REPORT ON STAKEHOLDERS’ MEETING

ACCELERATING THE SCALE UP OF INTERVENTIONS TO REDUCE NEONATAL MORBIDITY AND MORTALITY

July 22nd – 23rd, 2013

Miklin Hotel, Accra
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PLAN Ghana
Focus Regions Health Project/USAID

All presenters and participants at the Newborn Stakeholders’ Meeting for their contributions in helping to attain the objectives of the meeting.
ACRONYMS

BFHI    Baby Friendly Hospital Initiative
CBA     Community-based agents
CBSV    Community-based Surveillance Volunteer
CHN     Community Health Nurse
CHO     Community Health Officer
CHPS    Community – based Health Planning and Services
DHIMS   District Health Information Management System
DHMT    District Health Management Team
EID     Early Infant Diagnosis (of HIV)
EmONC   Emergency Obstetric and Neonatal Care
FANC    Focused Antenatal Care
FHD     Family Health Division
FRHP    Focus Regions Health Project
GDHS    Ghana Demographic and Health Survey
GHS     Ghana Health Service
HMIS    Health Management Information System
HPO
ICD     Institutional Care Division (GHS)
IMNCI   Integrated Management of Neonatal and Childhood Illnesses
IPT     Intermittent Presumptive Treatment (of malaria)
JICA
KMC     Kangaroo Mother Care
LSS     Life Saving Skills
MAF     MDG Acceleration Framework
MCHS    Maternal and Child Health Services
MDA     Ministries/departments and agencies
<table>
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<tr>
<th>Acronym</th>
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<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MNCH</td>
<td>Maternal, Newborn and Child Health</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>MTMSG</td>
<td>Mother-to-mother support group</td>
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<tr>
<td>NICU</td>
<td>Neonatal intensive care unit</td>
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<tr>
<td>NMR</td>
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<td>PNC</td>
<td>Postnatal Care</td>
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<td>Neonatal Network and Supportive System</td>
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<td>QI</td>
<td>Quality Improvement</td>
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<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<td>Untrained TBA</td>
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<tr>
<td>U5MR</td>
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<td>UNFPA</td>
<td>United Nations Fund</td>
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EXECUTIVE SUMMARY

Although Ghana has made significant progress in under-five mortality reduction in recent times it is unlikely that the Millenium Development Goal (MDG) 4 targets on reducing under-five mortality will be met without intensified efforts to address newborn deaths.

Currently neonatal deaths constitute a significant proportion, 40 per cent, of deaths in children below 5 years, and indicators for neonatal mortality have not improved much in the past 10 years.

The major causes of neonatal mortality include: preterm birth, birth asphyxia, and infections. Evidence-based interventions for prevention and treatment of these causes are available and include skilled care during pregnancy and at the time of birth, clean cord care, essential newborn care including neonatal resuscitation, early initiation of breastfeeding, thermal care including Kangaroo Mother Care (KMC) and home visits by health workers to provide support to mother and babies during first seven days after delivery. The challenge is that there are major gaps in access to and utilization of these interventions. Ghana Health Service (GHS) organized a meeting of stakeholders in July, 2013, to deliberate on the prevailing situation of children in Ghana and plan the way forward. This was a follow on activity to the stakeholders’ meeting held in July 2012.

OBJECTIVES

1. To review progress made in the implementation of newborn health action plans at both National and Regional levels.

2. To share best practices from the implementation of interventions to improve newborn care.

3. To agree on a common understanding of a coordinated national strategy for accelerated reduction in neonatal mortality.

4. To contribute towards the development of three year national and regional scale up action plans to improve newborn care with timeframe and available resources.

PROCEEDINGS

Day 1

A Message was delivered on behalf of the United Nation (UN) partners by Susan Gongi, the Country representative for UNICEF. She stated that it was important the strategy for the newborn should span the continuum of care from family to community and health facilities.
The Minister for Gender, Children and Social Protection stressed the need to translate policies and strategies into action so that every mother and new born baby gets quality health care. She was pleased interventions were being scaled up so that babies would not die needlessly.

Dr Hari Banskota, UNICEF Child Health Specialist, spoke on the Global Every Newborn Action Plan. The goals are that no woman should die while giving life, no new born should die, no baby should be stillborn and no young child should be malnourished or die. The plan requires national action by everybody, professionals, policymakers, parents. Time is running out for us to come up with an effective, coordinated country action plan.

Dr Isabella Sagoe-Moses, Child Health Division of GHS, presented an update on the current situation of new born health in Ghana. The fact of much concern was that no progress had been made in reducing under-five and neonatal mortality rates (NMR) since 2008 from latest data obtained from the 2011 Multiple-Indicator Cluster Survey (MICS). There is the need to improve coverage and quality of interventions.

The keynote address was delivered by the Chief Director, Ministry of Health on behalf of the Minister. She stressed the importance of intensifying efforts to reach the MDG4 targets.

Dr Cynthia Bannerman spoke on the Quality Improvement (QI) initiatives in Kintampo & Navrongo. She reiterated the fact that what was needed was dedicated trained staff. All staff at the various facilities participating in the initiative were trained in KMC, management of neonatal sepsis and neonatal resuscitation.

Dr Nana Brako presented on neonatal services at Ridge Hospital. Issues of concern included the high neonatal mortality rate of 25% due to several factors including poor condition on arrival of referrals, high number of admissions, poorly maintained equipment and lack of ventilatory support.

Dr Patrick Aboagye of the Ghana Health Service gave an update on the implementation of the MDG acceleration framework (MAF). This included completion of plans of action at all levels, transfer of funds for activities, training and capacity building at all levels.

Regional updates on the status of newborn care were presented by all the regions except Central Region who arrived on day two and Eastern Region who was not well represented. Updates included the achievements, activities, innovations, challenges and the way forward for each region.

**Day 2**

Group work was undertaken on the second day. All the regions were tasked to develop 3 year plans for accelerating the scale up of interventions to reduce neonatal mortality. The National team evaluated what had been achieved over the
past year and developed a three year plan. Presentation of draft plans were made by five regions. All the regions were asked to complete the plans and submit within two weeks of their return to their regions.

In his closing remarks, Dr Banskota stated that no child below five years should die. The country should have one integrated plan and strategy with one framework at all levels. There should be the right care, at the right place and at the right moment. Regions should include data on premature births and stillbirths in reports to be able to determine if the regions are achieving their targets.

**Best Practices and innovations include:**

District Assemblies/traditional leaders support for maternal and new born care solicited.

Hospital and polyclinic quality improvement teams.

Setting up a call centre to give expert advice and coordinate emergency referrals.

Maternal waiting home in deprived district.

Saturday pregnancy schools for fathers.

Community emergency transport system.

Neonatal network and support system (NNSS) linking peripheral health centres to the Neonatal unit.

Volunteers trained to identify sick newborns and refer.

Stamp designed and used for easy visibility of postnatal visit dates by mothers.

Perinatal/neonatal death audit meetings.

**Recommendations include:**

**Policy**

Maternity leave should be extended to six months or more

**Strategy**

A concerted national action by all stakeholders is required and this is crucial.

Integration of known continuous Quality Improvement methods found to be successful in sections of the health system, including standardizing approved protocols and guidelines for improved maternal and newborn care should be scaled up nationwide.

**Service delivery**
Ensure interventions to reduce morbidity and mortality in particular from prematurity, birth asphyxia and neonatal sepsis are scaled up.

Effective linkages should be created between communities and referral services.

Capacity in referral facilities to care for mothers and the newborn must be strengthened.

There is the need to work out greater cohesion and clearly outline Public Health and Clinical care roles towards the planning, implementation and monitoring of neonatal interventions at regional and district levels.

**Capacity building**

Community Health Nurses should be trained in postnatal care

Discussions should be held with health training institutions to ensure pre-service curricula incorporate modules that will impart the required knowledge and skills.

**Data management**

Strengthen data management at all levels as this is a critical component for planning, monitoring and evaluation.

Data on premature births and still births should be reported on.
INTRODUCTION/BACKGROUND

Although Ghana has made significant progress in under-five mortality reduction in recent times it is unlikely that the MDG 4 targets on reducing under-five mortality will be met without intensified efforts to address newborn deaths.

Currently neonatal deaths constitute a significant proportion, 40 per cent, of deaths in children below 5 years, and indicators for neonatal mortality have not improved much in the past 10 years. Although a recent survey (the 2011 Multiple Indicator Cluster Survey) showed improvement in some child health indicators, there was a decline in coverage for some key child health interventions. Overall, there was also a lack of improvement in under-five mortality rate (U-5MR) which was estimated at 82/1000 live births (Fig. 1). This means that 1 out of every 13 children born die before their fifth birthday. There is regional variation in neonatal mortality rates (NMR) (Fig. 2).
The major causes of neonatal mortality include: preterm birth, birth asphyxia, and infections (Fig. 3). Evidence-based interventions for prevention and treatment of these causes are available and include skilled care during pregnancy and at the time of birth, clean cord care, essential newborn care including neonatal resuscitation,
Early initiation of breastfeeding, thermal care including Kangaroo Mother Care (KMC) and home visits by health workers to provide support to mother and babies during first seven days after delivery. These evidence-based interventions for prevention and treatment of the major causes of new born mortality have proven scalable even in low-resource settings. They have been clearly articulated in Ghana’s Child health Policy and Strategy documents.

Fig.3

Causes of Newborn Death –
(Ghana EmONC Study 2010)

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>Number</th>
<th>%</th>
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<tbody>
<tr>
<td>Birth Asphyxia</td>
<td>150</td>
<td>41</td>
</tr>
<tr>
<td>Neonatal Sepsis</td>
<td>57</td>
<td>15</td>
</tr>
<tr>
<td>Preterm/ Low birth weight</td>
<td>56</td>
<td>15</td>
</tr>
<tr>
<td>Other (No information)</td>
<td>35</td>
<td>10</td>
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<tr>
<td></td>
<td>72</td>
<td>19</td>
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</table>

The challenge is that there are major gaps in access to and utilization of these interventions. There are also gaps in the quality of services provided. Urgent action is needed not only to reverse this trend but also to accelerate progress towards attainment of MDG4. Ghana Health Service organized a meeting of stakeholders in July, 2013, to deliberate on the prevailing situation of children in Ghana and plan the way forward. The two-day meeting brought together stakeholders including health service managers and providers from all regions of the country, academic and research institutions, development partners, civil society organizations as well as ministries and departments whose mandates impact on child health.

OBJECTIVES

5. To review progress made in the implementation of newborn health action plans at both National and Regional levels.

6. To share best practices from the implementation of interventions to improve newborn care.
7. To agree on a common understanding of a coordinated national strategy for accelerated reduction in neonatal mortality.

8. To contribute towards the development of three year national and regional scale up action plans to improve newborn care with timeframe and available resources.

This was a follow on activity to the stakeholders’ meeting held in July 2012 during which annual new born intervention action plans were drawn up by National and Regional representative teams.

Day One – Monday, 22nd July 2013

Session one: Chairperson - Dr Patrick Aboagye (GHS, FHD)

The meeting started at 9.15 am following the opening prayer.

A total of 75 participants from all the ten regions, development partners – UNICEF, WHO, USAID, JICA, NGOS - PLAN Ghana, FIVES’ Alive, Focus group, representatives of professional bodies and academia attended.

Dr Patrick Aboagye welcomed all present to the meeting. He then stated the objectives and expectations of the meeting.

A Message was delivered on behalf of the UN partners by Susan Gongi, the Country representative for UNICEF. She stated that convening this meeting was an indication of stakeholders’ concern about the status of child health and their commitment to contribute to reducing new-born and child mortality and that it was important to include a strategy that spanned the continuum of care from family to community and health facilities. She reminded all that we must consciously pay attention to how the poorest in the most remote part of the country would benefit from these interventions.

The Minister for Gender, Children and Social Protection, in her address, advised that the scope of stakeholders for such a meeting should be broadened to include women’s groups. She stressed the need to translate these policies and strategies into action so that every mother and new born baby gets quality health care. She was pleased interventions were being scaled up so that babies would not die needlessly. She reassured the participants that her Ministry would want to be involved in the plans and stressed the necessity for all stakeholders to contribute towards the achievement of MDG4.

Global Newborn Action Plan

Dr Hari Banskota, Unicef Child Health Specialist, spoke on the Global Every Newborn Action Plan. The goals are that no woman should die while giving life, no new born should die, no baby should be stillborn and no young child should be malnourished or die. He mentioned the major causes of under-5 mortality and the main killers of the newborn (Fig. 4). Data from Ghana shows that 41% of neonatal deaths are due to birth asphyxia.
The interventions to prevent majority of newborn deaths are simple, not rocket science. These include effective resuscitation, thermal care including KMC and appropriate cord care to minimise neonatal infections. Application of Chlorhexidine to the cord has been shown to be effective in prevention of neonatal deaths.

Fig. 5

Absolute target by 2035 for A Promise Renewed
Under 5 mortality = 20/1000

Unless we achieve major acceleration for newborn survival, we cannot reach our goal for ending preventable child deaths by 2035
He mentioned the commitment by all governments in June 2013 in what is termed a promise renewed, to tackle the issue of new born deaths. Unless there are accelerated efforts, it is unlikely the country will reach the target of U-5MR 20/1000 by 2035 (Fig. 5). It is critically important to address issues of quality. Every new born action plan is a platform for harmonised action by all partners. It requires national action by professionals, policymakers, parents, everybody. Time is running out for us to come up with an effective, coordinated country action plan.

**Current Situation of Newborn Health in Ghana**

Dr Isabella Sagoe-Moses, Child Health Division of GHS, presented an update on the current situation of new born health in Ghana. Unfortunately, the regions did not return questionnaires sent out to them in time for analysis and inclusion in the presentation.

Fig. 6

**Stagnation in the Reduction of Neonatal Mortality** *(Source: GDHS 2008)*

![Graph showing stagnation in the reduction of neonatal mortality](image)

The fact of concern was that no progress had been made in reducing under-five and neonatal mortality rates since 2008 from latest data obtained from the 2011 multiple-Indicator Cluster Survey (Fig. 6). Many new born deaths are unaccounted for.

Fig. 7
As shown (Fig. 7), the regions with highest neonatal mortality rates are Brong Ahafo, Volta and the three northern regions.

Fig. 8

The poorest are at a disadvantage with higher neonatal mortality rates (Fig. 8). Although there has been some improvement, there is still wide regional variation in skilled delivery (Fig. 9).

Fig. 9
It has been noted that there are harmful cord care practices in some communities. There is also inadequate care for low birth weight neonates with low coverage of KMC nationally. Less than 50% maternity facilities are designated baby friendly with gaps in care for the sick newborn as there are no protocols and guidelines at facility level. There has been a drop in exclusive breastfeeding rates (Fig. 10).

Fig. 10

Breastfeeding – MICS 2011

Factors contributing to high neonatal mortality:
– Health system factors – low coverage of effective interventions, poor service quality (human resource numbers, skills, guidelines), inadequate health infrastructure, inadequate data.

- Socio-economic factors – sociocultural (pregnancies not disclosed early, newborn kept indoors, inappropriate feeding practices, delayed care seeking), transportation and poor road network, lack of potable water in some areas and poor standards of sanitation, limitations in financial access to care.

There is the need to improve coverage and quality of interventions. A concerted national action by all stakeholders is crucial.

**Keynote Address**

The keynote address was delivered by the Chief Director, Ministry of Health (MOH) on behalf of the Minister. She stressed the importance of intensifying efforts to reach the MDG4 targets. She informed participants that the MOH and partners had agreed to work together.

**Session 2:** Chairperson – Dr Linda Van-Otoo, Greater Accra Regional Director of Health Services.

**Quality Improvement Initiative**

Dr Cynthia Bannerman spoke on the Quality Improvement initiatives in Kintampo & Navrongo. She reiterated the fact that what was needed was dedicated trained staff. All staff at the various facilities participating in the initiative were trained in KMC, management of neonatal sepsis and neonatal resuscitation. Staff included health assistants, physician assistants in Out-Patient Departments, ward nurses, nurse anaesthetists. There was the recognised need for separate wards for the new born. Following on the initiative, there was a marked improvement in knowledge. There were monthly regional supervisory visits and onsite refresher training. Issues included lack of monitoring charts for the new born and poor documentation.

Dr Nana Brako presented information on neonatal services at Ridge Hospital, a regional referral facility. Issues of concern included the high neonatal mortality rate of 25% due to several factors. These include poor condition on arrival of referrals, high number of admissions with pressure on the limited space available (fig. 11), old and poorly maintained equipment and lack of ventilatory support.

Fig. 11
Update on MAF implementation

Dr Patrick Aboagye of the Ghana Health Service gave an update on the implementation of the MDG acceleration framework (MAF). Implementation of MAF started in late 2010. The goals were to contribute to the reduction of maternal mortality from 451/100,000 live births in 2008 to 185/100,000 live births by year 2015 and to contribute to reduction in institutional maternal mortality ratio from 196/100,000 live births in 2009 to 54/100,000 live births in 2015.

Objectives of the MAF Operational Plan:

- To increase contraceptive prevalence rate from 17% in 2008 to 28% in 2015
- To increase family planning acceptor rate from 34% in 2010 to 45% in 2015
- To increase skilled delivery rate from 59% in 2008 to 80% in 2015
- To increase access to basic emergency obstetric and neonatal care (EmONC) from 0.74% in 2010 to 60% in 2015 & comprehensive EmONC from 27% in 2010 to 60% in 2015 (fig. 12)

Achievements:

MAF regional, national and teaching hospital plans have been completed. Sub-committees i.e. Behaviour Change Communication, Procurement, Monitoring, Evaluation and Training have been established.

Family planning – a meeting has been held to review the policy for community Health Nurses (CHNs) to be able to insert family planning implants. A community based family planning manual is being developed.

Funds – These have been transferred to the various regions, teaching hospitals and pre-service department of MOH. Also funds have been allocated for procurement.
Capacity strengthening of the Family Health Directorate and related Divisions at national and regional levels is being undertaken and programme officers have been appointed.

Fig. 12 Map showing sites offering basic or comprehensive EmONC (2010)

Data management – smart phones have been distributed and staff at DHMTs trained in DHIMS2 software management.

Skilled delivery – Midwives trained in Focused Antenatal Care (FANC). 4 ultrasound machines for Northern and Upper East Regions have been procured and distributed. Job aids have been printed and distributed with the support of Japanese government through JICA and FOCUS Regions health project/USAID. Health service providers have been trained in ENA and midwives have been trained in Life Saving Skills (LSS).

EMONC capacity building – some doctors in Northern Region were upgraded in obstetric skills. Client satisfaction surveys have been undertaken in some districts. In three northern regions, supported by UNICEF and JICA, health service providers have been trained in home based LSS and essential newborn care. Relevant service providers from all regions have been trained in coaching, supervision, monitoring and evaluation. 3 midwifery schools in Western and Northern regions have been given teaching aids, logistics and refresher training. UNFPA has procured 35 blood bank fridges for distribution.

Key planned activities:

GHS will pilot perinatal audits in three zones. Collaboration with UNICEF to build capacity in Early Infant Diagnosis (EID) of HIV in three regions. Adaptation of LSS manual planned. An orientation meeting for paediatricians and obstetricians is due to be held.
Discussion:

The presentations were followed by a discussion.

Maternity leave – the issue of no refrigerators to store breast milk and no private places for breastfeeding mothers to express milk at work was brought up. It was agreed that Maternity leave should be extended to six months or more. The participants were informed that the Ghana Medical Association has proposed six months maternity leave for mothers. Were also informed that the Ministry of Health will, starting in its own offices, ensure facilities are made available for nursing mothers to breast feed and express breast milk. It was proposed that an appeal be made to have such facilities available in all workplaces nationwide.

Data/trend on postnatal visits – the meeting was informed that the child health registers have been revised to record data on postnatal visits. It is also being collected on the District Health Information Management Systems (DHIMS).

Comparing neonatal mortality rates between different groups in the country, it was explained that shortcomings of the health system appear to be the main reason for high neonatal mortality amongst both educated and uneducated mothers and both high and low socioeconomic groups.

What about records on home deliveries? Participants were informed that the Community Health Officers (CHOs) are being trained to capture this during home visits. Information is also being obtained from Traditional Birth Attendants (TBA)s and this is reported on every quarter.

On discussing neonatal death audits and how the data is being recorded, a participant stated that some regions (Greater Accra, Western, Upper West) have initiated neonatal death audits. This is yet to be captured at National level.

Staff motivation at Kintampo and Navrongo quality initiative sites was brought up. There was a comment that training is very practical, resulting in a high level of confidence afterwards. All staff who could potentially be required to use these skills are included in training. Kintampo has subsequently established a neonatal unit.

It was remarked that babies are crying silently for action. Facilities should use IGF for special interventions to keep babies alive. Paediatricians and obstetricians should work together. Nurses’ training should address new born survival issues effectively. Transfer of paediatric trained nurses to areas where their skills are not utilised should be avoided. It was stressed that documentation is important. Clinical care and public health teams should work together to ensure adequate follow up of new borns.

A participant mentioned that the issue of apportioning blame (“witch hunting”), though incorrect, is assumed by nurses so this affects filling out of perinatal audit forms. The filling of these forms is also thought of as additional work.

A comment was made that TBAs do not retire at 60 years so the GHS needs to assess ergonomics in coming up with ways to help older midwives work well.

Another issue brought up was the need to teach customer care in pre-service institutions.
The Paediatric Society of Ghana was tasked to come up with a standardised tool for neonatal examination.

Regional Updates:

Upper East Region:

Achievements: Fig. 13 & 14. show performance indicators over the last three years. Percentage of supervised deliveries has gone up slightly.

Activities for postnatal care - Postnatal clinics are held daily, fortnightly clinics are held for neonates. Mothers who deliver in health facilities are linked to CHOs for follow up community visits.

Planned activities: Training has been arranged for paediatric trained nurses and for midwives to be held at the Ridge hospital neonatal unit in Accra for one month. The region has developed a perinatal/neonatal audit tool and perinatal/neonatal death audit meetings are held weekly in some hospitals. This is due to be introduced in all district hospitals.

Activities undertaken for 2012/2013: Have organised durbars to educate the community on KMC. Health staff have been trained on newborn care. Have trained 1200 Red cross mothers on newborn care. With assistance from UNICEF, equipment has been acquired to start a (neonatal intensive care unit) NICU at the Regional and War memorial hospitals.

Fig. 13

<table>
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<th>INDICATOR</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
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<tr>
<td>Supervised Del</td>
<td>59.9</td>
<td>67.1</td>
<td>69.13</td>
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<td>TT2+</td>
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<tr>
<td>PNC</td>
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<td>78.9</td>
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<tr>
<td>Stillbirth Rate</td>
<td>1.8</td>
<td>1.6</td>
<td>1.8</td>
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Data from DHIMS 2
Innovations: Have instituted Saturday pregnancy schools in the region. Low birth weight babies are linked to CHO for follow up in the community. Fortnightly neonatal clinics have been started. Neonatal units are in the process of being established in the some hospitals.

Fig. 14

<table>
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<th>INDICATOR</th>
<th>2010</th>
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<th>2012</th>
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<td>55.6*</td>
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<tr>
<td>Exclusive Breastfeeding</td>
<td>63</td>
<td>58.4*</td>
<td>60</td>
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<tr>
<td>Neonatal Mortality Rate</td>
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<td>34*</td>
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<td>U5 Mortality Rate</td>
<td>-</td>
<td>98*</td>
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*Data from MICS Report 2011

Upper West Region:

Achievements: Summary of performance indicators is as shown in Fig. 15. Slight improvement in numbers of skilled deliveries but there has been a reduction in immunization coverage for pregnant women. There is improved feedback on postnatal visits – mothers are linked to community structures – CBOs, CBAs, mother-mother support groups (MTMSG). The region has developed a stamp that is put on the maternal records for easy visibility of postnatal visit dates by mothers (Fig 16). Region has instituted quarterly supervisory visits to all facilities, supported by JICA.

Perinatal and neonatal death audits are undertaken at the regional hospital. Referring facilities are invited to these audits. Outcomes and findings from audit include - neonatal and perinatal deaths have been linked to morbidity in the mothers. Sociocultural beliefs and practices lead to late presentation and still births. Emergency preparedness for resuscitation and new born care is low. Practice of KMC is low.

Interventions: JICA is distributing basic EMONC equipment to all health centres. Midwives have been trained on safe motherhood skills. Nurses have been trained in
essential new born care. A telephone directory for emergency obstetric and neonatal care has been instituted. There is a quality improvement initiative under Project fives Alive being undertaken.

Fig. 15

### Summary of performance on newborn care

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC REGISTRANTS</td>
<td>24100 (88%)</td>
<td>23943 (86%)</td>
<td>24720 (85%)</td>
</tr>
<tr>
<td>SKILLED DELIVERY</td>
<td>12580 (46%)</td>
<td>14687 (53%)</td>
<td>13389 (53%)</td>
</tr>
<tr>
<td>TT2</td>
<td>19748 (72%)</td>
<td>15945 (61%)</td>
<td>17449 (60%)</td>
</tr>
<tr>
<td>IPT2</td>
<td>59%</td>
<td>56%</td>
<td>42%</td>
</tr>
<tr>
<td>STILL BIRTHS</td>
<td>310 (2.5)</td>
<td>365 (2.5)</td>
<td>334 (2.2)</td>
</tr>
<tr>
<td>FRESH</td>
<td>105</td>
<td>127</td>
<td>106</td>
</tr>
<tr>
<td>MACERATED</td>
<td>205</td>
<td>238</td>
<td>228</td>
</tr>
<tr>
<td>BREAST FEEDING INITIATION</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EBF</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Fig. 16

### Example

<table>
<thead>
<tr>
<th></th>
<th>Expected Dates</th>
<th>Actual dates</th>
<th>Name of facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery date</td>
<td>02/01/2013</td>
<td>03/01/2013</td>
<td>Charikpong H/C</td>
</tr>
<tr>
<td>1st PNC 48 hours</td>
<td>04-05/01/2013</td>
<td>04/01/2013</td>
<td>Charikpong H/C</td>
</tr>
<tr>
<td>2nd PNC 7 days</td>
<td>09/01/2013</td>
<td>10/01/2013</td>
<td>Saa CHPS Compound</td>
</tr>
<tr>
<td>3rd PNC 6 weeks</td>
<td>14/02/2013</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Challenges: Neonatal deaths are poorly recorded as no names given by families, no funerals and these deaths are not discussed by families. Home visits are not well established and challenges are also due to the cultural practices of restrictions on when and who is allowed to see the newborn. Emergency preparedness is low due to inaccessible roads, poor transportation, lack of communication, inadequate equipment for newborn care, lack of skills and poor staff attitude. There are data challenges as data from facility to regional levels sometimes do not tally.

Way forward: maternal death audit teams are due to include neonatal death audits. On-site training of midwives in newborn survival interventions are to be instituted. Community based Surveillance Volunteers (CBSVs) to be utilized to assist in verbal autopsies. Region will set up model communities and league tables to promote zero tolerance of neonatal deaths. The community emergency transport system will be strengthened. To link up with training institutions to ensure requisite practical aspects of training are undertaken.

Northern Region

Performance indicators: There has been a gradual increase in skilled deliveries (Fig. 18). Of concern is the rise in infant death rate (Fig 19). About 80% of newborns who died were delivered by traditional birth attendants (Fig 20).

Achievements: Advocacy - District Assemblies/traditional leaders support for maternal and new born care was solicited in all the 7 implementing districts. Communities - 100 sensitization durbars were carried out in the entire 7 selected districts between October and December 2012.
Health centres/CHPS - 700 volunteers were trained over the past year in all the 7 districts to identify sick newborns and refer. They consisted of – CBAs, TBAs, Community Based Surveillance (CBS) volunteers, MTMSGs and growth promoters. A total of 230 front-line workers consisting of CHOss, CHNs and Enrolled Nurses were trained on new born care.

District hospitals - Medical assistants and midwives were trained as intermediate referral points (health center level). Medical officers were trained on essential new born care. Medical Officers also trained in life saving skills (LSS) organized by Liverpool school of tropical medicine, this includes new born care.

Fig. 18

**ANC 4+ VISITS AND SKILLED DELIVERY TREND 2010 - 2012**

- 4+ ANC TG = 60
- Skilled Del = 58%
- Gradual increase in both indicators
- Skilled del achieved target - re-basing of population

Fig. 19
Trainer of trainers (TOTs) - regional and district staff consisting of doctors, midwives, public health nurses and HPO were trained as TOTs. 5 of the TOTs were selected as champions.

Regional Referral Points - Tamale central hospital has been identified as the regional referral hospital for newborn care. Midwives and other nurses have been trained for this.

Innovations: Neonatal network and support system (NNSS) linking peripheral health centers to the neonatal unit in Tamale Teaching Hospital to improve patient referral has been established. Most facilities have been given phones to call to the neonatal unit before referral. CBSVs Neonatal and Infant death audits have been instituted.

Other innovations: Parent classes on basic newborn care (eye, cord care, bathing and identifying danger signs) have been instituted. A neonatal registry has been established in Tamale Teaching Hospital. Training on newborn care for both staff of the NICU and staff of referring centres is being undertaken.

Fig. 20
Challenges: There is a continuous demand for staff time – limited staff who are burdened with other key activities in their facilities. There exist human resource shortages. There are inadequate training materials for volunteers training.

Way forward: To establish NICUs in other strategic facilities in the region. NICU equipment obtained from Japan Government through UNICEF to be sent to Bole, Tamale Central Hospital, Yendi and Savelugu. The region will work with Tamale Teaching Hospital to help establish these centres. The region will also re-enforce the neonatal network and support system (NNSS). There will be mop up training for CHOs, CHNs, doctors and midwives on newborn care. CHOs/CHNs will be re-trained on data management and accurate data capturing. Home visits to be intensified by CHOs. There is the need to carry out newborn care data validation. The referral capacity in health facilities will be strengthened to cater for mothers and the newborn and to create linkages between communities and referral services.

**Brong Ahafo Region**

Achievements: There has been a steady rise in percentage of skilled deliveries (Fig. 21). The percentage of babies born low birth weight has also shown a gradual rise.

Interventions: Training of relevant staff on management of labour, neonatal resuscitation and immunisation has been undertaken. There is IPC practice intensification. Exclusive breastfeeding practices are being re-enforced. Trained staff are being maintained in their areas of expertise eg paediatric nurses at NICU. There is increasing collaboration with relevant partners, example, Project 5s Alive.
Way forward: To implement the MAF Plan. To partner with IPAS to implement the Comprehensive Abortion Care. To implement UNFPA Annual Work plans in six selected districts in the Region. The region will partner with NGOs, Queen mothers, District Assemblies, regional coordinating council and MDAs to scale up reproductive health services. Plea was made to UNICEF, JICA and others to come and support the region.

Ashanti Region

Interventions: Promotion of 2 PNC visits - Midwives, Public Health Nurses & CHNs have been orientated on this. Health Information Officers have also been orientated during DHIMS 2 training. Monitoring/supportive visits are being carried out and antenatal clinic mothers are being sensitized on the new practice of 2 PNC visits. KMC - midwives in Kumasi have been trained with support from MASHAV and mothers are being educated on KMC for LBW babies. Infrastructure for KMC has been provided at Suntreso & Kumasi South Hospitals.

Activities planned for 2012/2013: Integrated Management of Neonatal and Childhood Illnesses (IMNCI) training will be undertaken. Staff will be trained on neonatal death audit and these audits will be implemented. Doctors and midwives will be trained on FANC. Assessment of facilities for baby friendly status to be undertaken.

Activities carried out: Training in neonatal resuscitation has been done with support from Latter Day Saints Church. Midwives have undergone training in safe
motherhood. The region has implemented the friendly labour ward concept. Supportive supervision has been carried out in maternity units. There has been community sensitization on early PNC visits.

Innovation: A maternal waiting home has been established in a deprived district (Bosome Freho). The region has implemented maternal/neonatal taskforce activities.

Challenges: There are insufficient resuscitation equipments. There is a knowledge gap in new born care among staff and clients. Funds available for training and monitoring are inadequate.

Way forward: Will implement the regional action plan on new born care. The region will work with PATH and Project Fives Alive! to implement new born care programme. The Region will intensify capacity building for service providers in neonatal care.

**Volta Region:**

Achievements: performance indicators show a slight increase in percentage of skilled deliveries (Fig. 22)

**Fig. 22**

<table>
<thead>
<tr>
<th>PERFORMANCE INDICATORS ON NEWBORN 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INDICATOR</strong></td>
</tr>
<tr>
<td>SKILLED DELIVERY (%)</td>
</tr>
<tr>
<td>LOW BIRTH WEIGHT (%)</td>
</tr>
<tr>
<td>STILL BIRTHS (SB) %</td>
</tr>
<tr>
<td>FRESH SB (%)</td>
</tr>
<tr>
<td>MACERATED SB (%)</td>
</tr>
</tbody>
</table>

Activities: The region has developed a reporting format to aid districts report home visits and other community level activities. Facilities have been equipped to practice KMC. Early infant diagnosis of HIV is being carried out. A regional stakeholder meeting on newborn care was held. Training of improvement coaches for all hospitals has been undertaken with Project Fives Alive!
Challenges: There is inadequate knowledge and skills of service providers about neonatal care. There is no neonatal intensive care unit in the region. Insufficient financial resources at the district level to carry out regular home visits. There is irregular supportive supervision to health facilities.

Way forward: To undertake regular supportive supervision to facilities conducting deliveries. To ensure the provision of resources at the district level to facilitate home visits for babies delivered at home and for the second PNC visit. A Mother Baby Unit (MBU)/ neonatal intensive care unit will be established in the region. A regional coordinator on new born care will also be appointed. MoTech will organize a forum with queen mothers on maternal and newborn care.

**Western Region**

Performance indicators: Figs.23 & 24 show a gradual reduction in Infant mortality rate as at 2008. There has also been a gradual increase in skilled deliveries (Fig. 25)

**TREND OF REGIONAL PERFORMANCE IN SOME KEY MATERNAL AND CHILD HEALTH OUTPUT/OUTCOME INDICATORS-GDHS**

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Fertility Rate</td>
<td>5.54</td>
<td>4.70</td>
<td>4.50</td>
<td>4.2</td>
<td></td>
</tr>
<tr>
<td>Infant Mortality Rate/1,000 LB</td>
<td>76.9</td>
<td>76.3</td>
<td>68.0</td>
<td>66.0</td>
<td>51</td>
</tr>
<tr>
<td>Under 5 Mortality/1,000 LB</td>
<td>151.2</td>
<td>131.8</td>
<td>109.7</td>
<td>109.0</td>
<td>65</td>
</tr>
<tr>
<td>Neonatal Mortality Rate/1,000 LB</td>
<td>47.3</td>
<td>38.3</td>
<td>37.0</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Perinatal Mortality Rate/1,000 LB</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Under 5 Malnourished</td>
<td>33.1</td>
<td>25.6</td>
<td>16.5</td>
<td>10.3</td>
<td></td>
</tr>
</tbody>
</table>

Activities planned (2012/2013): Training of Midwives in LSS undertaken. Promoting Maternal Infant Survival Excellence (PROMISE) initiative conference was held in April 2012. Distribution of equipment procured by MOH/FRHP was done. Assessors were brought in to the region to assess 13 health facilities as baby-friendly. A 5-day training for staff in infant and young child feeding & counselling was carried out. Establishment of Pregnancy Schools has been implemented in all districts. Clinical supervisory visits have been undertaken to selected MNCH facilities. Training of staff
(CHOs, Medical Assistants, and Clinical nurses) in IMNCI was undertaken. Supportive on-the-job supervision in IMNCI has been conducted in selected health Institutions. The implementation of other Focus Regions Health Project activities have been undertaken.

Fig. 24

**TRENDS OF INFANT MORTALITY RATE (PER 1000 LIVE BIRTHS) IN WESTERN REGION FROM NATIONAL SURVEYS**

<table>
<thead>
<tr>
<th>Year</th>
<th>Reg IMR</th>
<th>Nat IMR</th>
<th>Nat $ Reg Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992 GRHS</td>
<td>76.9</td>
<td>76.3</td>
<td>69.7</td>
</tr>
<tr>
<td>1993 GRHS</td>
<td>68.7</td>
<td>68.4</td>
<td>62.4</td>
</tr>
<tr>
<td>1998 GDHS</td>
<td>70.1</td>
<td>71.0</td>
<td>55.1</td>
</tr>
<tr>
<td>2003 GDHS</td>
<td>47.9</td>
<td>47.8</td>
<td>40.5</td>
</tr>
<tr>
<td>2006 MICS</td>
<td>40.5</td>
<td>43.3</td>
<td>38.3</td>
</tr>
<tr>
<td>2008 GDHS</td>
<td>33.2</td>
<td>47.9</td>
<td>32.2</td>
</tr>
<tr>
<td>2011 MICS</td>
<td>25.0</td>
<td>49.3</td>
<td>20.0</td>
</tr>
</tbody>
</table>

Fig. 25

**Trend of Skilled Delivery Coverage - 2007 to 2012**
Activities carried out: Two Postnatal visits - sensitization of health staff about the new policy on PNC has been done. Discussions on preparation and submission of returns were held at various forums and during monitoring visits. Community sensitization on PNC visits have been undertaken. Monitoring of early PNC visit through DHIMS is being done. Kangaroo mother care - training of midwives undertaken during LSS sessions. Sensitisation of health staff about KMC at the PROMISE conference and at general meetings occurred. There was also community sensitization about KMC. Guidance of mothers on KMC is being undertaken by trained midwives during antenatal and post-natal sessions. Implementation of intensive activities occurred under the Focus Region Health Project.

Innovations: PROMISE Initiative (since 2009) - main focus is on motivating health personnel and communities to carry out key result-driven activities using limited funds.

Challenges: Inadequate number of midwives and Public Health Nurses in districts. Consolidating and sustaining Pregnancy schools is challenging. There is incomplete capture of TT2 figures by service providers. Monitoring progress and sustaining PROMISE initiative is problematic. There is inadequate critical equipment for many hospitals. Staff turnover especially at CHPS compounds is high. There is a general problem with quality of data management.

Way forward: Inventory of critical staff to be used as a guide for new postings and redistribution. Training of more midwives in safe motherhood skills will be carried out. Monitoring of reporting on pregnancy school and registration at community and Institutional level is required. Strict implementation of MAF plan is required to ensure sustenance of the positive trends in MNCH performance. Baby Friendly Facilities will be monitored. Improve TT2+ data capture by trainings and discussions at various forums. There will be lobbying of more sources for funding of future “PROMISE” sessions. To in-corporate “Let it happen” strategies into future conferences. The curricula of pre-service training institutions will be influenced to make it more responsive to the needs of the region. The region will improve the content of maternal and newborn health during orientation of new RCH staff. Inclusion of more equipment requests in plans to FRHP will be made. Refresher training to be undertaken for more RCH staff at all levels.

**Greater Accra Region**

Achievements: Skilled delivery coverage is gradually improving (Fig 26).

Activities: Post natal care - Capacity building training for midwives undertaken. Sensitization of all staff on the need for 2 PNC visits by 1 week of birth has been done. CHNs have been assigned to zones for home visits. Sensitization of new mothers on PNC visits being undertaken. Midwives link with CHNs to follow up new mothers in the communities. Pregnancy schools have been opened in some hospitals (Tema General Hospital, Achimota Hospital, Mamprobi Polyclinic) for the
education of fathers. Newly qualified health care assistant nurses have been trained and oriented and assigned to the PNC clinics and labour wards to assist midwives in postnatal care.

Breast feeding – Staff in most facilities have been trained on exclusive breastfeeding. There are 30 baby friendly facilities in the region. All hospitals and Polyclinics have been designated as baby friendly.

Kangaroo Mother care – There has been no formal training on KMC. Ridge hospital practices KMC. Thermal care is practiced in all facilities through skin to skin contact.

Capacity building - LSS training has been undertaken with emphasis on neonatal resuscitation, infection prevention practices and lactation management. Learning sessions have been organized for hospital quality improvement teams.

Activities planned (2012/2013): Training and Sensitizations on Job Aids for New born Care for Midwives. Perinatal Death Audits to be carried out. Training in Life Saving Skills and infant resuscitation will be carried out. There are plans to Upgrade NICU services at Ridge Hospital. Training of improvement coaches to promote under-5 care to be undertaken. The Region will form hospital and polyclinic quality improvement teams.

Activities carried out: Training and Sensitization on Job Aids undertaken. Midwives have been trained on Job Aids. Perinatal Deaths Audit has been piloted at Ridge and
La General. There was sensitization of Regional Health Management Team on Job Aid on Newborn Care. Training in LSS and Neonatal Resuscitation has been undertaken. There has been collaboration with partners in securing equipment including incubators, radiant warmers, weighing scales in a bid to improve the quality of newborn care.

Innovations: A Creche for infants of staff has been established at Maamobi hospital. The region is in the process of setting up a call centre to give expert advice and coordinate emergency referrals

Challenges: Supervision of trained staff to utilize the new skills acquired. There is a general lack of funds to support planned activities. Incomplete Documentation on mortality audit Forms. There is a lack of adequate working areas and inadequate numbers of staff, especially pediatric nurses, in most health facilities.

Way forward: To roll out the use of the peri-natal audit guidelines. There will be training of staff in KMC and intensification of supportive supervision.

Day 2: Tuesday, 22nd July 2013

Group Work: To develop 3 year plans for accelerating the scale up of interventions to reduce neonatal mortality. All the regions represented were tasked to develop three year plans. The National team also evaluated what had been achieved over the past year and developed a three year plan.

Presentation of plans by regions – Five regions presented their draft 3-year plans. All regions were tasked to complete the plans and submit within two weeks of their return to their regions. Regional and National Plans are attached. See appendix.

Discussion:

The regions were advised to turn their attention to districts and facilities that were not performing well so as to institute interventions to strengthen them. Facilities and health workers should have protocols and guidelines to improve standards of care.

The issue of data capture being defective was mentioned and the importance of addressing this was stressed.

On the question of the mandate and training given to volunteers, it was noted that the volunteers are mainly involved in preventive health care, example, home visits to pregnant women, promoting birth preparedness, advising on keeping babies warm, breast feeding and seeking care for sick newborns. Regions were advised to effectively monitor volunteers by CHOs and to ensure that capacities of existing volunteers are built up for newborn care instead of training new volunteers.
Regions were advised to map out the key stakeholders in their districts who would be able to help implement the regional plan.

Regions were also advised to think about how best to reach the difficult-to-reach areas.

**Closing Address**

The UNICEF Child Health Specialist, Dr Banskota, congratulated GHS and all stakeholders for the roles they have played so far. He emphasized the importance of a good continuum of care, tackling prematurity, birth asphyxia and neonatal sepsis and urged the regions to include in their plans two major interventions that would address these. Hard to reach areas should be tackled lower down as problems should be addressed where they are found. There should be identification of pertinent issues, brainstorming, planning and then sharing ideas with the higher level. No child below five years should die. People should enjoy quality care. The country should have one integrated plan and strategy with one framework at all levels. There should be integrated implementation, monitoring and evaluation. An integrated continuum of care should be ensured. There should be the right care, at the right place and at the right moment. At health facilities, should not separate safe motherhood from newborn care so maternity and paediatrics should be linked. The key process indicators that need monitoring include 4+Anc visits, use of partograph, skilled delivery, IPT2, PMTCT, C/S rate. PNC at CHPS, facility and district levels should be monitored. Regions should include data on premature births and stillbirths in reports as it is important to be able to determine if the regions are achieving their objectives.

The meeting ended at 4pm.
Best Practices and innovations

General:
District Assemblies/traditional leaders support for maternal and new born care solicited
Forum with queen mothers
Community sensitization durbars
Hospital and polyclinic quality improvement teams
Setting up a call centre to give expert advice and coordinate emergency referrals

Antenatal care:
Maternal waiting home in deprived district
Saturday pregnancy schools for fathers.
Education on newborn care including KMC at antenatal clinics

Delivery:
Institution of telephone directory for emergency obstetric and neonatal care.
Community emergency transport system.

Newborn & Postnatal:
Quality improvement initiatives - all staff at the various facilities participating in the initiative were trained in KMC, management of neonatal sepsis and neonatal resuscitation. Training is very practical, resulting in a high level of confidence afterwards. All staff who could potentially be required to use these skills are included.

Neonatal network and support system (NNSS) linking peripheral health centers to the NICU in TTH to improve patient referral, most facilities given phones to call to the NICU before referral.

Link mothers who deliver in health facilities to CHOs for community visits.
Linking low birth weight babies to CHO for follow up.
Durbars to educate community on KMC.
Parent class on basic newborn care
Application of Chlorhexidine for cord care effective in prevention of neonatal deaths.
Volunteers trained to identify sick newborns and refer
Stamp designed and used for easy visibility of postnatal visit dates by mothers.

Conduct daily postnatal clinics, fortnightly clinics for neonates.

Perinatal/neonatal death audit meetings weekly.

Model communities and league tables for zero tolerance of neonatal deaths.

Creche for staff infants created at Maamobi hospital.
RECOMMENDATIONS:

Policy

Maternity leave should be extended to six months or more

Should institute Baby friendly workplaces in GHS facilities and advocate for this in all workplaces, nationwide.

Strategy

A concerted national action by all stakeholders is required and this is crucial.

A standardised tool for neonatal audit should be developed at National level.

The Paediatric Society of Ghana tasked to come up with a standardised tool for neonatal examination.

Integration of known Continuous Quality Improvement methods found to be successful in sections of the health system, including standardizing approved protocols and guidelines for improved maternal and newborn care should be scaled up nationwide.

Service delivery

There is the need to improve coverage and quality of all interventions that will improve newborn care.

Ensure interventions to reduce morbidity and mortality in particular from prematurity, birth asphyxia and neonatal sepsis are scaled up.

Transfer of paediatric trained nurses to units where their skills are not utilised should be avoided.

Clinical care and public health teams should work together to ensure follow up of new borns after discharge from facilities.

Effective linkages should be created between communities and referral services.

Capacity in referral facilities to care for mothers and the newborn must be strengthened.

There is the need to work out greater cohesion and clearly outline Public Health and Clinical care roles for Public health and Clinical Care units towards the planning, implementation and monitoring of neonatal interventions at regional and district levels.

Capacity building

Community Health Nurses should be trained in postnatal care
A simpler training guide for CHO/CHN should be developed

Nurses’ and midwives’ training should address new born survival issues effectively.

Discussions should be held with health training institutions to ensure pre-service curricula incorporate modules that will impart the required knowledge and skills.

**Data management**

All levels of the health workforce should be trained to enable the requisite use of data management in informed decision making.

Strengthen data management at all levels as this is a critical component for planning, monitoring and evaluation.

Data on premature births and still births should be reported on.