GLOBAL HEALTH

NEWBORN LEGACY

Save the Children
100 YEARS

July 2019

OUR NEWBORN HEALTH LEGACY

ORIGINS OF THE GLOBAL NEWBORN HEALTH MOVEMENT

Prior to 2000, newborn health was nominally a part of maternal and child health (MCH) programs globally, including in Save the Children's MCH portfolio. Most MCH experts and governments considered reducing newborn mortality beyond the scope and resources of public health, assuming that this required advanced clinical interventions, largely neonatal intensive care. Dr. Abhay Bang at SEARCH in Gadchiroli, India challenged this perception with a study published in *The Lancet* in 1999. The study showed a 62% reduction in neonatal deaths by trained volunteer community health workers (CHWs) implementing home-based newborn care, including preventive care and simple management of common but life-threatening newborn complications (Bang et al. *The Lancet*, 1999). This evidence heralded new thinking that newborns could and should be included in global public health programs, given the large proportion of under-five deaths in the newborn period (just under 40% in 2000). Leading the emerging effort to finally address newborn mortality, **Save the Children (USA) proposed and received a $50 million award from the Bill & Melinda Gates Foundation (BMGF) in 2000 to establish a flagship newborn health program** of research, program learning, advocacy, and resource mobilization at global and country levels—***the Saving Newborn Lives (SNL) initiative***.

100 YEARS OF CHANGE FOR CHILDREN

Save the Children has long been on the leading edge of global progress for children. In commemoration of our 100-year anniversary in 2019, we looked back to capture our legacy in three key areas of global health where we have focused our efforts: **Community Health, Newborn Health, and Nutrition**. To do this, we reviewed and documented our impact on women, children and their communities through our global achievements, leadership roles, key contributions, and program learning and results. After a century of progress, our bold ambition for children is clearly within our sights, and we hope to leverage our learning and experience in these critical areas of global health over the past 20 years to continue the unfinished work that lies ahead.

SAVE THE CHILDREN'S ROLE IN THE NEWBORN HEALTH MOVEMENT

Over the ensuing 18 years, the catalytic successes of three successive phases of ***SNL*** **helped put newborn health solidly on the global policy agenda and led a concerted research movement to identify the burden and causes of newborn deaths**, and to greatly expand the evidence base of feasible, affordable interventions to save newborns. At country level, *SNL* introduced and enabled the prioritization of newborn health in policies, programs, and research in over 20 countries. Through *SNL*, Save the Children was the de facto leader in evidence generation and innovation, global and national newborn health policy advances, the establishment of global and country partnerships and networks, and leveraging new resources for newborn health research and program implementation.

Due to the strategic *SNL* initiative, Save the Children leveraged its newborn health expertise to introduce and expand newborn health policies and programs in many low- and middle-income countries (LMIC) with major funding support

from U.S. government and private sector donors. Since 2004, we have been the newborn health lead in the following USAID flagship maternal, newborn and child health (MNCH) programs:

- ***Access to Clinical and Community Maternal, Neonatal and Women's Health Services*** (*ACCESS*, 2005-2009);
- ***Maternal & Child Integrated Program*** (*MCHIP*, 2010-2014); and
- ***Maternal & Child Survival Program*** (*MCSP*, 2015-2019).

Together, these programs have reached over 30 LMICs. We also led/are currently leading newborn health components of large USAID bilateral awards in a number of LMICs (e.g., Bangladesh, Indonesia, Malawi, Mali, Nepal, and Pakistan).

Our Department of Global Health further expanded its newborn health reach utilizing our learning and expertise to leverage additional private funds from donors such as Johnson & Johnson and Comic Relief, for newborn health programs in six countries. Furthermore, we assumed a global leadership role focusing on newborn health innovation, specifically to reach the most vulnerable newborns and their families in humanitarian crisis settings and in urban slums. **Save the Children is currently a leading partner in the nascent global effort to include newborn health in humanitarian emergency health response and preparedness**, previously neglected in humanitarian emergency responses.

The remarkable progress in newborn health over the last 18 years is an excellent example of our theory of change in action. Save the Children has been *the voice* for newborns and stillborn babies. **The *innovations* developed and tested under our leadership have been widely incorporated into global and country policies and practices**. Save the Children's catalytic approach has enabled partners to come together to adopt and implement lifesaving interventions for newborns in many LMICs, including those with the highest burden of newborn deaths, and to bring many of these interventions to scale.

BUILDING GLOBAL ATTENTION AND MOBILIZING ACTION

In countries where Save the Children has focused on newborn health, we **deliberately forged a close collaboration with governments, development partners, UN agencies, donors, nongovernmental organizations, and other stakeholders** to spotlight newborn health. Similarly, we established close linkages with national professional associations and leading pediatricians, obstetricians/gynecologists, nurses and midwives, to bring attention and awareness to newborn health and the evidence-based interventions and program tools to save newborn and maternal lives and avert preventable stillbirths. Save the Children's approach has been to convene ministries of health, donors and other stakeholders to develop national newborn health strategies, guidelines and standards for newborn care, and core newborn health indicators. Such partnerships helped to galvanize and elevate national-level discourse around a common newborn health policy agenda.

Save the Children is **among the leaders in translating evidence into policies and programs, raising awareness and leveraging new commitments** by countries and partners to address newborn mortality. We were one of the leading voices formulating and disseminating newborn health messages that were the major themes of global and country discourse on newborn survival. These advocacy messages focused attention on the importance of newborn survival toward achieving the UN Millennium Development Goal 4 target. As newborn mortality declined more slowly than among children older than 28 days over the last few decades, the proportion of under-five deaths contributed by newborns steadily rose, with the most recent estimate at 46%.

Save the Children launched the Healthy Newborn Partnership in 2002, serving as convener and secretariat for global partners committed to improving newborn survival. In 2005, we played a key role in merging with the Partnership for Maternal and Child Health to become the Partnership for Maternal, Newborn & Child Health (PMNCH), and represented civil society organizations on the PMNCH Steering Committee.

We also co-led the seminal *The Lancet* 2005 neonatal series. This landmark series of articles captured international attention for newborn survival, and outlined evidence-based, cost-effective interventions that could be implemented in LMICs to reduce neonatal mortality.

In 2010, we **launched the first online network solely dedicated to improving newborn health globally: the Healthy Newborn Network (HNN)**. This knowledge platform allows partners to highlight newborn health research, resources, tools and blogs. Since its inception, HNN gained over 5,300 members and 150 partner organizations, publishing thousands of blogs, technical resources and tools, and news articles on newborn health. Save the Children utilizes multiple social media platforms linked to HNN to drive readership, serving as an adjunct source of breaking news, events, and information on newborn health.

Building on our successful advocacy leadership, almost 50 global agencies and partners came together to produce the breakthrough 2012 *Born too Soon* publication, **the first-ever global report on prematurity** that reached more than a billion people on social media. This report generated more than 30 pledges from governments, donors, UN agencies and other organizations to address the problem of prematurity through funding and programming. The global response and actions sparked by *Born too Soon* galvanized global leaders to develop the *Every Newborn Action Plan* (ENAP), which launched in 2014 at the World Health Assembly, with all participating countries as signatories. ENAP led global agencies to agree on and set targets based on the shared goals to end preventable child and maternal deaths by 2035. The Sustainable Development Goals (SDGs) include tracking neonatal mortality as a key metric of progress (Goal 3). By 2017, 75 countries were reporting annually on ENAP progress, and 44 countries had established national newborn plans or integrated ENAP content into their reproductive, maternal, newborn, and child health plans.

In 2013, Save the Children (via *SNL* and *MCHIP*) played a **leading role in organizing the first-ever global newborn health conference** in collaboration with the World Health Organization (WHO) and UNICEF. In 2015, we strengthened our global leadership in newborn health as co-organizer for the Global Maternal Newborn Health Conference in Mexico City. Both of these global meetings brought together researchers, policy makers, and health professionals from over 50 countries to share their experiences scaling up high-impact interventions addressing the leading causes of newborn and maternal deaths.

Our successful global advocacy for newborn health is the result of the strategic use of a number of pivotal moments and mechanisms to elevate the importance of newborn health, including the publication and dissemination of new evidence, participation at high-level events and annual advocacy days, links to global media, and the use of social media and champions. After almost two decades, we continue to be a global and country leader in advocacy for newborn health.

LEARNING FROM NEW EVIDENCE: SHIFTS IN NEWBORN HEALTH PRIORITIES AND LANDSCAPES

Over the nearly two decades of the newborn health movement, there have been a few noteworthy changes in the landscape based on new evidence, implementation learning, demographic trends, and health policies and systems. **Save the Children has been one of the leaders in generating much of the evidence and implementation learning in this dynamic environment.**

The early evidence to improve newborn survival was community-based newborn care, based on studies such as SEARCH (India) (Bang, *The Lancet*, 1999) and *SNL*-supported Projahnmo (Bangladesh) (Baqui, *The Lancet*, 2008). These studies led by *SNL* demonstrated significant reductions in neonatal mortality by empowering CHWs. These projects trained CHWs to conduct pregnancy surveillance, make home visits to pregnant women, attend home deliveries with traditional birth attendants (TBAs), and make postnatal home visits to counsel families on newborn care and to detect and manage suspected newborn infections. Large reductions in newborn mortality were observed when these packages were implemented, but this evidence was largely limited to research settings.

Save the Children supported several other studies in South Asia, with CHWs providing individual and group counselling, community mobilization, and pre- and post-natal home visits. Findings again demonstrated significant impact on newborn mortality, most notably where baseline neonatal mortality rate (NMR) exceeded 50 deaths per 1,000 live births and in settings where the vast majority of births occurred at home (Kumar et al., *The Lancet*, 2008). Concerns remained about whether these findings would hold up in non-research settings, in places with more facility deliveries and lower NMRs.

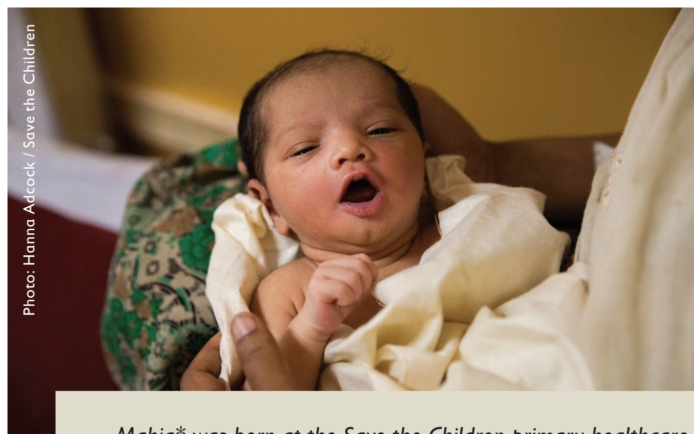
Photo: Hanna Adcock / Save the Children

Mahia was born at the Save the Children primary healthcare center in Cox's Bazar, Bangladesh. *Name changed.*

In response to these concerns, *SNL* undertook several new research trials of community-based newborn care packages, mostly in Africa. Almost all included CHW pregnancy surveillance, prenatal visits to counsel the pregnant women, postnatal visits to counsel the family and assess the newborn, and links to referral facilities for newborn complications. These trials—conducted in Ghana, Tanzania, South Africa, and Uganda—showed different results than the preceding South Asia studies: no significant impact on NMR, rapidly increasing trends of facility deliveries, lower than expected CHW postnatal home visit coverage, and relatively higher utilization of home-based newborn health practices (e.g., delayed bathing, clean instrument to cut cord) than the previous South Asian studies. These findings gave impetus to an emerging shift recognizing the limits of programs providing CHW home visits and suggesting the need to strengthen linkages to health facilities. **Save the Children pioneered the concept of "household-to-hospital continuum of care" (HHCC)** and successfully implemented this approach in a number of countries through both maternal and newborn health projects.

More recently, Save the Children led a multi-agency effort to assess program performance of CHW postnatal home visits for mothers and newborns in countries that scaled up this approach through existing program platforms. Case studies conducted in 12 countries in Asia and Africa examined the extent of coverage of CHW postnatal home visits, the country and programmatic contextual factors, and any adaptations and adjustments (McPherson and Hodgins, *Journal of Global Health*, 2018). The results demonstrated variable, but largely very low coverage of postnatal home visits—especially within two days of delivery—and suggested that countries should adapt their approach to fit the particular context. These findings were shared with WHO and implementation guidance was published by *SNL*, *MCSP*, and USAID to assist countries in program decision making and design (Hodgins, McPherson, and Kerber. *Postnatal Care, with a Focus on Home Visitation: A Design Decision-Aid for Policymakers and Program Managers*, 2018). Save the Children also assumed a leading role in the effort to strengthen the linkages of facilities with CHWs who conduct home visits after discharge. Implementation research is currently underway by *MCSP* in India to improve the quality of pre-discharge care (using a discharge checklist) for mothers and newborns, and to build and sustain closer links between families and CHWs for postnatal follow up.

As many LMICs rapidly shifted to more facility deliveries, evidence emerged that NMR and maternal mortality ratio (MMR) were not declining as expected, indicating that improvements in quality of care had not kept pace with the increased demand for and utilization of facilities. The 2014 *Every Newborn Action Plan* captured and highlighted the need to improve quality of care around the time of birth, noting the triple return on investment in care at the time of birth: reduced newborn deaths, reduced intrapartum stillbirths, and reduced maternal mortality.

Save the Children has contributed to global and country efforts to improve quality of facility-based care through initiatives such as Maternal Perinatal Death and Surveillance Reviews and projects providing innovative approaches to skill maintenance to deliver maternal and newborn interventions (e.g., mentoring, learning collaboratives, "low-dose, high-frequency" practice). **We have a long history of implementing programs in which communities participate in an accountability mechanism to ensure and improve facility-based quality of care as a key to increasing demand** for and utilization of facility-based care: Partnership Defined

Quality (PDQ). PDQ has been implemented—including at scale—in many countries by Save the Children through *ACCESS*, *MCHIP*, and *MCSP* programs.

WHO led a recent global focus on quality of maternal and newborn care in developing a Quality-Equity-Dignity (QED) framework to provide guidance to countries in setting up and strengthening quality of care efforts. We partnered with WHO globally in the development and launch of a QED Network, and provided technical support in a number of countries to introduce and sustain quality improvement in maternal and newborn health clinical care and programs.

KEY ACHIEVEMENTS IN INNOVATION TO PROGRAMMING AT SCALE

Save the Children has been at the forefront of innovation in newborn health over the past two decades. **Strategic investments in research and innovation, program learning, and identifying and finding solutions to implementation challenges have been the hallmarks of our newborn health leadership**. One indicator of Save the Children's remarkable leadership in innovation, learning, implementation, and scaling up is the extensive library of more than 350 peer-reviewed publications produced by *SNL* since 2000. The following examples illustrate our major achievements in newborn health innovation—demonstrating leadership in developing and testing innovative tools, approaches, and programming, conducting implementation research, and learning what is needed to scale up effective interventions.

Chlorhexidine (CHX) Cord Care

Photo: Siegfried Modola / Save the Children

A nurse shows a mother how to apply CHX on her 1-day-old baby's cord in Kenya.

Saving Newborn Lives **helped to generate the evidence base establishing the efficacy of CHX cord care as a lifesaving intervention in LMICs**. In Bangladesh, *SNL* supported research that demonstrated that CHX applied to the freshly cut umbilical cord on the day of birth significantly reduced all-cause neonatal mortality (El Arifeed et al. *The Lancet*, 2012). This evidence, along with similar studies from Nepal and Pakistan, provided the global evidence for WHO to recommend CHX as a lifesaving intervention in high NMR settings.

Save the Children has since been one of the global leaders to facilitate policy adoption, introduction, and implementation of CHX cord care, with successful adoption and implementation in nine countries. In Bangladesh, Ethiopia, Nepal, and Nigeria, we have been a key leader/partner and catalyst to effectively scale up CHX at national level. Save the Children also contributed technical expertise and leadership to the CHX Technical Working Group (TWG) convened by PATH and provided a platform on HNN for TWG technical documents and resources to assist many countries to introduce and implement CHX through a global community of practice.

Management of Possible Serious Bacterial Infection (PSBI)

In many LMICs, life-threatening newborn infections frequently lead to severe illness and death in a matter of hours or days. Lifesaving treatment at the hospital level, as recommended by WHO, requires multiple daily antibiotic injections for 10 to 14 days. This option is not available or feasible for many families in LMICs for a variety of reasons, such as distance and cost. Globally, **Save the Children partnered with WHO and USAID to find a solution that would enable safe and effective treatment of PSBI closer to home as a key strategy to reduce neonatal mortality from infection**.

Based on recommendations from a global expert consultation co-convened by *SNL*, Save the Children, WHO, and USAID set up three separate research trials: Simplified Antibiotic Therapy Trials (SATT) in Bangladesh and Pakistan, and African Neonatal Sepsis Trial (AFRINEST) in DRC, Kenya, and Nigeria. The *SNL* project supported both SATT studies and received additional funding for a common steering committee to standardize the research protocols and harmonize implementation across the three trials. The trials examined whether simplified antibiotic regimens (of 7, 4 or 2 antibiotic injections along with oral antibiotics) were equivalent to a standard 14-injection regimen. The results from these three studies confirmed that each simplified regimen worked as well as the standard regimen (African Neonatal Sepsis Trial group, Tshefu et al., *The Lancet*, 2015; Baqui et al., *The Lancet Global Health*, 2015; Mir et al., *The Lancet Global Health*, 2016). Based on these findings, WHO released new guidelines in 2015 for outpatient treatment of PSBI when hospitalization is not possible. To sensitize professional leaders and policy makers about the new evidence, which runs counter to conventional medical wisdom, **Save the Children collaborated with WHO, UNICEF, and USAID to develop and disseminate a Joint Statement on PSBI management** (WHO, 2016).

We furthered our technical leadership by undertaking implementation research in Bangladesh, Ethiopia, India, Malawi, Nigeria, and Pakistan to learn what it takes to deliver PSBI management services through existing public health systems. Based on the early implementation learning, we recently collaborated with WHO, UNICEF, and USAID to develop an implementation guide for countries to adopt policies, and to introduce, implement, and scale up PSBI management: *Operationalizing management of sick young infants with possible serious bacterial infection (PSBI) when referral is not feasible in the context of existing maternal, newborn, and child health programmes* (WHO, 2017).

Kangaroo Mother Care

Kangaroo Mother Care (KMC), first developed in Bogota in 1974 as a solution to the lack of incubators and overcrowded neonatal units, was promoted and marginally implemented in LMICs for years, and recently in high-income countries (HIC). KMC involves skin-to-skin contact between the mother and her small and/or preterm newborn, providing warmth, bonding, and exclusive breastfeeding. Despite experience and evidence showing the benefits of KMC—especially in low-resource settings—there has been limited uptake and sustained KMC programming in LMICs. Since the beginning of *SNL*, we recognized the potential of KMC as a simple, affordable intervention to save the lives of small and premature newborns. **Save the Children has been a leader at global and country levels to understand and help overcome common barriers to KMC use among health providers, mothers, and families**.

Photo: Siegfried Modola / Save the Children

A new mother uses Kangaroo Mother Care at the Bungoma County Referral Hospital, Kenya.

Malawi is probably the best example of our leadership in KMC. *SNL* led this effort, engaging the Ministry of Health and the local nursing school to implement KMC across the country, using locally adapted tools such as a new KMC implementation guide developed under technical leadership from Save the Children. Malawi thus became the first African country to widely implement KMC. Early lessons learned enabled us to expand implementation of KMC in a number of countries through the *ACCESS*, *MCHIP*, and *MCSP* programs. Critical lessons for successful and sustained implementation began with close engagement to build ownership and support of ministries of health, key professional leaders, and in a number of countries, "KMC champions." Yet KMC coverage in most countries and globally remained low and stagnant, even in the face of evidence showing—for the first time—the reduced mortality benefit in LMICs.

In 2014, the BMGF convened a global technical consultation and **the Kangaroo Acceleration Partnership (KAP) was established, with Save the Children as the leading partner and secretariat**. Through our collaboration with WHO, UNICEF, USAID, and BMGF, the KAP:

- enabled new research to identify barriers and enablers of KMC implementation;

- prioritized KMC indicators;
- spawned KMC innovation (e.g., KMC wrap, KMC space and furniture design);
- produced a Joint Statement endorsing KMC for all small babies with global professional societies (e.g., pediatrics, obstetrics, midwifery) as signatories; and
- developed a web-based community of practice to facilitate country learning and sharing of tools and implementation lessons.

When ongoing lessons from Malawi found KMC implementation to be weak and ineffective in many settings, *SNL* undertook a series of studies and activities to introduce and scale up sustainable quality improvement efforts, largely through a government-led clinical mentoring program that now serves as a model for other countries. **Save the Children's technical leadership, advocacy, and knowledge management have been a significant factor in the growing acceptance, endorsement, and utilization of KMC** in both HICs and LMICs. Through USAID- and private donor-supported projects, we continue to be a global leader in implementing and scaling up KMC best practices in 17 countries in Africa and Asia.

Essential Newborn Care via Global Development Alliances

Essential Newborn Care (ENC) is care at and after the time of birth needed by all newborns, regardless of where they are born and irrespective of their size and gestational age, including: thermal care (e.g., immediate skin-to-skin), hygiene and cord care, early and exclusive breastfeeding, and neonatal resuscitation for non-breathing newborns. However, many newborns—even those born in facilities—do not receive these essential interventions, putting their lives at risk.

WHO developed and endorsed tools, but widespread uptake and effective implementation of ENC has lagged in LMICs. The American Academy of Pediatrics led the development of simple, user-friendly training tools for frontline health providers to acquire and retain skills to provide all elements of ENC.

Save the Children was among the partners and experts contributing to the development and testing of these tools:

- Helping Babies Breathe (HBB), and
- Essential Care for Every Baby (ECEB).

We were also **one of five founding members of the HBB Global Development Alliance (GDA) and, subsequently, the Helping Babies Survive GDA**. HBB was introduced in more than 70 countries over several years, and many engaged in efforts to scale up nationally. Through *MCHIP*, *MCSP*, and the ***Johnson & Johnson-funded newborn health project***, Save the Children implemented HBB/HBS in more than 15 countries in Africa and Asia. We were among the global partners to document that HBB was poorly implemented in a number of countries due to lack of:

- integration with existing programs;
- attention to skill retention among providers;
- usable data in facility records and Health Management Information Systems (HMIS); and
- reliable procurement and logistics management systems to guarantee availability of functional equipment.

Not only did GDA partners develop modifications in HBB/HBS, but Save the Children also implemented corrective measures to address these gaps drawn from emerging evidence about skill retention and the importance of frequent practice and mentoring.

Field Guide for Newborn Health in Humanitarian Emergencies

In 2012, Save the Children convened a global meeting of humanitarian emergency agencies and newborn health experts **to consider how best to include newborn health interventions in humanitarian emergency response and preparedness**. The consultation recommended the development of key resources including a field

manual for newborn health and a kit of necessary equipment, medicine, and supplies for newborn health interventions in humanitarian emergencies.

Photo: Jonathan Hyams / Save the Children

Midwife Jeanne holds a newborn baby she delivered at Mahama Refugee Camp, Rwanda. Save the Children built, equipped, and staffed the maternity ward.

In collaboration with UNICEF and other partners, **we led the development of the field guide and kit and leveraged funds to field test these tools** in two humanitarian settings: South Sudan and Somalia. Field experience and results informed revisions, leading to its endorsement by multiple humanitarian partners including UNICEF, WHO, UNHCR, IAWG, and CDC. Save the Children continues to engage with global partners to ensure utilization of the newborn field guide in current and future humanitarian response efforts, as well as becoming institutionalized in emergency preparedness by humanitarian response agencies.

Other Examples of Innovation

Upright Resuscitator

As noted above (see Essential Newborn Care), neonatal resuscitation skills retention has been identified as a programmatic challenge. One of the key learnings of this global scale up effort was that skills in bag-and-mask ventilation declined significantly by about six months post-training. One innovative technical solution developed by Laerdal Global Health was a vertical rather than horizontal orientation of the bag and mask, the "upright resuscitator." Under the HBB GDA, PATH conducted user testing of the upright resuscitator with a sample of U.S. neonatologists and neonatal nurses, finding better performance of, and greater user preference for, the upright resuscitator, which is also one-third cheaper than the standard bag and mask. To assess whether this device would be easier to use by lesser skilled providers, **Save the Children conducted a comparison study of simulated resuscitation with skilled birth attendants** (SBAs) from primary health centers in rural India. The findings found much greater preference for the upright resuscitator over the standard bag and mask, especially among the SBAs with less resuscitation experience. The results of this study, coupled with similar findings from Tanzania, led to regulatory approval in Europe, inclusion of the upright resuscitator in Laerdal's trainer kit for neonatal resuscitation, and consideration of the upright resuscitator evidence by the International Liaison Committee on Resuscitation, a body which reviews resuscitation evidence and sets global standards.

Bubble Continuous Positive Airway Pressure

Bubble Continuous Positive Airway Pressure (bCPAP or Bubble CPAP) is a non-invasive, gentle method to deliver respiratory support to newborns with premature lung disease. While CPAP has been used in HICs for years, experience in LMICs is limited to a few studies that have shown potential for increased survival, but also potential for harm if not practiced and integrated with routine ENC. The 2015 *WHO recommendations on interventions to improve preterm birth outcomes* recommend CPAP for the treatment of preterm newborns with respiratory distress syndrome. With limited implementation experience in LMICs, **Save the Children assumed leadership to include bCPAP in several projects**. First, district hospitals piloted bCPAP in Indonesia as part of the ***USAID bilateral project Expanding Maternal and Newborn Survival (EMAS)***. Currently through *MCSP*, we are supporting selected secondary hospitals to incorporate bCPAP in their newborn health services in three Nigerian states: Kogi, Ebonyi, and Cross River. Through these efforts, **Save the Children contributes to the evidence base on how bCPAP can be effectively applied as an integrated component of care of the small and sick newborn**, providing evidence and experience to guide scale up efforts.

IMPROVING MEASUREMENT

As the focus on newborns increased within global health, so has the need to track progress related to the reach and quality of newborn-related interventions. Save the Children has promoted data use at global, national, subnational, facility, and community levels for decision-making to improve programs and policies aimed at newborns.

We are one of the leading agencies in developing, testing, and promoting newborn health metrics. The activities range from developing scale up readiness benchmarks to funding estimates and ensuring newborn indicators are included in routine HMIS monitoring. Through *SNL*, Save the Children funded the earlier rounds of estimates for neonatal cause of death, preterm birth, and stillbirths, successfully advocating for their institutionalization in existing global mechanisms. The newborn readiness benchmarks were developed and tested in nine countries, and we led the development of intervention-specific action sequences and indicators for KMC and PSBI.

In 2008, Save the Children established the Newborn Indicator TWG to improve the availability, quality, and consistent use of newborn health data. Since then, the TWG has coordinated inputs across partners to identify testing priorities and develop specific recommendations for household surveys (Multiple Indicator Cluster Survey (MICS) and Demographic and Health Surveys (DHS)), as well as health facility readiness surveys (Service Provision Assessment (SPA), Service Availability and Readiness Assessment (SARA), and Emergency Obstetric and Newborn Care (EmONC)). Since 2014, we have participated in the ENAP metrics working group to define indicators of impact, coverage, process, and readiness for incorporation at national and sub-national levels, and to develop a roadmap for improved measurement.

Save the Children has also played a key role in global measurement working groups since 2000. Our role on these groups is to ensure newborn content is included, analyzed, and interpreted for decision-making, and to ensure that global discussions reflect country level lessons. These global TWGs include: Countdown to 2015 (coverage, policy, equity); Countdown to 2030 (coverage, equity, drivers); MoNITOR (WHO expert advisory group on Maternal and Newborn Indicators for Tracking Outcomes and Results); ENAP/Ending Preventable Maternal Mortality (EPMM) metrics; and three of the four newborn-specific groups under the UN Commission on Life-Saving Commodities (UNCoLS).

In addition to the global-level measurement work, Save the Children advocates for the inclusion of newborn indicators in routine national HMIS. Each of our multi-country projects (*SNL*, *MCHIP,* and *MSCP*), have worked with ministries of health to ensure newborn data was captured and used for decision making.

LOOKING FORWARD—THE UNFINISHED AGENDA

While we celebrate the remarkable progress in newborn health and survival, Save the Children is cognizant of the unfinished newborn health agenda to which we remain committed. First, we recognize that no country has yet accomplished the goal of providing high-effective coverage of lifesaving newborn health interventions. This challenge is partly due to knowledge gaps in how to deliver timely, high-quality interventions, especially where health systems are weak. Most importantly, countries and donors must increase resource commitments to maternal and newborn health.

We have identified future newborn health priorities under the "unfinished agenda," namely improving newborn survival among the world's most vulnerable newborns and marginalized groups. Small and sick newborns, most of whom are premature, represent the most *vulnerable* group of newborns biologically, having the highest risk of newborn death and contributing the majority of the world's disabled children. Perhaps the greatest future challenge, however, is reaching the **most *marginalized* groups – those in humanitarian emergencies and in urban slums**. Newborns, as the most vulnerable citizens, are especially at risk in these settings where health systems are fragile or even non-existent.

Complications of Prematurity

Complications of prematurity now account for 18% of under-five deaths. Managing these complications to improve preterm survival is a pillar of Save the Children's work, and we will continue to implement evidence-based interventions which provide additional survival benefits and are feasible and effective in low-resource settings, such as KMC, facility-based antenatal corticosteroids for women with threatened preterm delivery, and CPAP for respiratory distress syndrome.

Newborn Health in Conflict and Emergencies

Save the Children is working on tailored intervention packages recommended for greater effectiveness in humanitarian and fragile contexts post-conflict, which require development and humanitarian communities to work together. Women and newborns are particularly vulnerable in these settings; WHO estimates suggest that over half of maternal and children under 5 deaths occur in areas of conflict or disaster.

Newborn Health in Urban Settings

More than one billion people live in slums or informal settlements, and this population is increasing rapidly. Migration (between countries, within countries, and within and between slums) has significant impact on social cohesion, knowledge of services, and the power dynamics of the communities. These communities are often invisible and uncounted due to a lack of legal recognition and rejection by governments of their rights to live in those areas. Health service coverage reports for urban areas often provide urban averages that ignore the lack of service coverage or burden of disease among the urban poor, and that can be worse than rural averages in many instances.

Though the world is rapidly urbanizing, the health of the urban poor remains a neglected topic. Save the Children recognizes that addressing the needs of these populations is critical to the global goal of ending preventable deaths among women, newborns, and children by 2030. As we move into a new strategy period with a renewed emphasis on reaching the most deprived, Save the Children has committed to expanding its work to help ensure that urban poor families have access to and use high-impact, affordable health services and practices.

KEY ACHIEVEMENTS IN NEWBORN HEALTH

The impact of Save the Children's work in newborn health can be seen at all levels—from individual communities to national policies and programs to commitments and investments by global leaders. **The cornerstones of our successful global leadership in newborn health include**:

- advocacy to raise awareness about the burden of newborn deaths;
- evidence generation about what works to save newborn lives and how; and
- development and promotion of robust metrics to track progress in effective coverage and impact of key interventions.

Over the last two decades, Save the Children has worked in more than 30 countries to advance newborn health. The success stories are too numerous to recount. Nonetheless, **a few countries stand out for the remarkable progress achieved, largely due to our leadership: Bangladesh, Ethiopia, Malawi, and Nepal**. In each of these countries, we have been the leading partner to help develop national strategies and policies to improve newborn survival, conduct research on innovations and implementation approaches, implement high-impact newborn health interventions through existing programs, promote behavior change and care seeking, and incorporate newborn health indicators into routine monitoring systems.

The transformative global and country leadership of Save the Children in newborn health continues, as we further strengthen and expand upon the achievements to date. Notably, newborn health is embraced as a priority by our global movement with the recent endorsement of the movement-wide Saving Newborn Lives approach. Through this recent global commitment, we are positioned to continue and build upon a remarkable legacy of newborn health leadership.

Save the Children believes every child deserves a future. In the United States and around the world, we work every day to give children a healthy start in life, the opportunity to learn and protection from harm. When crisis strikes, and children are most vulnerable, we are always among the first to respond and the last to leave. We ensure children's unique needs are met and their voices are heard. We deliver lasting results for millions of children, including those hardest to reach. We do whatever it takes for children – every day and in times of crisis – transforming their lives and the future we share.

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