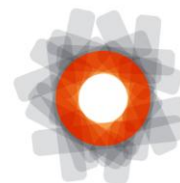


INTEGRATION OF
MATERNAL &
NEWBORN
HEALTH CARE

9-10 September, 2014 | Boston, Massachusetts

Meeting Report



Maternal Health **Task Force**

Table of Contents

Executive Summary	2
Introduction	4
Meeting Goal and Objectives.....	5
Summary of Major Themes	6
Meeting Sessions	7
Day 1	7
Day 2	9
Conclusions	10
Next Steps	11
Appendix A: List of Recommended Actions	12
Appendix B: Meeting Agenda	16
Appendix C: List of Participants	18
Appendix D: Summary of Pre-meeting Survey Responses	21
Appendix E: List of identified barriers to and opportunities for Integration	24

Executive Summary

Background

In resource-limited settings around the world, the risk of maternal and newborn mortality is great, with the most deaths occurring during labor, delivery, and immediately postpartum. About 60 percent of maternal deaths occur during this period, and 50 percent of those happen in the first 24 hours. Every year one million newborns die on the first day of life; almost two million more die within the first month, and an additional 2.6 million babies are stillborn. Postpartum hemorrhage, eclampsia, and sepsis are leading causes of maternal deaths, while prematurity, low birthweight, infections, and delivery complications are common causes of death and long-term disability in newborns. Poor-quality care is a persistent threat to both mother and baby: preventing and managing complications and providing appropriate follow-up care are critical to improving maternal and newborn health.

From a biological perspective, maternal and newborn health are inextricably linked, yet program efforts addressing the health of mothers and infants are often planned, managed, and delivered separately. A persistent divide between maternal and newborn health training, programs, service delivery, monitoring, and quality improvement systems limits effectiveness to improve outcomes.

In an effort to strengthen bridges between the maternal and newborn health communities, Saving Newborn Lives (SNL) and the Maternal Health Task Force (MHTF) convened a technical consultation in September 2014 entitled *Integration of Maternal and Newborn Health Care: In Pursuit of Quality*. This meeting brought together more than 50 key members of the maternal and newborn health communities (see Appendix C for participant list) to identify opportunities at the policy and program level for integration to improve quality of care during the antenatal, intrapartum, and postnatal periods. Needs of donors and technical assistance agencies were also addressed.

Meeting Goal and Objectives

The overall goal of the meeting was to increase collaboration between the maternal and newborn health communities in order to improve the quality of maternal, fetal, and neonatal health care (see Appendix B for meeting agenda).

To achieve this goal, the meeting had the following objectives:

1. Review knowledge base on the state of the evidence regarding integration of maternal and newborn health care and the promising approaches, models, and tools that exist for moving this agenda forward
2. Identify the barriers to and opportunities for integrating maternal and newborn care across the continuum
3. Develop a list of actions the global maternal and newborn health communities can take to ensure greater programmatic coherence and effectiveness

Summary of major themes

The following issues emerged as major themes over the course of the two days.

1. **Integration is a means to an end.** It is not a goal or outcome in and of itself, nor will it inherently improve any program. Rather, integration should be viewed as an approach to improving quality of care, provider and user satisfaction, and health outcomes by prioritizing the needs and desires of mothers, newborns, and providers first and foremost. Not all care could or should be integrated.
2. **Language matters.** In the quest to effectively organize health care, artificial divides have been created between maternal, fetal, and newborn health at the global, national, and service delivery levels. The effective integration of maternal and newborn health care can be furthered with clear and consistent usage of the term “integration” to capture the aspiration for high-quality, equitable care. New language is needed that unites, rather than divides, the maternal and newborn health communities.

3. **Understanding context is critical.** Evidence and experience suggest that successfully integrated, high-quality care is planned, delivered, and evaluated with the needs of mothers, newborns, providers, and families at the center and with the contextual barriers and opportunities for providing care in mind. While successful and unsuccessful examples provide excellent learning opportunities, a program or care delivery platform that is accessible, affordable, acceptable, and of high quality in one context may not be so in another. A strategic focus on the underlying theory of change and the constraining and facilitating factors contributing to outcomes is key to working effectively in a given setting.
4. Cost dimensions cut both ways. The maternal and newborn health communities must **consider the financial and budgetary dimension of integration**, including the cost implications for client themselves in addition to health system costs. Some examples were shared where avoiding unnecessary duplication of care could cut costs, and other examples noted that the cost implications associated with changing an existing care delivery system can be immense.
5. In designing integrated programs, there is a need to **be opportunistic and tactical**. Systems and processes must be designed to integrate care across space and time and at point of delivery, rather than requiring one provider to be responsible for all care at once.
6. The maternal and newborn communities need to **plan strategies around established platforms**, rather than use resources to build new ones. At the global level, the post-2015 Sustainable Development Goals, Ending Preventable Maternal Mortality, Every Newborn Action Plan, Every Mother Every Newborn, and global funding mechanisms, such as Saving Mothers, Giving Life, all provide powerful platforms to further the integration agenda. At the country level, technical working groups, professional associations, and policymaking processes also provide established platforms. There are a host of service delivery-level opportunities to be leveraged, including facility-based quality improvement teams, community health workers, and mechanisms for community-facility communication.
7. **Leaders in the maternal and newborn communities must act as advocates in complex political processes.** It is vital that they understand the complexity of the power structure, professional interests, and “territory” in which they are working. To achieve coordinated planning, delivery, and evaluation of maternal and newborn health care, concerted advocacy and behavior change communication are needed to explain the benefits of integrated care as well as the missed opportunities for improving quality that are created by disintegrated care.
8. **The maternal and newborn health communities need to “walk the talk.”** Participants agreed that we all need to demonstrate the benefits of integrated care so that there is a clear evidence base and ready models showing how shared priorities between the maternal and newborn health communities, including improving the quality of care provided to mothers and newborns, can be seized.

Conclusion

There was widespread agreement among the participants that now is the time to dig into the universe of opportunities that integration offers to improve health outcomes for mothers and newborns. At the same time, some voices cautioned that much needs to be done in terms of implementation science to know how best to integrate programs and policies and that mindsets need to shift among all of us—from donors and researchers to program implementers and policymakers—in order to consider the role and benefits of integration, understand when it makes sense to integrate care, and how best to do so. To move the integration agenda forward in concrete and practical terms, meeting participants created a list of recommended actions (see Appendix A).

Introduction

Biologically, genetically, culturally, and socially, maternal and newborn health are inextricably linked. Pregnant women and mothers are key to a baby's growth, social development, and overall health. Without this care, newborns and infants suffer. In fact, the riskiest period for women, fetuses, and newborns occurs during labor, delivery, and immediately postpartum – approximately 60 percent of maternal deaths happen during this period, while about one million newborns die each year on their first day of life. In addition, 2.6 million babies are stillborn each year. Poor maternal health, limited access to high-quality technical and interpersonal care, weak health systems, and a myriad of user-related barriers are leading causes of these deaths. Beyond pregnancy, delivery, and the immediate postpartum period, mothers continue to shape and influence the health, survival, and wellbeing of their children and families.

Despite these clear linkages, program efforts addressing the health of mothers and infants are often planned, managed, and delivered separately. International funding streams often favor approaches that divide the resources available to benefit women, mothers, and children. Ministries of health and technical assistance organizations are typically organized into separate departments for maternal and child health, with newborn health placed in both, either, or neither. Funding and technical support often focus exclusively on care for just one category of user. These artificial divides create very real chasms between maternal and newborn health care, particularly in the way that training, programs, service delivery, data collection, quality improvement (QI), and monitoring and evaluation are structured. Moreover, with these divisions in place, opportunities to improve outcomes by addressing systems comprehensively are limited. Care during pregnancy, labor and delivery, and the postpartum period are important windows of opportunity for both a woman and her fetus/newborn. More attention is needed to determine which aspects of maternal and newborn health can be effectively integrated in order to improve health and wellbeing for both.

In order to maximize the potential for improving health outcomes during these critical time periods, further development and nurturing of collaborative relationships between the maternal and newborn health communities is needed. With this goal in mind, the Maternal Health Task Force (MHTF) at the Harvard School of Public Health and the Saving Newborn Lives program (SNL) at Save the Children convened a technical consultation in Boston in September 2014 entitled ***Integration of Maternal and Newborn Health Care: In Pursuit of Quality***. This meeting assembled key members of the maternal and newborn health communities to identify opportunities to develop and implement programs that promote and facilitate the integration of quality care during the antenatal, intrapartum, and postnatal periods.

Because there were a number of discussions around a definition for integration at the meeting and a variety of interpretations of “integration” used in practice, the MHTF and SNL decided it would be useful to put forward the definition noted below, which speaks to the issues raised in discussion at the meeting.

The MHTF and SNL teams' working definition of integration

Integration of maternal and newborn health care refers to the coordination of policies, funding, planning, delivery, and evaluation of care provided to mothers and newborns in order to ensure equitable access to the highest quality of such care. This integration can occur at multiple levels of the health system, as well as within technical assistance and funding agencies supporting maternal and newborn health care.

This report summarizes the discussions that took place at the meeting, with particular emphasis on key themes, conclusions, and recommended actions to guide next steps. Additional information is available from the knowledge [management](#) and social media tools that were used to disseminate information to the broader maternal and newborn health communities. A joint [blog series](#) by the MHTF and the Healthy Newborn Network (HNN) highlights participants' perspectives (in their words) on maternal and newborn health care integration, as well as presentations and key themes. Finally, Twitter posts ([#MNHIntegration](#)) and [videos](#) of the presentations are also available.

With increasing calls for effectively-integrated care, including discussions leading up to the post-2015 Sustainable Development Goals, the time is right to advance the understanding of integration, the barriers and opportunities to delivering it in practice, and the steps needed to use integrated care to simultaneously improve both maternal and newborn health outcomes. The outputs, relationships, and ongoing collaborative efforts stemming from this meeting will help shape critical discussions about how to take this work forward.

Meeting Goal and Objectives

The overall goal of the meeting was to increase collaboration between the maternal and newborn health communities in order to improve the quality of maternal, fetal and neonatal health care.

To achieve this goal, the meeting had the following objectives:

- 1) Review knowledge base on the state of the evidence regarding integration of maternal and newborn health care and the promising approaches, models, and tools that exist for moving this agenda forward
- 2) Identify the barriers to and opportunities for integrating maternal and newborn care across the continuum
- 3) Develop a list of actions the global maternal and newborn health communities can take to ensure greater programmatic coherence and effectiveness

Summary of Major Themes

The following issues emerged as major themes over the course of the two days.

- 1) Integration is a means to an end.** It is not a goal or outcome in and of itself, nor will it inherently improve any program. Rather, integration should be viewed as an approach to improving quality of care, provider and user satisfaction, and health outcomes by prioritizing the needs and desires of mothers, newborns, and providers first and foremost. Not all care could or should be integrated.
- 2) Language matters.** In the quest to effectively organize health care, artificial divides have been created between maternal, fetal, and newborn health at the global, national, and service delivery levels. We can further the effective integration of maternal and newborn health care with clear and consistent usage of the term “integration” to capture the aspiration for high-quality, equitable care. Language is needed that unites, rather than divides, the maternal and newborn health communities.
- 3) Understanding context is critical.** Evidence and experience tell us that successfully integrated, high-quality care is planned, delivered, and evaluated with the needs of mothers, newborns, providers, and families at the center and with the contextual barriers and opportunities for providing care in mind. While successful and unsuccessful examples provide excellent learning opportunities, a program or care delivery platform that is accessible, affordable, acceptable, and of high quality in one context may not be so in another. A strategic focus on the underlying theory of change and the constraining and facilitating factors contributing to outcomes should be widely used among the maternal and newborn health communities.
- 4) Cost dimensions cut both ways.** The maternal and newborn health communities must **think about the financial and budgetary dimension of integration**, including the cost implications for client themselves in addition to health system costs. When does integration make sense, and when does it hinder effective care? Some examples were shared where avoiding unnecessary duplication of care could cut costs, and other examples noted that the cost implications associated with changing an existing care delivery system can be immense.
- 5) In designing integrated programs, there is a need to be opportunistic and tactical.** Systems and processes must be designed to integrate care across space and time and at point of delivery rather than requiring one provider to be responsible for all care at once.
- 6) The maternal and newborn communities need to plan strategies around established platforms,** rather than use resources to build new ones. At the global level, the post-2015 Sustainable Development Goals, Ending Preventable Maternal Mortality, Every Newborn Action Plan, and global funding mechanisms such as Saving Mothers, Giving Life all provide powerful platforms to further the integration agenda. At the country level, technical working groups, professional associations, and policymaking processes also provide established platforms. There are a host of service delivery-level opportunities to be leveraged, including facility-based quality improvement teams, Community Health Workers, and mechanisms for community-facility communication.
- 7) Leaders in the maternal and newborn communities must act as advocates in complex political processes.** It is vital that they understand the complexity of the power structure, professional interests, and “territory” in which they are working in order to ensure endorsement of their goals. To achieve coordinated planning, delivery, and evaluation of maternal and newborn health care, concerted advocacy and behavior change communication are needed to explain the benefits of integrated care as well as the missed opportunities for improving quality that are created by disintegrated care.
- 8) Now the maternal and newborn health communities need to “walk the talk.”** We must work to demonstrate the benefits of integrated care so that there is a clear evidence base and ready models showing how shared priorities between the maternal and newborn health communities, including improving the quality of care provided to mothers and newborns, can be seized.

Meeting Sessions

Day 1

After a brief welcome from the meeting's conveners, the first session began with an introduction to the concept of appropriate integration of maternal and newborn health care as a means to improve equitable access to quality care. The presentations that followed examined vertical programs and their negative effects at multiple levels of health systems, as well as their impact on health outcomes of mothers, babies and families. It was recognized that integration of maternal and newborn care has not been thoroughly studied, and indicators for measuring the content and quality of integrated care are limited, leaving us with a weak evidence base and little information about the access to and quality of integrated services. Participants stressed that donors, policymakers, technical assistance partners, and care providers must "walk the talk" of integration by modeling behavior change and committing to gathering the evidence that will help strengthen health systems. Working in siloes was also widely recognized as often being profoundly limiting.

In the plenary discussions, participants emphasized that in order to affect change, it is important to focus on the entire health system, from strengthening provider training to improving supply chain management and health management information systems (HMIS). Special reference was made to the fact that we know little about the content of care delivery. For instance, despite increases in the number of antenatal care visits in many contexts, there is a notable lack of information about the actual interventions delivered during these encounters. Participants noted that a shift from "content-free contacts" to visits that provide evidence-based, high-quality interventions benefitting both mothers and newborns will require systems-level approaches that tackle inequities, improve the quality of care, increase user satisfaction, and support health care providers. Participants also agreed that maternal and newborn health care must be given equal weight along the continuum of care in order to ensure integration is successful, purposeful, and adequately addresses the needs of mothers and newborns. Renewed momentum and interest in universal health coverage was noted as an opportunity to examine the essential services of maternal and newborn health care, as well as an effective means to deliver integrated care.

While "integration" as a term has garnered a lot of attention in global health circles in recent years, implementation of integrated care across the maternal and newborn health continuum has proved difficult and successful examples are few. Numerous barriers exist between the respective communities, from disparate professional groups to physically separate clinic areas. Participants recognized, however, that there are also many opportunities to strengthen and promote integrated care that have not yet been fully realized. (Some compelling examples of integrated programs were shared later in day 1 and on day 2.)

Through a pre-meeting survey (see summary of results in Appendix D), those invited to the meeting (not all of whom could ultimately attend) expressed ideas about the barriers to and opportunities for integration of care. Several common themes emerged as barriers:

- The contribution of policy- and donor-driven vertical care siloes to disintegrated health care
- Poor linkages between maternal and newborn health care training programs
- Lack of understanding and consensus about the fact that integration is a tool that can be used to improve health outcomes, rather than a goal itself
- Inadequate staffing, considered both a limitation to integration efforts among overworked staff and a factor encouraging integration among staff who must multi-task due to working alone

Many opportunities for integration were also mentioned:

- High demands on staff time and skills suggests the need for increased support to strengthen their capacity to provide integrated care
- The delivery of high-quality integrated care around the time of birth through task-shifting and improved linkages between facilities

- The increase in support from policymakers, donors, and technical assistance partners who are recognizing the benefits of integrated care

At the end of the first morning, a presentation was given from a midwife who has practiced in northern Nigeria for almost four decades. Her message about the on-the-ground reality of integrating care was enlightening; she discussed situations where only one provider is available to give care to both mother and newborn, necessitating the integration of care. But she also referenced the substantial challenges to integration within her local health system – overburdened providers, trainings that do not match the context and provide little to no competency-based skills, poor infrastructure, and broken supply chains. She mentioned that in her context, a focus on competency-based training is needed to encourage integration.

The morning presentations led to discussion regarding the appropriateness of integration: *What components are necessary to make integration successful, and why? When should we not integrate care?* Participants emphasized that integration is context-dependent and effective integration begins with a true understanding of on-the-ground realities. To be successful, donors, policymakers, and implementers across maternal and newborn health must work together to develop integrated pre-service training as well as an integrated point-of-care infrastructure; packages of interventions; approaches to human resource management; supportive supervision; QI teams; and in-service, competency-based training. Those working on the design of programs must be able to see concrete benefits to integration and have the political capital to engender sufficient goodwill to make these changes. They also need to be able to take advantage of opportunities that they may not have originally planned for but that emerge as policies and programs are implemented.

When either the mother or newborn needs urgent or intensive interventions, however, the situation quickly becomes more complicated and is often limited by what is realistically possible for a provider to do in a given setting. Whatever the point of care, integration in these situations is secondary to meeting an individual user’s critical needs first, keeping in mind the clear goal of improved health outcomes for both mother and newborn. In these cases, there need to be contingency plans that allow for quick action following an established, specialized algorithm that may not be integrated – especially in cases where health outcomes of either the mother or the baby are threatened.

In the afternoon, three case studies presented different ways of providing high-quality, integrated maternal and newborn health care, with emphasis on the theory of change that supported each approach and the factors that enabled them to be successful in each context. Examples from Ecuador, Nigeria, Uganda, and Zambia illustrated potential models for integrating health systems, programmatic strategies, and service delivery in order to optimize maternal and newborn health outcomes. The cases illustrated the fundamental need for understanding context, and to this end, local stakeholders must be engaged from the beginning.

In the Ecuador program, QI teams are each comprised of obstetric, pediatric, pharmacy, and laboratory staff from a facility providing maternal and newborn health care. The team members work together to identify gaps in care provided across the facility, determine which measures could improve that care, develop indicators to monitor changes in care, and interpret the data that is generated to decide whether quality of care improved. Teams meet once a month to audit detailed perinatal health records and use this process to improve the care they provide to mothers and newborns and ensure sustainability. The Ecuadorean Ministry of Health also requires participating facilities to provide monthly reports of these audits, which allows for the monitoring of quality of care as well as development of standardized protocols and training. Analysis has shown significant improvement in a variety of indicators in participating facilities, from increased partograph use during labor to increased compliance with essential newborn care standards.

In Northern Nigeria, where facility-based delivery is rare, another program takes advantage of close-knit community networks to deliver essential maternal and newborn commodities to pregnant women. With the support of local leaders, community-based health volunteers are trained to dispense misoprostol and chlorhexidine for use just after home delivery to prevent post-partum hemorrhage and umbilical cord infections, respectively. By working with community leaders and ensuring local buy-in, the program has successfully increased demand for these life-saving drugs. Preliminary data suggest that the communities served by this effort have lower morbidity and mortality among mothers

and newborns. The drugs are now being made in-country, and the program is working with the Federal Ministry of Health to implement these community networks nationwide.

A multi-country public-private partnership targeted district-level maternal and newborn health services in Uganda and Zambia. The first phase of the program specifically focused on strengthening health networks using the Three Delays framework. It aimed to increase awareness among women, families, and community leaders of the importance of seeking maternal and newborn health services, improve access to such care by strengthening connections between service delivery points and expanding transportation networks, and improve the quality of care available at facilities by providing Emergency Obstetrics and Newborn Care (EmONC) training and strengthening basic service delivery at lower-level facilities. By coordinating efforts among donors and implementing partners alike, the program saw a significant decrease in maternal mortality, as well as a (non-significant) drop in neonatal mortality in both countries. In future phases, the program will increase its focus on the newborn while continuing to strengthen integrated services.

The first day ended with small group discussions on the barriers to and opportunities for effective integration of care, which built on the previous sessions of the day. Participants discussed in more detail how to bridge the siloed efforts at the national and service delivery levels, and highlighted the insufficient research on successful models of integration. Opportunities for future progress included the adoption of a universal terminology and definitions for integrated maternal-fetal-newborn health care to unite the maternal and newborn communities, global guidelines that involve universal best practices but leave room for context-specific adaptations, mechanisms to increase community participation and strengthen political will, ways to strengthen health systems to enable them to provide integrated care, and interdisciplinary training for maternal and newborn care providers. For a full list of the barriers and opportunities that were discussed, please see Appendix E.

Day 2

Following a recap of the first day's progress towards addressing the meeting's goal and objectives, the morning of Day 2 explored both successful and failed experiences of integrated care. Through the pre-meeting survey, examples in both categories were also shared (see Appendix D).

The first session allowed for further analysis of common themes among unsuccessful programs. With an ultimate goal of the best possible outcomes for both mothers and newborns, care must address both. Vertical siloes of care, which apply to only the mother or only the newborn, were identified as ineffective. Rather, when care is delivered across stages of the life course (and when providers are trained and supported in providing integrated, comprehensive care across the pregnancy, labor and delivery, and postnatal periods) the needs of mothers, newborns, and providers can all be addressed. Similarly, existing platforms for service delivery can be utilized to provide integrated care: for example, communities in which populations have ready access to health facilities can use facility-based teams to deliver care along the maternal and newborn continuum of care. On the other hand, areas with low rates of facility attendance and where home delivery is common can concentrate efforts on community-based outreach teams. Finally, providers should be empowered to deliver the care they have been trained to provide, regardless of rank: for example, a nurse trained in emergency obstetric care should be able to deliver that care when necessary without waiting for a supervising doctor to arrive.

The following session featured an integrated presentation by an OB/GYN and a midwife about what integrated care *can* look like. Presenters asked participants to consider approaching program and service delivery design with a team that includes all stakeholders. For example, when women, OB/GYNs, midwives, nurses and neonatologists are asked to agree on priorities together, successful integration of service delivery packages can occur and improve the quality of care provided. The primary focus of this presentation was on what the mother, newborn, family, and provider want and need throughout the care-seeking and treatment processes, and how including those ideas in a care delivery model contribute to its success. While opportunities for integration exist at multiple levels and platforms, they depend on context-specific care packages and interventions, care models, care teams, care settings, care structures, and organization of the health system.

In the plenary discussion that followed, participants noted that government involvement is also important for program sustainability. Serious consideration must be given to determining when integration is appropriate and when it will cause more harm than good. In addition, many women and families are more comfortable with traditional providers of care, such as traditional birth attendants. In order for traditional providers to deliver high-quality care, they must have a recognized, supported role within integrated health systems. Finally, community needs must be taken into account; town hall meetings, public hearings, and shared governance within communities have been found to be effective ways of ensuring mothers and families are involved in developing the care they receive.

The afternoon was spent in small groups exploring clear, specific actions that can be undertaken to better integrate maternal and newborn care. The actions discussed are applicable at the facility or service delivery level, at the national level for policymakers and program implementers, and at the global level for donors and technical assistance partners. Some common themes emerged under which specific actions were noted (see brief list below and more detailed list in Appendix A).

Common themes

- Data and measurement
- Commodities
- Advocacy
- Human resources
- Technical support/coordination
- Funding
- Standards of care

Brief highlights from extensive list of actions generated

- Improve indicators and data collection tools to measure integrated care, including in national HMIS
- Establish quality improvement teams at service delivery sites
- Standardize evidence-based decision tools and job aids
- Revise national human resources for health standards and protocols to be evidence-based
- Develop integrated funding streams for maternal and newborn health
- Continue to hold joint conferences and technical meetings to bring the global maternal and newborn communities together

For a full list of the identified actionable items, please see Appendix A.

Conclusions

Communications: Terminology that can unite the maternal and newborn health communities is sorely needed. Using common, agreed-upon language, these communities should develop a comprehensive, indivisible term that promotes integrated care and drives home the idea that mothers and their babies are inextricably linked. Similarly, advocacy groups, program implementers, and others would benefit from talking points that use this common language to show the importance of working across the continuum of care. Clear, concise messages would strengthen advocacy efforts and encourage support for integration from ministries of health, donors, and care providers.

Knowledge management: The development of a common knowledge management system (KMS) platform that specifically covers the integration of maternal and newborn health is vital for supporting integration moving forward. This platform should cover the informational needs of donors, policymakers, researchers, technical assistance partners, and implementers who are interested in providing unified care across the continuum. Acting as a “one-stop shop,” this KMS platform should assist the maternal and newborn health communities with accessing the evidence base and

disseminating information in order to develop appropriate interventions, build common communications strategies, and foster collaboration.

Health systems: In order to actively support true change, strategies for integrating maternal and newborn health care should be developed to work within existing health systems, as complex and idiosyncratic as they are. At the same time, the considerable existing divisions between the maternal and newborn health communities must be taken into account. These considerations will ensure that new maternal, newborn, and child health programs address the problems of both today and tomorrow by being context-specific, conscious of existing resource constraints, and forward-looking. As one participant noted, until we are able to manage what’s happening to us today while also keeping an eye on growing problems that will be bigger tomorrow—such as non-communicable diseases, massive rates of urbanization, increasing numbers of adolescents giving birth, etc.—we will never be able to plan adequately for integration.

Data and measurement: Participants identified approaches to support integration in facilities, national policies and programs, and donors and technical assistance partners. At all three levels, improvements in data collection and measurement were seen as critical for facilitating integrated approaches. Critical thinking around process and outcome indicators, data collection and reporting tools including HMIS, and content- and quality-related measures will ensure future integration efforts are evidence-based with adequate monitoring and evaluation.

Funding streams: Existing funding for maternal and newborn health care is often siloed, discouraging the development of integrated programs and rendering innovative solutions difficult. Moving forward, helping donors to think differently to integrate funding that simultaneously contributes to improving the health of both mothers and newborns is necessary. This change in structure can be supported by raising awareness among donors via collaborative communication strategies from the maternal and newborn communities, strong evidence supporting integration, and increased demand for integration from care providers, technical assistance partners, and national-level policymakers.

Training: Pre-service and in-service training should be competency-based and include team-building skills, supportive supervision, and quality improvement techniques.

Next Steps

Each of these elements is crucial to improving access to high-quality maternal and newborn care. Donors, policymakers, researchers, program implementers, and care providers all have a role to play. As the maternal and newborn communities consider the role of integrated, coordinated care in improving quality, we must continue to work together on collecting high-quality data, disseminating information, building political will, strengthening health systems, and ensuring that locally-developed priorities are heard and supported by decision-makers. While much remains to be done, circulating the recommended actions list (Appendix A) to create a shared understanding of who is taking on which activities, continuing to be in conversation about joint planning for policies and programs, convening joint technical discussions, and conducting research that bridges the maternal and newborn communities will continue to advance the field.

Appendix A: List of Recommended Actions

One of the objectives for this meeting was to develop a list of actions the global maternal and newborn health communities can take to ensure greater programmatic coherence and effectiveness. During breakout sessions on Day 2 of the meeting, participants met in groups to answer questions related to actions that should be taken at multiple levels of the health system:

1. List *the specific actions your group recommends to better integrate maternal and newborn care **at the facility/service delivery level***
2. List *the specific actions your group recommends to better integrate maternal and newborn care **at the national level in terms of policy and program management***
3. List *the specific actions your group recommends that **donors and technical assistance partners should take to support and facilitate more integrated approaches to maternal and newborn care***

Each small group created their own list of priority action items in response to these questions. Similar items have been consolidated, edited for clarity, and labeled “recommended actions” in the chart below. The chart will be widely circulated to meeting participants, as well as to those who did not attend the meeting. If an organization is working on a specific issue, an individual from that organization is asked to note this work in the column labeled “contributing organization.” In cases where an organization is already playing a coordinating or leadership role, that organization is asked to note this work in the column labeled “leading/coordinating organization.”

The information gathered in this chart will be shared widely so that members of the maternal and newborn health communities, as well as allied fields, will have a shared sense of the landscape of work underway on maternal and newborn integration, and have the opportunity to connect with those working in similar areas.

Question 1: *List the specific actions your group recommends to better integrate maternal and newborn care **at the facility/service delivery level.***

<u>Recommended Action</u>	<u>Contributing Organization(s)</u>	<u>Leading/ Coordinating Organization(s)</u>
<u>Data/measurement</u> 1. Establish, improve, or adapt the design of unified data collection tools and systems, such as maternal and perinatal death and/or disability audits, that are actionable at the facility level and focused on health outcomes.		
2. Gather information on health outcomes and service delivery performance at the point of care through process mapping; synthesize to develop an action plan that addresses gaps in the organization and delivery of care and improves quality of care for mothers and newborns.		
3. Disseminate local data on health outcomes, service delivery performance, and information about patient rights within communities to ensure transparency and encourage demand for high-quality, integrated services. Examples include improved links between the community and the facility and greater patient-provider communication and transparency.		

<u>Recommended Action</u>	<u>Contributing Organization(s)</u>	<u>Leading/ Coordinating Organization(s)</u>
<u>Commodities</u> 4. Strengthen supply and distribution management within the facility and the community to ensure that necessary maternal and newborn commodities are equally available and accessible.		
<u>Advocacy</u> 5. Create and use advocacy tools, such as talking points, to increase engagement among facility-level stakeholders—including community leaders, facility managers, and providers—on specific barriers to and opportunities for integration of maternal and newborn care.		
<u>Human resources</u> 6. Provide leadership and mentorship at service delivery points about how best to organize people-centered and provider-friendly integrated care.		
7. Establish, improve, and work within multidisciplinary teams that cut across cadres, strengthen the linkages between health facilities, and work together to deliver coordinated care to improve maternal and newborn health outcomes.		
8. Support team-based, in-service training and supervision that meets professionals' needs, including competency-based clinical skills, facility and human resource management, data collection, quality improvement, and interpersonal communication.		

Question 2 List the specific actions your group recommends to better integrate maternal and newborn care **at the national level in terms of policy and program management.**

<u>Recommended Action</u>	<u>Contributing Organization(s)</u>	<u>Leading/ Coordinating Organization(s)</u>
<p><u>Data/measurement</u></p> <p>1. Strengthen national monitoring and reporting systems to include indicators and measurements of coverage, content, and quality of maternal and newborn health services. Use this data to fortify health systems, including supply and distribution chains for maternal and newborn care commodities.</p>		
<p><u>Commodities</u></p> <p>2. Strengthen national supply and distribution chains to ensure that necessary maternal and newborn commodities are equally available and accessible across the health system.</p>		
<p><u>Advocacy</u></p> <p>3. Create and use advocacy tools, such as talking points, to engage with ministries of health and other national-level stakeholders on specific barriers to and opportunities for integration of maternal and newborn care.</p>		
<p><u>Standards for care</u></p> <p>4. Identify shared goals and priorities between the Every Newborn Action Plan and Ending Preventable Maternal Mortality frameworks to ensure national harmonization of policies and programs.</p>		
<p>5. Strengthen links between reproductive, maternal, newborn, and child health technical working groups and national programs to act upon the highest-impact opportunities for effective integration across the care continuum.</p>		
<p>6. Update and adapt national maternal and newborn health clinical care guidelines in accordance with current WHO recommendations, and articulate the linkages between these guidelines to ensure appropriate integration of care, with particular attention to adequate human resources.</p>		
<p>7. Prioritize resources that hold facilities and providers accountable for achieving high-quality maternal and newborn care. Examples include strengthening accreditation, quality assurance, and quality improvement mechanisms to help facilities achieve national standards and improve outcomes.</p>		
<p><u>Human resources</u></p> <p>8. Revise health cadre competencies and scopes of work based on existing resources to optimize supply, access to and quality of services for mothers and newborns. Important examples include task shifting and distribution of health care workers based on need.</p>		
<p>9. Support team-based, pre-service training and supervision that meets professionals' needs, including competency-based clinical skills, facility and human resource management, data collection, quality improvement, and interpersonal communication.</p>		

Question 3 List the specific actions your group recommends that **donors and technical assistance partners should take to support and facilitate more integrated approaches to maternal and newborn care.**

<u>Recommended Action</u>	<u>Contributing Organization(s)</u>	<u>Leading/ Coordinating Organization(s)</u>
<p><u>Data/measurement</u></p> <p>1. Support assessment of the data and information needs of global, national, and local stakeholders and ensure that monitoring and reporting systems include indicators and measurements of coverage, content, and quality of maternal and newborn health services. Assist with the interpretation of this data to develop evidence-based resources and tools and fortify health systems.</p>		
<p><u>Advocacy</u></p> <p>2. Create and use advocacy tools, such as common messaging and integrated initiatives, to engage with donors and other global stakeholders on specific barriers to and opportunities for integration of care for mothers and newborns, including stillbirths.</p>		
<p><u>Technical support</u></p> <p>3. Consolidate management units in technical assistance organizations and donor agencies to strengthen integrated maternal and newborn health programmatic efforts, especially those addressing relatively neglected areas such as antenatal care and stillbirths. Where appropriate, ensure integration with allied fields such as malaria and HIV programs.</p>		
<p>4. Conduct planning and strategy development sessions which include donors, technical assistance agencies, and multilateral bodies and reflect the interrelated needs of women and children across the reproductive, maternal, newborn, and child health spectrum.</p>		
<p>5. Consolidate existing knowledge management tools and platforms, including websites, email listservs, and social media presence to disseminate coordinated content on the integration of maternal and newborn care.</p>		<i>MHTF/SNL</i>
<p>6. Strengthen linkages between the maternal and newborn communities, including donors, to support the development of innovative thinking around integration as well as action-oriented resources such as technical briefs, evidence reviews, curricula, and programmatic recommendations on the appropriate integration of care along the continuum.</p>		
<p>7. Provide resources, including specific yet flexible evidence-based care guidelines and support for implementation research, that assist countries in contextualizing and operationalizing policies and programs.</p>		
<p>8. Organize and convene joint maternal and newborn health conferences and technical meetings, except in cases with a clear need for a more specialized, topic-specific focus.</p>		
<p><u>Funding</u></p> <p>9. Establish or bolster integrated funding streams, where possible, which encourage strong linkages between maternal and newborn health programs at all levels of the health system.</p>		

Appendix B: Meeting Agenda

INTEGRATION OF MATERNAL & NEWBORN HEALTH CARE

Day 1 • September 9, 2014

8:30-9:00 *Registration and breakfast*

9:00-9:30	Welcome and orientation to meeting	Tim Thomas (facilitator) Ana Langer Joy Riggs-Perla
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9:30-9:45	Integration in pursuit of quality and equity	Mariam Claeson
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9:45-10:15	Performance gaps and the cost of inaction	Joy Riggs-Perla (moderator) Ana Langer Rifat Atun Koki Agarwal
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10:15-11:00	Plenary discussion	Tim Thomas
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11:00-11:15 *Coffee/tea break*

11:15-11:35	The value and limitations of the continuum of care framework	Sharad Iyengar
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11:35-11:50	Barriers to and opportunities for integration of care	Jim Litch
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11:50-12:10	Reality check: Reflections from a midwife on real world challenges	Nafisatu Omar
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12:10-12:45	Plenary discussion	Tim Thomas
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12:45-1:45 *Lunch*

1:45-2:45	Promising approaches to integration of care	Eddie Mhlanga (moderator) Jorge Hermida Nosa Orobato Priya Agrawal
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2:45-3:00	Explanation of small group work	Tim Thomas
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3:00-3:15 *Coffee/tea break*

3:15-4:15	Barriers to and opportunities for integration of care	Small group work
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4:15-4:45	Report out and plenary discussion	Tim Thomas
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4:45-5:00	Day 1 wrap up	Mary Nell Wegner
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5:00-6:30 *Reception*

INTEGRATION OF MATERNAL & NEWBORN HEALTH CARE

Day 2 • September 10, 2014

8:30-9:00	Breakfast	
9:00-9:15	Review of Day 1 and orientation to Day 2	Tim Thomas
9:15-9:30	Using what has not worked to guide our approach	Steve Hodgins
9:30-10:00	What could integrated care look like? Areas for exploration	Mary Mwanyika-Sando (moderator) Jeff Smith Rima Jolivet
10:00-10:45	Plenary discussion	Tim Thomas
10:45-11:00	Coffee/tea break	
11:00-11:15	Explanation of small group work	Tim Thomas
11:15-12:00	Integration of health care at the facility/service delivery level	Small group work
12:00-1:00	Lunch	
1:00-2:00	Integration of policy and program management at the national level	Small group work
2:00-2:45	Coordination of support that donors and technical assistance partners can provide	Small group work
2:45-3:00	Coffee/tea break	
3:00-4:00	Report out and plenary discussion	Tim Thomas
4:00-4:30	Synthesis, wrap up, and next steps	Kathleen Hill

Appendix C: List of Participants

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Appendix D: Summary of Pre-meeting Survey Responses

What is your vision of success for maternal and newborn health care? How does integrated service delivery relate to that vision?

- Support for a functioning health system, including proper allocation of resources and political will, is needed to ensure adequate facilities, equipment, and staff for maternal and newborn care. Seamless transitions across home, clinic, and referral facility levels must be matched with evidence-based guidelines and adequate staffing.
- Standard protocols for training, clear guidelines for service delivery, and supportive supervision need to be in place to support integrated maternal and newborn care. Where feasible, care delivery teams may help skilled providers with sufficient resources to provide integrated care in an organized, coordinated, and timely way.
- Evidence-based care standards and interventions must be grounded in local context in order to be successful. All women and newborns, regardless of wealth or socioeconomic status, need access to trained, competent care providers who have the necessary equipment, commodities, and referral networks to provide high-quality care.
- Care must be people-centered and meet the needs of mothers, newborns, and families. Women and their partners should be empowered to make choices in their care along the reproductive, maternal, neonatal, and child health (RMNCH) continuum, and feel that the care they receive is comprehensive and high-quality.
- Maternal and newborn health programs should be integrated from planning through implementation and evaluation. Services such as PMTCT, nutritional planning, contraception, and post-abortion care should also be included.

What do you see as the major barriers to the effective integration of maternal and newborn health care?

- Effective integration is poorly defined and models for integrating care are limited. Unclear messaging from the maternal and newborn sectors has led to poor local-level engagement and weak advocacy for integration; thus, support for the integration of maternal and newborn care has been inadequate among donors and policymakers.
- Donors and international technical partners often prioritize funding for vertical approaches that treat mothers and newborns as separate entities, hindering the integration of training, service delivery, and quality of care guidelines.
- The siloed nature of many initiatives is also driven by the separate and distinct training for maternal and newborn care providers, lack of collaboration between their academic and professional organizations, the extensive specialization of providers, and poor communication between global maternal and newborn communities.
- Ineffective or nonexistent referral systems, gaps in knowledge, separation of services for mothers and newborns, poor infrastructure and supply chain management, and lack of proper mechanisms to ensure patient safety and quality care render the integration of maternal and newborn health care difficult.
- Women, health care providers, and communities are often left out of the conversation regarding the applicability, feasibility, and potential benefits (or detriments) of integrating maternal and newborn health care.
- The lack of trained, well-equipped, and regulated providers in maternal and newborn health care has led to high workload and limited capacity for providing integrated care. In addition, there are few training opportunities to increase the number of health care professionals who can manage both maternal and newborn complications.

What do you see as the major opportunities for the effective integration of maternal and newborn health care?

- Building awareness among patients and providers that complications affecting the mother often impact the newborn may encourage care-seeking and build support for integrated approaches. Antenatal and postnatal care are particularly important platforms in which integrating maternal and newborn care may improve quality.
- In many settings where few health care workers are available, integration happens by necessity. Developing standardized training and clinical care guidelines will ensure that quality is not compromised.
- Client-centered, context-specific approaches that deliver quality services in the period around childbirth can positively impact the health of both mothers and newborns. Integrated training for maternal and newborn care providers, appropriate use of task-shifting, and improved linkages between facilities and communities can contribute to improved integration of care.
- Clear language around the integration of maternal and newborn health care will promote stakeholder buy-in. Many countries already support integrated efforts through universal access to maternal and newborn care, task-shifting, and health systems strengthening, but joint messaging will increase collaboration between global, national, and community-level partners, strengthening in-country initiatives.
- Numerous global movements, such as ongoing discussion around the post-2015 Sustainable Development Goals, provide important opportunities for supporting integration of care. Improved awareness of the need for skilled care, increasing gender equality, and better global connectivity will also increase support for integration.
- Generating context-specific evidence by strengthening quality improvement indicators, measuring cost-effectiveness of interventions, and documenting successful programs will further support integration efforts.
- Ongoing opportunities for all levels of the maternal and newborn communities (including women, community leaders, providers, government officials, donors, and technical assistance partners) to come together and discuss ways to improve the effectiveness, efficiency, and cost-effectiveness of care will lead to increased integration and better quality of care.

In your experience, what approaches have been successful to delivering quality maternal and newborn health care? Why?

- Successful programs are supported by the engagement of political leaders, including ministries of health and policymakers, who advocate for effective, evidence-based interventions. Political will is critical to improving the quality of maternal and newborn care as well reducing social and cultural barriers for women seeking such care.
- Maternal and newborn care programs can be successful when local infrastructure and facilities are supported by strong health systems and health-related policies. Coordinated financing, guidelines for training and clinical practice, data collection, and supply chain management should be prioritized.
- High-quality maternal and newborn care programs are driven by evidence-based planning and budgeting with a focus on standardizing care, streamlining efficiency, and utilizing data.
- De-centralized, community-based approaches that support frontline workers and respond to local barriers are key. Small-scale, context-specific care delivery models, local buy-in, and a focus on service delivery processes all contribute to successful integration of maternal and newborn care.
- Approaches addressing supply and demand issues, including those related to infrastructure and essential commodities, buy-in from providers, and patient involvement in care, can facilitate the successful delivery of quality care.
- Providing comprehensive training and skills development, supportive supervision, and frequent feedback and quality assessment to all maternal and newborn health care professionals is crucial. Successful programs emphasize provider accountability, offer opportunities, and ensure availability of necessary equipment and commodities.

- Sustained support from donors for integrated programs is vital for delivering high-quality maternal and newborn care. Additional collaboration with other fields, such as HIV and malaria, can increase the sustainability and quality of MNCH interventions.

In your experience, what approaches have not been successful to delivering quality maternal and newborn health care? Why?

- Approaches that do not include adequate indicators for measuring coverage and quality of care, and/or have unclear standards of care, are ineffective and do not meet client needs or improve quality of care.
- Programs that do not give both providers and communities appropriate input into intervention design, including any supply- or demand-side issues to be addressed, will not meet the needs of local stakeholders.
- Approaches that do not account for local context, including available resources, the socio-cultural/political landscape, and demand for services, will not have enough local buy-in to be successful.
- Programs focused on tertiary hospitals without strengthening primary care facilities will not meet needs. Programs must also be sustainable and include built-in evaluations to ensure quality improvement. Improving equipment and supplies, rather than only provider competencies, should also be considered.
- Quality care provision is hindered by the disempowerment of skilled RMNCH care providers, whether by the health system or by their colleagues. Maternal and newborn providers also need adequate pre- and in-service training, supportive supervision, and appropriate equipment and supplies.
- Approaches, including funding and programmatic efforts, that focus narrowly on either the mother or the newborn artificially divide families and create numerous missed opportunities. Many instances, such as newborn immunization visits, could be more effectively used by serving the needs of both members of the dyad.

What would need to happen in this meeting and in follow-up activities for you to feel it was successful and useful? What topics would be essential to discuss if we are to foster more effective integration of maternal and newborn health care?

- Agreement on a clear definition of effective integration, as well as stronger joint messaging from the maternal and newborn communities, will assist with advocacy efforts promoting appropriate integration among donors, policymakers, program implementers, and maternal and newborn care providers.
- Collaboration between the maternal and newborn is needed to clearly define stakeholder roles, develop integrated care guidelines, training curricula, and supervision tools, maximize the effectiveness of limited resources (including funding), and strengthen access to and quality of care across all levels of the health system.
- Health systems strengthening should be prioritized by technical assistance partners, donors, governments, and others. Joint efforts can ensure integration across levels of services, coordinated supply chain management, meaningful quality indicators, and prepared maternal and newborn care providers.
- Interventions to improve maternal and newborn health should be developed with clear, concrete, and sustainable plans for implementation. Provider support, quality improvement mechanisms, clearly defined target groups, context-specific service delivery, and built-in program evaluations are crucial to successfully integrating efforts.
- Donor projects and funds should be focused on strengthening infrastructure and health systems and delivering integrated services. Areas to prioritize include case studies of successful models, implementation research focused on coordinated care, and approaches that unify actors from the maternal and newborn communities.
- Researchers, donors, implementers, and providers focused on maternal and newborn health care should work to expand and disseminate the evidence base regarding cost-effective interventions focused on integration. Stronger evidence should be used to inform management guidelines, standards of care, and health systems structures.

Appendix E: List of identified barriers to and opportunities for Integration

Global barriers and opportunities

- There has been a call to action at the global-level: there is an opportunity for a new, inclusive, unified term for work with maternal/newborn care.
- Global maternal and newborn integration efforts should focus on the reasonableness and feasibility of the recommendations – we must keep in mind that systems in different contexts are in different stages.
- We need humanized, not commoditized care: We must think about the people we are serving. It makes more sense to think about integrated care with the mother-baby dyad in mind.
- Global guidelines for interventions such as kangaroo care, exclusive breastfeeding, and emergency obstetric care must be evidence-based and applicable in all contexts. Only then can they be tailored to a particular context.

National barriers and opportunities

Policymaking

- Countries must have a process for establishing evidence-based global guidelines that can be implemented regardless of context.
 - Countries are good at macro planning, but need to improve translating this to sector-specific planning.
 - Countries need a costed, evidence-based package of integrated interventions.
- There is poor political will, which is necessary to support integration and the use of technical assistance.
- National commitments to global efforts—such as ENAP and EPMM—and movements toward universal health coverage need to be leveraged.
 - Universal health care can support accessibility, affordability, acceptability, and quality of integrated care.
- Countries must ensure that the logistics and supply chains for maternal and newborn care are integrated.
- We must rebalance funding for all levels of the health system – from tertiary to primary care.

Programmatic

- There is a lack of communication and collaboration between the maternal and newborn communities – we need to have a joint vision.
 - A perinatal commission at the federal level would help coordinate maternal and newborn communities.
- We must ensure that we position perinatal health outcomes within maternal health and the RMNCH continuum.
- Language matters: how do we talk about maternal and newborn care and needs in a unified, uniform way, and how do we implement the way we approach the mother-baby dyad? This should be uniform across cadres.
- We need to design HMIS with a focus on integration from the start. There is currently a lack of data for monitoring performance.
- Technology and mHealth are great ways to communicate with mothers, manage human resources, and ensure standardized protocols are utilized.

Human Resources for Health

- We need to work on coordinating professional organizations as well as maternal and newborn departments/initiatives within federal systems.
- Staffing and human resource needs must be addressed before we can address quality.
- We need to be sure that nations have the capacity, staff, and infrastructure for integration – there are human resource shortages at all levels of the health system.
- There are turf battles between maternal and newborn care providers/researchers/policymakers – attitudes must be changed to promote collaboration rather than competition.
- Pre-service education must be integrated from the beginning so that we talk about an interdisciplinary, perinatal approach for all cadres.
- We must integrate maternal and newborn training systems, as well as health systems processes like QI.
- More incentives are needed to encourage cadres, especially specialists and professional groups, to integrate.
- Countries need to have scopes of work for health care providers that explicitly promote integration.

Facility/service delivery level barriers and opportunities

- We must further leverage the private sector and public-private partnerships.
- We need local champions embedded at the facility level, sometimes with support from external influence to get started.
- We need to have integrated language for mothers and babies at the service delivery level.
- At the facility level, there is a lack of clarity and guidance around the delivery of recommended interventions (for example, community-based postnatal care).
- We need more models that can be operationalized in different contexts, regardless of resource availability.
- We need more implementation research on integration.
- More community participation in the design of health care services would increase local buy-in and success of integration efforts. For example, we should keep in mind what the end user wants to receive when they come to a facility, what providers want, and what is actually delivered.
- We must be more thoughtful about audits – when used properly, these can catalyze service change and QI.
- Units (and providers) must communicate with each other to improve integration throughout referral networks.
- Training of maternal and newborn care providers should be integrated where feasible.
 - Providers do not leave pre- or in-service training with the skills they need.
- Providers should be trained to provide respectful maternity care, and be empowered with the resources and capacity to provide such care.
- Accountability of providers should be enforceable and consistent. Non-physicians should be empowered to provide emergency care for which they are adequately trained.
- Turnover and attrition of providers should be limited by using incentives (monetary, skills development, etc) in order to reduce the shortage of providers across cadres, from CHWs to specialist groups.
- Now that visits to facilities have increased (in particular for ANC and delivery services), we must take advantage of the increase in patients to ensure that quality of care is improved.
- Mothers and newborns should be kept physically together whenever possible (i.e. unless there is an emergency that dictates their separation).
- A redesign of physical infrastructure can support integration.
- Commodities are fragmented at the facility level and need integration.
- Appropriate use of tools can facilitate tangible integration: for example, the Safe Childbirth Checklist, integrated perinatal health cards, etc.
- Process of care: During labor we need integrated intrapartum monitoring and metrics to assess both mother and fetus. This should apply postnatally as well. The postpartum period needs to be addressed in an integrated way across formal and informal sectors – mothers and newborns move between them after birth, and this should be as seamless as possible