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A mother practicing Kangaroo care, at the Regional Hospital of Korhogo. Côte D'Ivoire.

The *Lancet* 'Small vulnerable newborns' series: Reflections from a 'MAMI' perspective

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What we know:

This year's *Lancet* series on small vulnerable newborns **(page 38)** draws attention to a preventable truth – around a quarter of babies born alive face one or more of three vulnerabilities: born too soon, born too small, or born with low birth weight.

What this adds:

This article reiterates a blog Marie McGrath posted on 7 June 2023[1] responding to the authors' call for action. Having featured a critique of calls for action in the last edition of Field Exchange,[2] this is one that looks like it is warranted.

The recent *Lancet* series on small vulnerable newborns (SVN) comprised three hearty papers of evidence and analyses and a call for action to prevent babies being born dead, too early, and too small.

Figuring out the care of these tiny babies and their mothers has been my primary worry and professional focus for the past 14 years, so I dived in with interest. Here are a few of my gut reactions.

Connecting SVN and wasting actions: Don't miss this trick

Reducing SVN burden will reduce malnutrition caseloads. The new SVN conceptual framework shared in Figure 2 of Paper 1 (Ashorn et al, 2023) reflects how the SVN of today are the wasted, stunted, and underweight babies of tomorrow. Paper 4 (Hofmeyr et al, 2023) estimates that increased coverage of eight proven health and nutrition interventions would reduce stunting by 2.9% in 81 countries by 2030.

Which makes me think – why not extend the analyses for wasting and underweight? This would help hammer home that SVN prevention is critical to achieving nutrition targets and really help join forces with the nutrition world. Doing so will be pushing an open 'nutrition' door: one of the targets of the Global Action Plan on Child Wasting (UNICEF et al, 2023) is to decrease low birth weight (LBW) and reduce wasting prevalence to less than 3% by 2030 (SDG 2.2). Reduction in LBW is one of four critical outcomes that national operational plans[3] set to translate these international commitments into national action. This process offers a critical window for multi-speciality co-action around women's and infant's health and nutrition. A bit more data and you'll be invited right in!

Around 35 million small vulnerable babies: Acting now to mitigate risk

The focus of this series is on critical prevention. While we act to prevent, what to do with the estimated 35 million SVNs already (and continuing to be) born is something we need to also address right here, right now. They are at increased risk of death and poor growth and development. How do we handle that? The Management of small and nutritionally at-risk infants under six months and their mothers (MAMI) Global Network[4] – an established global community of practitioners working together for more than 10 years – is already trying to figure out how to find and best target risk-mitigation care for small and nutritionally at risk (in other words, vulnerable) infants under six months and their mothers.

To fill a critical gap in 'how', we collectively developed the MAMI Care Pathway Package,[5] an adaptable framework and resources to guide integrated continuity of care across maternal and child systems of health and nutrition. It is being piloted/programmed around the world with implementation experiences and research helping build a critical evidence base. The MAMI approach involves enrolling small vulnerable infants under six months and their mothers in community-based care to six months of age to provide targeted support, keep a watchful eye, and enable prompt action. LBW is included as an independent enrolment criterion and prematurity an added marker of risk.

Through MAMI, we aim to prevent as much as 'treat'; these babies' troubled start to life may well be fuelling subsequent malnutrition episodes, relapse, and failure to respond to treatment later on. We always consider the mother–infant pair – a vulnerable baby may often mark a vulnerable woman. Systems and services to manage small and vulnerable babies offer a critical entry point to cater for long-neglected women's health and nutrition (Lelijveld, 2022).

[1] https://www.ennonline.net/mediahub/blog/mamireflectionsonthelancetsmallandvulnerablenewbornsseries
[2] https://www.ennonline.net/fex/69/calls-to-action-global-health
[3] https://www.childwasting.org/the-gap-framework
[4] https://www.ennonline.net/ourwork/research/mami
[5] https://www.ennonline.net/mamicarepathway

Lightening can strike twice: Targeting prevention

The 'Call for Action' (Mohiddin et al, 2023) challenged me to think more deeply on what we can do on the preventative side for babies under six months and their mothers who we identify for care in the MAMI approach. Starting life as a small vulnerable baby is catastrophic for an individual's life chances. To prevent it happening to more people, we could target preventative action to those already affected. On this front, multiple micronutrient supplementation (MMS) feels like a low hanging fruit. The authors of Paper 4 (Hofmeyr et al, 2023) conclude that evidence supports the provision of MMS instead of just iron and folic acid for women in low- and middle-income countries (LMICs). Broadening the World Health Organization (WHO) recommendations from the use of MMS in the context of research, to use for all women in LMICs could result in substantial reductions in small for gestational age (SGA) births, stillbirths, and neonatal deaths.

This makes me think: if a woman already has a small vulnerable baby, shouldn't she be a prime candidate for MMS supplementation? Should we be more directive on MMS in the MAMI Care Pathway? We'll be examining this in our 'Mothers in MAMI' review planned for later this year.

If we don't look, we don't see

Small vulnerable babies and their mothers are everywhere, in some places more than others. We often don't see them because we don't look for them. Through our MAMI approach we are trying to change that. In January this year, I visited a health clinic in Ethiopia where the London School of Hygiene and Tropical Medicine, ENN, Jimma University, and GOAL are conducting a randomised control trial and process evaluation of the MAMI Care Pathway Package integrated within outpatient health clinics in Jimma Zone and Deder *Woreda*.[6] A very underweight baby and her mother were enrolled in the trial and came for follow-up support to an outpatient clinic while I was there. Identified as severely underweight through screening at first vaccination as part of the trial, it transpired this four-month-old was one of triplets, born premature at 28 weeks and the sole survivor. Without proactive screening, this mother and baby would not have been picked up unless they presented sick or malnourished.

When we look, it's still hard to see

The Lancet aims to bring much greater visibility to the nature of the SVN burden beyond what LBW offers. Prematurity and SGA are the 'driving pathways for vulnerability' that informed the development of the 'SVN' umbrella term and the accompanying conceptual framework (Lawn et al, 2023). This focus on functional outcomes resonates with the direction of travel in MAMI and in the world of nutrition: whether a child is small or tall doesn't matter – what matters is whether they survive and thrive and live long and fruitful lives (Kerac et al, 2020).

The authors set an ambitious call and target for premature and SGA data collection at health facilities worldwide. I worry that such depth of data in routine services will not be feasible anytime soon. Our experience through MAMI is that even birthweight data is not available in many contexts, making it difficult to exactly identify these babies for follow-up care. So, while we strive for the ideal, I think we need plans B, C, and D to handle the many realities, with interim pragmatic options to identify those infants most at risk of dying. For example, we have found that weight-for-age and mid-upper arm circumference, measured at six-week vaccination, pick up infants at higher risk of death (which is critical to know), which includes LBW infants (which is good to know) (Mwangome, 2019). These indicators won't give the visibility on SVNs that this series is seeking, but at least it will help us ensure that these babies and their mothers access timely, supportive care.

Working together is not easy, but so worth it

SVNs are a result of *mal*-nutrition, *mal*-health, *mal*-development, *mal*-you name it. We all need to be on the case. Collaboration isn't easy. It involves negotiation, brokerage, and willingness to compromise. Paper 2 (Lawn et al, 2023) digs into collaboration with an insightful analysis of the four main challenges that global health networks tasked with LBW reduction face in generating attention and resources. These findings resonate with our experiences at the MAMI Global Network. Here's some of what we're doing and have learned along the way.

Different definitions and fragmented guidelines are two of the challenges that have hindered clarity and action on LBW reduction. They also hinder co-action across nutrition and health. Our definitions create obscurity – one person's SVN becomes someone else's underweight six-week-old who becomes someone else's wasted seven-month-old. Yet we are all talking about the same baby. This makes it a nightmare to join up the dots across initiatives and creates headaches for advocates trying to herd us all into simple, shared messages to galvanise attention and resources (Kerac, 2020).

With this exact problem in mind, ENN is now undertaking a scoping review of global health and nutrition guidance relevant to the care of small and vulnerable babies under six months and their mothers. We are working to unravel concepts, definitions, and development processes to identify synergies, gaps, and practical opportunities to work together. Opportunities already leaping out at us include the ongoing implementation guidance development to accompany the recently released WHO updated guidelines on wasting management[7] and recommendations for the care of premature and LBW infants (WHO, 2022). It's madness if we don't make that happen. For the review, we are collaborating across agencies including UNICEF and WHO, as well as with partners in the Healthy Newborn Network,[8] and across disciplines, and welcome any offers to join in, help shape our work, or to invite us to contribute to your efforts.

When we developed our MAMI Global Network five-year strategy, we scrutinised the strategies, visions, and objectives of health and nutrition initiatives.[9] We called out common ground to help connect. But making this happen takes a lot more work. We've found that it really helps to have something practical to convene around, rather than some well-meaning but vague intent to 'work together'. We've had positive experience of this with the Inter-Agency Working Group on Reproductive Health in Crises,[10] contributing a MAMI take on 'Success Depends on Collaboration: Cross-Sector Technical Brief on Maternal and Newborn Health and Nutrition in Humanitarian Settings'.

Throwing collaboration into the already busy mix may well slow things down and bring complexity. But from 25 years of experience of this at ENN, I can say it is worth it. A great example is the update of the MAMI Care Pathway Package. We originally planned to update it in six months. It took 16 months. Why? We engaged nutritionists, neonatologists, and specialists across nutrition, early childhood development, maternal mental health, and child health in the process. Committed individuals found the time to review, suggest, and appraise content to generate a completely revamped version. What resulted was so much stronger, not only in terms of relevance and content but also shared ownership and buy-in. This was only possible because of the strong relationships with individuals we had nurtured though our networking over the years, and through flexible, intelligent funding from Irish Aid and the Eleanor Crook Foundation who saw the value of collaboration, trusted us, and invested in a process whose value is way beyond what can be measured in monetary terms. I'm happy to say, the Bill and Melinda Gates Foundation is now supporting our network in a similar vein.

We know what to do but do we know how to do it?

The series clearly identifies what to do and why to prevent SVNs. But, at the Cape Town launch,[11] I did sense an air of disappointment that there was nothing new in the package of interventions proposed for scale. I'm worried this will prompt a hunt for that elusive magic bullet missing from our repertoire. Instead, we need to turn our attention to the 'how'. We need to take that particular bull by the horns, embrace the complexity of real life, and invest in implementation capacity and research (Greenhalgh & Papoutsi, 2018). Why do interventions work or not, how, for whom, in which contexts? How do we lessen the load of overburdened health systems? Otherwise, we will be still scratching our heads in 2030 when we have failed to come even close to SDG targets.

Recognising this longstanding evidence gap, *BMJ Global Health* is now encouraging sub-

[6] https://www.ennonline.net/ourwork/research/mamiriseethiopia
[7] https://app.magicapp.org/#/guideline/noPQkE
[8] https://www.healthynewbornnetwork.org
[9] Including the Every Newborn Action Plan: https://www.who.int/initiatives/every-newborn-action-plan
[10] https://iawg.net/about/sub-working-groups/maternal-newborn-health
[11] https://vimeo.com/825728733

mission of implementation science articles as a sign of their commitment to the 2016 Ottawa Statement to achieve "more and better implementation research". Perhaps *The Lancet* would consider joining this movement to help bring rigour and attention and catalyse investment in research? This would be a great dimension to feature in the future *Lancet* series planned on the management of SVNs. Given our efforts on this front, we would love to contribute by tapping into the rich body of implementation evidence on the 'how' that is accumulating through the MAMI Global Network.

We hear your rallying cry loud and clear!

The smallest babies have the quietest voice. *The Lancet* SVN series has raised the volume, generated clamour, and is making noise on their behalf. We hear you, we're acting, and we are keen to join forces in whatever shape or form collaborators may come in.

Forewarned is pre-armed; we will come knocking on various doors. Please let us in! The favour is returned; our door is always open. Come in and pull up a chair.

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No child faces: Examining the use of child images from nutrition assessments

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Positionality statement:[1] *The authors acknowledge that we are white females in our 30s, born and raised in middle-class families in the United States. We are able-bodied, neurotypical, and hold Master's degrees. These factors provide elements of privilege, bias, and blind spots that limit us when speaking about people with lived experiences different to our own.*

We are publishing this article independently, without affiliation, and any views expressed do not necessarily reflect the views of affiliate organisations. We thank Martha Nakakande and Sarah King for their insightful feedback, suggestions, and review.

What we know:

The use of images of children, whether distressed or smiling, is standard practice in the humanitarian sector. In the worst cases, such photos are used by nonprofits and charity organisations to gain sympathy and contributions from donors by showing exploitative imagery of people living in destitute conditions.

What this adds:

This article is a critical examination of child images used in nutrition assessments based on the experience of the authors. We ask the reader, and ourselves, to think of images of minors as a form of sensitive data and question the conditions under which these images are extracted.

Naming the problem

The use of child images, particularly in the humanitarian sector, is problematic. In the worst cases, child images are used by nonprofits and charity organisations to gain sympathy and donations by showing exploitative imagery of people living in destitute conditions – referred to as 'poverty porn'.[2] More ubiquitously, pictures of identifiable minors in humanitarian contexts continue to be relied on for internal communications, fundraising campaigns, technical guidelines, articles, case studies, grey literature, and donor reports. This is despite existing guidelines and the sector espousing a central 'Do no harm' principle.

Unhealthy power dynamics, often in the form of 'saviourism' (Box 1), are at the root of colonialism and current global health practice. The 'White Man's Burden', a term used mainly in the 19th century, expressed the idea that European countries had a duty to control countries and entities in parts of the world with less money, education, or technology (Kipling, 1899).

Perpetuating inaccurate narratives

Depictions of saviourism are perpetuated through imagery today. Pictures that emerge from humanitarian projects too often centre on the work of foreign actors and fail to portray communities outside of their recipient or 'beneficiary' status. In 2005, Dorrie Chetty, Senior Lecturer at Westminster University, wrote specifically about the lack of varied representation in Field Exchange and how images in humanitarian publications support neo-colonial and 'otherness' narratives (Chetty, 2005).

The images we share are therefore detached from the contextual and cultural facets that

[1] Positionality refers to the personal values, views, and location in time and space that influence how one engages with and understands the world and is influenced by power and power dynamics. This definition is adapted from *The Encyclopedia of Geography* and included in a set of resources from the Anti-Racist Teaching & Learning Collective. See **https://antiracistteaching.org/**

[2] **https://edition.cnn.com/2016/12/08/health/poverty-porn-danger-feat/index.html**