Caring for preterm babies is a test of how we respond to our most vulnerable citizens

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Global progress in child survival cannot be achieved without tackling the issue of prematurity. World Prematurity Day, on Nov 17, 2013, provides an opportunity to raise concerns about the increasing rates of preterm births during the past two decades in many countries around the world.[1]

More than 1 million children around the world die each year due to complications of preterm birth, which is the second leading cause of death in children younger than 5 years after pneumonia.[2] Yet at least three-quarters of babies born too soon could survive with greater availability of cost-effective, proven forms of care. Kangaroo mother care, for example, involves the practice of skin-to-skin warmth to protect babies from hypothermia and exclusive breastfeeding to prevent infections. Nearly half of all preterm deaths could be prevented by 2015 if families and caregivers in the most affected countries around the world were to practise kangaroo mother care.[3]

Another cost-effective form of care is the use of antenatal corticosteroids. Given to women in premature labour to speed up fetal lung development and prevent respiratory distress of premature babies, antenatal corticosteroid injections cost as little as US$0·50 per dose and are routinely given to women in high-income countries.[4] Yet only about 5% of women in middle-income and low-income countries have routine access to this intervention.[5] Use of antenatal corticosteroids is a key recommendation of the UN Commission on Life-Saving Commodities for Women and Children.[6] Greater availability of antibiotics is also important in tackling prematurity. Newborn babies with infection require immediate injectable antibiotics. Similarly, women who experience membrane rupture before 37 weeks—a major risk of preterm delivery—require access to antibiotics to reduce the risk of infections and to delay birth.[3]

Looking at the connection between the health of women and children, better access to family planning can prevent unwanted births. This need is particularly acute for adolescent girls, who have a proportionately increased risk of having premature and low birthweight babies.[7] An estimated 230 000 lives could be saved if access to family planning was scaled up to 60% coverage or to the level of achieving a total fertility rate of 2·5.[3]

Preventing and caring for prematurity is an important part of the work that needs to be done to enhance newborn survival and health. The global *Every Newborn* action plan,[8] which will be launched in 2014, hinges on this simple message: we can and must do better for

	Brazil	Uganda
Preterm birth rate (world ranking)*	9·2% (107th)	13·6% (29th)
Number of preterm newborn babies in 2010 (world ranking)*	279 300 (10th)	205 400 (12th)
Leadership for change	• Launched Grand Challenges for preterm birth to identify innovative solutions in Brazil[9] • Improved national data and linked this to action[10] • *Stork Network* (*Rede Cegonha*): national strategy to improve pregnancy and newborn health care as a government priority[11] • Kangaroo mother care promoted for underweight newborn babies[12] • Brazilian Network of Human Milk Banks: about 130 000 L of quality-certified pasteurised human milk were delivered to more than 170 000 newborn inpatients in intensive/semi-intensive care units in 2012. Much of the donated milk is used to feed premature and low birthweight babies[13]	• National commitment to the *Global Strategy for Women's and Children's Health* to scale up care for preterm babies, including kangaroo mother care and antenatal corticosteroids[14] • Undertook national analyses of the health systems bottlenecks for scaling up these interventions and created targeted plan to overcome these challenges[8] • Women parliamentarians advocated for girls, mothers, and newborn babies, leading a global resolution on maternal and child health by the Inter-Parliamentary Union[15]

*World ranking for 186 countries, highest rates and numbers to lowest, source Blencowe and colleagues.[1]

***Table*: Leadership for change for preterm birth in Brazil and Uganda**

women and their babies, especially at the time of birth, when lives are so vulnerable, particularly for those born premature. We need to focus attention on the critical period during labour, childbirth, and the days after birth, when the delivery of quality care, supported by the right drugs and the right supplies, makes such a difference. If there is anything that we can do to accelerate our progress to 2015 and beyond for maternal and child survival, then better care at the time of birth is essential. Birth is the world's golden moment for action.

Political leadership to help improve the fate of preterm babies is needed. Since World Prematurity Day last year, action has been taken on commitments, such as in Brazil and Uganda (table). In the UK, politicians came together this year to publish an across-party manifesto on the importance of the 1001 critical days from when a baby is conceived until the age of 2 years, signalling the importance of this issue to the UK.[16] This year, let us dare to dream of further improvements for those born too soon, and then work to make them happen. Our health systems can be judged by how we care for newborn babies, especially preterm babies who can die, or be saved, by an effective health system. Is saving newborn lives not an important measurement and fitting indicator of universal health coverage in the post-2015 environment?

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Electronic cigarettes for smoking cessation

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In *The Lancet*, Christopher Bullen and colleagues[1] report the results of a study that is likely to have an important effect on the discussion of the role of electronic cigarettes (e-cigarettes) in tobacco control. Bullen and colleagues randomised 657 adult smokers wanting to quit to 16 mg nicotine e-cigarettes (as needed), 21 mg nicotine patches (one per day), or placebo e-cigarettes (no nicotine, as needed) in a 4:4:1 ratio. Participants, who all lived in Auckland, New Zealand, could access the national Quitline (a telephone counselling service), but received no additional support. At 6 months, 21 of 289 (7·3%) participants in the nicotine e-cigarettes group had achieved biochemically verified abstinence, compared with 17 of 295 (5·8%) participants in the patches