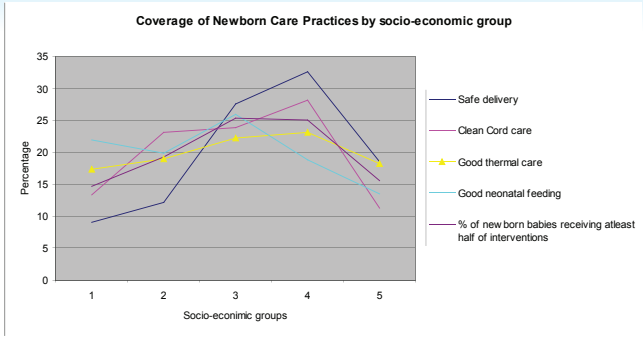


Skilled attendance at delivery and postnatal care

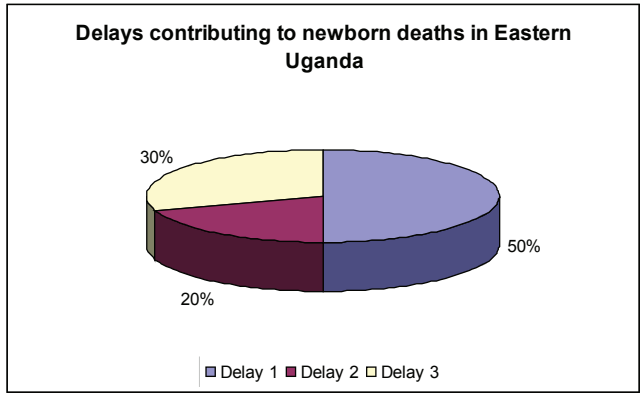
- Only 41.8% delivered from a health facility and 50% of labour started at night
- Care practices at birth are generally poor.
- Over all, coverage of neonatal practices was as follows: good thermal care - 35%; good cord care - 41%, good neonatal feeding - 30%; and only 42% of newborns received at least half of the available newborn interventions.
- Newborn care is lowest among the poor and least poor groups
- Skin to skin care at birth is not existent and early bathing is the norm: - 56% of the babies were bathed in the first 6 hours and 82% in the first 12 hours.
- Only about half of babies were breastfed in the first hour after birth.
- 35% of babies had feeds other than breast milk in the neonatal period.
- In 67% of cases the cord was cut with a razor blade.
- About half of all mothers applied something to the cord to “help it heal”;
- Postnatal care does not exist in the study districts

CARE FOR PRETERM AND SMALL BABIES

- Communities are aware of the problem of preterm births
- Communities believe that preterm babies should be cared for in health facilities.
- No facilities or program for care of preterm babies exists in the study community
- Providing warm care is improvised at home and in facilities with charcoal stoves and hot water bottles.

CAUSES OF NEWBORN DEATH

- Most deaths (47%) occurred on the day of birth; 78% in the first week, and only 22% occurred in the last three weeks of the neonatal period.
- Causes of deaths: neonatal sepsis - 31%; birth asphyxia – 30% and complications of preterm birth contributing 25%. Tetanus was responsible for 3% of the neonatal death.
- Delays contributing to neonatal deaths: 1st delay ***(delay in deciding to seek care)***; delay II/***access delay;*** delay III/***the health facility delay***



CONCLUSION

Neonatal practices are poor across all socioeconomic groups. Most available neonatal interventions are not reaching newborns and health facilities lack basic supplies like gloves for a safe delivery. Strategies to improve newborn care practices need to focus not only on the poor but also the least poor, and should address both demand and supply.

Acknowledgments

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Improving Newborn Health and Survival in Uganda Through a Community Based Intervention Linked to Health Facilities

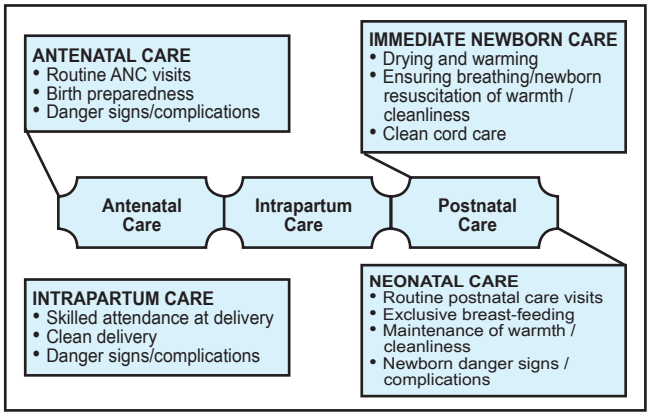
Summary of the formative research results from Iganga and Mayuge districts

Peter Waiswa, George W Pariyo, Elizabeth Ekirapa, Romano Byaruhanga , Juliet Kiguli, Margaret Nakakeeto , Karin Kallander , Stefan Peterson

BACKGROUND

Despite the presence of cost effective interventions, 4 million neonatal deaths occur every year, and are a major barrier to achieving the fourth Millennium Development Goal – to reduce child mortality by two thirds by 2015. In Uganda, we loose up to 45000 newborn babies every year, and an equal number of stillbirths also occur.

Conceptual framework for reducing Newborn Deaths



Adopted from Marsh DR, Darmstadt GL, Moore j, Daly P, Tinker A, "Advancing newborn health and survival in developing countries: a conceptual" J. Perinatology 22(2002): 572-576

Aim: We are conducting an interventional community based study to adapt, develop and cost an integrated maternal-newborn care package that links community and facility care, and evaluate its effect on maternal and neonatal practices in order to inform policy and scale-up in Uganda.

The three components of the intervention:

The planned intervention will have three components:

1. Home visits by community health workers to pregnant and newly delivered women in the first 1st week after birth;
2. Strengthening linkages between the community and health facilities;
3. Facility strengthening: training and provision of basic equipment, drugs and supplies.

Methods for the formative research

Population based cross-sectional study among 413 newly delivered mothers with babies 1-4 months in Iganga/Mayuge Demographic surveillance Site. Assessment among 52 health workers on knowledge on newborn care; a health facility survey in 16 health facilities and Qualitative interviews – 52 narratives; 12 FGDs; 15 KIs with health workers, community members, and health managers.

KEY FINDINGS FROM THE FORMATIVE RESEARCH

Status of health facilities

- There is lack of equipment, supplies and medicine as well as protocols and guidelines for emergency obstetric care (EmOC.) and emergency neonatal care (ENC)
- The health workers lack knowledge on specifically essential newborn care practices and emergency obstetric care. Only 5.6% of all the staff in the health facilities in the study had undergone training in newborn resuscitation.
- The availability of records and their use is very poor. Delivery records and registers were generally incomplete, partographs were not used to monitor labor progress and information on the postnatal period and discharge were not available.

Community health workers

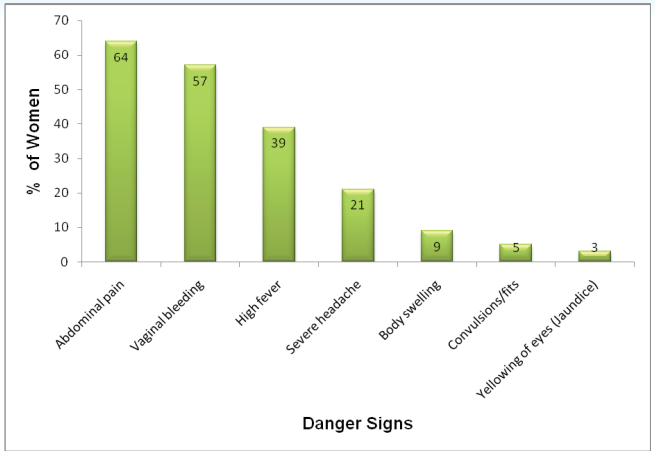
- The CHWs were widely accepted in the community as health educators to improve care of mothers and newborn babies through home visits to households
- No uniform supervision and motivation processes exist, they all depend on the initiators of the programs

Antenatal care (ANC)

- Only 30.4% of women attended ANC the recommended 4 times;
- Most women start attending ANC late - 54% of pregnant women started ANC in the second and 27% in the third trimester.
- Only 58% of the women reported to have tested for HIV during pregnancy in spite of the "opt-out" testing strategy.

Maternal and newborn danger signs and complications

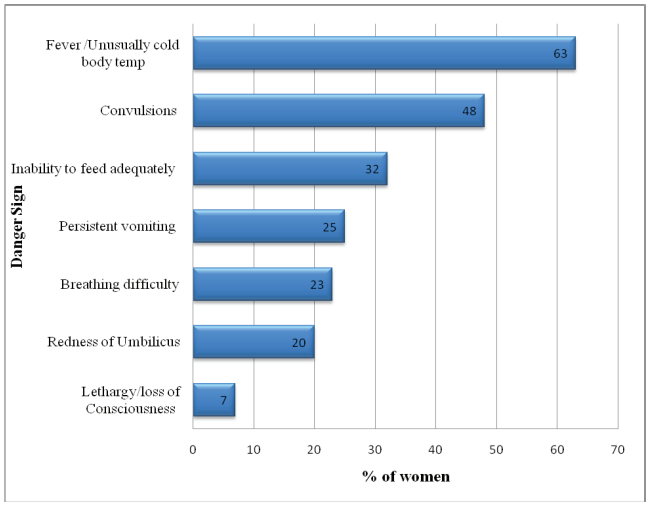
- Newborn danger signs are more known than maternal danger signs
- Only 34.5% of the mothers knew at least 3 pregnancy danger signs.



Knowledge of danger signs and complications during pregnancy

- 48% of mothers knew at least 3 newborn danger signs; but 11% didn't know any.

Knowledge of newborn danger signs



Birth Preparedness

- Women preparation for birth is limited by poverty, lack of male support and cultural beliefs that prevent preparing for the "unborn".
- Selecting of a provider for delivery is almost non-existent and health facilities lack *mama* kits which are an additional cost and barrier to facility delivery.