Evidence brief-informed stakeholder's Dialogue

Reducing Neonatal Mortality in Ethiopia: A call for Urgent Action!

Dialogue Report

Adulala Resort and Spa, Bishoftu, Ethiopia
May 2021

This report was prepared by Knowledge Translation Directorate, Ethiopian Public Health Institute

This stakeholder's dialogue was informed by the following evidence brief:

Reducing Neonatal Mortality in Ethiopia: A call for urgent action

What is a stakeholder's dialogue?

A structured discussion focused on an evidence-based policy brief

The agenda from the policy dialogue is attached as Appendix 1

Who participated in the dialogue?

People with relevant expertise and perspectives, including policymakers, researchers, civil society, and the mass media

The complete list of participants is attached as Appendix 2

What was the aim of the stakeholder's dialogue?

+ For discussion and careful consideration to contribute to well-informed health policy decisions

× The dialogue did not aim to reach a consensus or make decisions

What is included in this report?

+ Views, opinions and insights of individual participants reported without attribution

The opinions included in this report reflect the understanding (or misunderstanding) of individual participants in the dialogue

× These opinions may or may not be consistent with or supported by the policy brief or other evidence

It should not be assumed that the opinions and insights in this report represent a consensus of the participants unless this is explicitly stated

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Key Messages

- ***The following statements represent views, opinions and insights of individual participants in the policy dialogue.***

The Problem

- Dialogue participants recommended the problem to be coined as neonatal mortality in Ethiopia is persistently high and its contribution to the under-five mortality is increasing rather than neonatal mortality is rising

Policy Options

- Participants suggested the interventions/policy options be organized in the form of life course approach i.e., pre-pregnancy, pregnancy and post-pregnancy interventions.
- It was stated that most of the interventions mentioned in the brief are being implemented in the country but the main gap lies in implementation.

Implementation Considerations

- Considering incentive packages for community health workers, closing skill gaps of the health workers, and continuous supply of drugs and equipment that are in the form of pediatrics preparation were raised by participants to be considered during implementation.
- According to participants, a death audit and review of newborn deaths must be initiated and should become routine practices.

The views, opinions and insights in this report reflect the understanding or misunderstanding of individual participants in the dialogue. These opinions may or may not be consistent with or supported by the evidence for policy brief that informed this dialogue or other evidence. It should not be assumed that the opinions and insights in this report represent a consensus of the participants unless this is explicitly stated. Nor should it be assumed that they represent the views of the authors of this report.

The Problem

The majority of the participants raised the issue that neonatal mortality in Ethiopia cannot exactly be stated as increasing or rising, rather it is fair to say it is persistently high without significant change over the last decade. Furthermore, dialogue participants stressed that even though the mortality has increased from 29 per 1000 live birth to 33 per 1000 live births it is still in the confidence intervals of the previous estimates of the 2016 DHS. With this progress, they said the country cannot achieve the SDG. Participants also mentioned that neonatal mortality contribution to the under-five mortality is increasing and it will continue to increase in the future as well. A participant suggested the magnitude of the problem to be seen in terms of urban versus rural and agrarian versus pastoralist.

Regarding the cause section, a need for elaborated discussion of the quality of care and basic causes was aired. Some dialogue participants believed that most deaths are occurring at the facility level because of a quality-of-care-related issue in the country. However other participants mentioned that we should see this with caution since there is a low level of skilled birth attendance in the country and there might be neonatal deaths from the community which is not reported. They also stressed that neonatal death at the health facility level is a missed opportunity and we should explore why newborns are dying in health facilities.

A participant raised that at the labor and delivery unit there is no responsible person for the neonate rather much attention is given to the mother. Another participant added that "*there is a perception by the community that newborns are not considered as human beings, even their death is not recognized as human death but simply as material loss referred as 'Tefa/ጠፋ' in Amharic and only the mother mourns to whom the loss is real*."

Everyone in health facilities focuses on saving a mother's life because health workers know there is accountability for the loss of a mother but not for a newborn. Besides, a newborn's death is sometimes counted as stillbirth to avoid any sort of accountability related to neonatal death at health facilities.

In general, participants stressed that there is poor infrastructure dedicated to newborns including limited or no space for newborn care in the delivery room, the far distance between the delivery room and Newborn Intensive Care Unit (NICU), and the absence of the accountable person at service delivery points. It was stated that most deaths at the facility occur as a result of poor care, especially during night and weekend shifts.

Even though the recommendation is for mothers and newborns to stay at a health facility for a minimum of 24-hours after delivery, the health facilities especially hospitals are not capable of accommodating the overload thus letting them leave within six hours after delivery. As felt by the participants this could be one cause for the death of newborns.

Furthermore, there was a suggestion from some participants for the basic cause to be elaborated especially the aspect of social determinants. Regarding maternal nutrition, it was suggested that horticultural and gardening issues be considered in the cause and options sections.

Participants promised to share additional reference documents including local studies to the team who developed the brief.

Policy Options

The policy option discussion started with clarification of the methods used. Participants aired if the policy brief brings new options/interventions as they felt that most of the indicated interventions are already being implemented. After thorough discussion, it was cleared out that policy briefs are not necessarily expected to bring new options. Additionally, it was clarified that policy options are based on the best available evidence to address the identified problems regardless of the implementation status in the country.

Most dialogue participants suggested that the interventions would be better if organized across the life course i.e., pre-pregnancy, pregnancy and post-pregnancy intervention. It

was also aired that most interventions have already been endorsed and were recognized in the previous national NCSS but they felt that the gap is with implementation. To learn from past experiences, identify gaps and design better strategies; participants said that evaluation should have been conducted before the revision of the national NCSS.

Implementation Consideration

For community health workers and voluntarily working mothers, it would be wise to consider benefits packages to bring change. As stated by dialogue participants, voluntarism alone may not work and benefit packages including non-financial incentives must be considered. In other countries for instance voluntarily working mothers are recognized nationally and are presented with certificates for their achievement as an effort to make them feel proud.

A participant raised that the country is not implementing preconception care despite the presence of evidence that pre-conception care is effective and suggested the inclusion of such evidence in the brief to serve as a pushing factor for the implementation of the already existing strategy. Further discussion by other participants focused on the importance of identifying the right time and place for pre-conception care. A participant also aired that health education interventions that are provided during ANC are key and is the right time to educate mothers. In this regard, EPHI is capable and should be responsible to produce health education packages supported by video.

Another issue discussed was the presence of a skill gap in newborn health care provision. Participants called for the closure of this gap through capacity-building initiatives including on-job training and skill transfer for health workers. Participants also stressed strengthening continuous professional development endeavors. For a successful skill transfer, there must be an incentive scheme to motivate skillful professionals to train their counterparts. At all levels of health facilities, there is a shortage of human power for neonatal care which must be addressed through pre-service training. Another participant said that the ratio of HEWs to population is below the standard.

Dialogue participants urged for the need for a continuous supply of drugs, medical equipment, and their maintenance. Newborn medical supplies should also be pediatrics friendly in terms of size and preparations e.g., IV fluids, blood bags, etc.

According to the dialogue participants, newborn death audit and review must be initiated and should become a routine practice like that of maternal death audit and review.

Way Forward

- Inclusion of more local evidence in the document
- Finalization of the work as soon as possible for it to serve as an input to national strategy (NCSS)
- Refine, enrich and share the document with all policy dialogue participants and relevant stakeholders

Appendix 1: Agenda

Policy Dialogue on reducing neonatal mortality in Ethiopia: A Call for Urgent Action!

Knowledge Translation Directorate

Ethiopian Public Health Institute

(Bishoftu, Ethiopia, 2021)

Ethiopian Public Health Institute Knowledge Translation Directorate (KT) Stakeholders dialogue on Reducing Neonatal Mortality in Ethiopia, 2021, Bishoftu, Ethiopia Agenda of the Dialogue			
Time	**Activities**	**Responsible person**	**Moderator**
	Day 1		
8:30 - 9:30 AM	Registration	Zelalem & Wudenesh	
9:30-9:40 AM	Opening remarks	Dr. Getachew Tollera (DDG, EPHI)	Ms. Firmaye Bogale (KT Directorate Director, EPHI)
9:40-9:55 AM	Introduction of dialogue participants and facilitator	All Attendees	
9:55- 10:15 AM	Brief overview of KT	Mr. Yosef	
10:15 – 10:45 AM	Presentation on HTA	iDSI	
10:45-11:00 AM	Discussion on the presentation (Q&A)	Participants and iDSI	
11:00-11:20 AM	**Health break**	**Organizers**	
11:20-11:50	Brief presentation on the prepared evidence brief for policy	Ms. Firmaye	Prof. Mirkuzie
11:50-12:00 AM	Procedure and rules of the dialogue	Participants	
12:00-12:30 AM	Going through the problem section (Background and how big is the problem sections)	Participants	
12:30-1:45 PM	**Lunch**	**Organizers**	
1:45 - 2:30 PM	Continued discussion on problem sec	Participants	Prof Mirkuzie
2:30-3:30 PM	Going through the cause section	Participants	
3:30 - 3:45 PM	**Health Break**	**Organizers**	
3:45-4:30 PM	Continued discussion on the cause	Participants	Prof Mirkuzie
4:30-5:00 PM	Going through the Policy options	Participants	
	Day 2		
9:00 – 10:30 AM	Continued discussion on Policy options	Participants	Prof Mirkuzie
10:30 - 10:50 AM	**Health Break**	**Organizers**	
10:50 AM -12:30 PM	Going through the Implementation considerations	Participants	Prof Mirkuzie
12:30-1:45 PM	**Lunch**	**Organizers**	
1:45 – 2:45 PM	Continued discussion on implementation consideration	Participants	Prof Mirkuzie
2:45-3:00 PM	The way forward/Next steps	Participants	
3:00-3:10 PM	Closing Remark	Ms. Firmaye	

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Competing interests

None

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