health (MNCH)

**Indonesia**

8. Dr Ni Made Diah Permata Laksmi  
   Deputy Director for Underfive and Pre-School Children’s Health  
   Directorate of Family Health  
   Ministry of Health

9. Ms Natasia Meutia  
   Head, Sub-Division of Competency Analysis  
   Centre of Training on Human Resources for Health  
   Ministry of Health

**Maldives**

10. Mr Abdulla Muza Adam  
    Senior Public Health Programme Officer /HPA  
    Ministry of Health

11. Ms Azmeela Hassan  
    Clinical Nurse  
    Dr Abdu Samad Memorial Hospital  
    Ministry of Health

**Sri Lanka**

12. Dr Nethmini Thenuwara  
    Consultant Community Physician  
    Family Health Bureau  
    Ministry of Health, Nutrition and Indigenous Medicine  
    Colombo, Sri Lanka

13. Dr Suranga Fernando  
    Consultant Community Physician  
    Office of Provincial Director of Health Service, Central Province  
    Ministry of Health, Nutrition and Indigenous Medicine  
    Colombo, Sri Lanka
Thailand
14. Dr Nongnuch Pataraanuntanop
   Director-Regional Health Promotion Centre 1, Chiang Mai
   Department of Public Health
   Bangkok, Thailand

15. Assist.Prof. Dr. Suppawat Boonkasidecha
   Medical Officer
   Senior Professional Level
   Neonatologist and Pediatrician
   Queen Sirikit National Institute of Child Health
   Department of Medical Services

Timor-Leste
16. Mrs. Fatima Isabel da Costa Gusmao
   Officer for Health Reproductive
   Ministry of Health

17. Dr Jose Felix C. Freitas
   Officer for Integrated Management of Childhood Illness (IMCI),
   Ministry of Health

18. Mr Domingas Soares
    Focal Point, National Institute of Health
    Ministry of Health

Special invitees
19. Dr Vinod K Paul
    Member
    Niti Aayog (National Institution for Transforming)
    India

20. Dr Harish Chellani
    Head of Department of Paediatrics
    Vardhman Mahavir Medical College and Safdarjung Hospital
    New Delhi, India

21. Dr Vikram Datta
    Director & Professor
    Kalawati Saran Children’s Hospital
    New Delhi, India

22. Dr Krishna P Bista, President
    Nepal Paediatric Society (NEPAS)
    Kathmandu, Nepal

23. Dr Elizabeth Mary Mason
    Independent Consultant
    Geneva, Switzerland

WHO Collaborating Centre
24. Dr Anu Sachdeva
    Assistant Professor
    Department of Paediatrics
    All India Institute of Medical Sciences
    New Delhi, India

25. Mrs Meena Joshi
    Nurse Educator
    All India Institute of Medical Science
    New Delhi, India

Other Agencies
26. Dr Artha Camellia, MHA, MPH
    Health Specialist
    United Nations Children’s Fund
    Indonesia

27. Dr Sarabibi Thuzarwin
    Specialist in Maternal, Newborn and Child Health
    United Nations Children’s Fund
    Myanmar
28. Dr Afsana Karim  
Senior MNH Advisor  
USAID’s MaMoni MCSP  
MaMoni Maternal & Newborn care  
Project, Save the Children Bangladesh

29. Dr Rajesh Khanna  
Senior Technical Advisor  
Health and Nutrition Save the Children  
National Support Office  
United States Agency for International Development (USAID), New Delhi, India

30. Dr Sachin Gupta  
Advisor (Maternal and Child Health)  
United States Agency for International Development (USAID)  
New Delhi, India

**WHO Headquarters**

31. Dr Wilson Milton Were  
Medical Officer  
HQ/PPP Policy, Planning and Programmes  
Geneva, Switzerland

**WHO Country offices**

32. Dr Deepti Agarwal  
National Professional Officer  
(Newborn and Child Health)  
WCO India

33. Dr Hla Hla Aye  
Consultant, RMNACH  
WCO Myanmar

34. Dr Pooja Pradhan  
National Professional Officer  
WCO Nepal

35. Dr Jermias Da Cruz  
National Professional Officer  
WCO Timor-Leste

**Regional Office for South-East Asia**

36. Dr Neena Raina  
Director a.i., FGL

37. Dr Rajesh Mehta  
Regional Adviser  
CAH

38. Dr Jayathilaka Chandani Anoma  
Medical Officer  
MRH

39. Dr Shuchita Gupta  
Technical Officer

40. Mr Ekkadu Rangarajan  
Programme Operations Officer  
FGL

41. Ms Pushpa Prabhu  
Executive Assistant  
GER

42. Ms Pooja Verma  
Executive Assistant  
CAH
Annexure III. Group photograph

Regional meeting to accelerate reduction in newborn and child mortality towards achieving SDG 2030 targets
15 - 17 October 2019, New Delhi, India
ANNEXURE V.
Country Action Plans

Newborn & Quality of care: Timelines for key actions

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<th>Activity</th>
<th>Bangladesh</th>
<th>Bhutan</th>
<th>India</th>
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<th>Myanmar</th>
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<th>Sri Lanka</th>
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Child Health: Timelines for key actions

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<th>Sri Lanka</th>
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<td>Adoption of global Pediatric standards and QI for Pediatric care</td>
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