THIRD BIENNIAL MEETING OF THE INDEPENDENT REVIEW GROUP ON VALIDATION OF EARLY ESSENTIAL NEWBORN CARE PROGRESS

27–29 November 2019
Manila, Philippines
Third Biennial Meeting of the Independent Review Group on Validation of Early Essential Newborn Care Progress
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MEETING REPORT

THIRD BIENNIAL MEETING OF THE INDEPENDENT REVIEW GROUP ON VALIDATION OF EARLY ESSENTIAL NEWBORN CARE PROGRESS

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NOTE

The views expressed in this report are those of the participants in the meeting and do not necessarily reflect the policies of the World Health Organization.

This report has been prepared by the World Health Organization Regional Office in the Western Pacific for those who participated in the Third Biennial Meeting of the Independent Review Group on Validation of Early Essential Newborn Care Progress which was held in Manila, Philippines from 27 to 29 November 2019.
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**KEYWORDS:** Infant, Newborn/ Infant care/ Infant welfare/ Child health services/ Regional health planning
SUMMARY

Since the endorsement of the *Action Plan for Healthy Newborn Infants in the Western Pacific Region (2014–2020)* in 2013, eight countries with the highest burdens of maternal and newborn mortality have rolled out Early Essential Newborn Care (EENC) to improve quality of care. In 2015 and 2017, an Independent Review Group (IRG) convened to review and validate country progress with EENC implementation. With several actions taken in countries since 2017 to strengthen implementation, the Independent Review Group reconvened to validate new data. Vanuatu, which rolled out EENC in 2018, also submitted data for review.

The Third Biennial Meeting of the Independent Review Group on Validation of Early Essential Newborn Care Progress was held in Manila, Philippines from 27 to 29 November 2019. All priority countries (Cambodia, China, the Lao People’s Democratic Republic, Mongolia, Papua New Guinea, the Philippines, Solomon Islands and Viet Nam, as well as Vanuatu (at the country’s request)) submitted data on all indicators in the regional EENC monitoring and evaluation framework.

The principal conclusions of the workshop were as follows:

**EENC impact and population coverage**

- Data on population coverage and impact measures for newborn health were validated for all countries. Population-based surveys undertaken since 2017 in three countries (Lao People’s Democratic Republic, Mongolia, Papua New Guinea) included new indicators on skin-to-skin contact, drying and early bathing.
- Newborn mortality is estimated to have decreased by 15–50% in seven of the nine countries since the adoption of the Action Plan in 2013. For the Lao People’s Democratic Republic, Mongolia, Papua New Guinea and the Philippines, comparisons with previous survey data show improved trends in breastfeeding initiation and exclusive breastfeeding in the first month of life.
- Overuse of caesarean section remains a challenge in some countries of the Region. In four countries with new data since 2017 (China, Lao People’s Democratic Republic, Mongolia, Philippines), population-based caesarean section rates have increased by 2–3%, with rates higher in urban areas.
- Hospital impact measures were reported by the nine countries, with data quality issues noted for indicators disaggregated by gestational age and birthweight and on sepsis and birth asphyxia. These findings were substantiated by assessments of hospital information systems for maternal and newborn health, which found numerous data gaps, including incorrect application of indicator definitions and nonrecording of stillbirths.

**EENC scale-up readiness benchmarks**

- Data on EENC scale-up readiness were available and validated for all countries. Improvements were noted in all benchmarks except the inclusion of EENC in pre-service training curricula, which has been partially done in four of the nine counties and has shown no progress since 2017.
EENC clinical practices

- Data on EENC health facility standards were available and validated for each of the nine countries.

- An estimated 5955 facilities are implementing EENC, a 77% increase from 2017. Four countries have achieved the regional target of 80% of childbirth facilities implementing EENC, and an additional two countries are on track to achieve the target by 2020.

- Validated data show that close to 35,000 staff have been coached on EENC in the nine countries, though country estimates put the figure at around 50,000 since roll-out in the Region. For more accurate estimates of facilities that have introduced EENC and health workers coached, data collection needs to be improved.

- An estimated 278 national, regional, and provincial hospitals (63% of hospitals excluding China) have begun implementation of Kangaroo Mother Care (KMC) (using EENC Module 4) across the nine countries. In five countries with available data, 68% of staff providing childbirth and newborn care services have been coached in hospitals implementing KMC.

- Effective delivery practices in the priority countries showed no change from 2017, with less than half of all women having a companion of choice (26%) and more than half adopting a non-supine position in the second stage (57%), food and fluids (66%) and correctly completed partograph (54%). Harmful practices (enema [17%], fundal pressure [18%]) were less likely to be practised than in 2017, a positive trend.

- The proportion of babies receiving any skin-to-skin contact (91%) improved from 2017. Immediate skin-to-skin contact (72%) and exclusive breastfeeding (78%) remained high and unchanged. Less than half of all babies received uninterrupted skin-to-skin contact for at least 90 minutes (37%) and completed a first breastfeeding of at least 15 minutes while in skin-to-skin contact (33%) – small improvements since 2017.

- Immediate newborn care for stable preterm and low birthweight (PTLBW) babies has marginally improved since 2017. PTLBW babies were less likely than term babies to receive any skin-to-skin contact (69%) or immediate skin-to-skin contact (58%), complete a first breastfeeding of at least 15 minutes (13%), remain in uninterrupted skin-to-skin contact for at least 90 minutes (18%) and be exclusively breastfed (75%) in the first days of life. Close to half of PTLBW babies (≤ 2000 grams) received KMC, but only 10% received continuous KMC for at least 20 of the previous 24 hours.

- Since 2017, countries have adopted national protocols to guide EENC implementation during cesarean section. Still, babies born by cesarean section are significantly less likely than those born vaginally to receive all early care practices.

- Episiotomies were performed in 27% of deliveries (range: 2% in Vanuatu to 49% in Vietnam), an increase of 4% from 2017.

EENC monitoring and evaluation: methods and tools

- Testing and completion of EENC Module 5: Managing Childbirth and Postpartum Complications is a high priority for some countries in the Region, followed by its scale-up and use for hospital planning. Updates are proposed to the assessment tool.
- Establishing EENC centres of excellence (CoE) will help to build national and subnational capacity, establish accreditation criteria and provide incentives. Finalized guidance on EENC CoE should now be tested in countries where this is a priority.

- Guidance to promote and enforce nonseparation of mothers and newborns is critical towards improving newborn health outcomes. Draft regional guidance should be further reviewed, finalized and adapted for use in countries where this is considered a priority.

Member States were encouraged to consider the following:


2) Conduct or follow up assessments of hospital information systems for maternal and newborn health to identify and manage gaps and develop strategies to improve data quality.

3) Continue biennial EENC implementation reviews using the revised and updated indicators for planning and tracking progress (EENC Module 1).

4) Support the continued scale-up of EENC in caesarean section and KMC at hospitals by developing and enforcing nonseparation guidance, developing accreditation mechanisms, and identifying and managing other system barriers.

5) Begin assessments of complications during childbirth (EENC Module 5) to identify gaps and take actions to improve childbirth care.

6) Adopt hospital CoE standards and begin the process of accreditation in collaboration with the WHO Regional Office for the Western Pacific.

7) Develop approaches to evaluating EENC pre-service training curricula.
1. INTRODUCTION

In response to the challenge of continued high rates of newborn mortality, the WHO Regional Office led the development of the Action Plan for Healthy Newborn Infants in the Western Pacific Region (2014-2020).\(^1\)\(^2\) The Action Plan outlines an approach to improve the quality, reach and demand for key childbirth and newborn care services through implementing and scaling up Early Essential Newborn Care (EENC). EENC is a package of simple and low-cost interventions, demonstrated to be effective in preventing newborn deaths from the most common causes. In addition, EENC promotes the cessation of outdated, harmful or ineffective practices that are still widespread. At the October 2013 session of the Regional Committee for the Western Pacific, Member States noted the Action Plan and recognized the need to take steps to change current practices to save newborn lives and prevent illness in the Region.\(^3\) At the 2016 and 2019 sessions of the Regional Committee, Member States noted the significant progress in the Region and affirmed their commitment towards realizing the goals of the Action Plan and improving newborn health.

1.1 Background

Since 2013, eight priority countries with the highest rates of newborn mortality (Cambodia, Lao People’s Democratic Republic, Mongolia, Papua New Guinea, Philippines, Solomon Islands, Viet Nam) and the highest number of newborn deaths (China) have implemented the EENC Action Plan. In August 2015, four technical experts representing the fields of midwifery, obstetrics and gynaecology, neonatology, and paediatrics convened to review and validate country data on implementation of the Action Plan. In 2016, the Independent Review Group for Early Essential Newborn Care (IRG) was formally established, comprising six technical experts. This meeting represented the third review of country EENC implementation data since 2015, to validate data on progress in implementation of EENC and data quality and to advise on how to improve indicators, data collection and information use. Vanuatu, which rolled out EENC in 2018, also submitted data for the 2019 review.

The meeting was held on 27–29 November 2019 in Manila, Philippines. Six independent experts who form the IRG (from China, United Kingdom of Great Britain and Northern Ireland, Japan, Philippines, United States of America, Viet Nam) were responsible for validating country data. Resource persons included a maternal and child health consultant and two technical officers from the Maternal Child Health, Quality and Safety Unit of the Division of Health Systems and Services at the WHO Regional Office for the Western Pacific (see Annex 1 for a list of participants). The meeting agenda and timetable are provided in Annexes 2 and 3, respectively.

1.2 Meeting objectives

The objectives of the meeting were:

1) to validate the most recent EENC monitoring and evaluation data submitted by countries;

2) to prioritize and recommend additional indicators on antenatal care and caesarean section for the EENC monitoring and evaluation framework; and

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\(^3\) Early Essential Newborn Care: Clinical practice pocket guide. Manila: WHO Regional Office for the Western Pacific; 2014.
3) to provide recommendations on improving data quality and information use in countries.

2. PROCEEDINGS

2.1 Opening remarks

Participants were welcomed by Dr Howard Sobel, Coordinator of the Maternal Child Health, Quality and Safety Unit at the WHO Regional Office. In his opening presentation, he noted that in several countries EENC has been used as an example of a practical systems approach and adopted for other programme areas. He emphasized that regular validation of country data continues to be essential to tracking progress and ensuring that data and methods used are valid and reliable. He described the progress that has been made since 2017, including: the publication of the Second Biennial Progress Report: Action Plan for Healthy Newborn Infants in the Western Pacific Region (2014–2020) in 2018; further introduction in additional countries beyond the Western Pacific Region, including Bhutan, Myanmar, Lesotho and Pakistan; publication of several peer-reviewed journal articles documenting EENC progress; and downward trends in neonatal mortality in several countries. Following participant introductions, Dr Maria Asuncion Silvestre, neonatologist and public health specialist, was elected to chair the meeting.

2.2 Methods

The workshop was conducted as small-group reviews of country data, followed by plenary discussions on EENC monitoring and related programme tools.

2.3 Summary of findings: review of country data

In advance of the workshop, countries submitted data on indicators in the Early Essential Newborn Care Monitoring and Evaluation Framework (2015–2020). The framework tracks key inputs, outputs, outcomes and impact measures in five data tables: (1) scale-up readiness benchmarks, (2) health facility standards, (3) hospital impact, (4) EENC population coverage, and (5) EENC impact indicators. In addition, countries provided supporting documents to validate the status of each indicator. Country data and supporting documents were entered in an online maternal and child health data portal, recently developed by the Maternal Child Health, Quality and Safety Unit.

To conduct the validation, the IRG divided into pairs, with each pair reviewing data from three countries. IRG members did not review their own country data. Using the data portal, IRG pairs reviewed data and supporting documentation for each indicator and indicated whether data were available and validated, and provided any comments including reasons for non-validation if data were not validated. For Tables 2 and 3 of the EENC Monitoring and Evaluation Framework, the IRG verified primary data and conducted recalculations of indicators. For Tables 4 and 5, which are based on data from population surveys, data provided in summary reports (for example Demographic and Health Survey reports) and tabulations were considered adequate for validation purposes. Resource persons provided clarifications on country data and context, when necessary. Validation of country data was completed on the afternoon of the second day (28 November).

Review of EENC indicators and methods

On the afternoon of the second day and morning of the third day (29 November), the IRG, in plenary, commented on indicators in the Monitoring and Evaluation Framework advising on any revisions
required. Programmatic tools developed to improve monitoring and implementation of EENC were then discussed: standards for EENC centres of excellence (CoE), EENC Module 5: Managing Childbirth and Postpartum Complications, an updated nonseparation policy for babies born vaginally or by caesarean section, and future terms of reference (TOR) for the IRG. These discussions focused on technical definitions, standards, targets and programmatic questions related to how methods and tools will be used in country programmes. Final recommendations of each review and discussion were summarized.

Conclusions and recommendations

At the end of the third day, final conclusions and recommendations were developed and reviewed by the group, and next steps were agreed. Reviewers provided final clarifications on any pending issues related to country data in the two weeks following the workshop to develop reports on the validation of EENC data for each country.

2.3.1 Validation of country data and comments on EENC indicators

The status of EENC indicators by country are summarized in Tables 1 and 2. Validation findings and comments on indicators are presented below beginning first with EENC impact indicators to show how status of actions in other areas are contributing to achieving impact.

EENC impact indicators

Impact indicators for tracking newborn health impact were reported by all nine countries. Sources of impact data included the United Nations Inter-agency Group for Child Mortality Estimation (IGME) (for neonatal mortality estimates and causes of death),\(^4\) population based surveys, and routine surveillance data in countries with relatively high system coverage and reporting (China, Mongolia). Since 2017, data from new population-based surveys were available for three countries (Lao People’s Democratic Republic, Mongolia, Papua New Guinea). Modelled estimates were used to estimate preterm birth rates and low birthweight rates in some countries.\(^5,6\) Ninety-four per cent of impact indicators for newborn health were reported by countries. Data were most frequently unavailable for perinatal mortality. Ninety-four per cent of available data were validated (Table 1).

Main findings:

- Newborn mortality is estimated to have decreased by 15–50% in seven of the nine countries since the adoption of the Action Plan in 2013, based on modelled estimates by IGME. Largest estimated declines are noted in the Lao People’s Democratic Republic and Solomon Islands (Fig. 1).

- For all nine countries, preterm and/or low birthweight rates were based on modelled estimates. It is recommended that these indicators be included in population-based surveys or routine data systems, given their contribution preterm and low birthweight deliveries make to neonatal mortality.

- Countries should consider prioritizing improvements in the collection of newborn data using routine health management information systems (HMIS). Data from countries that have

\(^4\) WHO/Maternal Child Epidemiology Estimation group estimates. 2015 estimates reported in 2015 and 2017; 2017 estimates reported in 2019


conducted assessments of childbirth and newborn data reported in HMIS (Cambodia, Mongolia, Viet Nam) show several challenges, including under-registration and under-reporting of live births and neonatal deaths (number and causes), and application of incorrect indicator definitions or definitions that are not aligned with global recommendations. HMIS data are currently used for tracking newborn health impact data in two countries (China, Mongolia).

Fig. 1: Neonatal mortality rates in nine countries implementing EENC, 2013 and 2018

![Neonatal mortality rates in nine countries implementing EENC, 2013 and 2018](image)

**EENC scale-up readiness benchmarks**

Ten benchmarks are used to track scale-up readiness for EENC. All nine priority countries provided data for at least nine benchmarks, with data available for 93% of benchmarks overall. Ninety per cent of completed or partially completed benchmarks were validated (Table 1). Data were least often validated for the benchmarks “EENC stakeholder group formed” and “EECN technical working group meeting regularly” due to insufficient supporting documentation.

Main findings:

- All countries completed a newborn health situation analysis within the last five years, had a full-time EENC focal person in the health ministry and conducted an EENC implementation review in the last two years. Eight of the nine countries had adapted and produced the EENC clinical pocket guide and had a mechanism to ensure support of professional associations for EENC. Seven of nine countries had a funded 12-month EENC implementation plan available. Six of nine countries had a functional EENC technical working group and stakeholder group.

- Only four countries reported data on incorporation of EENC interventions in pre-service curricula, of which only two reported updated data from 2017. It was recognized that collecting these data is difficult and time consuming. Countries may have many different pre-service training institutions and curricula may differ between them. The IRG therefore recommended adding a sub-indicator: percentage of pre-service trainers that have received
EENC coaching. This may better capture progress towards integration. An audit-based method is required to review curricula and resources allocated for staff to conduct reviews.

Comments on indicators:

- It was advised that EENC implementation reviews cannot be counted as a newborn situation analysis, as the latter are broader and should include antenatal and postnatal care in addition to a review of impact and coverage data. In addition, the year of the situation analysis should be clearly noted.
- If the EENC technical working group and stakeholder group are comprised of the same core members, both of these benchmarks can be counted as completed.
- The definition of the benchmark “full-time newborn health focal point” proved difficult because staff are often requested to undertake activities in areas outside of newborn health. Staff in this position should be full-time or mostly full-time, provided additional responsibilities do not compromise their ability to complete newborn health programming.

**EENC health facility standards**

Twenty-three indicators are reported for EENC facility standards. Data were available for 56% of indicators across all countries, partially available for 41% and not available for 3%. Of all indicators, 91% were validated (Table 1). Data validation was not possible for a few indicators where supporting data were not provided, or where different indicator definitions were applied.

Main findings:

- An estimated 5955 facilities with more than 50 deliveries per year are implementing EENC across the nine countries: a 77% increase from 2017. An additional 153 health facilities with fewer than 50 deliveries per year have introduced EENC, increasing the total to 6108 facilities. Four countries have achieved the regional target of 80% of childbirth facilities implementing EENC, and an additional two countries are on track to achieve the target by 2020 (Fig. 2).
- Validated data show that close to 35 000 staff have been coached on EENC in the nine countries, though country estimates put the figure at around 50 000 since roll-out in the Region (Table 2). Coaching data for some countries were not complete (for example, some data were not data not available from national hospitals) or could not be validated due to concerns on data quality (for example, use of assumptions to estimate numerators or denominators). Data collection methods need to be improved for both staff and facilities to allow coverage to be tracked over time. Denominators should be based on staff currently working in maternity and newborn care areas. Development and use of a standardized electronic system/form for capturing these data was recommended.
- An estimated 278 national regional and provincial hospitals (63% of hospitals excluding China) have begun implementation of Kangaroo Mother Care (KMC) (using EENC Module 4) across the nine countries. In five countries with available data, 68% of staff providing childbirth and newborn care services have been coached in hospitals implementing KMC.
• Seventy-one per cent of hospitals had established an EENC hospital team, a 16% increase from 2017. A quality improvement approach was being used in 31% of hospitals, a 12% increase from 2017.7

Fig. 2: Proportion of facilities that have introduced EENC, by country, 2017 and 2019

- Effective delivery practices in the priority countries showed no change from 2017, with less than a third of women having a companion of choice at birth (26%) and half assuming a non-supine position in the second stage (50%), encouraged food and fluids (65%) and having a correctly completed partograph (54%). Harmful practices (enema [18%], fundal pressure [18%]) were less likely to be practised than in 2017, a positive trend.

- Forty-one per cent of mothers have syphilis test results recorded, a 9% increase from 2017. HIV screening results were recorded for 50% of cases, a decline from 55% in 2017.

- The proportion of babies receiving any skin-to-skin contact (91%) improved 5% from 2017. Babies receiving immediate skin-to-skin contact (72%) remained high with minimal change, while a 7% decrease was noted for babies exclusively breastfed in the immediate newborn period (from 85% in 2017 to 78% in 2019). Less than half of all babies received uninterrupted skin-to-skin contact for at least 90 minutes (37%) and completed a first breastfeed of at least 15 minutes while in skin-to-skin contact (33%) – small improvements since 2017.

- Immediate newborn care for stable preterm and low birthweight (PTLBW) babies has marginally improved since 2017. PTLBW babies were less likely than term babies to receive any skin-to-skin contact (69%) or immediate skin-to-skin contact (58%), complete a first breastfeed of at least 15 minutes before separation (13%), remain in uninterrupted skin-to-skin contact for at least 90 minutes (18%) and be exclusively breastfed (75%) in the first days of life (Fig. 3). Close to half of PTLBW babies (≤ 2000 g) received KMC, but only 10% received continuous KMC for at least 20 of the previous 24 hours.

- Since 2017, countries have adopted national protocols to guide EENC implementation during caesarean section. Babies born by caesarean section are significantly less likely than those

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7 Quality improvement approach consists of: (1) regular and documented meetings of the EENC team, (2) at least two EENC assessments per year, and (3) developing and updating an EENC hospital action plan at least quarterly.
born vaginally to receive all early care practices. Of caesarean births, 73% received any skin-to-skin contact. Less than half received skin-to-skin contact within 1 minute (43%), completed a first breastfeed of at least 15 minutes before separation (18%) and received skin-to-skin contact for at least 90 minutes (20%) (Fig. 4).

- Episiotomies were performed in 27% of deliveries (range: 2% in Vanuatu to 49% in Vietnam), decrease of 10% from 2017.

**Fig. 3: Skin-to-skin practices for term and preterm/low birthweight babies, nine countries, 2019**

![Graph showing skin-to-skin practices for term and preterm/low birthweight babies](image)

**Fig. 4: Skin-to-skin practices for term babies born vaginally and by caesarean section, nine countries, 2019**

![Graph showing skin-to-skin practices for term babies](image)

- Thirty-five per cent of maternity, neonatal intensive care (NCU) and postnatal care rooms had adequate sink handwashing facilities available: clean sinks with running water, soap and disposable towels (948/2676). Of all maternity and newborn care rooms, 72% (1926/2676) had alcohol hand gel available in the room on the day of the visit. In most facilities, gaps were noted in postnatal care rooms, where patients were required to provide soap and towels. In these rooms, provision and use of soap and towels were highly variable.

- Most resuscitation areas were clean and dry (97%, 896/925) and had functional ambu bags and masks (term and preterm) available (85%, 786/925).
• Four per cent (8/216) of hospitals had baby food company materials visible or available in a room. Half of hospitals (49%, 98/200) had hospital policies or orders prohibiting use of infant formula or linkages with milk formula companies displayed in wards or public areas.

• Health facilities were assessed to determine whether essential medicines and supplies were available on the day of the visit, stored correctly, had stock records available and with no stock-outs in the previous 12 months. Facilities were least likely to have fulfilled all these conditions for syphilis test kits (37%, 71/194), HIV test kits (58%, 112/194) and routine eye prophylaxis (59%, 114/194). These conditions were fulfilled for 70% or more of health facilities for other essential medicines and supplies.

Comments on indicators:

• Problems were noted with the definition of non-supine position in childbirth, which was in some cases applied to both first and second stages of labour. This indicator should be applied to the second stage of labour only (since it is virtually universal in the first stage).

• Denominators used for delivery practice indicators should be women who had a vaginal delivery. Caesarean section deliveries should not be included, as a proportion of cases delivered surgically are not eligible to receive the standard package of delivery services.

• Currently, the indicator on availability of hospital orders prohibiting use of infant formula and other linkages with milk formula companies is calculated as a proportion of all rooms with orders displayed, and the standard is 100% (all rooms have the order displayed). This standard is difficult to meet and may not be necessary. It is recommended that the definition of the indicator be modified to pertain to common care rooms or public spaces rather than all maternity, newborn and postnatal care rooms.

Hospital impact indicators

Nine indicators are reported on hospital impact, and data were reported by all countries. As in 2017, gaps in hospital data continue to be noted. Of hospitals that have introduced EENC, only 19% (n=126) reported hospital impact data. Complete data were available for 64% and partial data for 28% of indicators (Table 1). Frequently, data were not disaggregated by gestational age or birthweight. Partial reporting also occurred because not all hospital levels reported. Ninety-five per cent of hospital impact indicators with complete or partial data were validated. Clear trends in indicators are not yet visible within countries, which may be partly due to issues with data quality.

Comments on hospital impact data:

• Large-scale routine collection of hospital data has not been possible in any country except Mongolia, which has integrated hospital impact data into the routine maternal and child health (MCH) surveillance system that collects data every two weeks from all facilities using an electronic database.

• Assessments of hospital information systems for childbirth and newborn health in Cambodia, Mongolia, the Philippines and Viet Nam have proved useful for identifying gaps in data quality, reasons for these gaps and corresponding solutions. Practical and feasible action plans to strengthen these systems are now needed.

• Common problems identified include incomplete recording and/or reporting particularly for birth weight and gestational age and incorrect or inconsistent application of indicator definitions (mortality and preterm, birth asphyxia and sepsis births/deaths).
• Common reasons for gaps or problems include: the use of paper-based systems; lack of coordination between data collection mechanisms in maternity and newborn care areas; lack of staff training; absence of feedback on reported data; and lack of systems for data validation and quality assurance.

• Consider a regional approach to improving hospital information systems in hospitals meeting EENC centres of excellence standards or wishing to achieve excellence standards. By focusing on a smaller number of high-performing hospitals, methods and approaches can be developed and used to stimulate further country improvements. High-quality data from participating “sentinel” hospitals will then be available for national and regional monitoring.

**EENC population coverage indicators**

Thirteen indicators are reported to track population-based coverage. All nine countries reported on the coverage indicators, with data available for 78% of indicators. Ninety-six per cent of available data were validated. Coverage data were least often available from countries that have not conducted large-sample population-based surveys regularly. China reported all population-based indicators from routine health information system reports. Therefore, data were not available for several indicators. Viet Nam reported some population-based indicators from routine health information system reports. Indicators most frequently reported by all countries were skilled birth attendance, facility delivery rates and caesarean section rates, and mothers receiving postnatal care within two days of birth. Indicators least frequently reported continue to be immediate and postnatal newborn care practices and breastfeeding practices at 0 to 1 month.

Main findings:

• Population-based surveys undertaken after 2015 in three countries (Lao People’s Democratic Republic, Mongolia, Papua New Guinea) included new indicators on skin-to-skin contact, drying and early bathing. Most population-based surveys conducted before 2015 did not include early newborn care indicators. Programme managers and planners need to be actively involved in the questionnaire development process to ensure that national surveys include key newborn care indicators.

• For the Lao People’s Democratic Republic, Mongolia, Papua New Guinea and the Philippines, comparisons with previous survey data show improved trends in breastfeeding initiation and exclusive breastfeeding in the first month of life.

• In countries with population-based data on skin-to-skin contact, rates are well above 50% in Mongolia (58.9%) and the Philippines (72.7%), and below 50% in the Lao People’s Democratic Republic (16%) and Papua New Guinea (43%).

• Overuse of caesarean section remains a challenge in some countries of the Region. In four countries with new data since 2017 (China, Lao People’s Democratic Republic, Mongolia, Philippines), population-based caesarean section rates have increased by 2–3%, with rates higher in urban areas. Estimated caesarean section rates remain above the recommended target of 10% of live births in five of the nine countries.

• National coverage rates mask important inequities by wealth and education status, urban/rural residence and other factors that remain common in most countries.
### Table 1: Summary of the availability of EENC indicator data and validation status by country, November 2019

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<th>MNG</th>
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<th>PNG</th>
<th>SLB</th>
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<td>28</td>
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</tr>
<tr>
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<td>8</td>
<td>0</td>
<td>2</td>
<td>23/81 (28.4)</td>
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<td>6/81 (7.4)</td>
</tr>
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<td>9</td>
<td>9</td>
<td>9</td>
<td>71/75 (94.7)</td>
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<td>2</td>
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<td>4/75 (5.3)</td>
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</table>

#### Summary of EENC Review Table 4: Coverage indicators for EENC (N=13)

<table>
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<tr>
<th></th>
<th>KHM</th>
<th>CHN</th>
<th>LAO</th>
<th>MNG</th>
<th>PHL</th>
<th>PNG</th>
<th>SLB</th>
<th>VNM</th>
<th>VUT</th>
<th>n/N (%)</th>
</tr>
</thead>
<tbody>
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<td>6</td>
<td>12</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>10</td>
<td>11</td>
<td>9</td>
<td>91/117 (77.8)</td>
</tr>
<tr>
<td>Number with data not available</td>
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<td>7</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>26/117 (22.2)</td>
</tr>
<tr>
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<td>12</td>
<td>11</td>
<td>11</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>9</td>
<td>87/91 (95.6)</td>
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<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>4/91 (4.4)</td>
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</table>

#### Summary of EENC Review Table 5: Impact indicators for EENC (N=9)

<table>
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<th>LAO</th>
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<th>PHL</th>
<th>PNG</th>
<th>SLB</th>
<th>VNM</th>
<th>VUT</th>
<th>n/N (%)</th>
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<td>8</td>
<td>7</td>
<td>9</td>
<td>9</td>
<td>8</td>
<td>9</td>
<td>76/81 (93.8)</td>
<td></td>
</tr>
<tr>
<td>Number with data not available</td>
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<td>5/81 (6.2)</td>
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<td>9</td>
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<td>71/76 (93.4)</td>
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<td>Number not validated</td>
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<td>0</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6.6 (5/76)</td>
<td></td>
</tr>
</tbody>
</table>

KHM = Cambodia, CHN = China, LAO = Lao People’s Democratic Republic, MNG = Mongolia, PHL = Philippines, PNG = Papua New Guinea, SLB = Solomon Islands, VNM = Viet Nam, VUT = Vanuatu

* Validation of data applies only to those benchmarks for which data was available, and for benchmarks that had been achieved or partially achieved.

* Validation of data applies only to those indicators for which data was available or partially available.
Table 2. Health facilities that have begun coaching and total number of staff coached by country, November 2019

<table>
<thead>
<tr>
<th>System level</th>
<th>KHM</th>
<th>CHN</th>
<th>LAO</th>
<th>MNG</th>
<th>PNG</th>
<th>PHL</th>
<th>SLB</th>
<th>VNM</th>
<th>VUT</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>% (n/N)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td><strong>Total</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of health facilities providing delivery services that have begun EENC coaching</td>
<td>89.4 (1187/1328)</td>
<td>0.5 (118/25 860)</td>
<td>35.4 (105/297)</td>
<td>67.6 (69/102)</td>
<td>72.6 (300/413)</td>
<td>92.3 (1544/1673)</td>
<td>84.0 (37/44)</td>
<td>96.9 (2587/2669)</td>
<td>8/ No data</td>
<td>18.4 (5955/32 386)</td>
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<tr>
<td>National/Regional</td>
<td>55.6 (5/9)</td>
<td>1.0 (20/1954)</td>
<td>66.7 (4/6)</td>
<td>75.0 (9/12)</td>
<td>100.0 (1/1)</td>
<td>93.3 (111/119)</td>
<td>100.0 (1/1)</td>
<td>81.3 (13/16)</td>
<td>2/ No data</td>
<td>7.8 (166/2118)</td>
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<tr>
<td>First-level referral</td>
<td>93.9 (107/114)</td>
<td>0.5 (36/6850)</td>
<td>46.1 (70/152)</td>
<td>70.8 (24)</td>
<td>No data</td>
<td>85.0 (267/314)</td>
<td>100.0 (9/9)</td>
<td>98.6 (350/355)</td>
<td>4/ No data</td>
<td>11.2 (882/7849)</td>
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<tr>
<td>Primary health facilities</td>
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<td>0.9 (7009)</td>
<td>22.3 (31/139)</td>
<td>65.2 (43/66)</td>
<td>No data</td>
<td>94.0 (1166/1240)</td>
<td>79.4 (27/34)</td>
<td>100.0 (2224/2224)</td>
<td>2/ No data</td>
<td>39.9 (1360/3474)</td>
</tr>
<tr>
<td>Proportion of staff coached in health facilities that have introduced EENC</td>
<td>75.6 (4216/5578)</td>
<td>88.9 (3310/3724)</td>
<td>1235/No data</td>
<td>68.3 (1331/1949)</td>
<td>1186/No data</td>
<td>72.0 (3227/4485)</td>
<td>559</td>
<td>52.7 (8613/16354)</td>
<td>65.5 (72/110)</td>
<td>34 528</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National</td>
<td>254/No data</td>
<td>86.6 (1168/1349)</td>
<td>70.1 (138/197)</td>
<td>92.6 (654/706)</td>
<td>No data</td>
<td>75.1 (2506/3395)</td>
<td>126</td>
<td>55.9 (1887/1215)</td>
<td>65.2 (43/46)</td>
<td>6797</td>
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<tr>
<td>First-level referral</td>
<td>77.3 (931/1205)</td>
<td>85.9 (1094/1273)</td>
<td>1017/No data</td>
<td>77.0 (537/697)</td>
<td>No data</td>
<td>68.2 (722/1059)</td>
<td>100</td>
<td>52.2 (7426/14229)</td>
<td>73.7 (28/38)</td>
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<tr>
<td>Primary health facilities</td>
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<td>95.1 (1048/1102)</td>
<td>80/No data</td>
<td>25.6 (140/546)</td>
<td>No data</td>
<td>42.9 (39/91)</td>
<td>333</td>
<td>No data</td>
<td>16.7 (1/6)</td>
<td>5486</td>
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</table>

*a The 25 860 health facilities in China may not all provide delivery services. Denominator for first-level referral facilities may include regional facilities; 10 045 facilities in China do not have a classification for level.
*b Denominators are underestimates as data on total number of health facilities are not available from VUT.
*c Denominator is an underestimate as data on total number of target staff are not available from national hospitals.
*d A total of 14 006 health workers have been coached in the Philippines, however a breakdown of coaching data by health facility is not available from all facilities. Data shown here by level are only for selected facilities.
*e A total of 14 006 health workers coached in the Philippines were included here to reflect that 34 528 staff have been coached in the Region. Proportion of staff was not calculated due to incomplete data from some countries.
*f Proportion of staff was not calculated due to incomplete data from some countries.
2.4 Summary of findings: review of programmatic tools

2.4.1 EENC centres of excellence (CoE) standards

The IRG reviewed the final draft of EENC CoE standards and provided final feedback as follows:

- Development of CoE should be an “opt-in” for countries who can decide whether they want to introduce CoE standards at selected hospitals. The approach could be linked to the Baby-friendly Hospital Initiative if this is being implemented locally.

- Three-yearly cycles of accreditation are recommended. Accreditation assessments can be conducted as a part of biennial implementation review assessments or scheduled separately. EENC facilitators should conduct the assessments using standard tools; assessment teams should not work at assessed hospitals. Accreditation status should be registered at the WHO country office and WHO Regional Office on an online CoE database.

- Labour and delivery practices should be limited to vaginal deliveries as discussed previously for definitions of monitoring and evaluation indicators. Recommended targets for delivery practices are as follows: companion of choice – 80%, position in the second stage of labour – 90%, food and fluids during labour – 90%.

- Episiotomy rates should be included in final delivery practice standards since this is a common and potentially harmful and unnecessary practice. Recommended targets need to be decided locally. No clear guidelines for an optimal target for episiotomy in Asia are available, although it is expected that the optimal rate should be less than 30–40%.

- For skin-to-skin contact for 90 minutes and breastfeeding before separation, this indicator can also be calculated to include effective breastfeeding practices: breastfeeding initiated after 15 minutes and of a duration of at least 15 minutes duration. There were concerns that the validity of breastfeeding timing measures based on mothers’ reports is not yet known and subject to bias. Therefore, it is not yet clear that timing of breastfeeding should be included in the indicator. The EENC indicator validation study, which will be completed in 2020, will provide further data on indicator validity which will help answer this question.

- Maternal death reviews should be included in CoE standards, in addition to perinatal death reviews because of the strong association of maternal risk factors and deaths with newborn deaths. It is recommended that 100% of maternal deaths be reviewed and at least 25% of perinatal deaths, with at least 25% of perinatal death reviews to include stillbirths. Routine death reviews should be closely linked with hospital quality assurance mechanisms.

2.4.2 EENC Module 5: Managing childbirth and postpartum complications

The IRG reviewed the draft of EENC Module 5 and made the following recommendations:

Review of maternal deaths

- Death review should be an optional part of the EENC Module 5 assessment because some countries already have a functional review process in place. In addition, incorporating maternal
death reviews in some countries may be politically sensitive and make it difficult to get approval for use of the module.

- A time limit of 2–3 years on maternal deaths is proposed to ensure that findings reflect current policies, practices and interventions. At least 10 maternal deaths can be included, although in many countries in the Region it will not be possible to obtain this number of deaths over 2–3 years.

- All possible methods should be used to identify maternal deaths. Methods should reinforce that labour ward and delivery register, maternal death records, death certificates, and death audit reports should all be used.

**Selection of cases for emergency care**

- Consider removing normal vaginal delivery as a case for review since this is done for EENC assessments and does not involve management of complications.

- Add guidance on case-finding to ensure that cases that may not be managed in delivery wards, such as abortion or ectopic pregnancy, are identified.

- Conditions reviewed: The core conditions reviewed (postpartum haemorrhage, sepsis and eclampsia) are the most important causes of maternal death in the Region. Delayed or obstructed labour is reviewed under labour augmentation. The focus should be on the most important causes of mortality. Therefore, antenatal haemorrhage, uterine rupture and ectopic pregnancy should not yet be included.

- Caesarean section: A decision needs to be made about whether to include singleton or multiple births. To keep the assessment consistent across facilities, it is advised to include singleton births only.

**Review of data collection tools**

- Maternal interview:
  - The tool should focus on stage 3 delays and not attempt to get information on stage 1 and 2 delays. These require more detailed tools and are influenced by factors other than quality of facility-based care.
  - Review questions to ensure that they are appropriate for the target audience and do not include technical terms or difficult language.

- Case management tools: Ensure that gravity and parity are included in each. Postpartum haemorrhage tools should include availability of baseline and follow-up haemoglobin measurements and bleeding volume measurements.

- Checklist 4: Consider reducing the number of essential medicines and supplies and dividing them into primary and secondary. Review tracer medicines in Jhpiego and WHO emergency obstetric care (EmOC) guidelines.

- Checklist 5: For hospital register review, consider adding uterine rupture to the list of conditions for which data are collected.
• Checklist 7: For presence of an EmOC team, consider removing this question as it is not clear whether an EmOC team will ever be present or different from the EENC team.

• Checklist 8: For staffing, add anaesthetists as a staff category with a role in management of complications.

2.4.3 Review of supplementary guidance on eligibility and practice standards for EENC to reduce unnecessary separation of mothers and babies

Application in countries

• Each country should decide how, where and when to introduce guidance on unnecessary separation. In China, it may be best to introduce it through the Baby-friendly Hospital Initiative where there is already widespread acceptance of early newborn care practices and breastfeeding. Other countries should review the current capacity of implementing hospitals. Guidance is most likely to be useful in settings where EENC practices are adopted for a high proportion of stable term vaginal births – where action is needed to reach preterm/low birthweight babies and those born by caesarean section.

• Guidance should include recommendations on the systems issues that need to be addressed to prevent unnecessary separations. These include available space, standing orders and practice guidelines (at all levels), and adoption and acceptance by paediatric and neonatal staff who are often responsible for separations; coordination between disciplines is particularly important. The need for increased space within NCUs for mother–baby (nonseparated) care should also be noted.

• Guidance could include recommendations specific for caesarean section delivery for which there are often unique features. These include the need to coach the entire delivery team in the approach as a unit, the critical importance of the environment (placement of warmers, transfers to recovery, time in recovery, staff support available in recovery, delay of routine tasks to the postnatal ward) and the need for maternal consent before surgery.

Technical issues

• A lower limit for nonseparation of preterm/low birthweight babies should be included: 32 weeks is suggested, with a weight limit of 1500 grams (consistent with EENC standards).

• Criteria for separation of newborns from the mother could include not feeding and persistent cyanosis.

• The section on non-valid reasons for separation of mother and baby should note that mothers and babies can be kept together both in and outside NCUs (see above). Care with the mother within the NCU may improve the chances of nonseparation because of the availability of trained staff, CPAP and other equipment.

• More technical details could be provided on the management of babies who are not separated for intensive care, for example how CPAP can be provided, how to manage a baby with respiratory distress when CPAP is not available and how to manage jaundice outside of NCU (equipment and staff needed).
2.4.4 Review of the terms of reference for the IRG

There was general consensus on the terms of reference for the IRG, which include support for activities in three areas: 1) support monitoring and evaluation of EENC progress in the Region; 2) support development of EENC technical guidelines; and 3) support research to document regional and country experiences in scaling up EENC and outcomes achieved. The group membership, working methods (remote support with periodic meetings for biennial reviews) and mechanism of support through the WHO Regional Secretariat were agreed by consensus.

In the area of documenting progress, the IRG proposed the following:

- Cross-regional documentation of progress is important. Mortality change is unlikely to be demonstrable with available data. Therefore, this type of evaluation should focus on changes in population-based coverage indicators including equity, facility practice measures, and estimated cost impacts (possibly using the Lives Saved Tool or LiST to model potential mortality impacts).
- Country-by-country summaries of progress will also be useful. These could review parameters mentioned above. They could also include qualitative evaluations of adult learning through coaching, policy and systems changes and staff attitudes and approaches to improving quality.

3. CONCLUSIONS AND RECOMMENDATIONS

3.1 Conclusions

EENC impact and population coverage

- Data on population coverage and impact measures for newborn health were validated for all countries. Population-based surveys undertaken since 2017 in three countries (Lao People’s Democratic Republic, Mongolia, Papua New Guinea) included new indicators on skin-to-skin contact, drying and early bathing.
- Newborn mortality is estimated to have decreased by 15–50% in seven of the nine countries since the adoption of the Action Plan in 2013. For the Lao People’s Democratic Republic, Mongolia, Papua New Guinea and the Philippines, comparisons with previous survey data show improved trends in breastfeeding initiation and exclusive breastfeeding in the first month of life.
- Overuse of caesarean section remains a challenge in some countries of the Region. In four countries with new data since 2017 (China, Lao People’s Democratic Republic, Mongolia, Philippines), population-based caesarean section rates have increased by 2–3%, with rates higher in urban areas.
- Hospital impact measures were reported by the nine countries, with data quality issues noted for indicators disaggregated by gestational age and birthweight and on sepsis and birth asphyxia. These findings were substantiated by assessments of hospital information systems for maternal and newborn health, which found numerous data gaps, including incorrect application of indicator definitions and non-recording of stillbirths.
**EENC scale-up readiness benchmarks**

- Data on EENC scale-up readiness were available and validated for all countries. Improvements were noted in all benchmarks except the inclusion of EENC in pre-service training curricula, which has been partially done in four of the nine counties and has shown no progress since 2017.

**EENC clinical practices**

- Data on EENC health facility standards were available and validated for each of the nine countries.
- An estimated 5955 facilities are implementing EENC, a 77% increase from 2017. Four countries have achieved the regional target of 80% of childbirth facilities implementing EENC, and an additional two countries are on track to achieve the target by 2020.
- Validated data show that close to 35 000 staff have been coached on EENC in the nine countries, though country estimates put the figure at around 50 000 since roll-out in the Region. For more accurate estimates of facilities that have introduced EENC and health workers coached, data collection needs to be improved.
- An estimated 278 national regional and provincial hospitals (63% of hospitals excluding China) have begun implementation of Kangaroo Mother Care (KMC) (using EENC Module 4) across the nine countries. In five countries with available data, 68% of staff providing childbirth and newborn care services have been coached in hospitals implementing KMC.
- Effective delivery practices in the priority countries showed no change from 2017, with less than half of all women having a companion of choice (26%) at childbirth and more than half adopting a non-supine position in the second stage (57%), encouraged food and fluids (66%), and having correctly completed partograph (54%). Harmful practices (enema [17%], fundal pressure [18%]) were less likely to be practised than in 2017, a positive trend.
- The proportion of babies receiving any skin-to-skin contact (91%) improved from 2017. Immediate skin-to-skin contact (72%) and exclusive breastfeeding (78%) remained high and unchanged. Less than half of all babies received uninterrupted skin-to-skin contact for at least 90 minutes (37%) and completed a first breastfeed of at least 15 minutes while in skin-to-skin contact (33%); small improvements since 2017.
- Immediate newborn care for stable preterm and low birthweight (PTLBW) babies has marginally improved since 2017. PTLBW babies were less likely than term babies to receive any skin-to-skin contact (69%) or immediate skin-to-skin contact (58%), complete a first breastfeed of at least 15 minutes (13%), remain in uninterrupted skin-to-skin contact for at least 90 minutes (18%) and be exclusively breastfed (75%) in the first days of life. Close to half of PTLBW babies (≤ 2000 g) received KMC, but only 10% received continuous KMC for at least 20 of the previous 24 hours.
- Since 2017, countries have adopted national protocols to guide EENC implementation during caesarean section. Still, babies born by caesarean section are significantly less likely than those born vaginally to receive all early care practices.
- Episiotomies were performed in 27% of deliveries (ranging from 2% in Vanuatu to 49% in Viet Nam), an increase of 4% from 2017.
EENC monitoring and evaluation: methods and tools

- Testing and completion of *EENC Module 5: Managing Childbirth and Postpartum Complications* is a high priority for some countries in the Region, followed by its scale-up and use for hospital planning. Updates are proposed to the assessment tool.

- Establishing EENC centres of excellence (CoE) will help to build national and subnational capacity, establish accreditation criteria and provide incentives. Finalized guidance on EENC CoE should now be tested in countries where this is a priority.

- Guidance to promote and enforce nonseparation of mothers and newborns is critical towards improving newborn health outcomes. Draft regional guidance should be further reviewed, finalized and adapted for use in countries where this is considered a priority.

3.2 Recommendations

3.2.1 Recommendations for Member States

Member States are encouraged to consider the following:


2) Conduct or follow up assessments of hospital information systems for maternal and newborn health to identify and manage gaps and develop strategies to improve data quality.

3) Continue biennial EENC implementation reviews using the revised and updated indicators for planning and tracking progress (EENC Module 1).

4) Support the continued scale-up of EENC in caesarean section and KMC at hospitals by developing and enforcing nonseparation guidance, developing accreditation mechanisms and identifying and managing other system barriers.

5) Begin assessments of complications during childbirth (EENC Module 5) to identify gaps and take actions to improve childbirth care.

6) Adopt hospital CoE standards and begin the process of accreditation in collaboration with the WHO Regional Office for the Western Pacific.

7) Develop approaches to evaluating EENC pre-service training curricula.

3.2.2 Recommendations for WHO

WHO is requested to consider the following:

1) Send country reports summarizing data validation findings to ministries of health for required clarifications or revisions.

2) Revise and update indicators in the regional EENC monitoring and evaluation framework as proposed by the IRG.

3) Revise, review, update, develop and field test *EENC Module 5: Managing Childbirth and Postpartum Complications*, the nonseparation guidance and EENC CoE standards.
4) Document progress in EENC implementation in priority countries, including outcomes, programmatic approaches, costs and sustainability.

5) Continue to support Member States to institutionalize monitoring and evaluation in the areas of routine information systems, policy development, programme development and scale-up, tracking EENC implementation, and pre-service curricula review and strengthening.

6) Continue to conduct EENC data validation followed by Member State meetings periodically.

7) Finalize and widely disseminate findings of the EENC validation workshop and Member State meeting as technical reports and peer-reviewed journal articles to document progress and encourage wider adoption of the approach.
ANNEXES

ANNEX 1: List of temporary advisers, observers and secretariat

1. Temporary Advisers

Dr Elizabeth Mary MASON, Independent Consultant, University College London, 23 Sylva Ct., Putney Hill, London, United Kingdom, email: masonelizabeth108@gmail.com

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Dr Hoang Thi TRAN, Deputy Director, Da Nang Hospital for Women and Children, 208 Le Duan Street, Da Nang, Viet Nam, Tel. no.: (84) 903543115, email: hoangtrandn@yahoo.com

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2. Secretariat

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ANNEX 2:  PROVISIONAL AGENDA

1. Opening ceremony
2. Overview of progress toward implementing the Regional Action Plan for Healthy Newborn Infants in the Western Pacific Region
3. Review and validate nine country Early Essential Newborn Care (EENC) Monitoring and Evaluation frameworks
4. Review of regional EENC tools
5. Discussion on EENC programme issues
6. Discussion on delivery indicators and criteria for EENC-CS
7. Discussion on terms of reference of the IRG & expansion of EENC
8. Review country reports on data validation
9. Finalize conclusions and recommendations for accelerating EENC in the Western Pacific Region
## ANNEX 3: PROGRAMME OF ACTIVITIES

<table>
<thead>
<tr>
<th>Time</th>
<th>Day 1, 27 November, Wednesday</th>
<th>Time</th>
<th>Day 2, 28 November, Thursday</th>
<th>Time</th>
<th>Day 3, 29 November, Friday</th>
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<tbody>
<tr>
<td>08:00–08:30</td>
<td>Registration</td>
<td>08:30–10:00</td>
<td>Working session 1: Continue</td>
<td>8:30-10:00</td>
<td>Working session 3: Discussion on EENC programme issues</td>
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<td>review</td>
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<td>1. Guidance on restricted NCU admission criteria for preterm/LBW babies</td>
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<tr>
<td>08:30–09:00</td>
<td>Opening ceremony</td>
<td>10:00–10:30</td>
<td>Mobility break</td>
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<td>2. Guidance on EENC-CS eligibility criteria</td>
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<td>Opening remarks</td>
<td>10:30–12:00</td>
<td>Working session 1: Continue</td>
<td>10:00–10:30</td>
<td>Mobility break</td>
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<td>09:00–09:30</td>
<td>Overview of progress toward</td>
<td>12:00–13:00</td>
<td>Lunch break</td>
<td>10:30–11:00</td>
<td>Working session 4: Discussion on delivery indicators and criteria for EENC-CS</td>
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<td>implementing the Regional</td>
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<td>1. Guidance on indicators/methods for delivery and caesarean section</td>
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<td>Action Plan for Healthy</td>
<td>13:00–15:00</td>
<td>Working session 1: Finish</td>
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<td>(2014-2020), Q &amp; A Administrative Announcements</td>
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<td>Evaluation frameworks</td>
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<td>09:30–10:00</td>
<td>Group photo and mobility</td>
<td>15:00–15:30</td>
<td>Mobility break</td>
<td>11:00–12:00</td>
<td>Working session 5: Discussion on terms of reference of the IRG &amp; expansion of EENC</td>
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<td>Working session 1: Review and</td>
<td>15:30–17:00</td>
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