How to reach every newborn: three key messages

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For the **Every Newborn Action Plan** see http://www.everynewborn.org/

For more on the **workshop** see www.equinam.global-health-inequalities.info

The Every Newborn Action Plan (ENAP) launched on June 30–July 1, 2014, envisages a world without preventable deaths of newborn infants.[1] The challenge is not technical (effective interventions exist), but instead social. The odds of a child surviving the first month of life are grossly unequal, even within one country, and are affected by wealth, education, caste, and access to health care. Large gains are achievable when interventions reach people who are in need, but this rarely occurs. Without dedicated efforts to reach poor people, ENAP initiatives are likely to favour wealthier people who have the lowest mortality risk.[2] We summarise lessons from an international workshop, New Evidence Supporting Equity in Newborn and Maternal Health in South Asia, held for researchers, policy makers, and practitioners in Kathmandu, Nepal, on May 8–9, 2014. Three key messages on how to reach poor people emerged—universalise, soft-target, and monitor.

Universalisation means reaching all individuals with good quality, effective interventions without financial hardship.[3] Coverage matters. Participatory women's groups are effective in reducing newborn mortality among poor populations[4] provided they involve about 30% of pregnant women in the population.[5] Initiatives to provide universal services, such as the Community Clinic Project in Bangladesh, are promising and need assessment. Low quality of services for the poor is a pervasive problem that reduces use. Community-level monitoring can help when law and order systems are weak.[6] Universality means inclusion of all people. Explicit exclusion criteria can weaken popular and political support for services that benefit poor people.[7] Income-based targeting is administratively demanding, costly, and prone to corruption, undercoverage, and leakage to wealthier groups when systems are weak.[8] Moreover, explicit criteria such as proof of residence or eligibility for institutional delivery schemes that are based on number of children can be hurdles for low-income groups.[9]

Provision of free services at the point of delivery is a key component of universalisation. Incentive schemes can promote service uptake among low-income people, but even when services are officially free and transport incentives are universally provided, such as in Nepal, uptake remains lower for poor people than for richer groups. Patients frequently still pay for services that are officially free. Health systems are often not ready for increased demand, damaging poor people the most as facilities become overcrowded. Improvements in knowledge of schemes in low-income groups are important. Substantial public investments are needed to make services really free, accessible, and available for all.

Prioritisation of the regions or communities that are most in need can support universal coverage of programmes when geographic inequalities are large. In Nepal, for instance, the incentive scheme for facility delivery pays more in the mountains, where transport costs are higher. Scorecards to identify vulnerable communities are a promising method for non-governmental organisations that do not have the resources to ensure coverage for entire populations.[10]

Soft-targeting involves the moulding of interventions to encourage self-selection by poor people into universally provided services.[11] This effort means provision of services and interventions at convenient times and places. Participatory women's groups reach out because they are established in poor hamlets at convenient times.[4] The opening hours, waiting times, and location of public services often disadvantage poor people because seeking care during working hours affects their subsistence income. Pragmatic solutions such as evening clinics should be considered. Soft-targeting also means respectful service provision, with communication that engages people with low levels of education. Women's groups have effectively improved health behaviours with use of visual materials, storytelling, and games. Disrespectful behaviour by service providers towards marginalised people needs to be addressed by better training of health professionals in communication skills,[12] empowering of families and communities to demand better care, and building capacity of managers to make system-level changes.[13]

The private sector is often better at soft-targeting across socioeconomic groups than is the public sector, reflecting its heterogeneity in quality and cost. Lower-end services are provided near poor populations and are often perceived to be friendlier and more efficient than public services. However, the private sector is less affordable, and low-income people usually receive the lowest quality care. Perverse incentives in the private sector can damage

health across social groups, as shown by the high rate of medically unnecessary caesarean sections among higher-income classes and the lack of emergency obstetric care for poor people.[14] Quality and cost in the private sector need much stronger regulation to benefit every newborn child. Novel schemes, such as cross-subsidies, to enhance contributions from the private sector to health care for poor people need assessment.[15]

Advocates are key to universality and soft-targeting. Locally, women's group facilitators have a crucial role to ensure inclusivity and that poor populations are reached.[4] Capacity building and support at the district and subdistrict level underpin the sustainability of pro-poor interventions, especially when planning is decentralised. National-level advocates, who ensure both long-term political support and increases in public spending on health, are fundamental to make services work for poor people. Without the political will to invest and to act as advocates for poor people, substantial improvements are unlikely.

Monitoring of inequalities in health and intervention uptake is essential and needs health information systems that include disaggregated data collection and reporting by district and subdistrict level and by socioeconomic strata. Evolving social contexts and changing cause-of-death patterns need continuous reappraisal from an equity perspective. If all ENAP stakeholders support universal coverage of soft-targeted programmes, and monitor and assess the effect of interventions on equity, then huge survival gains are possible.

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