

Newborn Care in Nigeria

Early Childhood Morbidity and Mortality Statistics remain alarmingly high in Nigeria. Current under-fives mortality rate (U5MR) is about 190-200/1000 live-births with infant mortality rate (IMR) estimated at 90-100/1000 live-births. More bothersome is the fact that the statistics are reflecting a worsening trend.

Neonatal deaths account for a significant proportion of the IMR with modest estimates of 40-50/1000 live-births. Strategies adopted for the control of neonatal morbidity and mortality will impact remarkably and positively on the current IMR and U5MR. Such intervention strategies, to be useful, must address the identified determinants of neonatal morbidity and mortality in Nigeria.

The major contributors to the persistently high neonatal mortality rate (NMR) include, among others, severe birth asphyxia, neonatal sepsis, neonatal tetanus, neonatal jaundice from various causes, prematurity and low-birthweight and their complications. Congenital anomalies also contributed their quota. While several of these morbidities can be suspected, detected and managed with carefully planned antenatal, intrapartum and postnatal interventions, the low patronage of antenatal services dim the actualization of such interventions.

Also, whereas health facilities are organised into the primary, secondary and tertiary levels of care with some tertiary facilities designated as centres of excellence for specialized services, the available neonatal services are not systematically and desirably organized into recognized levels of care: transitional care, special care, high-dependency care and intensive care with some possibly designated as centres of excellence in certain interventions. The available neonatal services also lack the desired level of expert personnel, equipment and facilities and, in fact, there is no comprehensive nationwide survey of these services to generate and maintain a functional directory of neonatal services detailing the available personnel, facilities and competencies for effecting purposeful referral and transfer of sick newborn infants. Transportation of such sick infants exposes other levels of difficulties in caring for the sick newborn in Nigeria.

The urgent imperative now is the review of strategies, interventions and

approaches to the care of sick newborn infants in Nigeria towards evolving locale-specific and determinants-related initiatives expanded to perinatal care. Such programmes for improved perinatal care should address the following, among others:- more patient-friendly and outcome-focused antenatal services, enhanced patronage and utilization of delivery facilities, development and maintenance of a functional national directory of neonatal services detailing levels of competencies and care, upgrading and equipping the existing neonatal services re: personnel and facilities.

With due regard to the existing constraints in this developing economy, some interventions for improved perinatal care may need to be adopted and adapted to reflect and suit the prevailing circumstances and peculiarities in terms of limited available funds, current inadequate skilled personnel in neonatal/perinatal care and the poor patronage and utilization of existing antenatal, delivery and neonatal services. We need to evolve a community-based perinatal and neonatal care initiative to complement the facilities-based interventions. Traditional Birth Attendants (TBAs) would need to be trained and involved in these initiatives.

These local initiatives for improved perinatal health and care require capacity-building training in critical care of sick newborns for the available personnel. The skills imbibed at such training may be adapted to assure efficacy, reliability, availability, affordability and sustainability.

With the possibility of collaborating within the evolving BAPM perinatal networks, we should be able to strengthen the components/services offered by these local initiatives for improved care of newborns in Nigeria. With a vision of improved care and equity, the local initiatives should facilitate our mission of commitment of the available limited resources, through optimal utilization, for enhanced perinatal health and care in Nigeria, outside the United Kingdom.

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Diary Dates 2006

6-7 April 2006
BMFMS Annual Conference
Cardiff

4 April 2006
Perinatal Session
RCPCH Spring Meeting, York

5 April 2006
Joint meeting of BAPM with Ethics
and Law Group
RCPCH Spring Meeting, York

17 May 2006
Perinatal Clinical Trials Meeting
RCOG, Regent's Park, London

14-15 September 2006
AGM and Scientific Meeting
Jubilee Campus, Nottingham

1 November 2006
Perinatal Trainees Meeting
RIBA, Portland Place, London

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BAPM News

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From the President

Spring is in the air at last - the snowdrops are out, the Health Service in crisis with lack of resources and great changes are afoot. For most perinatal services the advent of networks does not seem to have improved the capacity for intensive care as I receive many comments from units about long distance transfers and many referrals when on call! Modernising our maternity and neonatal infrastructure and enhancing our ability to provide quality obstetric, fetal and neonatal care are huge challenges in the current fiscal climate and BAPM is working hard to support and help the teams trying to enhance our governance and influence how we are paid for the work we do.

One of the biggest challenges will be the introduction of Payment by Results, centred around the setting of a tariff. Dr Gary Hartnoll is chairing a group advising the Department of Health Team about this difficult area for neonatal medicine. I have asked him to update us all in the next newsletter. There is a move to reimburse neonatal care based on a bed day basis with different reimbursements for different levels of care (using our Standards Document to define them). He will explain the detail of this but however it is structured the fiscal value attached to each category will be the critical decision. The process is supposed to be cost neutral and this brings with it the spectre that a common contract will be awarded that provides little room for investment. We are actively supporting moves to try to ensure that the tariff allows units to provide care to the standard accepted by the Department of Health Review published in 2003.

One potential spin off for this will be that it may galvanise the development and resourcing of adequate data collection systems for both maternity and neonatal care, something lacking from the near agenda for the IT providers around the country.

Turning to more enjoyable matters, I look forward to welcoming as many of you as are able to come to the Perinatal Session of the RCPCH in York (Tuesday 4 April). We had a large number of abstracts but because of limited time only a few can be presented. Apologies to those of you who submitted but

were not selected, one area we will have to evaluate is how to extend our ability to present more studies in future years. Poster sessions are difficult to fit in but if there was a majority opinion to include one we would certainly try.

Of particular interest to me this year is the joint meeting with the RCPCH Ethics and Law Group on Wednesday 5 April. As many of you are aware - the Nuffield Council on Bioethics has a Working Group currently evaluating critical care decisions in fetal and neonatal life. These decisions are frequently aired in the media, usually when conflict arises admittedly, but are of immense public interest. The Group will report in the autumn of this year but Professor Margot Brazier (the Chair of the Working Group) and Professor David Archard have agreed to contribute to the debate in this area - we will be discussing the influence of the Law in professional care and the ethics of firm guidelines for intervention at borderline viability and I feel sure that both of our guests and members contributing to the presentations will provide a stimulating and thought provoking session.

The Perinatal Trials Group Meeting will be held in the RCOG, London, on 17 May 2006. The programme is out on the website and promises to be very stimulating again covering 4 budding clinical trials of true perinatal relevance, information about the developing Medicines for Children Network and the role of economic evaluations alongside clinical trials. Please give it some



priority in your busy diaries; it is one of the best meetings of the year with much informal and constructive debate.

There has been some debate over the format of the Trainees meetings we have held for the past two years in the autumn. They have been well received and we have decided to run a further meeting in a similar format to last year's meeting. In the meanwhile we are debating, together with the RCPCH CSAC Neonatal Medicine, how we might more formally support specialist trainees and are looking for advice about which areas might be the subject of a new annual educational forum. We will be writing to trainees to ask them their opinion but we would also like to hear from any members - in particular we are trying to identify subject areas which appear in the curriculum but are difficult to provide a structured approach for locally.

Finally I hope to be able to meet many of you at the regional meetings over the next year. Discussion and debate are key ways in which we can achieve our goals as a progressive and successful Association.

Neil Marlow

Book Review: Feeding and Nutrition in the Preterm Infant

Editors: Elizabeth Jones and Caroline King

This is an attractive and modestly-sized book which covers a crucial but difficult area of neonatal care. The book deals with many important subject areas which are often regarded as the shadowy territory of the dietician, lactation specialist and speech therapist. The layout is good, with helpful chapter subheadings, and the effective use of bullet points, diagrams, tables, and photographs. It is written in an extremely readable style. There is thorough and well referenced review of the evidence in many areas, with suggested guidelines for management based on the experience of the authors where scientific evidence is lacking.

This book does not attempt to be a comprehensive treatise on preterm feeding and nutrition. It mainly deals with the enteral feeding of well preterm infants, and focuses on breast milk feeding. Appropriately, in my view, there is no attempt to cover parenteral feeding or the specialised feeding of babies with congenital or post-surgical gut dysfunction as this is covered well in other texts.

Although there is a lot of information about expression of breast milk, I would have liked more detail about the practicalities of its storage, fortification and delivery to the baby. In addition, no evidence or opinion is given as to the importance of the differences in composition of preterm formulas.

Importantly, there is no information on the approach to enteral feeding in relation to physiological instability and the treatments which are commonly used in the early neonatal period in unstable babies and those of extremely low birth weight. There are several places in this book where I would disagree with the authors' interpretation or emphasis, but this to a large extent reflects the limitations of the evidence available.

The availability of dedicated input to neonatal units from professionals with expertise in feeding and nutrition science is very variable at a time when multidisciplinary nutrition support teams are the standard for best practice in other clinical areas.

The book thus helpfully finishes by suggesting standards in feeding and nutritional care for neonatal units to aspire to and benchmark against.

This book should be available to all staff working in neonatal units. The accessibility of information in this book should help awareness of feeding and nutrition in neonatal care, stimulate healthy debate about the subject, and help enthusiastic young researchers to identify important research questions in this area.

Gopi Menon
Edinburgh

BAPM Data Group

In the last newsletter this group published some raw data on survival of babies at 27-28 weeks' gestation, ranked by unit. This was done to raise the awareness of the problems round interpretation of such data. This is important as the national audit project is moving forward and there will be more centralised data being collected and analysed. The group did not receive any comments about the survival data!

One of the roles of the BAPM data group will be to consider what questions should be addressed nationally. This will be the first step in deciding what data items need to be collected. We would welcome views on what members think are the vital questions which should be used for benchmarking.

As a further exercise to see what data are available from current systems we asked the question :

'How many inborn babies, below 29 weeks' gestation, have a temperature on admission to a neonatal unit below 35.5°C ? The time period was 1st January 2002 to 31st December 2004'

Data were available from Trent, Northern Region, and MANNERS (West Midlands) as well as some single units from Scotland and Wales.

Figure 1 shows the percentage of inborn admissions, less than 29 weeks, with an admission temperature below 35.5°C, ranked by unit.

To take account of differences in numbers admitted, figure 2 shows the units in the same order as figure 1 but includes total numbers of babies. Those with an admission temperature below 35.5°C are shown in red.

Even some of the larger units still have a significant number of preterm babies who are 'cold' on admission. Again care must be exercised when commenting on these data. We have to be sure that every unit is using the same definition and that there is

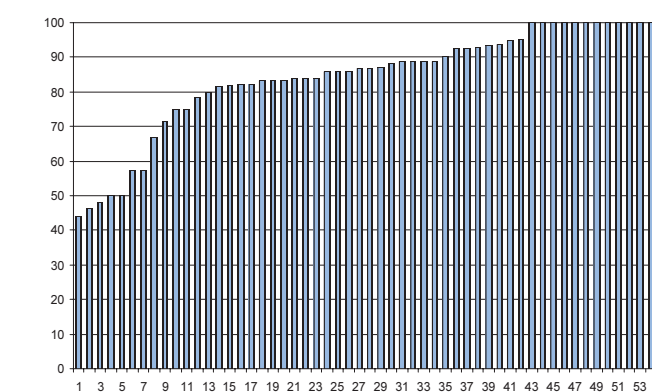


Figure 1

conformity in the how and when the temperature has been recorded.

Data for temperatures below 35°C showed that in many units there were still several babies admitted with a temperature below this level.

We would welcome your comments on these data.

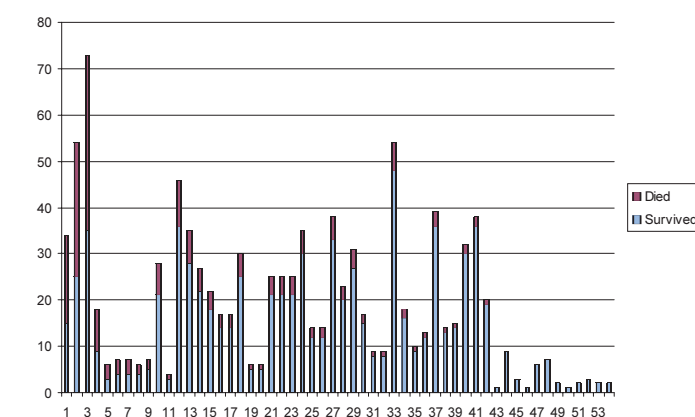


Figure 2

Letter from the Honorary Secretary

I trust by now everyone has settled into the New Year, which seems to be galloping along very quickly, or is that just a feature of my advancing age?

Following on from discussions about the future role of BAPM, changes have been made to the aim of the Association and the roles of the officers and members of the executive committee have been clarified. A new statement of vision and values, with the Association's aim and objectives, is now on the website.

The administrator's post has been renamed as Executive Officer to reflect better the changes in this role. Christine Cooper, as the Executive Officer, now becomes a full member of the executive committee.

A number of the issues that I mentioned in the last newsletter have been progressed.

BAPM responded to the NICE postnatal care guideline. Thank you for all those who sent in their comments. Most of the issues raised were around the newborn examination and prophylactic vitamin K. The second draft of this guideline has been circulated recently along with a response from NICE to our comments. I am pleased that NICE appear to have taken seriously our comments and changes have been made to the guideline. I will be responding to this second draft in the near future and the comments will be circulated to members.

I am receiving some questions about the change in the preparation of vitamin K. You should all be aware by now that Roche are finally withdrawing Konakion Neonatal from the 31st March 2006. Konakion MM Paediatric is licensed for oral and intramuscular prophylaxis in babies of 36 weeks' gestation and above. Below that gestation it is used by the intramuscular route in a dose of 0.4mg/kg. Roche are circulating prescribing information on this product and have a 0.5ml syringe to help measure small volumes.

The concerns raised by members, obstetric and neonatal, about inconsistencies in the way Coroners deal with some cases have been taken seriously and a working group has been organised, chaired by the RCOG. This group will meet with representatives from Coroners on 23 March. I will keep members informed on progress with this issue.

I have been surprised at the level of ongoing comment to the NPSA interim guideline on the testing of the position of nasogastric tubes. I only wish that members had responded when asked for comments on the proposed guideline before it was published by NPSA. It is clear that the implementation of this guideline is causing problems in some units. I have previously written about my concern of how alerts, often published as a 'knee jerk' response to adverse incidents, are being used to force changes in clinical management, even when the evidence base for the change is lacking. Archives of Disease in Childhood will publish electronically a paper on this subject in the very near future. I propose that in the next few months we circulate a questionnaire to units asking for comments on the NPSA guideline and how units have implemented the changes. If there are significant issues then it will be important to feed these back to NPSA. I feel that there should be a mechanism for NPSA to review their guidelines after they have been published.

The Nursing & Midwifery Council have produced a discussion document on Standards of Proficiency for a 'license

to prescribe'. This deals with the standards required for a nurse to become an independent prescriber. There are a few issues that need clarification and BAPM has responded to this document. This will then hopefully clarify how units can move forward prescribing for nurse practitioners.



The last newsletter included some data collected by the BAPM Data Group which compared, by unit, survival of babies born at 27-28 weeks' gestation. The idea was to stimulate discussion about the usefulness of such information and to highlight the difficulties in interpreting the data when it comes from a number of different sources. I have not received any comment from members. This newsletter includes some comparison data on temperature on admission of babies below 29 weeks' gestation. Again I would value any comments that members have on the use of such data.

There will be a meeting in the evening following the perinatal day in York where the national neonatal audit project will be discussed. BAPM support the national audit and are represented on the project board.

The perinatal day in York promises to be good with some high quality invited talks and free papers. I am also looking forward to our combined meeting with the Law and Ethics Group on the following day. The quality of debate on that day will be high. I hope to meet up with many of you at these meetings.

Andrew Lyon



**Inborn Errors in the Neonatal Period:
A practical course
University of Leeds, UK
17-19 May 2006**

Intended for: Neonatal clinicians with at least 3 years clinical experience. It will be limited to 35 participants. Participants will also be encouraged to present their own experience.

PROGRAMME COMMITTEE

Prof. James Leonard, London; Prof. Malcom Levene, Leeds
Prof. Jean-Marie Saudubray, Paris;
Mrs. Samantha Parker, Orphan Europe, Paris

LOCAL PROGRAMME COMMITTEE

Dr Mick Henderson, St James University Hospital, Leeds
Dr Luc Cornette, Leeds General Infirmary, Leeds

REGISTRATION DETAILS

Registration online **BEFORE** March 15th:

www.orphan-europe-academy.com

A CV, in English, must be sent with the registration form