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REGIONAL STRATEGY AND PLAN OF ACTION FOR NEONATAL HEALTH WITHIN THE CONTINUUM OF MATERNAL, NEWBORN, AND CHILD CARE

Introduction

1. Over the past 10 years, the Latin America and Caribbean region (LAC) has made great strides in reducing post-neonatal mortality (in infants and children under 5); however, neonatal mortality has not fallen at the same pace.

2. LAC is a region characterized by wide disparities in health indicators among the countries and enormous inequities within them.

3. Most of the countries of this Region need to accelerate the reduction of neonatal mortality to achieve the Millennium Development Goals aimed at reducing child mortality.

4. Simple, inexpensive, high-impact interventions based on sound scientific evidence are now available that could improve neonatal health, even in the poorest areas. Unfortunately, these interventions have not yet reached those who need them the most.

5. In response to this problem, the Pan American Health Organization has launched and served as coordinator for a consultative process that, together with partner organizations and representatives from almost every country in the Region, has studied the neonatal health situation in the Region and proposed intervention alternatives. One product of this highly participatory process is the publication *Reducing Neonatal Mortality and Morbidity in Latin America and The Caribbean: An Interagency Strategic Consensus* (PAHO/UNICEF/USAID/ACCESS/BASICS/CORE/Save the Children), which has served as the basis for this Strategy and Plan of Action on Neonatal Health within the Continuum of Maternal, Newborn, and Child Care 2008-2015.

6. The purpose of this document is to provide technical, operational, and strategic inputs that will support the development and execution of operating plans at the country level, in response to Resolution CD47.R19, Neonatal Health in the Context of Maternal, Newborn, and Child Health for the Attainment of the Development Goals of the United Nations Millennium Declaration in 2006.

Global Mandates and Initiatives

7. The launch of the *Millennium Development Goals* (United Nations, 2000), which are the health and human development goals to be achieved by the year 2015, is probably the most important social initiative in the history of humanity. All the member nations of the United Nations, among them the governments of Latin American and the Caribbean, have made a formal commitment to achieving the eight interconnected, synergistic Goals, half of which are directly or indirectly related to different aspects of public health. Goal 4 commits the international community to reducing mortality in children under 5 by two-thirds between 1990 and 2015 (United Nations, 2000).

8. The April 2005 *Delhi Declaration on Maternal, Newborn, and Child Health*, issues a call to action, urging the countries to take steps to save the lives of mothers, newborns, and children. To this end, it recommends that the countries focus their development plans and national budgets on achieving the Millennium Development Goals linked to maternal and child health, and that multilateral organizations, bilateral partners, international foundations, and nongovernmental organizations collaborate with the countries.

9. On 12 September 2005 the global *Partnership for Maternal, Newborn, & Child Health* was launched. This partnership reflects the growing world interest and attention to this issue. Its objective is to harmonize and intensify national, regional, and global activities geared to the achievement of the Millennium Development Goals linked to maternal, newborn, and child health.

10. At the regional level, in April 2005 the Latin America and Caribbean Newborn Health Alliance was formed during a workshop held in Washington, D.C. as part of World Health Day. On that occasion, representatives from the ministries of health of 16 countries explored the different actions to improve perinatal and neonatal health.

REGIONAL STRATEGIES

PAHO/WHO has developed several key strategies, launched a diverse of initiatives, and adopted a number of resolutions through its respective Governing Bodies, among them:

- Resolution CSP26.R13, Regional Strategy for Maternal Mortality and Morbidity Reduction (2002);
- Resolution CD45.R3, Millennium Development Goals and Health Targets (2004);
- Resolution WHA58.31, Working towards Universal Coverage of Maternal, Newborn, and Child Health Interventions (2005);
- Resolution CD46.R16, PAHO Gender Equality Policy (2005);
- Resolution CD47.R19, Neonatal Health in the Context of Maternal, Newborn, and Child Health for the Attainment of the Development Goals of the United Nations Millennium Declaration (2006);
- Resolution CE138.R2 Regional Strategy and Plan of Action on Nutrition in Health and Development (2006);
- In 1970, the Latin American Center for Perinatology, currently linked to the Women and Reproductive Health Unit (CLAP/SWR) was created to direct technical cooperation to the Latin American countries and develop appropriate technologies for improving perinatal care.

Analysis of the Situation in Latin America and the Caribbean

Magnitude of the neonatal problem

11. Each year in LAC, more than 190,000 babies die in the first 28 days of life. The average regional neonatal mortality rate is 14.3 per 1,000 live births (OPS, 2007). This average conceals the enormous disparities between countries, with rates ranging from 9.7 per 1,000 live births in the Southern Cone to 18.3 in the Latin Caribbean. Furthermore, average perinatal mortality is 21.3 per 1,000 live births. Neonatal mortality accounts for over 60% of infant mortality and nearly 40% of mortality in children under 5.

Causes of neonatal mortality

12. Like many public health problems, neonatal mortality is the most obvious consequence of other underlying causes, many of them structural, that reflect the poverty and inequity in society.

13. The primary direct causes of neonatal mortality in LAC are infections and perinatal asphyxia. Low birthweight, while not considered a direct cause of neonatal mortality, is a significant predisposing factor. Infections, asphyxia, and low birthweight are preventable. An estimated 9% of newborns in LAC suffer from low birthweight, but they account for some 60% to 80% of neonatal mortality.

14. The underlying causes of neonatal mortality are varied, and as mentioned earlier, reflect social inequities, such as women's position in society, access to formal education and health education, access to health services, and care practices. Poverty and education probably have the most influence on neonatal mortality and social determinants. For example, in Latin America and the Caribbean, 50% fewer births are attended by skilled personnel in the poorest quintile of the population than in the wealthiest quintile (Banco Mundial, 2007). Moreover, in the Region of the Americas, neonatal mortality in countries with high percentages of mothers without an education is four times higher than in countries where mothers have more schooling (OPS, 2007).

15. Rural and poor urban populations, marginalized communities, and indigenous and Afro-descendent populations also have very high neonatal mortality rates compared with those of other population groups.

16. In general, newborn survival and health have not received sufficient attention in communities or the health system. Fetal and neonatal deaths are still practically invisible, occur in the home, and often are not included in the official statistics.

Interventions in the Latin America and Caribbean Region

17. To a greater or lesser degree, the countries of the region have been adopting a series of health sector interventions directly or indirectly aimed at improving the health of newborns and reducing neonatal mortality.

Wider coverage

18. With a view to reducing and even eliminating the financial, cultural, and structural barriers that impede access to the health services, chiefly by the neediest population groups, some countries have adopted health sector reform processes to provide public insurance that promotes universal access to equitable, good quality maternal and child services.

19. Some of these processes focus on family health, as in the case of Brazil; others are unfolding within the framework of universal public insurance or programs that offer free maternity services, as in Bolivia, Ecuador, and Haiti.

20. In Bolivia, the Dominican Republic, Ecuador, Guatemala, Honduras, Nicaragua, Paraguay, and Peru maternal care programs are being strengthened with the neonatal component.

Care and access to skilled care in childbirth

21. Although 80% of births in LAC occur in health facilities, the quality of the care provided is often less than optimal.

22. In rural areas, geographical and cultural barriers pose obstacles to care during labor and delivery in health facilities and there are serious deficiencies in terms of access to skilled birth attendants, basic supplies, and functioning equipment compared to urban areas. Moreover, the referral network is generally inoperative. A high proportion of births in rural areas are attended by midwives who lack the proper training to attend normal births and the basic equipment and supplies necessary.

23. The highest proportion of home births is found in Bolivia, Guatemala, and Haiti; these births are usually attended by a traditional midwife, a family member, or an unskilled person, resulting in high maternal and neonatal mortality.

Integrated Management of Childhood Illness Strategy (IMCI)

24. The IMCI strategy includes a strong prevention and promotion approach in addition to the management of prevalent childhood illness. IMCI is designed to bolster the competencies of health workers through its clinical component, improve the care of children in the family and community through its community component, and strengthen the health systems.

25. The majority of the countries have implemented it to one degree or another, with some variations, since 1996. The countries that work with IMCI integrated the neonatal component in 2003,[1] and some have made efforts to integrate interventions with maternal health, thus contributing to an integrated maternal-neonatal-child approach. In many cases, IMCI has contributed to the training of hospital personnel in advanced neonatal resuscitation, employing the standards of the American Academy of Pediatrics. IMCI's neonatal component is critical for reducing the most hard-core fraction of infant and under-5 mortality.

26. The community component of IMCI, adopted since 2000 in countries such as Bolivia, Colombia, the Dominican Republic, Paraguay, and Peru has shown its potential

[1] Bolivia, Colombia, the Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Nicaragua, Panama, Paraguay, and Peru.

as a powerful tool for mobilizing society to improve child health, promoting the involvement and empowerment of the social actors that live and work in the community.

Vaccination

27. Vaccination has made a major contribution to the reduction of neonatal and infant mortality throughout Latin America and the Caribbean. Vaccinating mothers has been key to reducing neonatal tetanus, and universal rubella vaccination has helped to lower the prevalence of congenital rubella syndrome.

Micronutrients

28. Micronutrient deficiencies are common in women of childbearing age. At the start of pregnancy, many women have inadequate micronutrient reserves and display other signs of deficiencies that can seriously affect their health and that of their babies. According to WHO, 43% of women aged 15 to 49 in the developing countries suffer from anemia in pregnancy, a condition recognized as a risk factor for maternal mortality, low birthweight, and prematurity. It has been shown that clamping the umbilical cord at three minutes or more increases iron reserves and reduces anemia during the first six months of breast-feeding (Hutton EK, Hassan ES, JAMA 2007). Lack of folic acid during the preconception period heightens the risk of neural tube defects.

Breast-feeding

29. Beginning exclusive breast-feeding in the first hour of life is fundamental to survival in the neonatal period and the first years of life. In Latin America and the Caribbean, it is estimated that 66% of the deaths from diarrhea and acute respiratory infections in the first three months of life could be prevented by exclusive breast-feeding (Betran AP et al. BMJ 2001).

30. Although it is currently estimated that 90% of mothers in Latin America and the Caribbean breast-feed their newborns, fewer than one-third of them do so exclusively for the first six months. Moreover, giving babies other fluids is a common practice in the region that can prove highly detrimental. It has been shown that essential interventions, such as keeping the mother and baby together after delivery, skin-to-skin contact, and beginning breast-feeding in the first hour of life foster exclusive breast-feeding and its maintenance.

Prevention of Mother-to-Child Transmission of HIV

31. Since the early 1990s, the HIV epidemic has been a threat to infant survival, due chiefly to vertical transmission of the infection from mother to newborn. In Latin America and the Caribbean, some 49,000 children have been infected through vertical

transmission (OPS, 2007). Without effective medical interventions, at least one-third of the children born of HIV+ mothers will contract the virus, and most will die before their fifth birthday.

The Maternal-Newborn-Child Care Continuum Approach

32. The justification for adopting a strategy that covers the continuum of care is based on the close link between health and the well-being of families, women, newborns, children, and adolescents. The goal of addressing this continuum is to guarantee the availability of and access to evidence-based interventions that will make it possible to improve the health of mothers, newborns, and children.

33. This approach has at least three different dimensions with profound implications for the way in which policies, programs, and interventions are organized and executed. First, it means that care must be provided throughout the life cycle, which includes adolescence, the preconception period, pregnancy, delivery, and childhood, thereby taking advantage of natural interactions. Second, it indicates that care must be provided through a process that preserves absolute continuity and encompasses the home, community, health center, and hospital. Finally, the continuum of care also implies interventions in health promotion, disease prevention and control, treatment, rehabilitation, and reintegration into society.

Plan of Action

34. The Regional Strategic Plan of Action is based on the Interagency Strategic Consensus on Reducing Neonatal Mortality and Morbidity in Latin America and the Caribbean. Reflecting the commitment by the governments of the region for the eight-year period 2008-2015, its activities are geared to responding to that commitment, based on the following vision:

35. All mothers, newborns, and children in Latin America and the Caribbean shall receive the appropriate, effective, quality care that they need to live healthy and productive lives, thus making MDG-4 a reality.

General Objective

Support the countries of the Region in achieving Millennium Development Goal-4, emphasizing interventions to promote peri-neonatal health

Strategic Areas

36. This Plan of Action covers four interdependent strategic areas: 1) create an enabling environment for the promotion of peri-neonatal health; 2) strengthen health

systems to improve access to maternal, newborn, and child health services; 3) promote community-based interventions; and 4) develop and strengthen monitoring and evaluation systems. Each area has one or more lines of action, and each line of action has an objective that represents an expected result, with specific activities at the regional and national level.

Strategic Area 1. Create an enabling environment for the promotion of peri-neonatal health.

37. Ensuring better conditions for adapting, implementing, disseminating, and developing the neonatal health strategy will require Member States to take responsibility for creating conditions that will promote national plans to foster the creation of an enabling environment for the promotion of peri-neonatal health.

Line of action 1.1	***Promote the development of national plan to improve peri-neonatal health.***
Objective	By 2010, all priority impact countries (1) in Latin America and the Caribbean will have a national strategic plan in place.
Activities at the regional level	▪ Disseminate and promote the regional plan approved by the Governing Bodies ▪ Update the analysis of the maternal, newborn, child health situation in the countries of the region. ▪ Develop a regional advocacy strategy to promote neonatal health within the framework of the continuum of care
Activities at the national level	▪ Develop national plans to promote peri-neonatal health ▪ Adapt the advocacy strategy for promoting peri-neonatal health to the national level. ▪ Update the national analysis of the maternal, newborn, child health situation ▪ Review the legal framework governing the protection and rights of mothers and children (Priority impact countries: Bolivia, Brazil, the Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Nicaragua, Paraguay, and Peru.)
Line of Action 1.2	***Create and strengthen alliances and partnerships***
Objective	By 2010, the priority impact countries in Latin America and the Caribbean will have entered into partnerships with organizations that support implementation of the national plans.
Activities at the regional	▪ Strengthen the Latin American and Caribbean Newborn Health

level	Alliance to develop a joint work plan to support the initiative ▪ Share instruments and experiences through newsletters or other media ▪ Promote South-South cooperation
Activities at the national level	▪ Identify potential partners and social actors who can join the alliance to support implementation of the joint plan ▪ Develop and execute the joint work plan with institutions that support the regional plan

Strategic Area 2. Strengthen health systems to improve access to maternal, newborn, and child health services

38. Pregnancy and birth are part of a normal physiological process in which complications may occur. The health system must be prepared to address these needs, improving the quality of care at the different levels of the system, along with access, and promoting evidence-based practices.

Line of action 2.1	***Promote universal equitable access to maternal and neonatal care, giving priority to vulnerable groups***
Objective	By 2012, the priority countries will have achieved at least 80% coverage in terms of skilled care in childbirth
Activities at the regional level	▪ Provide technical assistance in the use of program instruments for delivering essential neonatal care in health facilities and communities; these instruments should include cost estimates. ▪ Develop, draft, and promote proposals that support interculturalism and good treatment ▪ Facilitate the sharing of experiences among countries that have developed insurance models for maternal and neonatal care
Activities at the national level	▪ Explore the various alternatives for financing universal access to maternal and neonatal health care, considering cost analysis ▪ Improve and promote good treatment and the intercultural approach in maternal and neonatal services ▪ Strengthen the referral and counter-referral system. ▪ Increase social network participation in financing the referral and counter-referral system

Line of action 2.2	***Update, disseminate, and implement maternal and neonatal health care interventions***
Objective	By 2009, all priority impact countries will be implementing evidence-based neonatal care standards and procedures as part of the continuum of care.
Activities at the regional level	▪ Develop and disseminate generic standards that can be adapted nationally and at the different levels of care. ▪ Facilitate adaptation at the country level ▪ Promote the sharing of experiences among countries
Activities at the national level	▪ Adapt and apply generic standards to the national situation ▪ Upgrade the competencies of human resources in health institutions and the community ▪ Strengthen the contents of undergraduate and graduate programs in institutions that train human resources for health ▪ Surveillance and monitoring of the standards application by level of care ▪ Guarantee the supply and distribution of drugs, equipment, and basic inputs for maternal and neonatal care ▪ Promote local application of the continuum of care

Strategic Area 3. Promote community-based interventions

39. Based on the international resolutions, evidence, and the lessons learned in the Region, the Latin American and Caribbean Newborn Health Alliance recommended the promotion of community interventions as an integral part of the regional strategy and plan of action in neonatal health. The main goal of this strategic area is to expand health care coverage for mothers and newborns through community-based interventions that have had a positive impact on maternal and neonatal mortality, especially in areas with limited access.

Health practices that can be promoted in the community

- Proper nutrition for mothers
- Immunization against tetanus
- Essential neonatal care, including a clean and safe birth
- Early recognition of danger signs and immediate transport
- Exclusive breast-feeding
- Safe sex
- A safe and clean environment
- Protection against violence
- Prevention of early pregnancy
- Education of girls

40. The interventions to improve family and community practices have had a real impact on neonatal health and development; they should therefore be given high priority. Families need knowledge and support to provide effective care to newborns in their home—for example, temperature control, early and exclusive breast-feeding, good hygiene, and use of the health services for immunization. They must also be able to recognize the signs of disease and be able to quickly take the newborn to an appropriate health facility.

Line of action 3.1	***Promote community interventions in national health plans to improve neonatal health***
Objective	• By 2010, the priority impact countries will have added instruments to their national program to improve the skills of community health workers and other social actors so that they can support health programs for mothers and newborns in the framework of the continuum of care.
Activities at the regional level	▪ Develop and distribute instruments to improve the skills of community workers and other social actors ▪ Technical support for the design and implementation of community-based interventions in health plans
Activities at the national level	▪ Adapt and use the instruments for improving the skills of community workers and other social actors to promote maternal and neonatal health ▪ Identify mechanisms that will strengthen ties between the community and health facilities ▪ Guarantee the quality, supervision, and monitoring of support, emphasizing good communication and negotiating skills ▪ Put basic measures in place in the home and community when referral is not an option
Line of action 3.2	***Community mobilization and communication strategies to promote healthy behaviors***
Objective	• By 2010, the priority impact countries will have implemented communication and social mobilization strategies.
Activities at the regional level	▪ Prepare guidelines for developing communication and social mobilization strategies that will promote healthy behaviors
Activities at the national level	▪ Adapt and implement the strategies for communication, social mobilization, and behavioral change ▪ Explore the most efficient dissemination modalities

- Promote the creation of networks of local/municipal maternal-neonatal health committees
- Identify mechanisms to strengthen the ties between communities and health facilities
- Promote intersectoral activities (e.g., education)
- Promote community analysis of the maternal-neonatal health information available at the local level to improve interventions

Strategic Area 4. Develop and strengthen monitoring and evaluation systems.

41. In the Region, the lack of quality peri-neonatal information and standardization is a problem, as is the lack of analysis and its use in decision-making. CLAP/SMR has collaborated with the ministries of health, high officials, and health professionals in several Latin American and Caribbean countries to create and promote perinatal clinical record-keeping and the perinatal information system as one of the key tools for maternal and perinatal health.

42. It is essential to oversee and monitor the performance of health workers and other human resources to guarantee compliance with basic standards of quality and improve competencies. Bolivia has conducted these neonatal IMCI monitoring activities in health services, a practice that is expected to be replicated in other countries of the region.

43. In order to improve perinatal and neonatal health information, WHO has devised a methodology for creating the country profile that can be used in developing a baseline.

Line of action 4.1	***Strengthen health information systems, with emphasis on maternal and peri-neonatal health***
Objective	By 2010, all the countries will have information systems that generate quality information on maternal and peri-neonatal health
Activities at the regional level	▪ Reach agreement on a standardized list of basic indicators for monitoring and comparison purposes; the list should include the identification of gaps and inequities, with evaluations 2010-2015 ▪ Provide technical support to the countries to strengthen their regular health information systems, prioritizing the indicators linked with MDG-4 ▪ Technical assistance to strengthen the Perinatal Health Information System
Activities at the national level	▪ Systematically integrate basic maternal and peri-neonatal health information into regular systems ▪ Improve the capture and quality of death records in civil registries and other information sources

	▪ Promote peri-neonatal morbidity and mortality surveillance initiatives
Line of action 4.2	***Create and strengthen health worker surveillance, monitoring, and performance evaluation systems within the framework of the continuum of care***
Objective	By 2010 the priority impact countries will have implemented health worker performance monitoring systems
Activities at the regional level	▪ Develop health worker quality performance indicators ▪ Develop and disseminate guidelines for developing baselines and conducting impact assessments within the framework of the continuum of care ▪ Provide technical cooperation for regional adaptation and dissemination of the neonatal IMCI surveillance and monitoring proposal within the framework of the continuum of care ▪ Promote the integration of neonatal and perinatal variables in national demographic and health surveys
Activities at the national level	▪ Implement quality of care indicators for health work performance ▪ Adapt the generic guidelines for neonatal monitoring and evaluation ▪ Systematic application of the neonatal IMCI monitoring and follow-up methodology ▪ Administer baseline and evaluation surveys in the sites with the greatest information deficits ▪ Encourage operations research

44. Pursuant to the resolution of the 47th Directing Council of PAHO, the following table proposes a series of differentiated activities to respond to different situations among and within the countries, together with a series of process, results, and impact indicators

Table 1. Proposed activities for addressing different situations based on mortality profiles

	Neonatal mortality of 20 or more *	Neonatal mortality of 15 to 19 *	Neonatal mortality of < 15 *
Principles	▪ Strengthen community outreach activities ▪ Increase skilled prenatal, delivery and postpartum care coverage for mothers and newborns ▪ Improve the quality of care in health facilities, respecting interculturalism ▪ Intensely promote essential care for newborns and the identification of danger signs	▪ Provide universal outreach and family and community care services, as well as skilled care ▪ Improve the care provided in facilities from the first referral on.	▪ Guarantee equity ▪ Promote quality ▪ Monitor and improve long-term results in the event of neonatal complications
Advocacy	▪ Develop specific neonatal care policies ▪ Devise financing mechanisms to protect the most vulnerable groups ▪ Distribute manuals and standards to all levels of care	▪ Develop specific neonatal care policies ▪ Distribute manuals and standards to all levels of care	▪ Develop specific neonatal care policies ▪ Distribute manuals and standards to all levels of care
Expansion of coverage	▪ Improve prenatal care (increase coverage, introduce standards of care, increase the availability of basic supplies) ▪ Improve early postnatal care	▪ Achieve full coverage and ensure that prenatal care is provided to populations that ordinarily do not receive this type of care ▪ Consider the possibility of introducing additional prenatal care interventions	▪ Provide care in facilities located near the patient ▪ Ensure the continuity of staff

	Neonatal mortality of 20 or more *	Neonatal mortality of 15 to 19 *	Neonatal mortality of < 15 *
Family and community	▪ Continue promoting the demand for care ▪ Improve family and community care ▪ Identify specific behavioral goals (e.g. increase exclusive breast-feeding up to 6 months) ▪ Consider community-based treatment for some specific problems of the newborn.	▪ Continue fostering healthy behaviors in the home, along with care-seeking.	▪ Create community criteria for combating harmful habits such as smoking and drug abuse.
Health services	▪ Increase the availability of care from skilled personnel ▪ Guarantee emergency obstetric and neonatal care in health facilities ▪ Set up comprehensive, good quality obstetric and neonatal health services in referral hospitals ▪ Improve the referral system and the links between communities and facilities ▪ Guarantee surveillance, monitoring, and evaluation	▪ Achieve universal coverage with skilled personnel, targeting populations that do not ordinarily receive these services ▪ Guarantee emergency obstetric and neonatal care in health facilities ▪ Improve the quality and cultural acceptability of obstetric and perinatal care. ▪ Establish comprehensive, good quality obstetric and neonatal health care in referral hospitals ▪ Guarantee surveillance, monitoring, and evaluation	▪ Achieve universal clinical care coverage, including neonatal intensive care ▪ Eliminate inequities ▪ Improve the quality of clinical care and promote good care for the whole family.

Table 2. Suggested indicators

Process	Results	Impact
• Number of staff trained in essential neonatal care • Number of staff trained in basic neonatal	• Percentage of maternal and child services that employ neonatal IMCI • Percentage of staff in	• Perinatal mortality rate per 1,000 live births • Fetal mortality rate per 1,000 live births

resuscitation • Percentage of maternal and child services with neonatal care standards or protocols • Percentage of maternal and child services with a referral and counter-referral system in place • Percentage of maternal and child services with a peri-neonatal information system in place • Percentage of maternal and child services with a surveillance, monitoring, and evaluation system in place • Percentage of maternal and child services with an information, education, and communication system (IEC) in place • Number of neonatal medical audits performed	maternal and child services that correctly administer essential neonatal care • Percentage of staff in maternal and child services that know at least 5 neonatal danger signs • Percentage of maternal and child services that have expanded their neonatal care coverage • Percentage of institutional births • Percentage of births attended by skilled personnel • Percentage of pregnancies with four or more prenatal check-ups • Percentage of newborns breast-fed within the first hour of life • Percentage of babies that receive post-natal care by the third day • Number of hospitals certified as mother- and baby-friendly • Number of communities that have a maternal-neonatal transportation plan in place	• Hospital mortality from neonatal causes • Early neonatal mortality rate (0-6 days) per 1,000 live births • Post-neonatal mortality rate (7-28 days) per 1,000 live births • Neonatal mortality rate (0-28 days) per 1,000 live births • Neonatal mortality by • Neonatal mortality due to low birthweight • Neonatal mortality due to gestational age • Prevalence of low birthweight

Role of the Pan American Health Organization

45. The Pan American Health Organization (PAHO) has served as a catalyst for securing technical and financial resources to strengthen the 11 Essential Public Health Functions (EPHF) in the Latin American and Caribbean countries (OMS/OPS, 2000; Múnoz F et al., 2000). Strengthening these functions can prevent mortality in newborns but requires the participation of external and internal actors through interprogrammatic efforts that employ a multisectoral approach.

46. Each strategic area of this Plan has one or more lines of action, thereby promoting an integrated, comprehensive methodology for managing the health of mothers, newborns, and children. In order to respond to new challenges and address the unfinished agenda in child health, the strategy also considers the PAHO technical cooperation framework.

47. In this context, the technical capacity of the Representative Offices must reflect the needs and priorities set for maternal, newborn, and child health. PAHO technical support to the countries will center on the health sector's response to maternal and neonatal care and will pay special attention to the training and upgrading of human resources and the development and adaptation of standards, guidelines, methodologies, and tools, along with the dissemination of information, including that on evidence-based interventions and best practices in care. It is equally important to strengthen the country's existing cooperation mechanisms and technical cooperation among countries. These technical cooperation mechanisms must guarantee real visibility for neonatal problems within the continuum of care and result in the mobilization of political, social, and economic support.

Partners

48. For years, interventions for improving maternal and child health have focused only on this issue and, thus, have ignored important links. Today it is recognized that neonatal health is the basic link between maternal, newborn, and child health programs. Linking interventions can lead to a substantial reduction in costs and improve the efficiency and effectiveness of program planning, monitoring, and supervision, as well as training and resource use.

49. No country, agency, or organization can tackle the entire problem of neonatal, perinatal, and maternal mortality on its own. Thus, joining forces will facilitate the creation of a continuum of care and an environment that facilitates achievement of the Millennium Development Goals in maternal and child health. The main partners will be multilateral and bilateral organizations, donors, the private sector, scientific and academic institutions, nongovernmental organizations, faith-based organizations, and civil society.

50. Consequently, this document is a call for a multisectoral interagency agreement on the technical program and policies that we should promote in Latin America in the area of neonatal health within the framework of the continuum of care. An effective partnership is critical for harmonizing and intensifying the measures adopted at the global, regional, national, and local levels to achieve Millennium Development Goals 4 and 5.

Action by the Directing Council

51. The Directing Council is invited to consider the proposed resolution adopted by the 142nd Session of the Executive Committee (Resolution CE142.R10, see Annex F).

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Annexes

Neonatal and maternal mortality rates, births attended by skilled personnel, and percentage of low birthweight newborns in countries of the Region of the Americas

Country	Neonatal mortality rate (x 1,000 lb) [a]	Perinatal mortality rate (x 1,000 lb) [b]	Maternal mortality ratio (x 100,000 lb) [a,c,d]	Percentage of births attended by skilled personnel [e]	Percentage of newborns with low birthweight (<2,500 g) [a]
Scenario 1: Neonatal mortality rate of 20 or more					
Haiti	34	54	630.0	23.8	21.0
Bolivia	27	31	230.0	60.8	7.0
Guyana	25	40	161.2	85.6	12.6
Scenario 2: Neonatal mortality rate of between 15 and 19					
Dominican Republic	19	28	80.0	98.7	10.8
Guatemala	19	23	148.8	41.4	6.8
Belize	18	20	68.4	83.8	14.1
Suriname	18	30	110.0	84.5	11.4
Honduras	18	28	108.0	55.7	10.0
Nicaragua	18	23	86.5	66.9	8.4
El Salvador	17	26	71.2	69.4	8.0
Ecuador	16	20	85.0	68.7	11.8
Peru	16	20	185.0	71.1	11.0
Paraguay	16	23	153.5	77.2	5.7
Brazil	15	20	76.1	87.6	8.2
Mexico	15	22	63.4	85.5	8.8
Scenario 3: Neonatal mortality rate of less than 15					
Colombia	14	23	72.7	90.7	6.2
Venezuela	12	18	59.9	94.0	9.5
Panama	11	15	66.0	92.5	9.4
Argentina	10	14	39.2	98.7	7.3
Jamaica	10	17	95.0	94.6	11.6
Uruguay	7	14	11.1	99.4	8.6
Costa Rica	7	13	39.3	97.5	6.8
Chile	6	8	19.8	99.8	5.5
U.S.A	5	8	13.1	99.0	8.1
Cuba	4	14	49.4	99.9	5.4
Canada	3	6	5.9	98.3	5.9
Average	**14.6**	**21.3**	**104.9**	**74.1**	**9.2**

Sources:
[a] PAHO/WHO, Health Situation in the Americas. Basic Indicators, 2007.
[b] WHO. Neonatal and Perinatal Mortality 2006
[C] UNICEF. State of the World´s Children 2006.
[d] WHO. Maternal Mortality in 2007: Estimates calculated by WHO, UNICEF, UNFPA.
[e] WHO. Factsheet. Skilled attendant at birth, 2006

Competencies of community health workers and activities for the family and community

Phase	Activities for community health workers	Activities for the family and community
Prenatal care	• Early detection of all danger signs • Adequate treatment skills for the stabilization of complications • Presence of a community transportation system for emergencies • Promotion of birth preparedness • Promotion and administration of tetanus vaccinations	• Early detection of all danger signs • Raising community awareness and provision of information about maternal and neonatal care • Promotion of tetanus vaccinations • Promotion of maternal nutrition and a reduced maternal workload • Community transportation system for cases with complications
Care in delivery	• Early detection of all danger signs • Adequate treatment skills for the stabilization of complications • Promotion of skilled care in childbirth • Referral to emergency obstetric care when needed • Delivery of supplies for hygienic birth in home births • Work to prevent mother-to-child transmission of HIV	• Early detection of all danger signs • Raising awareness and providing information about early institutional care when complications arise • Community transportation system for cases with complications
Newborn care	• Delivery of essential newborn care • Early detection of all danger signs • Adequate treatment skills for the stabilization of complications • Referral of newborns for emergency care when necessary • Promotion of exclusive breast-feeding • Promotion of hygiene (cord, eyes, and skin) and handwashing • Home care for the low birthweight baby • Promotion and administration of vaccinations • Work to prevent mother-to-child transmission of HIV	• Early detection of all danger signs • Raising awareness and provision of information about early institutional care in the event of complications • Community transportation system for cases with complications • Essential newborn care • Community-based case management • Promotion of exclusive breast-feeding • Promotion of immunization
Post-partum care	• Early detection of all danger signs • Adequate treatment skills for the stabilization of complications • Promotion of the use of family planning services • Promotion of exclusive breast-feeding • Work to prevent mother-to-child transmission of HIV	• Early detection of all danger signs • Raising awareness and provision of information about early institutional care in the event of complications • Community transportation system for cases with complications

Key elements for a continuous, functioning process in the health care system

Phase	Activities
Preconception care for all women of childbearing age[2] [3]	• Access to good quality health care for all adolescents • Vaccination (for example, rubella and hepatitis B vaccine) • Essential nutrition for girls and women and work to combat eating disorders (obesity prevention), including the administration of folic acid supplements • Preventive medical consultations, risk assessment, and psychological counseling (for example, prevention of psychotropic substance abuse, risk behaviors) • Family planning, including the promotion of planned, adequately spaced pregnancies • Detection and treatment of sexually transmitted infections, especially HIV/AIDS • Treatment of chronic diseases (for example, diabetes, hypothyroidism, malaria, tuberculosis, and Chagas' disease)
Prenatal care	Prenatal care that includes at least four medical check-ups consisting of: • A history and physical examination in which the following are evaluated: blood pressure, weight gain, uterine fundus height, urine (for the presence of protein - multi-test strip) • Anemia detection (hemoglobin level) • Blood group and Rh factor • Two doses of tetanus vaccine • Administration of iron and folate supplements • Counseling and HIV, drug abuse, and syphilis tests (including treatment for the latter) • Detection and referral of multiple pregnancies, abnormal fetal position, preeclampsia, and eclampsia • Planning of pregnancies and preparedness for emergencies • Prenatal counseling and counseling on risk-free pregnancy, and preparation for breast-feeding • Counseling and information to assist women exposed to domestic violence • Community mobilization and participation • Detection and treatment of common maternal infections (for example, urinary infections)
Care in childbirth	Skilled care during the different stages of labor, including: • Active care during the birth • Use of the partogram • Monitor maternal and fetal well-being, encourage the presence of a companion to provide support • Guarantee hygienic, beneficial birth practices • Optimal moment for clamping the umbilical cord: 2 minutes after expulsion of the baby • Treatment and clinical referral when the mother or newborn experiences complications (emergency obstetric care at the first level) and resuscitation of the newborn, if necessary • The package of emergency obstetric care measures (second and third levels)

[2] IMAN Servicios: Normas de atención de salud sexual y reproductiva de adolescentes (FCH/CA, PAHO/OMS, 2006). Found at http://www.paho.org/english/ad/fch/ca/sa-servicios.htm

[3] CDC/ATSDR Report. Preconception Care Work Group and the Select Panel on Preconception Care. MMWR Recomm Rep 2006; 55 (RR-6):1-23. Accessible at: http://www.cdc.gov/mmwr/ preview/mmwrhtml/rr5506a1.htm.

Post-partum and post-natal care	Essential care for all newborns should guarantee: • birth in a risk-free environment with access to full obstetric and neonatal care • bonding with the mother and avoidance of unjustified separation from her • early and exclusive breast-feeding, physical contact of the baby with the mother, rooming in of mother and baby, and feeding on demand, the 10 steps to successful breast-feeding, and proper storage of breast-milk • control of body temperature and no bath for the first 24 hours • infection control, including umbilical cord hygiene • after delivery, administration of vitamin A supplements to the mother • eye prophylaxis to prevent gonococcal conjunctivitis • information and counseling on care in the home and preparedness for emergencies
Additional care for small babies	• Additional home visits, breast-feeding support, temperature control in the newborn, and umbilical cord hygiene • Additional care in the areas of temperature, feeding, and early detection and treatment of complications • Temperature control in the newborn through skin-to-skin contact with the mother (mother kangaroo method) • Administration of vitamin K supplement at birth • Clinical care in a health facility for sick newborns, especially those with infections, who are premature, or have suffered perinatal asphyxia. Short and long-term follow-up • Early stimulation of neural development
Package of measures prior to discharge (in the facility or before the midwife leaves the mother in the case of a home birth):	• Careful assessment of factors associated with high risk or danger signs (for both the mother and newborn), • Counseling for the mother and the rest of the family about preventive care, recognition of warning signs, and the delivery of care (what to do and where to go) • Promotion of and referral to early post-natal care, • Follow-up care to encourage the spacing of pregnancies, vaccination, nutrition (breast-feeding), growth monitoring, and the baby's development.
Guarantee of proper care for mother and newborn in the home	• Autonomy, participation, and effective communication strategies, including community participation in the planning of maternal, newborn and child health programs • Community mobilization and participation to encourage changes in prenatal and post-partum behaviors in the home to foster evidence-based health practices (breast-feeding, temperature control in the newborn, and umbilical cord hygiene), care-seeking, and the demand for quality clinical care
Integrated management of childhood illness	• Strengthen implementation of the IMCI strategy, particularly in rural and poor communities, especially in the first week of life, which is fundamental

Different types of care necessary before, during, and after pregnancy and the different levels of participation, from family to health facility

Phase	Interventions	Situational coverage (in cases where certain specific conditions prevail)	Additional interventions
Package of family care measures (family and community care)	- Community mobilization and participation and communication for changes in prenatal and post-partum behaviors in the home, in order to promote evidence-based neonatal care practices (breast-feeding, temperature control in the newborn, umbilical cord hygiene), care-seeking, and the demand for quality clinical care. - Promotion and practice of a clean birth and referral of complications (for home births).	Chagas' disease, malaria, syphilis and sexually transmitted infections, HIV/AIDS. TORCH test	Promotion of healthy behaviors in the home and a favorable environment for women and newborns, including good nutrition, hygiene, and the danger signs, as well as domestic violence prevention.
Preconception period	Folic acid supplements.		
Prenatal	- Outreach consultations that involve taking a patient history and a physical examination that includes an evaluation of blood pressure, weight gain, uterine fundus height, urinalysis for protein detection, two doses of tetanus vaccine, the detection and treatment of syphilis, counseling about the birth plan, emergencies, and breast-feeding; referral when complications arise. Detection and treatment of asymptomatic urinary tract infections Prevention of preeclampsia and eclampsia (administration of calcium supplements)	Intermittent treatment of presumptive malaria	Rubella vaccine Universal access to quality health services, including counseling and STI and HIV/AIDS testing and access to family planning, with special programs for adolescents. Encouragement to quit smoking and stop drug and alcohol use during pregnancy Detection, treatment, and counseling about infections during pregnancy, including toxoplasmosis, tuberculosis, sexually transmitted infections (STI), and HIV/AIDS (including the prevention of mother-to-child transmission).

Phase	Interventions	Situational coverage (in cases where certain specific conditions prevail)	Additional interventions
During labor	Package of measures for skilled care for the mother and immediate neonatal care - Active care and monitoring of the first stage of labor (including use of the partogram) for early diagnosis of complications; skilled personnel during the birth; treatment and clinical referral in the event of complications in the mother or newborn (emergency obstetric care in a first-level health facility); early detection; detection and treatment for breach birth; clean birth; comforting encouragement from a birth companion; assistance with the birth (including vacuum extraction); antibiotics for premature breakage of waters; administration of corticosteroids for premature birth; resuscitation of newborn. Emergency obstetric care package: - Detection and clinical treatment of obstetric complications (obstructed labor, hemorrhage, hypertension, infections), including provision of the instruments necessary for birth, C-section, and blood transfusions.		Promote male participation during pregnancy and delivery Antiretroviral treatment for seropositive mothers and babies Guarantee of transportation (for example, by ambulance) in emergencies stemming from obstetric or neonatal complications Allow women in labor to ingest fluids, move around, and shift position during the birth Active care during the birth. Basic neonatal care: • Immediate assess the newborn. • Avoid separating mother and newborn • Begin breast-feeding in the first hour • Take prophylactic measures immediately after skin-to-skin contact • Vitamin K supplement • Start vaccination, according to the schedule • Register newborn

Phase	Interventions	Situational coverage (in cases where certain specific conditions prevail)	Additional interventions
Post-partum	-Additional community care for low birthweight babies (family and community care) - Additional home visits, support for breast-feeding , temperature control in the newborn, umbilical cord hygiene; early recognition of and care-seeking in the event of illness -Community treatment of pneumonia cases (family and community care) - Diagnosis and treatment based on the pneumonia algorithm, including oral antibiotic treatment -Package of neonatal emergency care measures - Clinical care in a health facility for sick newborns, especially those who have infections, are premature (for example, very low birthweight babies), cases of perinatal asphyxia or jaundice.	Mother kangaroo method (low birthweight babies in health facilities)	Basic care for newborns and mothers following the birth • Physical exploration of the mother and newborn; referral if danger signs are present • Counseling on basic aspects of neonatal care and hygiene, and recognition of danger signs in the mother and baby

Based on: Darmstadt, G. et al. 2005, "Evidence-based, cost effective interventions: how many newborn babies can we save?" *The Lancet*,Vol. 365: 12 March 2005: 977-988.

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

CD48/7 (Eng.)
Annex E

ANALYTICAL FORM TO LINK AGENDA ITEM WITH ORGANIZATIONAL AREAS

1. Agenda Item: 4.3	**2. Agenda Title:** Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn, and Child Care

3. Responsible Unit: Family and Community Health

4. Preparing Officer: Yehuda Benguigui FCH/CA

5. List of collaborating centers and national institutions linked to this Agenda item:

- Ministerios de salud, ministerios de la familia, obras sociales, secretarías de salud estatales y municipales a nivel de los países.
- Natonal societies of pediatrics, neonatology, perinatology, nursing, and public health.
- National Institutes of Health (NIH), USA
- Texas Children´s Hospital, USA
- Miami Children´s Hospital, USA
- Basic Support for Institutionalizing Child Survival (BASICS), USA
- Core Group, Washington, DC, USA
- Save the Children/Saving Newborn Lives, USA
- Plan International, USA
- Access Project, USA
- Universidad Complutense de Madrid, España
- Asociación Iberoamericana de Pediatría Social, España
- American Pediatric Association, USA
- Canadian International Development Agency (CIDA)
- Agencia Española de Cooperación Internacional (AECI)
- Asociación Latinoamericana de Pediatría (ALAPE)
- Asociación Latinoamericana de Docentes de Enfermería (ALADEFE)
- Instituto Nacional de Enfermedades Respiratorias “Emilio Cony” (INER) Santa Fé, Argentina
- Facultad de Medicina de la Universidad Maimonides, Buenos Aires, Argentina
- Comité de Educación Médica de la Sociedad Argentina de Pediatría (COEME), Buenos Aires, Argentina
- Centro Latinoamericano de Perinatología y Desarrollo Humano (CLAP), Montevideo, Uruguay
- Universidad Federal de Río de Janeiro (UFRI), Brasil
- Universidad de São Paulo (USP), Brasil
- Escuela de Salud Pública, USP, Brasil
- Instituto da Criança, São Paulo, Brasil
- Escola de Enfermerías da USP, São Paulo, Brasil
- Instituto Materno Infantil de Pernambuco “Fernando Figueira” (IMIP), Recife, Brasil
- Universidad Federal do Ceará (UFCE), Brasil

- Universidad Federal do Pará (UFPA), Brasil
- Sociedad Iberoamericana de Neonatología, México
- Instituto de Nutrición de Centroamérica y Panamá (INCAP), Guatemala
- Instituto Nacional da Salud del Niño (INSN), Lima, Perú
- Facultad de Medicina de la Universidad de Antioquía (FMUA), Medellín, Colombia

6. Link between Agenda item and Health Agenda of the Americas:

- Strengthens the Health Authority by proposing evidence-based interventions, norms, standards and instruments for women, newborns, and child care.
- Addresses the health determinants through the family and community health approach, improving primary health care, strengthening community interventions and health promotion activities among vulnerable groups.
- Takes advantage of the knowledge, science, and technology through the proposal and implementation of evidence-based practice of care.
- Strengthens solidarity and health security through the promotion of primary health care and community participation.
- Diminishes inequities in health among and within countries by scaling-up maternal, neonatal and child care, avoiding discrimination by gender and ethnic groups.
- Reduces the risks and burden of disease through the promotion of integrated care within the continuum of maternal, newborn and child health.
- Increases social protection and access to quality health services as the strategy and plan of action propose universal access to maternal, neonatal and child care, with equity and building of country capacity to implement evidence-based interventions to prevent neonatal mortality.
- Strengthens the management and development of people who work in the health field by developing and strengthening health workers' skills and competencies.

7. Link between Agenda item and Strategic Plan 2008-2012:

- **SO 4:** To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy aging for all individuals.
- **SO 1:** To reduce the health, social, and economic burden of communicable diseases.
- **SO 7:** To address the underlying social and economic determinants of health through policies and programs which enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches.
- **SO 9:** To improve nutrition, food safety, and food security throughout the life-course, and in support of public health and sustainable development.
- **SO 10:** To improve the organization, management, and delivery of health services.
- **SO 13:** To ensure an available, competent, responsive, and productive health workforce to improve health outcomes.
- **SO 14:** To extend social protection through fair, adequate, and sustainable financing

8. Best practices in this area and examples from other countries within AMRO:

- Sixteen evidence-based and cost-effective interventions have been identified to prevent and reduce child mortality, including neonatal mortality. At a high coverage level, a 50% reduction in neonatal mortality rates could be achieved if these interventions are incorporated into current practices of health outreach providers, family and community health practices and into the clinical management of the newborn. The strategy has been reviewed and discussed by most of the countries in the Region; Ecuador, Nicaragua, Paraguay, and Venezuela are already preparing national plans of actions. Nine countries have developed

and implemented national policies or programs to improve maternal and neonatal health; however, efforts are still required to implement and scale-up specific interventions throughout the continuum of maternal, newborn and child health, to reduce the neonatal mortality rate.

- With support of NGOs, other partners, and national agencies, the Region continues expanding its coverage of the clinical and community components of IMCI. Community IMCI successfully built upon existing community-based programs at the district level, promoted equitable access to services, improved access to quality health care at the health facility level, strengthened local capacity and ownership, and made the best and most cost-effective use of scarce resources. The community component of the IMCI strategy was scaled-up to the national level and carried forward the basic principles of primary health care to contribute to reaching the Millennium Development Goal 4. The expansion includes high-risk and vulnerable population areas and indigenous population groups. Many community IMCI methodological approaches have been sustained and introduced into national initiatives in Bolivia, Colombia, Ecuador, Guyana, Honduras, Nicaragua, Paraguay, Peru, and Venezuela. Countries made significant advances implementing sustained activities at the national and community levels (especially the household level promoting key family practices), and improving case management training at the clinical and community levels. The lessons learned through the implementation of IMCI will be an asset to implementing the Neonatal Health Strategy and Plan of Action.
- Preconceptional folic acid supplementation or wheat flour fortification with iron and folic acid, tetanus toxoid immunization, and prevention of mother-to-child transmission of HIV are current practices in most countries that help to reduce neonatal mortality rate.

9. Financial implications of Agenda item:

US$ 10,020,000 for the entire life-cycle (2008-2015) of the Regional Strategy including activities and staff costs

PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

142nd SESSION OF THE EXECUTIVE COMMITTEE

Washington, D.C., USA, 23-27 June 2008

CD48/7 (Eng.)
Annex F

ORIGINAL: SPANISH

RESOLUTION

CE142.R10

NEONATAL HEALTH WITHIN THE CONTINUUM OF MATERNAL, NEWBORN, AND CHILD CARE: REGIONAL STRATEGY AND PLAN OF ACTION

THE 142nd SESSION OF THE EXECUTIVE COMMITTEE,

Having reviewed the report of the Director, *Neonatal Health within the Continuum of Maternal, Newborn, and Child Care: Regional Strategy and Plan of Action* (Document CE142/12),

RESOLVES:

To recommend that the Directing Council adopt a resolution along the following lines:

THE 48th DIRECTING COUNCIL,

Having reviewed the report of the Director, *Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn, and Child Care* (Document CD48/7);

Recognizing that neonatal mortality continues to have a high impact on infant mortality in the Region, and that it will be necessary to redouble efforts to achieve the goals of the Millennium Declaration related to the reduction of infant mortality for 2015;

Considering Resolution CD47.R19 (2006) on neonatal health, in the context of the health of the mother, newborn, and child, which recommends the development of a strategy and an action plan to support the achievement of the goals of the Millennium Declaration; and

Noting that the Regional Plan of Action addresses persistent inequities, focusing on marginalized groups while proposing differentiated technical cooperation strategies and approaches to respond to multiple situations in countries,

RESOLVES:

1. To urge Member States to:

(a) support the reduction of neonatal mortality as a priority within health programs by expanding, strengthening or sustaining the implementation of the Strategy and Regional Plan of Action for neonatal health in the continuum of the mother, newborn, and child care;

(b) consider the Regional Plan of Action for neonatal health within the continuum of care when formulating national plans, and include differentiated strategies that effectively respond to multiple situations among and within countries, to protect recent achievements and reach the objectives related to mortality reduction of children under five by 2015 included in the Millennium Declaration;

(c) consider strengthening health systems based on primary health care to support the implementation of evidence-based strategies aimed at reducing neonatal mortality, and improving collaboration between programs and the different levels of care;

(d) support strong community and civil society participation so that they include, within their activities, actions directed to mothers, newborns, and children, with an equity, gender and ethnicity approach;

(e) consider undertaking, facilitating, and supporting national activities that promote universal access of health care for mothers, newborns, and children;

(f) consider strengthening national frameworks that protect mothers, newborns, and children;

(g) establish and maintain quality neonatal health monitoring and information systems, disaggregated by gender, socioeconomic status, ethnicity, and education of the mother;

(h) forge partnerships and associations with nongovernmental, community and religious organizations, with the academic and research community, as well as with relevant government agencies, to strengthen and expand policies and programs on maternal, neonatal and child health.

2. To request the Director to:

(a) support Member States in developing national plans aimed at reducing neonatal mortality, within the continuum of mother, newborn, and child, taking into account the Strategy and Regional Action Plan, and addressing inequities and directed to vulnerable and marginalized groups;

(b) collaborate in country evaluations to ensure adequate and evidence-based corrective actions;

(c) facilitate the exchange of successful experiences and promote horizontal technical cooperation by Member States in the implementation of the Regional Plan.

(Ninth meeting, 27 June 2008)

PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

48th DIRECTING COUNCIL

60th SESSION OF THE REGIONAL COMMITTEE

Washington, D.C., USA, 29 September-3 October 2008

CD48/7 (Eng.)
Annex G

Report on the Financial and Administrative Implications for the Secretariat of the Resolutions Proposed for Adoption by the Directing Council

1. Resolution: Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn, and Child Care	
2. Linkage to program budget	
Area of work	**Expected result**
▪ SO 4	▪ RER04.01, RER04.01.01, RER04.02, RER04.02:02, RER04.03, RER04.03.01, RER04.03.02, RER04.04, RER04.04.01, RER04.04.02
▪ SO 1	▪ RER01.01, RER01.01.01, RER01.01.02, RER01.01.02
▪ SO 7	▪ RER07.04 o RER07.04.01 ▪ RER07.05 o RER07.05.03
▪ SO 9	▪ RER09.03 o RER09.03.01
▪ SO 10	▪ RER10.01 o RER10.01.0

▪ SO 13	▪ RER13.04 o RER13.04.01
▪ SO 14	▪ RER14.04 o SO14.04.01

3. Financial implications

a) **Total estimated cost for implementation over the "life-cycle" of the resolution (estimated to the nearest US$ 10,000; including staff and activities):**
Approximately US $10,020,000 ($7,980,000 in operational costs + $ 2,040,000 in salaries)

b) **Estimated cost for the biennium 2008-2009 (estimated to the nearest US$ 10,000; including staff and activities):**

Operational Cost 2008-2009:		US $ 1,720,000
Staff Cost 2008-2009:	P6 50%	US $ 190,000
	P5 30%	$ 100,000
	G4 120%	$ 150,000
	Total	**US $ 2,160,000**

c) **Of the estimated cost noted in (*b,)* what can be subsumed under existing programmed activities?**

US $1,940,000

Additionally, some budgetary aspects should be included in the Plan of Action:

c.1) At country level, implementing national plans of action will involved additional: costs related to actions at health services level conducted by Ministries of Health and other national institutions that we cannot realistically estimate at this moment.

c.2) Other partners:
Estimations were made under the assumption that other partners, including those participating in the Interagency Regional Alliance on Neonatal Health, will contribute with approximately US $1,000,000 annually, directing 70% of these resources to countries.

4. Administrative implications

a) **Implementation locales (indicate the levels of the Organization at which the work will be undertaken and identify the specific regions, where relevant):**

Plan of action will be implemented at the following levels:

Regional level: Leadership, articulation with Regional Alliance, WHO/HQ and other partners for resource mobilization and advocacy; development of technical documents, implementation guides, training modules and updated clinical protocols; technical cooperation in the implementation and monitoring; follow-up and evaluation of the regional process.

Sub regional level: support of inter-country activities, common problems discussion and exchange of experiences, joint activities in border areas, coordinated resource mobilization.

National/local level: implementation of actions under the supervision and coordination of Ministries of Health with interagency and inter institutional support, at health facility and community levels. Monitoring, follow-up and evaluation at national and local level.

Specific countries/regions:

- Priority countries.
- Impact countries: those with Neonatal Mortality Rates equal or grater than 20/1000 l.b.
- Rural areas: those with the highest Neonatal Mortality Rates, areas with indigenous. population, etc.

b) **Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile):**

At least one additional full-time staff at the Regional level, with pediatrician profile.
A technician with epidemiological profile to support improvement of epidemiological data production and analysis, M&E of the implementation results would be desirable.

c) **Time frames (indicate broad time frames for the implementation and evaluation):**

Plan of Action implementation: 2008 – 2015

Evaluation: Partial: 2011
Final: 2016