World Health Organization Regional Office for the Western Pacific Region
Healthy Cities Recognition 2018

Early Essential Newborn Care (EENC) Standards for Health Facilities Providing Childbirth Services

Background

The World Health Organization, Member States and stakeholders in the Western Pacific Region share a vision for mother and child health in which every newborn infant has the right to a healthy start in life. Sadly, every two minutes death comes too quickly — and often needlessly — to a newborn infant in the Region. Together, we have taken bold steps to address this sad statistic, with Member States endorsing the Action Plan for Healthy Newborn Infants in the Western Pacific Region (2014–2020). Listed below are the standards that health facilities providing childbirth services need to meet to be considered as implementing EENC. The status of all standards, unless otherwise specified, is measured at the time of the assessment.

#	Standard	Target	Definition	Source of data
Clinical care practices				
1	Proportion of staff providing childbirth, newborn or postpartum care services that are coached in EENC	90%	Numerator: Number of staff providing childbirth, newborn or postpartum care services[1] that have achieved relevant skills in EENC[2] Denominator: Number of staff currently providing childbirth, newborn or postpartum care services at the health facility [1]Clinical staff such as doctors, nurses, midwives, anesthesiologists and non-clinical staff who support delivery of these services [2] As defined nationally but must include skills to care for normal and complicated childbirth and breathing, non-breathing and preterm infants relevant to their roles and responsibilities.	EENC program or coaching records EENC health facility assessments Supervisory reports
2	Facility uses a quality improvement approach to support implementation of EENC	Yes	The facility has all three components of a quality improvement approach for EENC in place, including: (1) formation of an EENC team, (2) at least quarterly, documented meetings of the team in the last 12 months and (3) at least two, documented quality improvement assessments have been conducted in the last 12 months[3]. [3] Quality improvement assessments assess clinical practice and facility supports, through: (1) exit interviews with mothers post-delivery, (2) chart reviews, (3) observations of practice using EENC clinical checklists, (4) medicines, supplies and environmental hygiene review, (5) policy review, (6) EENC coaching coverage review, and (7) hospital impact data review.	Summary reports of EENC health facility assessments and hospital plans; EENC team meeting minutes

#	Standard	Target	Definition	Source of data
3	Pregnant women of 24-34 weeks of gestation at risk of imminent preterm birth and with no clinical evidence of infection administered the full course of intramuscular dexamethasone or betamethasone prior to childbirth	100%	For facilities where conditions[4] are met: Numerator: Number of pregnant women of 24-34 weeks of gestation at risk of imminent preterm birth and with no clinical evidence of infection administered the full course of intramuscular dexamethasone or betamethasone prior to childbirth Denominator: Number of pregnant women of 24-34 weeks of gestation at risk of imminent preterm birth with no clinical evidence of infection assessed prior to discharge [4] Facility conditions: gestational age assessment can be accurately undertaken, adequate childbirth care is available, and the preterm newborn can receive adequate care if needed. (WHO recommendations on interventions to improve preterm birth outcomes, 2015)	Record review
4	Proportion of women receiving all key delivery care tasks:	90%	Health facility has achieved 4a – 4d.	See below (4a, 4b, 4c, 4d)
a.	Companion of choice	90%	Numerator: Number of pregnant women with a companion of choice during childbirth Denominator: Number of women who delivered at the health facility assessed prior to discharge	Exit interviews with mothers
b.	Non-supine position during second stage	90%	Numerator: Number of pregnant women who adopted a non-supine position for some or all of the second stage of labour Denominator: Number of women who delivered at the health facility assessed prior to discharge	
c.	Food and fluids	90%	Numerator: Number of pregnant women encouraged to eat and drink during labour Denominator: Number of women who delivered at the health facility assessed prior to discharge	Exit interviews with mothers
d.	No fundal pressure	90%	Numerator: Number of pregnant women who had no fundal pressure during childbirth Denominator: Number of women who delivered at the health facility assessed prior to discharge	
5	Proportion of mothers with a correctly completed partograph	90%	Numerator: Number of pregnant women whose partograph was correctly completed[5] Denominator: Number of women who delivered at the health facility assessed prior to discharge [5] A correctly completed partograph should normally include basic details of the mother, recording of vital signs and procedures undertaken at the delivery (such as induction or augmentation, artificial rupture of membranes), an alert line and an action line, and medications given during labour and immediately after delivery. Requirements may vary depending on the format used nationally.	Exit interview with mothers
6	Proportion of newborns that received:			See below (6a, 6b, 6c)

#	Standard	Target	Definition	Source of data
a.	Immediate skin-to-skin contact	90%	Numerator: Number of breathing newborns (full term and preterm/low birth weight) receiving immediate skin-to-skin contact (within 1 minute of birth for vaginal delivery and 3 minutes for caesarean section) Denominator: Number of full-term and preterm/low birth weight newborns currently alive assessed prior to discharge	Exit interview with mothers
b.	Early and exclusive breastfeeding in the immediate newborn period	90%	Numerator: Number of newborns who were first breastfed within 15-90 minutes of birth and exclusively breastfed[6] (no other liquids given to baby) prior to discharge Denominator: Number of newborns that have initiated feeding assessed prior to discharge [6] Newborns who need to be given other liquids due to clinical complications (Ex: oral sucrose for hypoglycaemia) are not included in the numerator and denominator	
c.	Immediate and sustained skin-to-skin contact for at least 90 min and a complete breastfeed	80%	Numerator: Number of breathing newborns (full term and preterm/low birth weight): (a) receiving immediate skin-to-skin contact (within 1 minute of birth for vaginal delivery and 3 minutes for caesarean section), (b) uninterrupted skin-to-skin contact for at least 90 minutes, AND (c) not separated from their mothers for interventions such as weighing until a complete breastfeed has taken place Denominator: Number of full-term and preterm/low birth weight newborns currently alive assessed prior to discharge	
7	Proportion of newborns with a birthweight ≤ 2000g who in the previous 24 hours received:			See below (7a, 7b)
a.	Any Kangaroo Mother Care (KMC)	80%	Numerator: Number of newborns with a birthweight of ≤ 2000g receiving KMC[7] (of any duration) in the last 24 hours Denominator: Number of live births with a birthweight ≤2000g assessed prior to discharge	Exit interview with mothers

#	Standard	Target	Definition	Source of data
b	Continuous Kangaroo Mother Care for at least 20 hours	50%	Numerator: Number of newborns with a birthweight of ≤ 2000g receiving KMC[7] for at least 20 hours in the last 24 hours Denominator: Number of live births with a birthweight ≤2000g assessed prior to discharge [7] KMC, care for preterm infants, includes early, continuous and prolonged skin-to-skin contact between mother and baby, and exclusive breastfeeding or feeding with breastmilk. As close to continuous practice of KMC should be provided, whereby skin-to-skin contact is practiced continuously throughout the day without breaking the contact between mother and baby. If continuous KMC is not possible, intermittent KMC – alternating between skin-to-skin contact and use of a radiant warmer/incubator – should be practiced. (WHO recommendations on interventions to improve preterm birth outcomes, 2015)	Exit interview with mothers
8	Proportion of women who receive breastfeeding counselling in the immediate newborn period	100%	Numerator: Number of women who delivered at the facility who received breastfeeding counselling[8] from health facility staff after delivery Denminator: Number of women who delivered at the health facility assessed prior to discharge [8] Counselling on feeding cues, positioning of the baby, signs of attachment, how often to feed ad how long to feed, importance of giving only breast milk and no other food or fluids	Exit interview with mothers
9	All delivery room(s), operation room(s), neonatal care units (NCU), and postnatal care room(s) at the facility have adequate hand washing resources	Yes	Delivery rooms, operation rooms, NCU, and postnatal care rooms in the facility have: (1) sinks with continuous supply of clean, running water[9], soap[10] and single-use towels, hand driers or sterile re-usable towels (all sinks in the rooms have the above) AND (2) alcohol hand gel/rub available for use before and after touching each baby or mother. [9] A water supply that is either piped in or (less optimal) from onsite storage with disinfection that meets WHO safety standards. [10] Detergent-based soap (bar soap, tissue, leaf or liquid preparations) that meets WHO standards. (see WHO, Hand Hygiene Self-Assessment Framework 2010)	Observations in delivery, recovery, NCU and postnatal care rooms
10	Health facility has no stock-outs of key life- saving medicines required to provide EENC	No stock-out for any medicine	Health facility has had no stock-outs in the previous 12 months of: • Magnesium sulfate for severe preeclampsia, eclampsia and fetal neuroprotection if gestational age <32 weeks • Oxytocin for prevention and control of postpartum hemorrhage • For facilities where conditions[4] are met , corticosteroids for women at 24-34 weeks of gestation at risk of imminent preterm delivery • Injectable antibiotics for management of newborn sepsis	Observations in delivery, recovery, NCU and postnatal care rooms, Record review, Staff interviews

#	Standard	Target	Definition	Source of data
11	Health facility has no stock-outs of functional key life-saving commodities required to provide EENC	No stock-out for any commodity	Health facility has had no stock-outs in the previous 12 months of: • Functional newborn ambu bag and preterm and term masks (sizes 0 and 1) within 2 meters of each delivery bed • Continuous supply of oxygen for newborn use (applies only to hospitals) • Continuous Positive Airway Pressure (CPAP) (applies only to hospitals)	Observations in delivery, recovery, NCU and postnatal care rooms, Staff interviews
12	Health facility has eliminated baby-food industry conflicts of interest	Yes	Health facility has achieved 12a, 12b and 12c.	See below (12a, 12b, 12c)
a	No mothers delivering at the health facility have products or gifts from baby food companies	100%	Numerator: Number of mothers delivering at the health facility who do not have infant formula, baby bottles, gifts or other products sponsored by baby food companies in postnatal wards prior to discharge from the facility Denominator: Total number of postpartum mothers assessed prior to discharge	Exit interviews with mothers
b	Health facility has a written policy to prohibit use of infant formula and other baby food company activities	Yes	Health facility has a written policy posted in delivery, operation, and postnatal care rooms and in neonatal care units prohibiting use of infant formula in the facility and other linkages with baby-food companies	Observations of delivery, operation, and postnatal rooms and neonatal care units
c	Health facility has no promotional baby food materials including posters, brochures, pamphlets, or items with logos on their premises	Yes	Health facility has no baby food promotional materials visible or available in delivery, operation, and postnatal care rooms and in neonatal care units	Observations of delivery, operation, and postnatal rooms and neonatal care units

Recognition of Best Practice

Recognition is given to cities who have met the stated criteria for all targets in more than 50% of their hospitals.

For further information, please contact:

Dr Howard Sobel (Coordinator for Reproductive, Maternal, Newborn, Child and Adolescent Health) at sobelh@who.int.

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Call for Applications for Best Practice

Title Page

a. **Thematic area**

b. **City and Country name**

c. **Full title of the project**

d. **Contact details**

i. Responsible person submitting the proposal
Please provide contact details (name, title, affiliation, email, address, telephone, fax)

ii. Additional contact person
Please provide contact details (name, title, affiliation, email, address, telephone, fax)

***[Note: Please keep to the word limits as that will be taken into account in the scoring process.]**

1. **Executive Summary (300 words)**
Please describe the intervention, who is the target population, what was done (strategies or activities), when was it implemented, and the achievements.

2. **Background (350 words)**
   a. Please describe why this project or intervention was proposed. Please describe the results from surveys, situation analysis, interviews, focus groups, needs assessment or consultation conducted to identify the problem/need being addressed

   b. Please describe the problem being addressed.

   c. Please describe other existing programmes, challenges and impact.

   d. Please describe the social and cultural context in relation to the problem.

3. **Objectives**
Please specify the proposed objectives (i.e. the anticipated outcome) and the period/timeline of the project.

4. **Planning structure (Maximum 1 page)**
   Please describe the core planning team; the settings where the project was carried out; the target population; and the activities, tasks, milestones, timeline, budget and source of funding.

5. **Multi-stakeholder collaboration (300 words)**
   a. **Community participation**: Please describe how the collaboration with community members including the target population, took place in the planning, implementation and/or evaluation phase of the initiative.

   b. **Other stakeholders (e.g. other government agencies, NGOs, private sector)**: Please describe how the collaboration with other sectors took place in the planning, implementation and/or evaluation phase of the initiative. Please also describe whether resources were shared (i.e. financial or technical).

6. **Equity (200 words)**
   Please provide evidence of the participation of marginalized and/or vulnerable groups (e.g. female or youth) during the planning and/or implementation/evaluation processes; and/or describe interventions that target them.

7. **Replicability or Scalability (300 words)**
   Please describe how the programme (activities, expertise and resources) can be scaled up and be applied and adapted to other settings or sites.

8. **Effectiveness or impact assessment (350 words)**
   a. Please provide evidence of programme achievements in relation to proposed objectives (e.g. improvement in health status, adoption of new law or policy). If possible, show or describe changes from baseline to the current status in 2016. Please provide supporting documents where available.

   b. Please describe how evaluation, surveys, data or routine monitoring were utilized to assess progress and outcomes.

9. **Measures for sustainability (300 words)**
   a. Please describe how the programme is or will be sustained. For example, through city ordinance, city government commitment, community ownership, regular budget allocation, etc.

10. **Bonus (Optional): Theoretical basis (200 words)**
    Please describe how theories of change (i.e., theories of behaviour change, policy development, social marketing, etc) have been utilized for programme development and implementation.