

Prevention and Treatment of Neonatal Infections in LMICs

*Prevention and treatment of neonatal infections in facility and community settings of low- and middle-income countries: a descriptive review*

Supplementary Material

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Appendix 1: Search Strategies

1.1 Strategies to Reduce Antimicrobial Resistance Review

Databases searched were Ovid MEDLINE, Ovid EMBASE, CINAHL, Global Index Medicus, and Cochrane CENTRAL. MEDLINE search strategy is shown below. This search strategy was adapted to all databases.

Table 1 Search strategy for Ovid MEDLINE, with date of final search on June 26, 2024

1	(newborn* or neonat* or infant* or baby or babies or birth* or deliver* or labo?r).ti.
2	exp Infant, Newborn/ or Neonatology/ or Perinatology/ or Intensive Care, Neonatal/
3	1 or 2
4	((antibiotic* or antimicrobial*) and (resistan* or stewardship)) or AMR).ti.
5	Drug Resistance, Microbial/ or exp Drug Resistance, Bacterial/ or Drug Resistance, Multiple, Bacterial/ or Antimicrobial Stewardship/

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<b>6</b>	4 or 5
<b>7</b>	("bacterial infection*" or "nosocomial infection*" or HAI* or "healthcare-associated infection*" or "health care-associated infection*" or sepsis or coloni#* or hygien* or cleaning or disinfect* or sterili\$* or saniti\$* or sanitary or susceptibility or culture* or antibiogram* or surveillance or monitoring or management or administration or utilization or usage or overuse or over-use or prescribing or prescription* or prophylaxis or therapy or treatment* or regimen*).ti.
<b>8</b>	exp Bacterial Infections/ or exp Cross Infection/ or exp Infection Control/ or Intensive Care Units, Neonatal/ or Antibiotic Prophylaxis/ or exp Microbial Sensitivity Tests/
<b>9</b>	7 or 8
<b>10</b>	(afghanistan or albania or algeria or "american samoa" or angola or "antigua and barbuda" or antigua or barbuda or argentina or armenia or armenian or aruba or azerbaijan or bahrain or bangladesh or barbados or "republic of belarus" or belarus or byelarus or belorussia or byelorussian or belize or "british honduras" or benin or dahomey or bhutan or bolivia or "bosnia and herzegovina" or bosnia or herzegovina or botswana or bechuanaland or brazil or brasil or bulgaria or "burkina faso" or "burkina fasso" or "upper volta" or burundi or urundi or "cabo verde" or "cape verde" or cambodia or kampuchea or "khmer republic" or cameroon or cameron or cameroun or "central african republic" or "ubangi shari" or chad or chile or china or colombia or comoros or "comoro islands" or "iles comores" or mayotte or "democratic republic of the congo" or "democratic republic congo" or congo or zaire or "costa rica" or "cote d'ivoire" or "cote d' ivoire" or "cote divoire" or "cote d ivoire" or "ivory coast" or croatia or cuba or cyprus or "czech republic" or czechoslovakia or djibouti or "french somaliland" or dominica or "dominican republic" or ecuador or egypt or "united arab republic" or "el salvador" or "equatorial guinea" or "spanish guinea" or eritrea or estonia or eswatini or swaziland or ethiopia or fiji or gabon or "gabonese republic" or gambia or "georgia (republic)" or georgian or ghana or "gold coast" or gibraltar or greece or grenada or guam or guatemala or guinea or "guinea bissau" or guyana or "british guiana" or haiti or hispaniola or honduras or hungary or india or indonesia or timor or iran or iraq or "isle of man" or jamaica or jordan or kazakhstan or kazakh or kenya or "democratic people's republic of korea" or "republic of korea" or "north korea" or "south korea" or korea or kosovo or kyrgyzstan or kirghizia or kirgizstan or "kyrgyz republic" or kirghiz or laos or "lao pdr" or "lao people's democratic republic" or latvia or lebanon or "lebanese republic" or lesotho or basutoland or liberia or libya or "libyan arab jamahiriya" or lithuania or macau or macao or "republic of north macedonia" or macedonia or madagascar or "malagasy republic" or malawi or niasaland or malaysia or "malay federation" or "malaya federation" or maldives or "indian ocean islands" or "indian ocean" or mali or malta or micronesia or "federated states of micronesia" or kiribati or "marshall islands" or nauru or "northern mariana islands" or palau or tuvalu or mauritania or mauritius or mexico or moldova or moldovian or mongolia or montenegro or morocco or ifni or mozambique or "portuguese east africa" or myanmar or burma or namibia or nepal or "netherlands antilles" or nicaragua or niger or nigeria or oman or muscat or pakistan or panama or "papua new guinea" or "new guinea" or paraguay or peru or philippines or philipines or philippines or philippines or poland or "polish people's republic" or portugal or "portuguese republic" or "puerto rico" or romania or russia or "russian federation" or rwanda or ruanda or samoa or "pacific islands" or polynesia or "samoan islands" or "navigator island" or "navigator islands" or "sao tome and principe" or "saudi arabia" or senegal or serbia or seychelles or "sierra leone" or slovakia or "slovak republic" or slovenia or melanesia or "solomon island" or "solomon islands" or "norfolk island" or "norfolk islands" or somalia or "south africa" or "south sudan" or "sri lanka" or ceylon or "saint kitts and nevis" or "st. kitts and nevis" or "saint lucia" or "st. lucia" or "saint vincent and the grenadines" or "saint vincent" or "st. vincent" or grenadines or sudan or suriname or surinam or "dutch guiana" or "netherlands guiana" or syria or "syrian arab republic" or tajikistan or tadjikistan or tadjhikistan or tadjhik or tanzania or tanganyika or thailand or siam or "timor leste" or "east timor" or togo or "togolese republic" or tonga or "trinidad and tobago" or trinidad or tobago or tunisia or turkey or turkmenistan or turkmen or uganda or ukraine or uruguay or uzbekistan or uzbek or vanuatu or "new hebrides" or venezuela or vietnam or "viet nam" or "middle east" or "west bank" or gaza or palestine or yemen or yugoslavia or zambia or zimbabwe or "northern rhodesia"

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	or "global south" or "africa south of the sahara" or "sub-saharan africa" or "subsaharan africa" or "africa, central" or "central africa" or "africa, northern" or "north africa" or "northern africa" or magreb or maghrib or sahara or "africa, southern" or "southern africa" or "africa, eastern" or "east africa" or "eastern africa" or "africa, western" or "west africa" or "western africa" or "west indies" or "indian ocean islands" or caribbean or "central america" or "latin america" or "south and central america" or "south america" or "asia, central" or "central asia" or "asia, northern" or "north asia" or "northern asia" or "asia, southeastern" or "southeastern asia" or "south eastern asia" or "southeast asia" or "south east asia" or "asia, western" or "western asia" or "europe, eastern" or "east europe" or "eastern europe" or "developing country" or "developing countries" or "developing nation?" or "developing population?" or "developing world" or "less developed countr*" or "less developed nation?" or "less developed population?" or "less developed world" or "lesser developed countr*" or "lesser developed nation?" or "lesser developed population?" or "lesser developed world" or "under developed countr*" or "under developed nation?" or "under developed population?" or "under developed world" or "underdeveloped countr*" or "underdeveloped nation?" or "underdeveloped population?" or "underdeveloped world" or "middle income countr*" or "middle income nation?" or "middle income population?" or "low income countr*" or "low income nation?" or "low income population?" or "lower income countr*" or "lower income nation?" or "lower income population?" or "underserved countr*" or "underserved nation?" or "underserved population?" or "underserved world" or "under served countr*" or "under served nation?" or "under served population?" or "under served world" or "deprived countr*" or "deprived nation?" or "deprived population?" or "deprived world" or "poor countr*" or "poor nation?" or "poor population?" or "poor world" or "poorer countr*" or "poorer nation?" or "poorer population?" or "poorer world" or "developing econom*" or "less developed econom*" or "lesser developed econom*" or "under developed econom*" or "underdeveloped econom*" or "middle income econom*" or "low income econom*" or "lower income econom*" or "low gdp" or "low gnp" or "low gross domestic" or "low gross national" or "lower gdp" or "lower gnp" or "lower gross domestic" or "lower gross national" or lmic or lmics or "third world" or "lami countr*" or "transitional countr*" or "emerging economies" or "emerging nation?" or "low-resource setting*" or "low-resource nation*" or "low-resource countr*" or "resource-limiting setting*" or "resource-limiting nation*" or "resource-limiting countr*").ti,sh.
11	3 and 6 and 9 and 10

### 1.2 Prevention of Hospital-Acquired Infections Review

Please refer to *Fitzgerald 2022* [1] for search strategy details.

### 1.3 Clean Birth Kits Review

Please refer to *Lassi 2020* [2] for search strategy details.

### 1.4 Chlorhexidine Cleansing Review

Please refer to *Zhou 2022* [3] and *WHO recommendations on maternal and newborn care for a positive postnatal experience (WHO 2022)* [4] for search strategy details.

### 1.5 Topical Emollients Review

For the topic of emollients for preterm neonates, please refer to *Cleminson 2021* [5] for search strategy details. For the topic of emollients for term neonates, please refer to *Priyadarshi 2022* [6] for search strategy details.



## 1.6 Probiotics Supplementation Review

Please refer to reviews by Sharif 2020 [7] and Imdad 2020 [8] for search strategy details.

## 1.7 Synbiotics Supplementation Review

Please refer to reviews by Sharif 2022 [9] and Imdad 2020 [8] for search strategy details.

## 1.8 Prophylactic Systemic Antifungal Agents Review

Please refer to Cleminson 2015 [10] for search strategy details.

## 1.9 Mixed Setting & Community-Based Antibiotic Delivery for PSBIs Review

Please refer to Duby 2019 [11] for search strategy details.

## Appendix 2: Eligibility Criteria

**Table 2** Eligibility criteria for de novo, updated, and as-is reviews

Topic	Population	Intervention	Comparator	Outcomes	Included studies
<b>Strategies to reduce AMR</b>  <b>– de novo review</b>	Preterm & term neonates	Interventions conducted in a neonatal unit or community setting, reporting on an intervention, policy, or strategy designed to promote antibiotic stewardship and/or mitigate the development of antimicrobial resistance	Standard practices, or no intervention	<b>Primary outcomes:</b>  All-cause neonatal mortality, lab confirmed and suspected EOS -community or hospital onset, lab confirmed and suspected LOS -community or hospital onset, localized infections (e.g., omphalitis, UTI, meningitis) – all, localized infections – due to MDROs, confirmed blood stream infections – all, confirmed blood stream infections – MDROs, & colonization with multidrug resistant bacteria.  <b>Secondary outcomes:</b>  Duration of antibiotic therapy, proportion of neonates receiving any antibiotic, length of hospital stay	Randomized or quasi-randomized trials, observational studies, program evaluations, and implementation studies

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				(inpatient newborns), & use of WHO watch and reserve antimicrobials.	
<b>HAI prevention</b> – <i>as-is review from Fitzgerald 2022 [1]</i>	Hospitalized neonates, including neonatal ward and/or NICU settings	Included both single interventions [e.g., probiotics, KMC, breastfeeding, fluconazole prophylaxis] and bundled interventions (e.g., vascular device care, hand hygiene and healthcare worker education combined)	Standard of care	<p><b>Primary outcomes:</b></p> <p>the effect of the interventions on (1) incidence of infection or (2) attributable mortality, depending on study definitions. Fungal or bacterial hospital-acquired invasive infections in hospitalized neonates were the primary events for study.</p> <p><b>Secondary outcomes:</b></p> <p>impact on incidence of laboratory-confirmed urinary tract infection, thrombophlebitis, NEC, device-associated infections (clinically suspected or culture proven) and clinically suspected infection where laboratory cultures were negative or not available.</p>	RCTs, controlled and noncontrolled before-after, controlled and noncontrolled ITS and cohort studies
<b>Clean birth kits</b> – <i>updated review from Lassi 2020 [2]</i>	Pregnant mothers	<p>3 main interventions</p> <p>(1) Training of TBAs, LHWs and CHWs</p> <p>(2) Distribution of CBKs</p> <p>(3) Health education/messages/counselling</p>	Standard of care	<p>-Neonatal mortality</p> <p>-Any omphalitis</p>	RCTs (individual and cluster), and quasi experimental studies
<b>Chlorhexidine cleansing</b> – <i>updated review from an existing WHO guideline [4] (i.e., Chlorhexidine Umbilical</i>	Neonates	Routine application of chlorhexidine to the umbilical cord stump	Dry cord care or usual cord practices	<p>-Neonatal mortality (defined as deaths due to all causes occurring any time during the first 28 days of postnatal life)</p> <p>-Omphalitis (Any omphalitis: Redness or pus limited to stump; Moderate omphalitis: Redness extending to the skin at the base of the cord stump less than 2 cm, with or without pus; Severe omphalitis: Redness extending more than 2 cm from the skin, with or without pus)</p>	RCTs (individual and cluster)

<b>Review Group's IPD meta-analysis) and a review from Zhou 2022 [3]</b>				-Possible serious bacterial infections (PSBIs) (Any PSBI: Presence of any one of the following symptoms or signs: stopped feeding, severe chest indrawing, movements only on stimulation, fever (>38°C axillary), hypothermia (<35.5°C axillary), convulsions; Severe PSBI: Presence of any one of the following symptoms or signs: convulsions, stopped feeding well, lethargy, hypothermia (<35.5°C))	
<b>Topical emollients for preterm neonates</b>  – as-is review from Cleminson 2021 [5]	Preterm infants (< 37 weeks' gestation)	Ointment or cream versus routine skincare <ul style="list-style-type: none"><li>• Oil versus routine skincare</li><li>• Ointment or cream versus oil</li><li>• One oil (or combination) versus another oil (or combination)</li></ul>	Standard of care	<b>Primary outcomes:</b>  Invasive infection diagnosed more than 48 hours after birth as determined by culture from a normally sterile site: cerebrospinal fluid; blood; urine (obtained by sterile urethral catheterisation or suprapubic bladder tap); bone or joint, peritoneum, pleural space, or central venous line tip; or findings on autopsy examination consistent with invasive microbial infection. If sufficient data were available, we planned to examine specific effects on infection with these organisms: <ul style="list-style-type: none"><li>• Coagulase-negative staphylococci</li><li>• Other bacteria (gram-negative bacilli, Saureus, enterococci)</li><li>• Fungi</li></ul> <b>Secondary outcomes:</b> <ul style="list-style-type: none"><li>• Death (all cause) before hospital discharge (in facility-based trials), or at latest assessment in community trials</li><li>• Growth: weight gain (g/kg/day); linear growth (mm/week); head circumference (mm/week); skinfold thickness (mm/week) during the trial period</li><li>• Neurodevelopmental outcomes assessed at more than 12 months post-term (measured using validated</li></ul>	Controlled trials using random or quasi-random participant allocation. Cluster-randomized trials where the unit of randomization was a group of infants (for example, in a neonatal unit) were eligible for inclusion.

				<p>assessment tools) and classifications of disability, including auditory and visual disability. A composite outcome of 'severe neurodevelopmental disability' was defined as any one or combination of the following: non-ambulant cerebral palsy, severe developmental delay, auditory impairment and visual impairment.</p> <ul style="list-style-type: none"> <li>• BPD (oxygen supplementation at 36 weeks' postmenstrual age)</li> <li>• NEC (Bell stage 2 or 3) (Bell 1978)</li> <li>• ROP requiring treatment (medical or surgical) (ICCRP 2005)</li> </ul>	
<p><b>Topical emollients for term neonates</b></p> <p>– as-is review from Priyadarshi 2022 [6]</p>	<p>Term healthy neonates (babies up to 28 completed days of life)</p>	<p>Emollients can be used as an additive in bath/wash products or applied on the body as leave-on emollients. Studies were included if one group had received a routine application of leave-on emollients (including oil, cream, ointment, lotion, or moisturizer) and another group did not receive any form of emollient. Included studies where the intervention was started in the neonatal period.</p>	<p>Standard of care</p>	<p>Key outcomes were neonatal mortality (all-cause death in the first 28 days of life); systemic infections (sepsis, pneumonia, or possible serious bacterial infection); atopic dermatitis (meeting the diagnostic criteria of at least one of the established tools, such as UK Working Party diagnostic criteria, up to one year of age); skin condition (based on a validated skin assessment score or erythema, rash, itching, oedema, exanthema, dry skin, and urticaria), and adverse events related to emollient application.</p>	<p>RCTs</p>
<p><b>Probiotics supplementation</b></p> <p>– as-is review from Sharif 2020 [7]</p>	<p>Included very preterm (&lt; 32 weeks' gestation) or VLBW (&lt; 1500 g) infants (pre-specified analyses for</p>	<p>Included enteral administration of any probiotic or probiotic combination for at least one week compared to placebo or no treatment.</p> <p>Categorised probiotic preparations at the genus level</p>	<p>Standard of care</p>	<p><b>Primary outcomes:</b></p> <ul style="list-style-type: none"> <li>• NEC, confirmed at surgery or autopsy or diagnosed by at least two of the following clinical features (Walsh 1986): <ul style="list-style-type: none"> <li>◦ abdominal radiograph showing pneumatosis intestinalis or</li> </ul> </li> </ul>	<p>Included RCTs and quasi-RCTs</p>

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	extremely preterm (< 28 weeks' gestation) or ELBW (< 1000 g) infants)	( <i>Bifidobacterium</i> spp., <i>Lactobacillus</i> spp., <i>Saccharomyces</i> spp., <i>Streptococcal</i> spp., others, and combinations thereof).		<p>gas in the portal venous system or free air in the abdomen;</p> <ul style="list-style-type: none"> <li>◦ abdominal distension with abdominal radiograph with gaseous distension or frothy appearance of bowel lumen (or both);</li> <li>◦ blood in stool</li> <li>◦ lethargy, hypotonia or apnoea (or combination of these).</li> </ul> <ul style="list-style-type: none"> <li>• All-cause mortality before discharge from hospital</li> </ul> <p><b>Secondary outcomes:</b></p> <ul style="list-style-type: none"> <li>• Late-onset invasive infection, as determined by culture of bacteria or fungus from blood or cerebrospinal fluid or from a normally sterile body space (&gt; 48 hours after birth)</li> <li>• Late-onset infection with the supplemented probiotic microorganism</li> <li>• Duration of hospitalization (days)</li> <li>• Neurodevelopmental impairment assessed by a validated test after 12 months' post-term: neurological evaluations, developmental scores, and classifications of disability, including cerebral palsy and auditory and visual impairment</li> </ul>	
<b>Probiotics supplementation</b>	Included neonates regardless of health status, including low	Neonatal oral probiotics/synbiotics supplementation	No probiotic supplementation/ placebo	<p><b>Primary outcomes:</b></p> <ul style="list-style-type: none"> <li>-All-cause neonatal mortality (death between 0–28 days of life)</li> </ul>	Studies selected for inclusion in this review were either experimental or

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<p>– <i>as-is review from Imdad 2020 [8]</i></p>	<p>birth weight and preterm infants</p>	<p>-All-cause infant mortality at 6 months (death between 0 days to 6 months of life)</p> <p>-All-cause infant mortality at 12 months (death between 0 days to 12 months life).</p> <p>In the event that the outcomes were not reported in the follow-up periods mentioned (e.g., 28 days, 6 months, and 12 months), we first contacted the authors to obtain this data. If that data were not available from the authors, the following actions were taken: Mortality within the first six weeks of life was included as neonatal mortality at day 28, between 3–6 months were included as 6 months, and between 9–12 months were included as 12 months. If there was not a clear follow-up, the mortality data from the longest follow-up was included.</p> <p><b>Secondary outcomes:</b></p> <p>-Sepsis specific mortality measured between 0–28 days, 0 days to 6 months and 0 days to 12 months of life</p> <p>-Neonatal sepsis (as defined by authors) in the first six weeks of life</p> <p>-Necrotizing enterocolitis (as defined by the authors)</p> <p>-Vitamin A Deficiency</p> <p>-Prevention of Hypoglycemia (as defined by authors) during the neonatal period -Treatment of Hypoglycemia (recurrence of hypoglycemia after the episode treated) - Any adverse reactions during the intervention period</p> <p>-Serious adverse events</p>	<p>quasi-experimental studies that were designed as RCTs. Other study designs were considered, such as before-after studies, regression discontinuity designs, interrupted time series (ITS) but none of these studies were included.</p>
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				<p>-Neurodevelopmental outcomes at 12 and 24 months and the longest follow-up</p> <p>A neurodevelopment outcome is an event that involves any cognitive, neurologic, and/or sensory outcomes.</p>	
<p><b>Probiotics supplementation</b></p> <p>– <i>as-is review from Thomas 2023 [12]</i></p>	<p>Very low birth weight (VLBW) neonates</p>	<p>Enteral supplementation of one or more species of probiotics</p>	<p>Another probiotic species/genera, or placebo/no probiotics</p>	<p><b>Primary outcomes:</b></p> <p>-All-cause neonatal mortality</p> <p>-Sepsis/severe infection at discharge or 28 days or the latest follow- up. (Sepsis was identified by a positive culture of bacteria or fungus from blood, cerebrospinal fluid, urine, or from a normally sterile body space or as defined by the authors of the individual studies.)</p> <p><b>Secondary outcomes:</b></p> <p>-Necrotizing enterocolitis (NEC)— stage 2 or more as per modified Bell’s staging.</p>	<p>Randomized controlled trials (RCT) or quasi-RCTs</p>
<p><b>Synbiotics supplementation</b></p> <p>– <i>as-is review from Sharif 2022 [9]</i></p>	<p>Very preterm (&lt; 32 weeks' gestation) or VLBW (&lt; 1500 g) infants</p>	<p>Prophylactic enteral synbiotics: any combination or dose of probiotic organisms and prebiotic oligosaccharides, commenced within 14 days of birth and continued daily (or more frequently) for at least one week. Probiotics and prebiotics need not be given simultaneously, but should be given on the same day.</p>	<p>Standard of care</p>	<p><b>Primary outcomes:</b></p> <ul style="list-style-type: none"> <li>• NEC before discharge from hospital, confirmed at surgery or autopsy or using standardized clinical and radiological criteria (VON 2020): <ul style="list-style-type: none"> <li>◦ at least one of: bilious gastric aspirate or emesis; or abdominal distention; or blood in stool; and</li> <li>◦ at least one of: abdominal radiograph showing pneumatosis intestinalis; or gas in the portal venous system; or free air in the abdomen</li> </ul> </li> <li>• All-cause mortality before discharge from hospital</li> </ul>	<p>Randomized or quasi-randomized (predictable allocation) controlled trials, including cluster-RCTs.</p>

				<p><b>Secondary outcomes:</b></p> <ul style="list-style-type: none"> <li>• Late-onset invasive infection, as determined by the culture of bacteria or fungus from blood or cerebrospinal fluid or from a normally sterile body space (&gt; 48 hours after birth until discharge from hospital)</li> <li>• Invasive infection with the supplemented probiotic micro- organism until discharge from hospital</li> <li>• Duration of hospitalization since birth</li> <li>• Neurodevelopmental impairment assessed by a validated</li> </ul> <p>test after 12 months' post-term: neurological evaluations, developmental scores, and classifications of disability, including cerebral palsy and auditory and visual impairment</p>	
<p><b>Synbiotics supplementation</b></p> <p>– as-is review from Imdad 2020 [8]</p>	<p>Included neonates regardless of health status, including low birth weight and preterm infants</p>	<p>Neonatal oral probiotics/synbiotics supplementation</p>	<p>No probiotic supplementation/ placebo</p>	<p><b>Primary outcomes:</b></p> <ul style="list-style-type: none"> <li>-All-cause neonatal mortality (death between 0–28 days of life)</li> <li>-All-cause infant mortality at 6 months (death between 0 days to 6 months of life)</li> <li>-All-cause infant mortality at 12 months (death between 0 days to 12 months life).</li> </ul> <p>In the event that the outcomes were not reported in the follow-up periods mentioned (e.g., 28 days, 6 months, and 12 months), we first contacted the authors to obtain this data. If that data were not available from the authors, the following actions were taken: Mortality within the first six weeks of life was included as neonatal mortality at day 28, between 3–6</p>	<p>Studies selected for inclusion in this review were either experimental or quasi-experimental studies that were designed as RCTs. Other study designs were considered, such as before-after studies, regression discontinuity designs, ITS but none of these</p>



				<p>months were included as 6 months, and between 9–12 months were included as 12 months. If there was not a clear follow-up, the mortality data from the longest follow-up was included.</p> <p><b>Secondary outcomes:</b></p> <ul style="list-style-type: none"> <li>-Sepsis specific mortality measured between 0–28 days, 0 days to 6 months and 0 days to 12 months of life</li> <li>-Neonatal sepsis (as defined by authors) in the first six weeks of life</li> <li>-NEC (as defined by the authors)</li> <li>-Vitamin A Deficiency</li> <li>-Prevention of Hypoglycemia (as defined by authors) during the neonatal period -Treatment of Hypoglycemia (recurrence of hypoglycemia after the episode treated) - Any adverse reactions during the intervention period</li> <li>-Serious adverse events</li> <li>-Neurodevelopmental outcomes at 12 and 24 months and the longest follow-up</li> </ul> <p>A neurodevelopment outcome is an event that involves any cognitive, neurologic, and/or sensory outcomes.</p>	studies were included.
<b>Prophylactic systemic antifungal agents</b>	Very preterm or VLBW infants, with or without evidence of fungal colonisation but without	Systemic antifungal prophylaxis, given by intravenous or enteral route	Placebo or no drug, oral or topical antifungal prophylaxis, or another systemic	<p><b>Primary outcomes:</b></p> <ol style="list-style-type: none"> <li>1. Confirmed invasive fungal infection as determined by <ul style="list-style-type: none"> <li>• culture of fungus from a normally sterile site e.g. cerebrospinal fluid, blood, urine, bone or joint, peritoneum, pleural space;</li> </ul> </li> </ol>	Randomized controlled trials or quasi-randomized controlled trials

<p>- <b>updated review from Cleminson 2015 [10]</b></p>	<p>evidence of invasive fungal infection at study entry</p>	<p>antifungal agent or dose regimen</p>	<ul style="list-style-type: none"> <li>• findings on autopsy examination consistent with invasive fungal infection;</li> <li>• findings on ophthalmological examination consistent with fungal ophthalmitis or retinitis;</li> <li>• pathognomonic findings on renal ultrasound examination such as 'renal fungal balls'.</li> </ul> <p>2. Death prior to hospital discharge.</p> <p>3. Development: (i) neurodevelopmental outcomes assessed using validated tools at 12 months or more corrected age, and classifications of disability including non-ambulant cerebral palsy, developmental delay, auditory and visual impairment; (ii) cognitive and educational outcomes at 5 years or more e.g. intelligence quotient or indices of educational achievement measured using a validated tool (including school examination results).</p> <p><b>Secondary outcomes:</b></p> <p>1. Bronchopulmonary dysplasia (oxygen supplementation at 36 weeks postmenstrual age).</p> <p>2. Necrotising enterocolitis (Bell stage 2 or 3).</p> <p>3. Retinopathy of prematurity: a) any stage; b) requiring treatment.</p> <p>4. Duration of intensive care unit or hospital admission (days).</p> <p>5. Emergence of organisms resistant to antifungal agents, as detected in individual infants enrolled in the study or, in the case of cluster randomized studies, on</p>
---------------------------------------------------------	-------------------------------------------------------------	-----------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

				<p>surveillance of other infants in the same unit in the study centre (including infants who were admitted to the unit following completion of the study).</p> <p>6. Adverse drug reactions attributed to the antifungal agent, such as rash, gastrointestinal disturbance, abnormal hepatic or renal function, cardiac arrhythmias, thrombophlebitis, seizures, and anaphylaxis or toxicity sufficient to cease drug administration.</p>	
<p><b>Mixed setting &amp; community-based antibiotic delivery for possible serious bacterial infections (PSBIs)</b></p> <p><b>- updated review from Duby 2019 [11]</b></p>	<p>Neonates born at any gestational age enrolled at any time between 0 to 27 completed days of life with possible serious bacterial infection (PSBI), as defined by the World Health Organization (WHO; WHO 2015). Confirmation of a bacterial infection with a positive culture from a sterile body site, can be contributory, but is not necessary for inclusion.</p>	<p><u>Comparison 1:</u></p> <p>Community-based programmes of newborn care that include the initiation of antibiotics in the community for PSBI in LMICs</p> <p><u>Comparison 2:</u></p> <p>Community-based delivery of simplified injectable antibiotics or oral antibiotics, or both for PSBI in neonates</p>	<p><u>Comparison 1:</u></p> <p>Community-based programmes of newborn care that do not include the provision of community-based antibiotics for PSBI in LMICs (i.e., standard hospital referral)</p> <p><u>Comparison 2:</u></p> <p>Community-based delivery of seven to 10 days of injectable penicillin/ampicillin and an injectable aminoglycoside for PSBI in neonates</p>	<p><b>Primary outcomes:</b></p> <p>1. Neonatal mortality - the number of neonatal deaths from any cause among all neonates. For individually-randomized and quasi-randomized trials, neonatal mortality was calculated as the number of neonatal deaths divided by the total number of neonates enrolled in the trial. For cluster-randomized trials, neonatal mortality was calculated as the number of neonatal deaths divided by the total number of live births within each cluster during the trial period.</p> <p>a. Early neonatal mortality: from birth through six completed days of life</p> <p>b. Late neonatal mortality: between 7 and 27 completed days of life</p> <p>2. Sepsis-specific neonatal mortality - the number of neonatal deaths secondary to PSBI among all neonates during the trial period. Similar calculation considerations applied to sepsis-specific mortality as neonatal mortality.</p> <p>a. Early neonatal sepsis-specific mortality: from birth through six completed days of life</p>	<p>Individually-randomized, cluster-randomized and quasi-randomized trials</p>

b. Late neonatal sepsis-specific mortality: between 7 and 27 completed days of life

**Secondary outcomes:**

1. Treatment failure - defined as any one of the following: 1) death within seven days after enrolment; 2) hospital admission within seven days after enrolment due to clinical deterioration; 3) change of antibiotic regimen due to lack of improvement/ clinical deterioration within seven days after enrolment

2. Neonatal antibiotic-associated adverse events - defined as occurrence of haematoma, bleeding or infection at an injection site, inability to pass urine for 12 hours, dehydration-associated severe diarrhoea, anaphylaxis, or development of rash within seven days of enrolment

3. Total cost (in USD) to manage all neonates with PSBI in the community during the trial period (including training, drug cost and delivery, and equipment)

4. Cost of intervention (in USD) per neonate life saved among all neonates with PSBI managed in the community during the trial period

5. Acceptability of antibiotics - defined as the number of mothers who accept community-based antibiotic treatment for their neonates among all mothers of neonates with PSBI identified during the trial period

6. Antibiotic resistance - defined as the number of cases in which there was isolation of bacteria resistant to penicillin/ampicillin and an aminoglycoside within 30 days after enrolment

### *Prevention and Treatment of Neonatal Infections in LMICs*

*BPD, Bronchopulmonary dysplasia; CBK, clean birth kit; ; CHW, community health worker; EOS, early-onset sepsis; ELBW, extremely low birth weight; ITS, interrupted time series; KMC, kangaroo mother care; LHW, lady health worker; LMICs, low- and middle-income countries; LOS, late-onset sepsis; MDRO, multidrug-resistant organism; NEC, necrotizing enterocolitis; ROP, retinopathy of prematurity; RCTs, randomized controlled trials; TBA, trained birth attendant/traditional birth attendant; USD, United States dollar; UTI, urinary tract infection; VLBW, very low birth weight; WHO, World Health Organization*

## Appendix 3: Classification of Antimicrobial Stewardship Interventions

**Table 3** Regulation, education, and restriction definitions

<b>Regulation</b>	Regulation interventions were defined as non-education and non-restriction structural or organizational actions which attempt to prevent or control the development and spread of infections and antimicrobial resistance (AMR), such as surveillance and audit, health-care worker vaccination, sterilization of the built environment and multi-patient use equipment, institution of patient isolation measures, and the implementation of protocols and policies for infection and AMR management.
<b>Education</b>	Education interventions were defined as efforts to educate and inform healthcare workers of the appropriate policies and procedures for infection and antimicrobial resistance prevention and control, including but not limited to training sessions, journal clubs, ward round discussions, and reminders in the form of wall posters with algorithms for improved decision-making.
<b>Restriction</b>	Restriction interventions were defined as prescribing- and dispensing-related actions intended to control or restrict the use of broad-spectrum antibiotics in favour of narrow-spectrum antibiotics, and reduce initiation or shorten duration of antimicrobials, in the treatment of newborns. This included using antimicrobial susceptibility testing for guided therapy, introducing antibiotic justification forms, and instituting hard stops or drug dispensing pre-authorization policies.

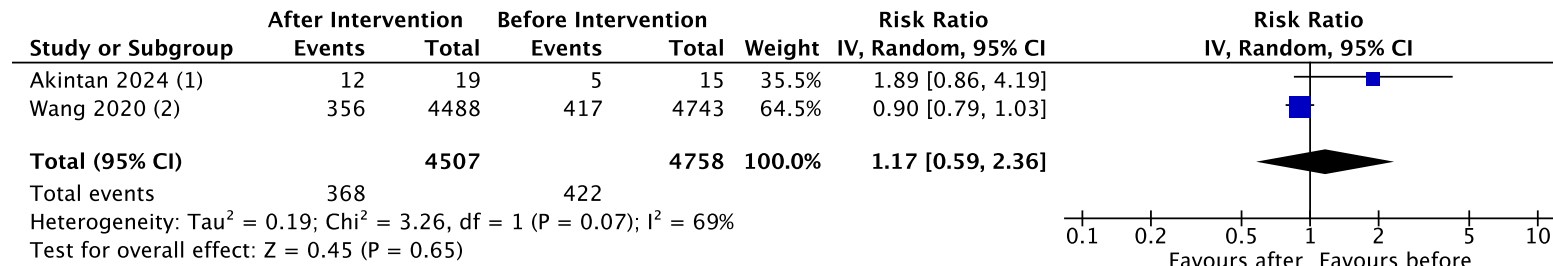
## Appendix 4: Forest Plots

### 4.1 Facility Level Forest Plots

#### 4.1.1. Strategies to Reduce Antimicrobial Resistance

##### Single-Component Intervention: Regulation

##### Outcome: Neonatal sepsis/suspected sepsis

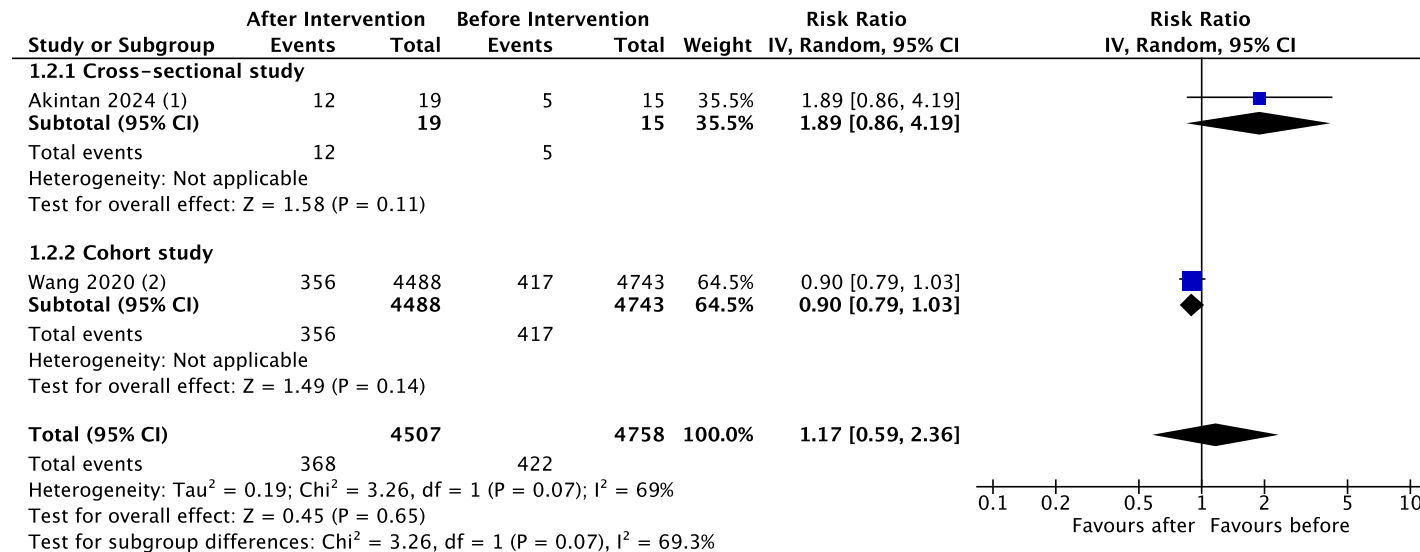


##### Footnotes

(1) Akintan 2024 reported sepsis among neonates prescribed antibiotics in the NICU

(2) Wang 2020 reported sepsis/suspected sepsis among neonates admitted to the NICU

##### Outcome: Neonatal sepsis/suspected sepsis by study design



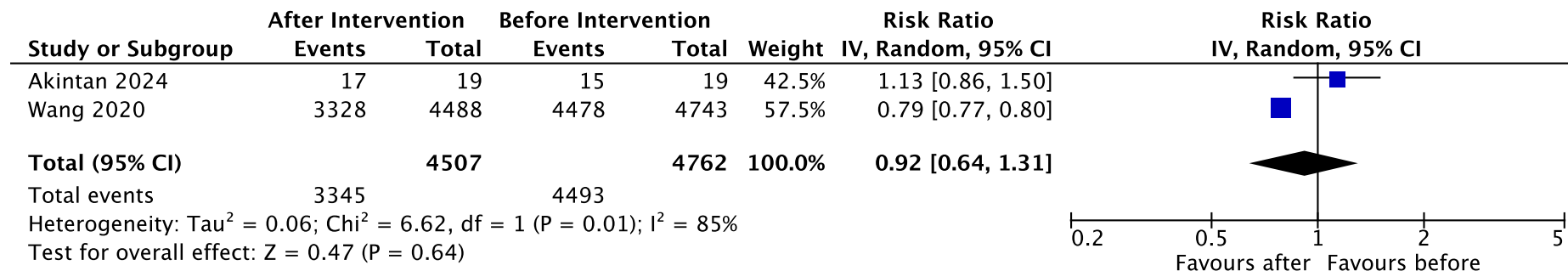
##### Footnotes

(1) Akintan 2024 reported sepsis among neonates prescribed antibiotics in the NICU

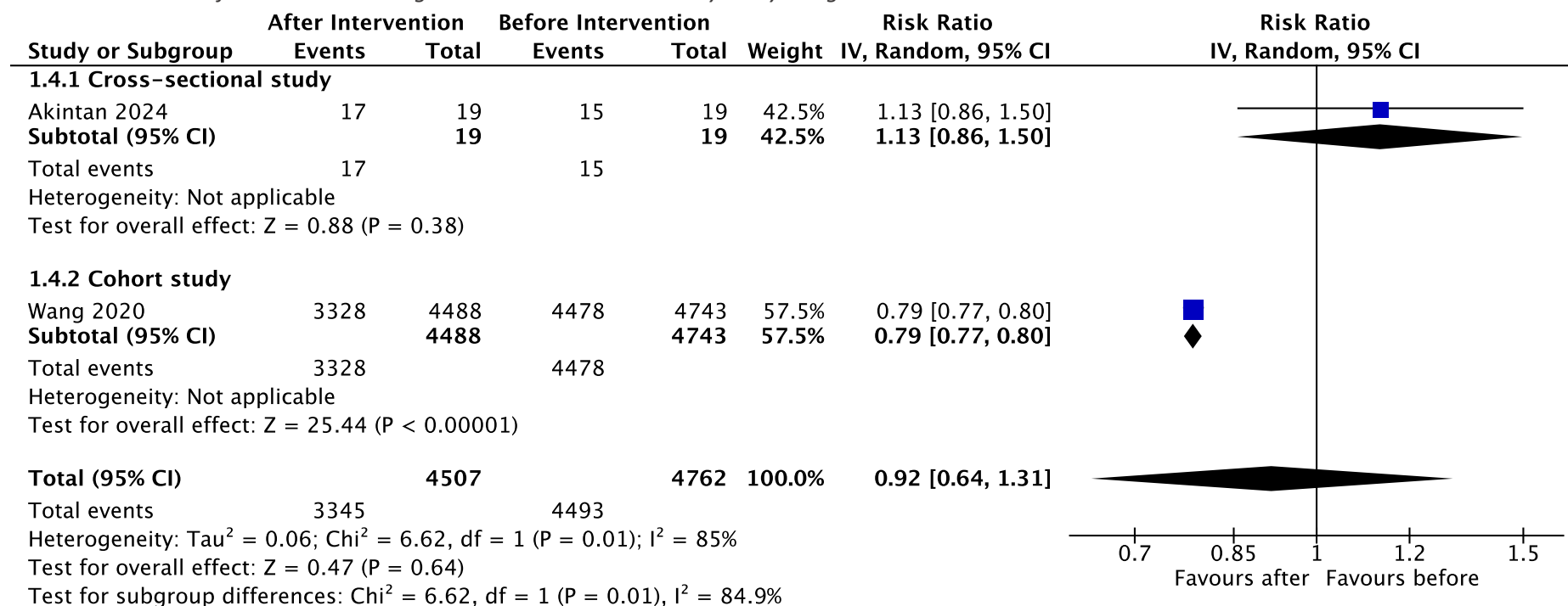
(2) Wang 2020 reported sepsis/suspected sepsis among neonates admitted to the NICU

## Prevention and Treatment of Neonatal Infections in LMICs

**Outcome:** Number of newborns receiving at least one antimicrobial



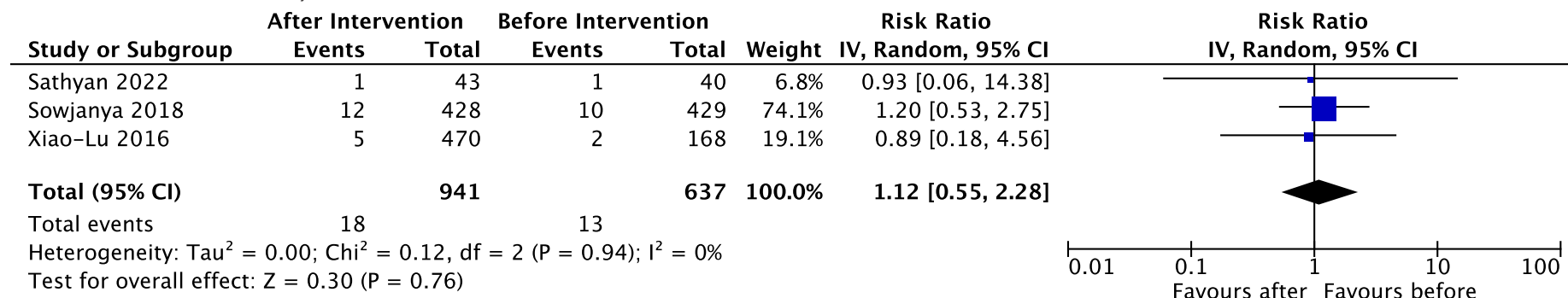
**Outcome:** Number of newborns receiving at least one antimicrobial by study design



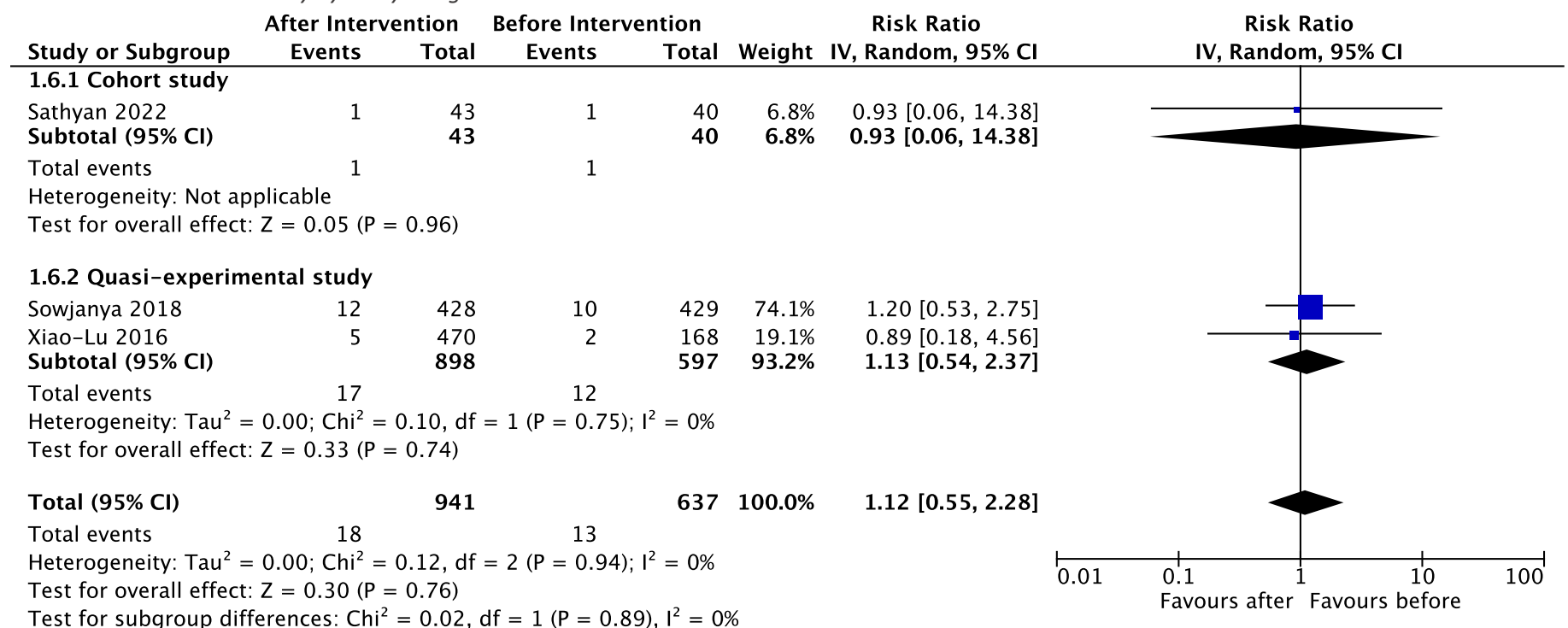
# Prevention and Treatment of Neonatal Infections in LMICs

## Single-Component Intervention: Restriction

### Outcome: Neonatal mortality



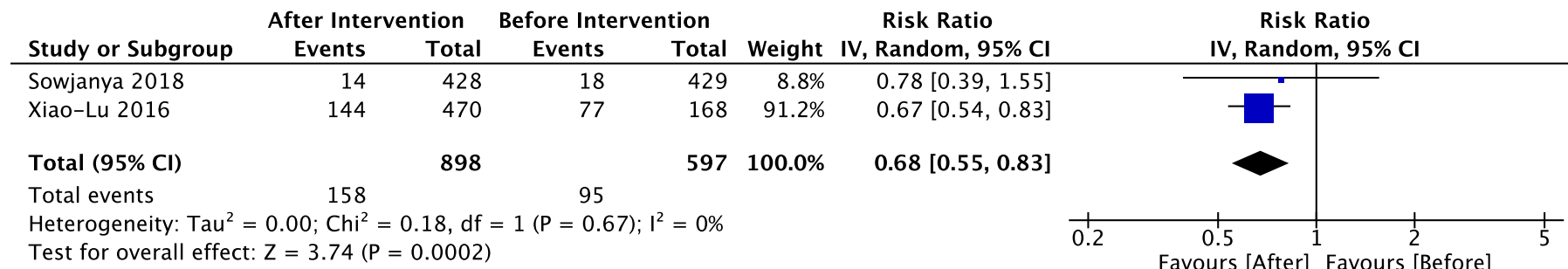
### Outcome: Neonatal mortality by study design



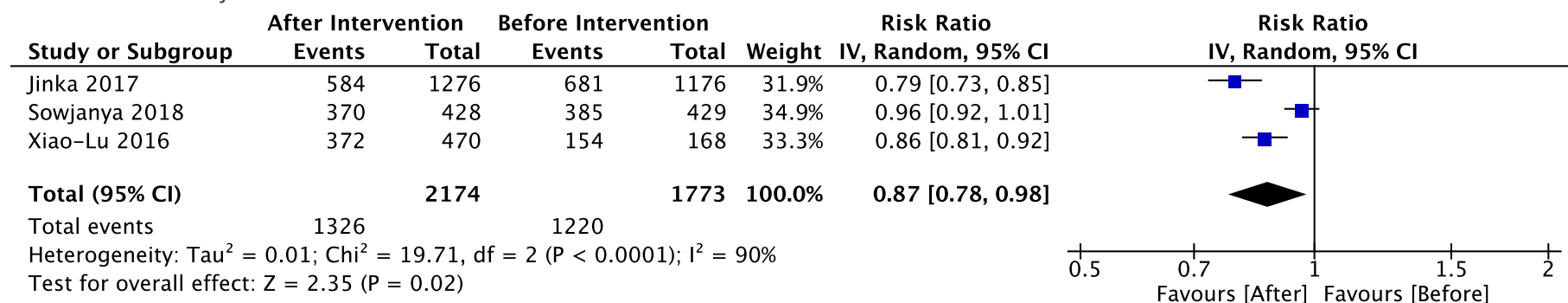


## Prevention and Treatment of Neonatal Infections in LMICs

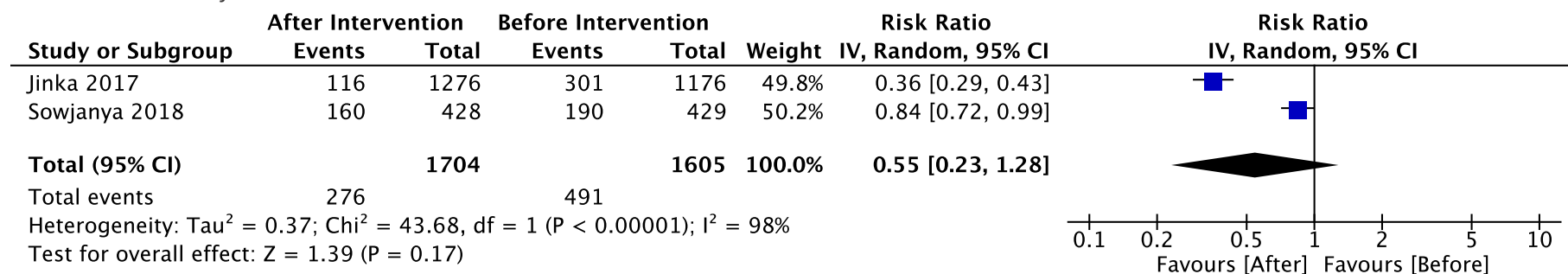
### Outcome: Culture-positive sepsis



### Outcome: Number of newborns on antibiotics

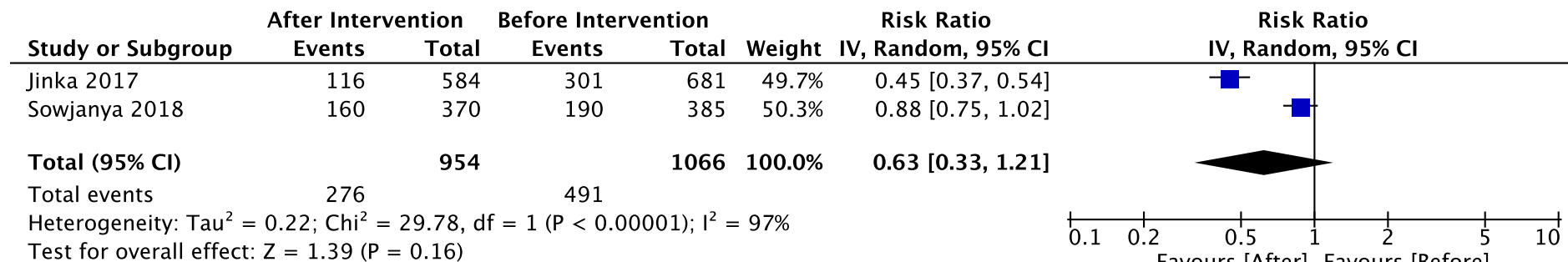


### Outcome: Number of newborns on amikacin

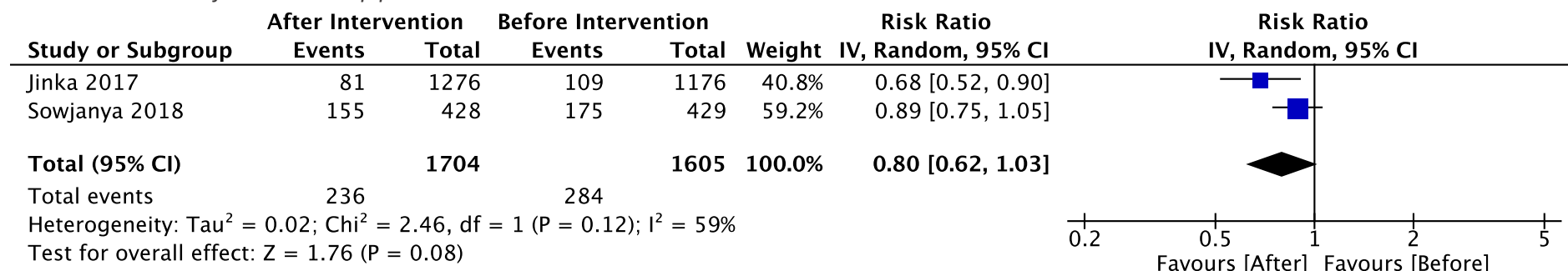


## Prevention and Treatment of Neonatal Infections in LMICs

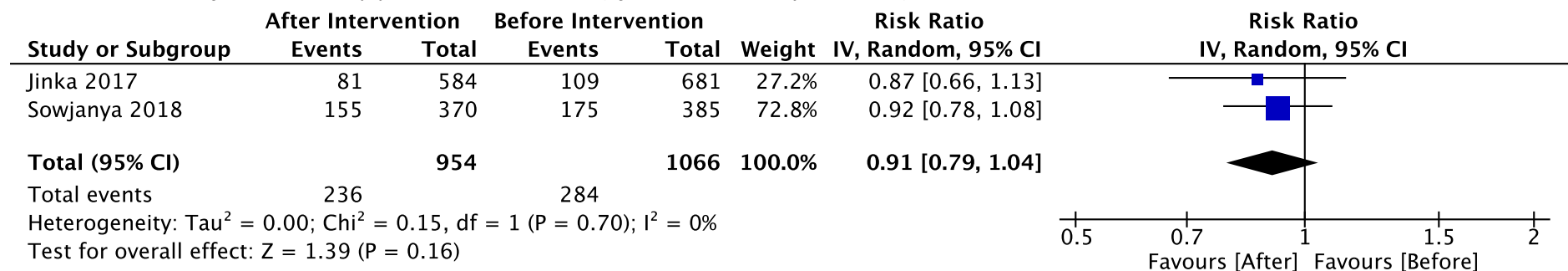
**Outcome:** Number of newborns on amikacin (of newborns on any antibiotic)



**Outcome:** Number of newborns on piperacillin-tazobactam

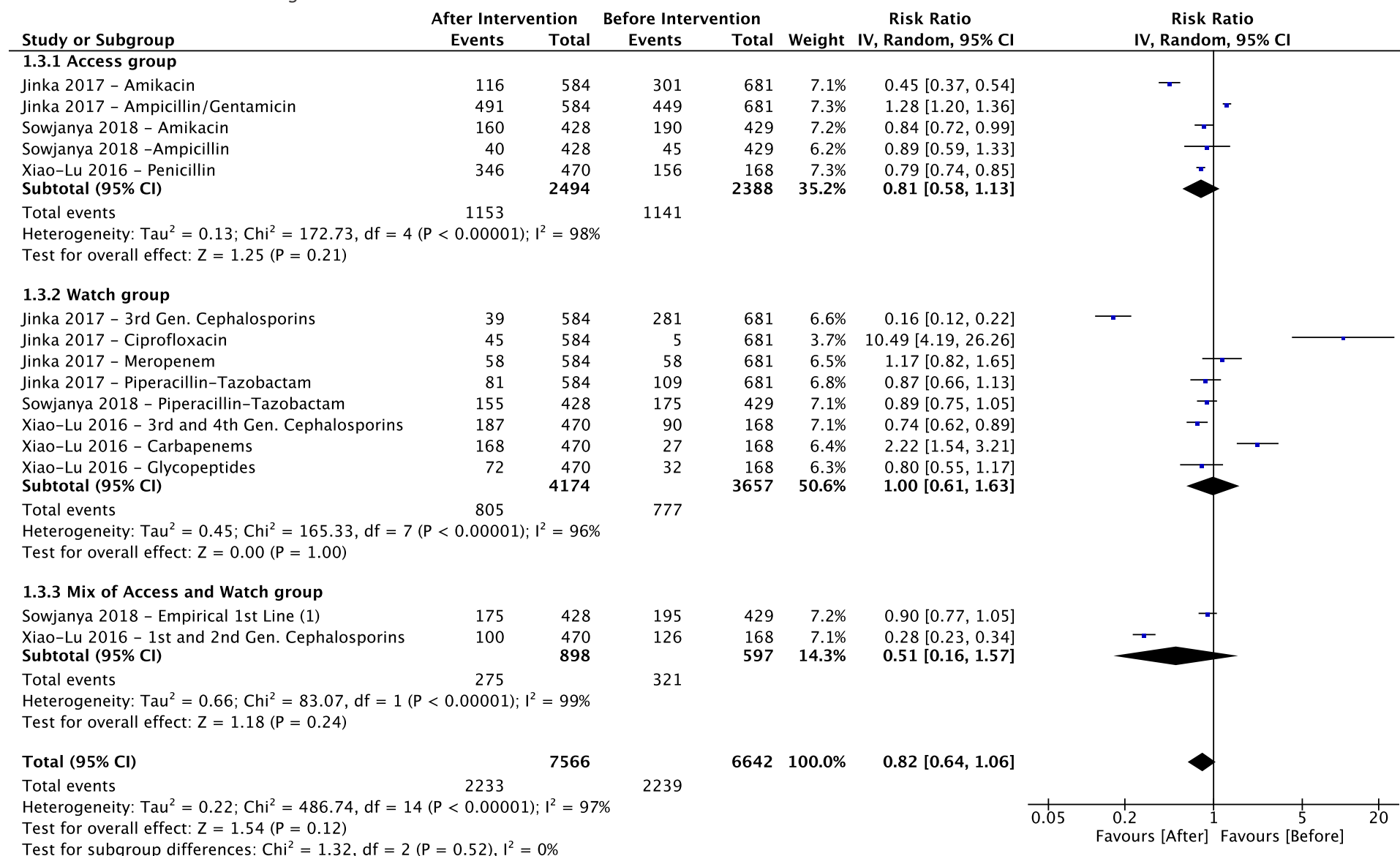


**Outcome:** Number of newborns on piperacillin-tazobactam (of newborns on any antibiotic)



# Prevention and Treatment of Neonatal Infections in LMICs

## Outcome: AWARe antibiotic usage



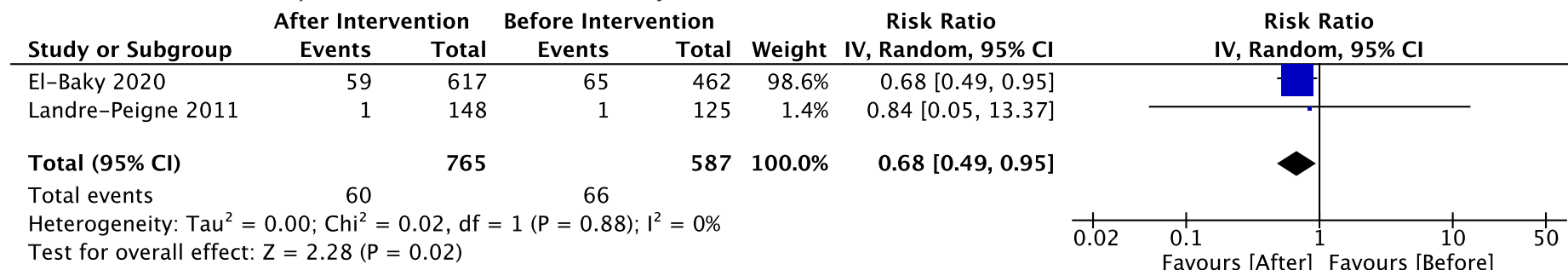
### Footnotes

(1) Amikacin, Ampicillin, and Piperacillin-Tazobactam

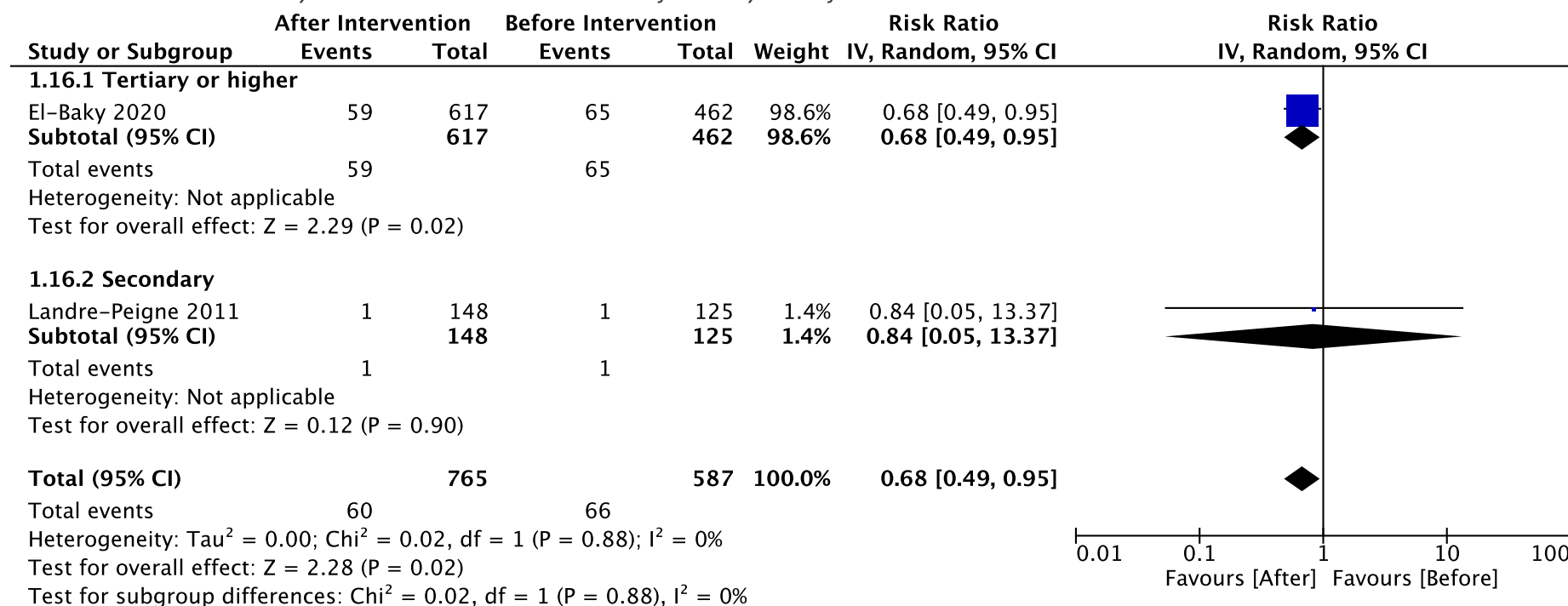
# Prevention and Treatment of Neonatal Infections in LMICs

## Multi-Component Intervention: Regulation & Restriction

**Outcome:** Neonatal mortality due to nosocomial bloodstream infection



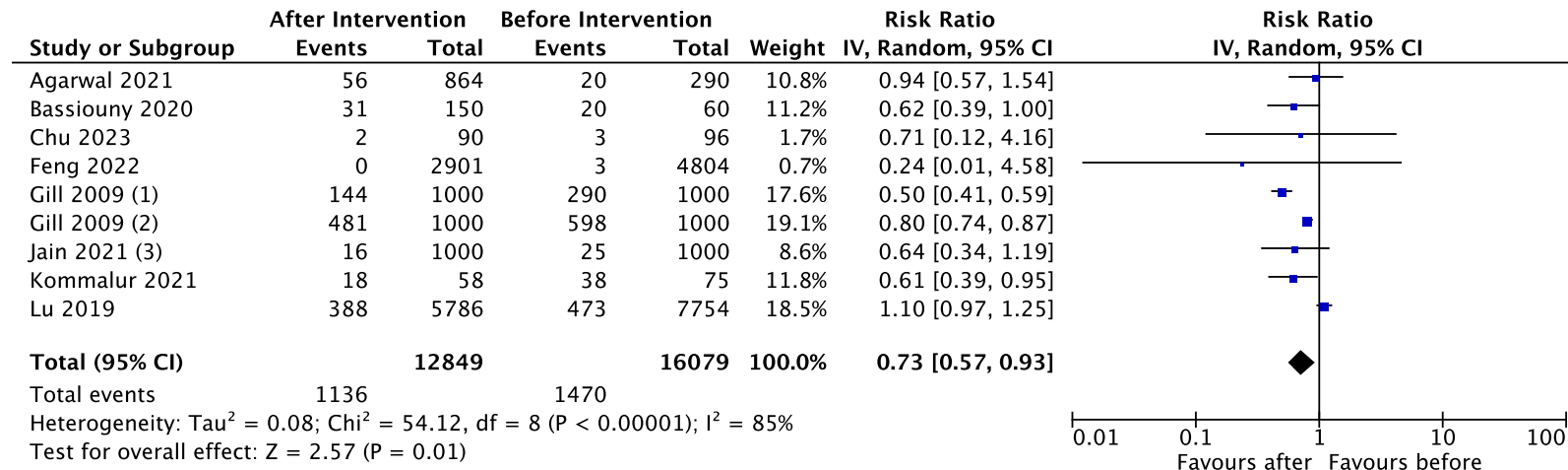
**Outcome:** Neonatal mortality due to nosocomial bloodstream infection by level of care



## Prevention and Treatment of Neonatal Infections in LMICs

### Multi-Component Intervention: Regulation, Education & Restriction

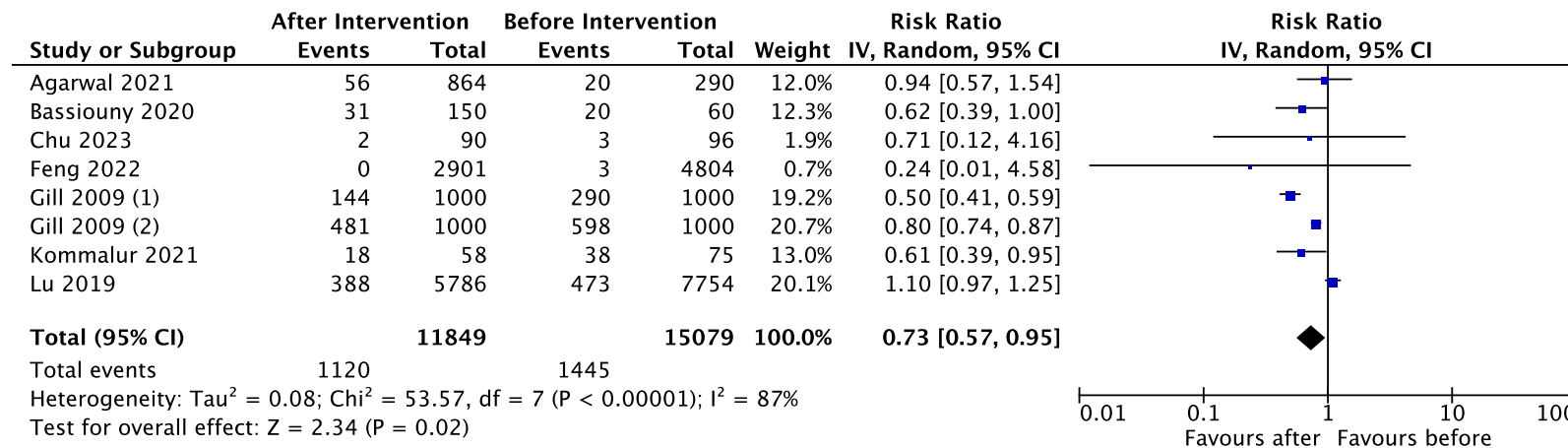
#### Outcome: Neonatal mortality



#### Footnotes

- (1) Gill 2009 reported neonatal mortality in NICU 1 as deaths per 1000 admissions  
 (2) Gill 2009 reported neonatal mortality in NICU 2 as deaths per 1000 admissions  
 (3) Jain 2021 reported neonatal mortality per 1000 live births

#### Outcome: Neonatal mortality – sensitivity analysis (omitting studies with high risk of bias)

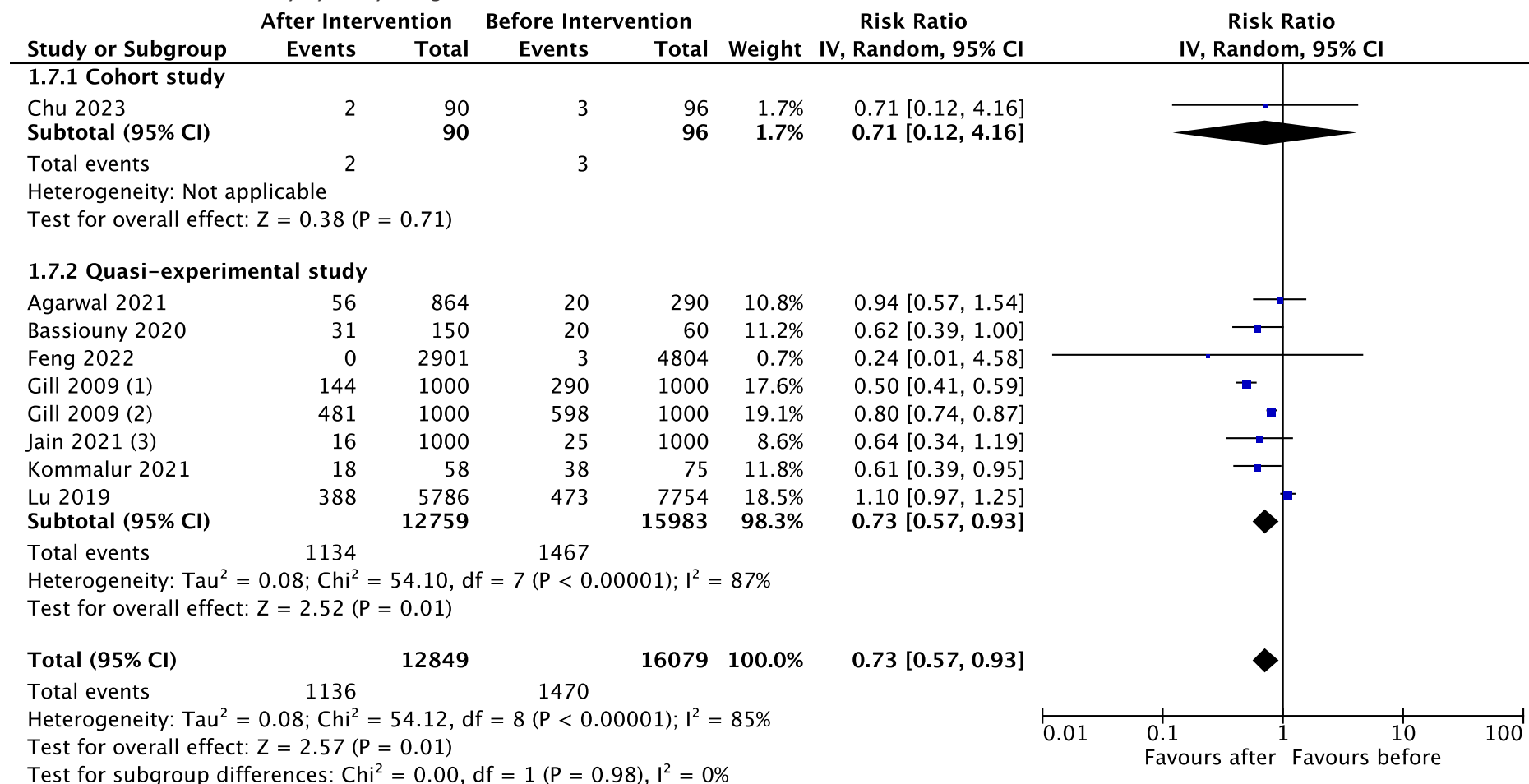


#### Footnotes

- (1) Gill 2009 reported neonatal mortality in NICU 1 as deaths per 1000 admissions  
 (2) Gill 2009 reported neonatal mortality in NICU 2 as deaths per 1000 admissions

# Prevention and Treatment of Neonatal Infections in LMICs

Outcome: Neonatal mortality by study design



## Footnotes

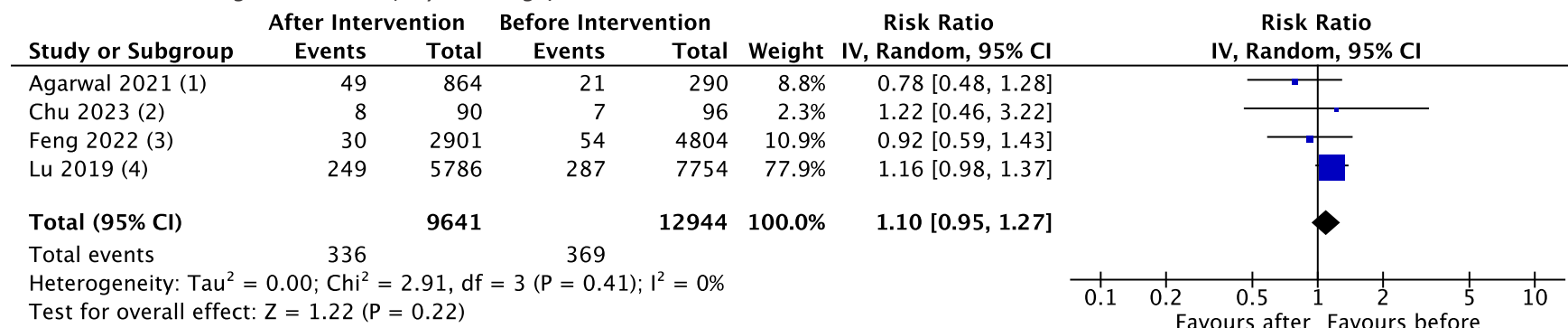
(1) Gill 2009 reported neonatal mortality in NICU 1 as deaths per 1000 admissions

(2) Gill 2009 reported neonatal mortality in NICU 2 as deaths per 1000 admissions

(3) Jain 2021 reported neonatal mortality per 1000 live births

## Prevention and Treatment of Neonatal Infections in LMICs

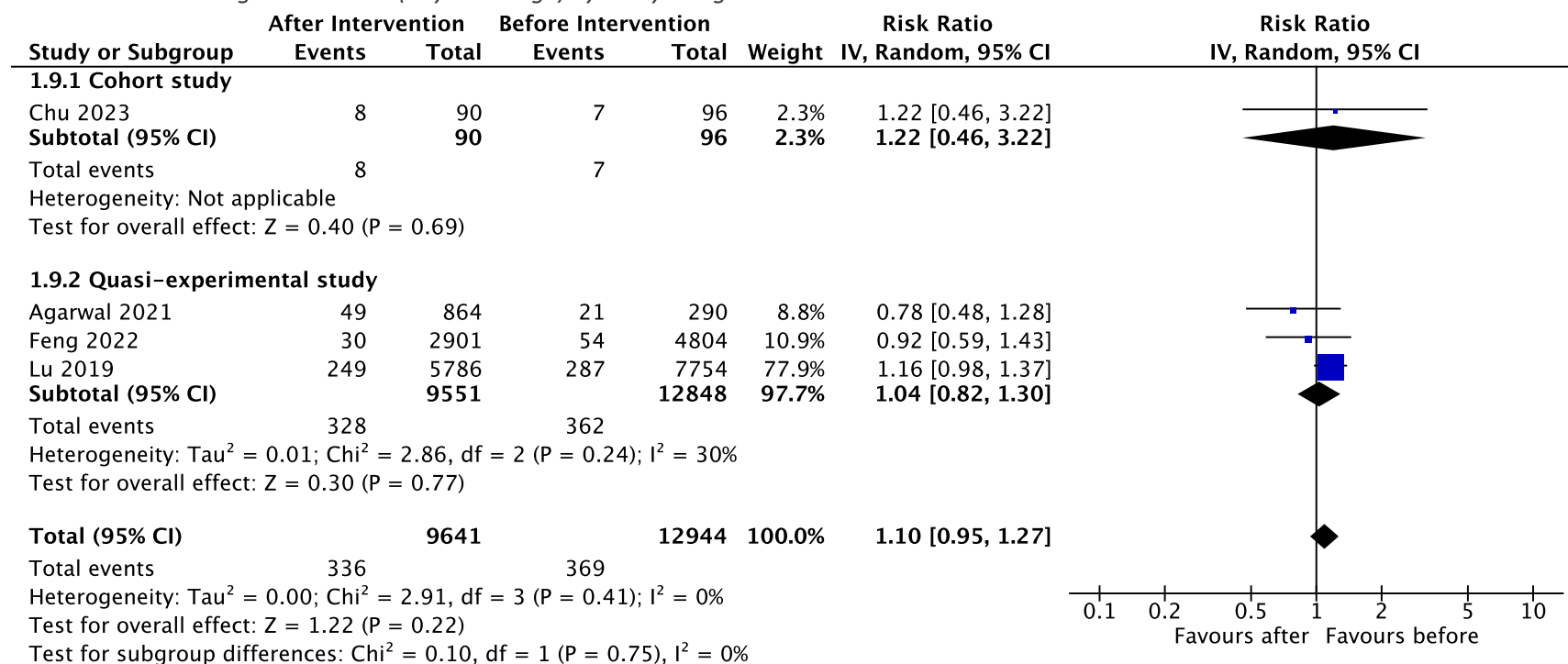
### Outcome: Necrotizing enterocolitis (any Bell stage)



#### Footnotes

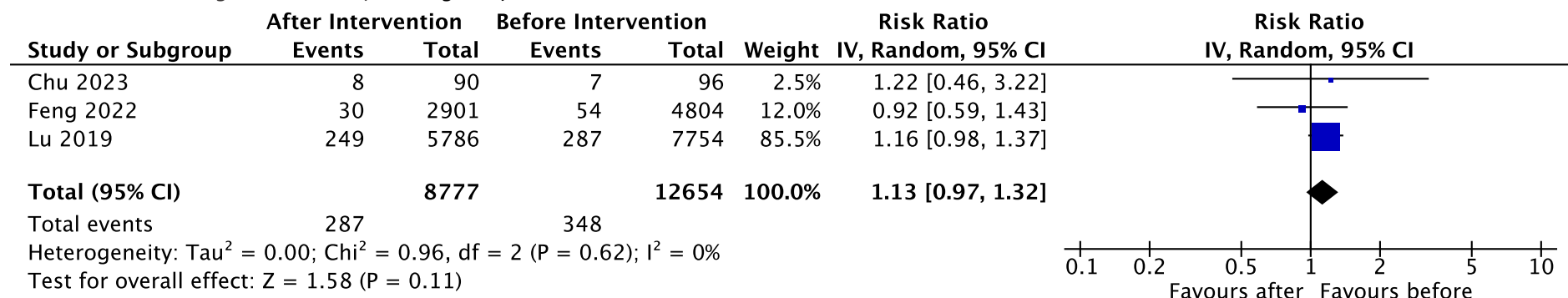
- (1) Agarwal 2021 reported overall NEC
- (2) Chu 2023 reported NEC (Bell stage  $\geq$  II)
- (3) Feng 2022 reported NEC (Bell stage  $\geq$  II)
- (4) Lu 2019 reported NEC (Stage  $\geq$  II)

### Outcome: Necrotizing enterocolitis (any Bell stage) by study design

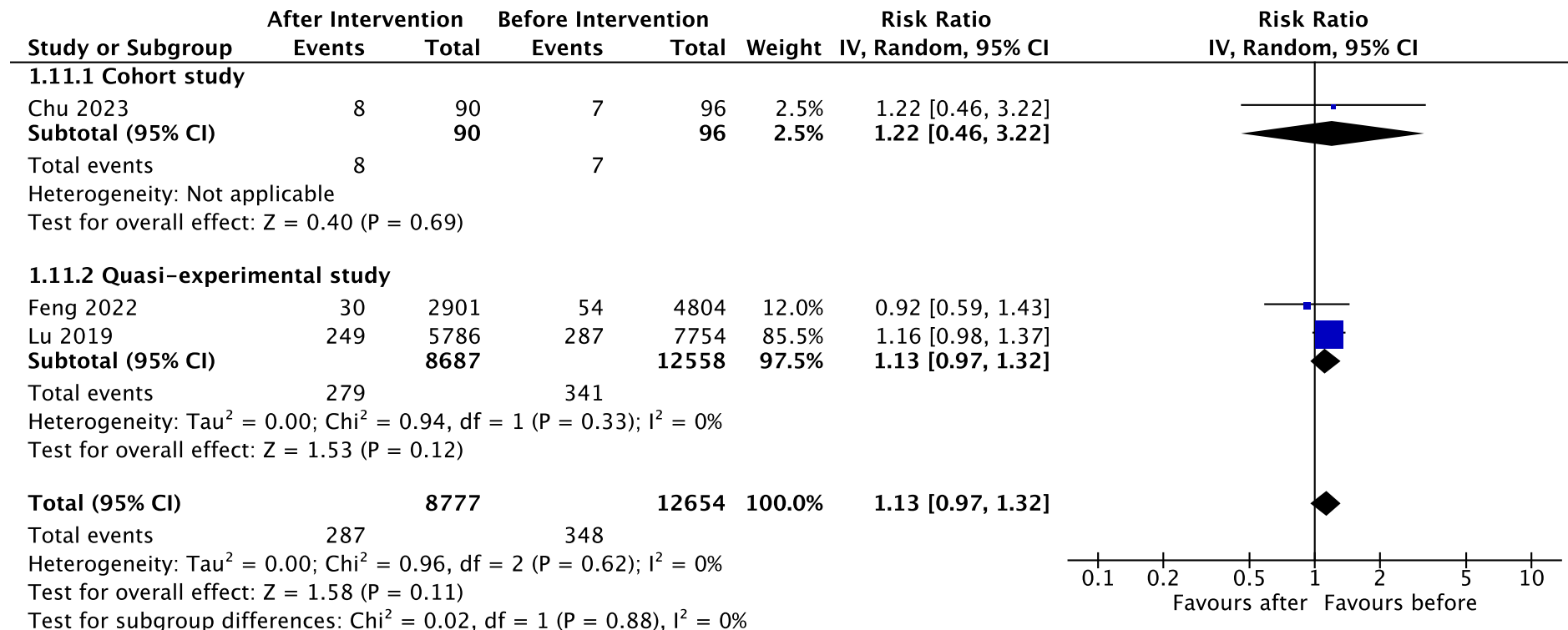


# Prevention and Treatment of Neonatal Infections in LMICs

## Outcome: Necrotizing enterocolitis (Bell stage $\geq$ II)



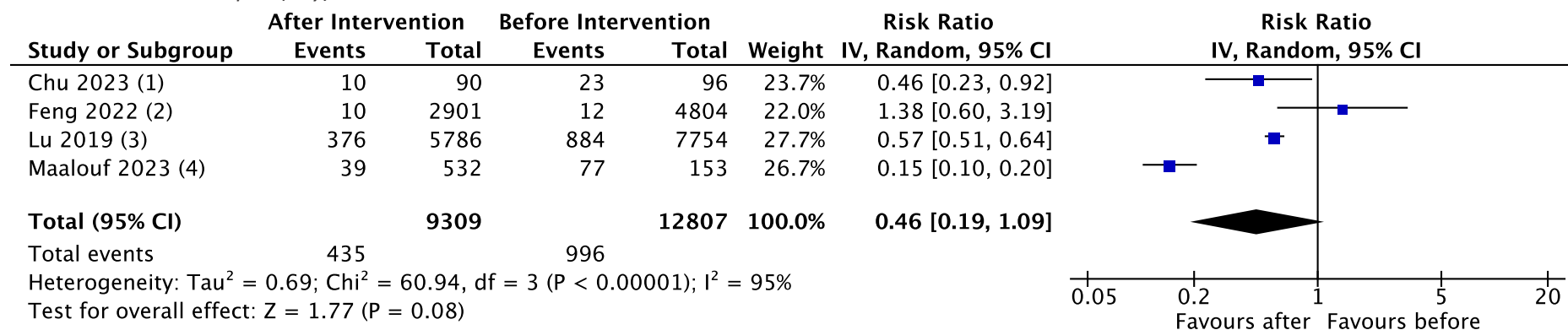
## Outcome: Necrotizing enterocolitis (Bell stage $\geq$ II) by study design





## Prevention and Treatment of Neonatal Infections in LMICs

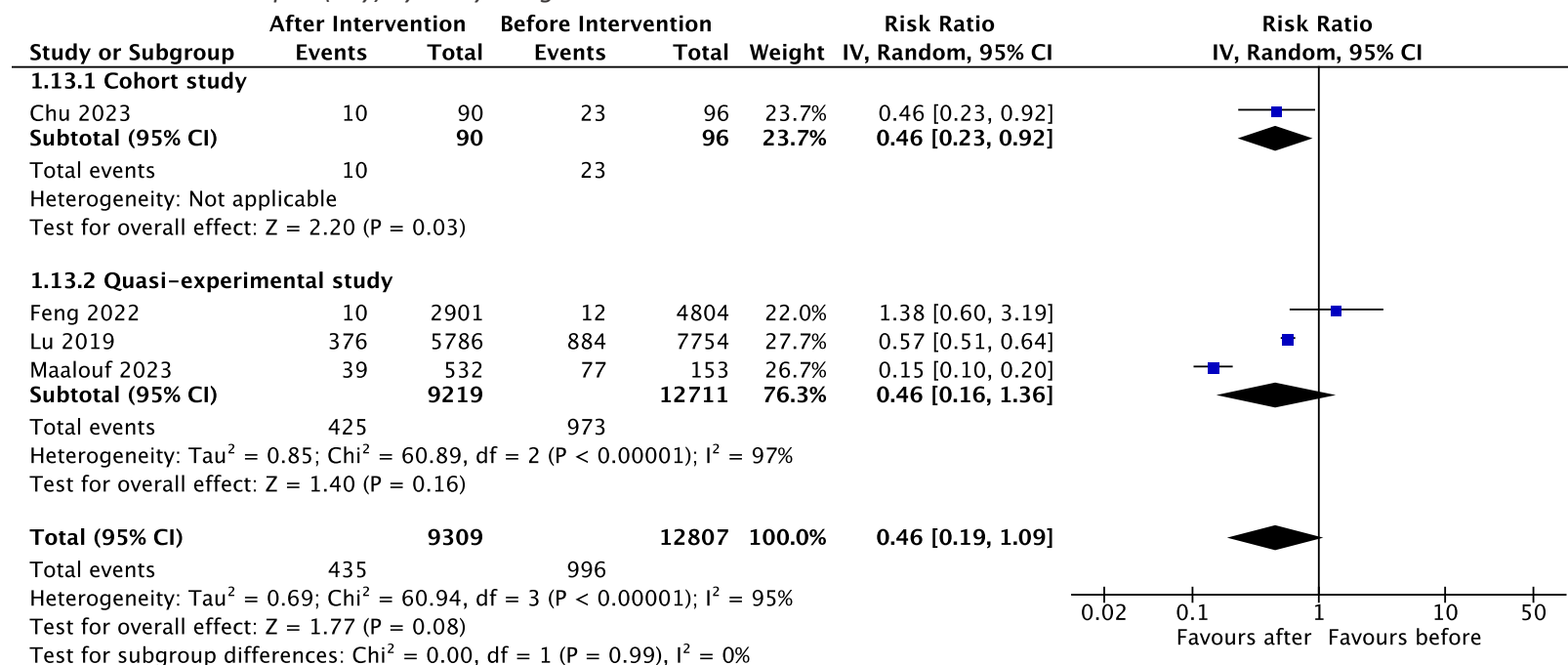
### Outcome: Neonatal sepsis (any)



#### Footnotes

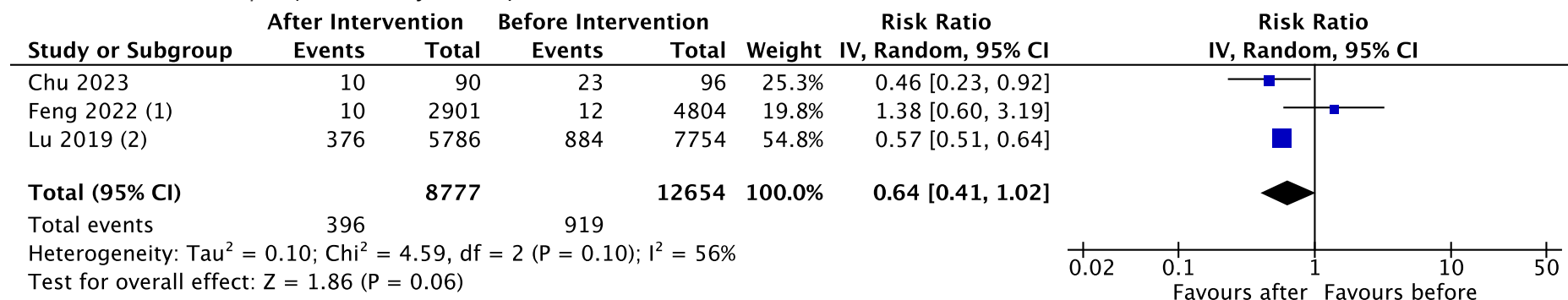
- (1) A positive blood or CSF fluid culture, or clinical deterioration and  $\geq 2$  abnormal blood indicators or changes in CSF consistent with meningitis  
 (2) LOS defined as  $> 72$  hours of age and positive pathogenic results in blood, urine, or CSF fluid specimens  
 (3) Late-onset defined as  $\geq 72$  hours after birth  
 (4) EOS defined as  $\leq 72$  hours after birth

### Outcome: Neonatal sepsis (any) by study design



## Prevention and Treatment of Neonatal Infections in LMICs

### Outcome: Late-onset sepsis (>72 hours after birth)

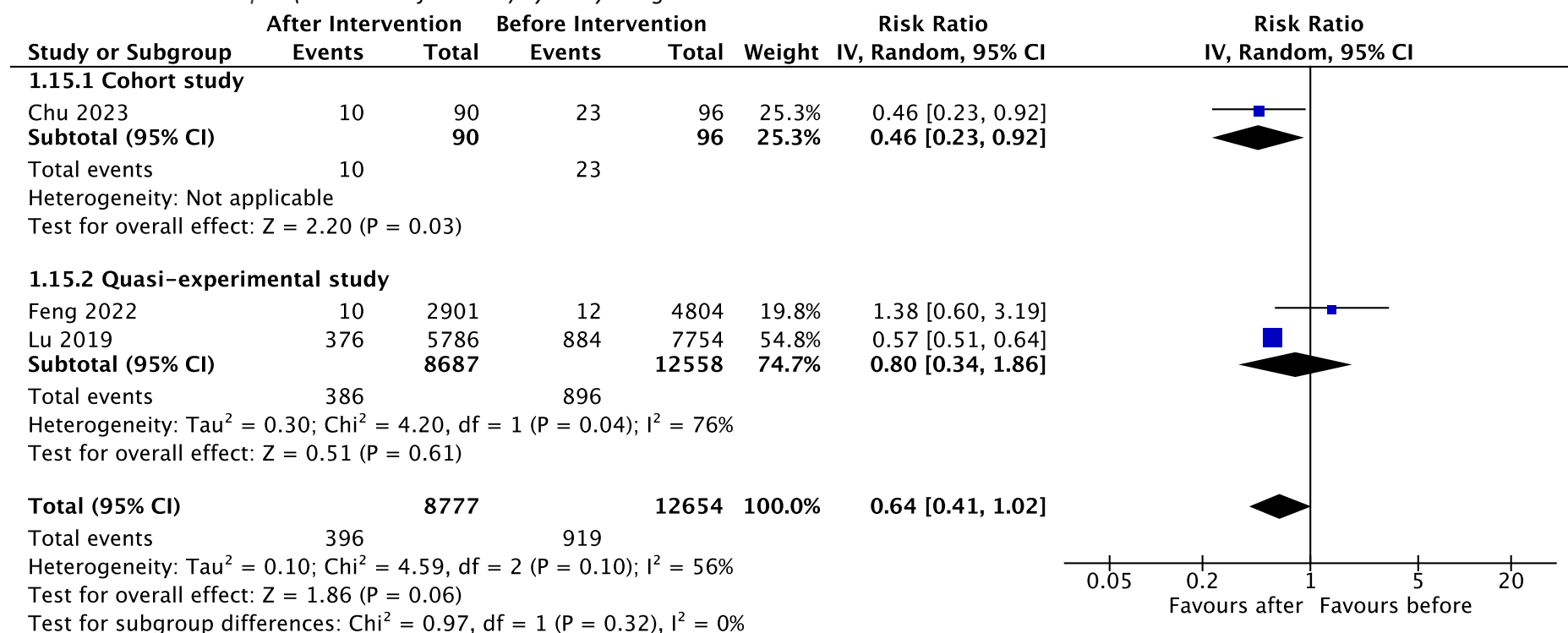


#### Footnotes

(1) Feng 2022 reported LOS defined as >72 hours of age and positive pathogenic results in blood, urine, or cerebrospinal fluid specimens

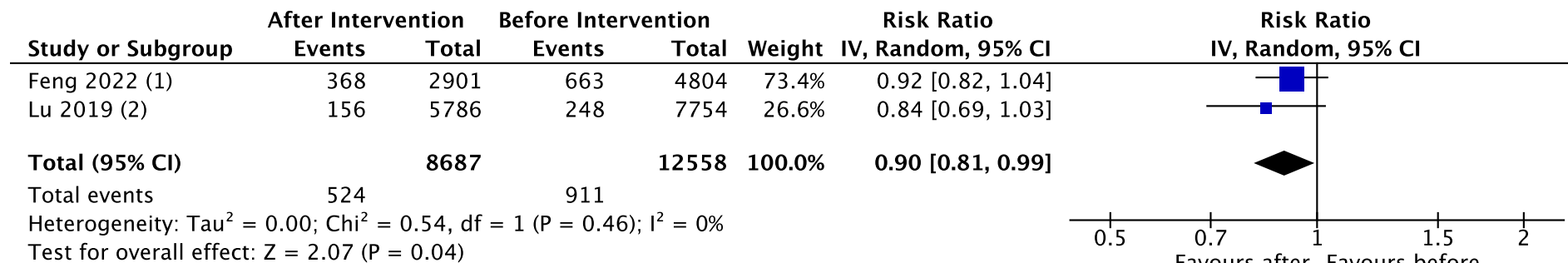
(2) Lu 2019 reported LOS and defined late-onset as  $\geq 72$  hours after birth

### Outcome: Late-onset sepsis (>72 hours after birth) by study design



## Prevention and Treatment of Neonatal Infections in LMICs

### Outcome: Culture-negative sepsis

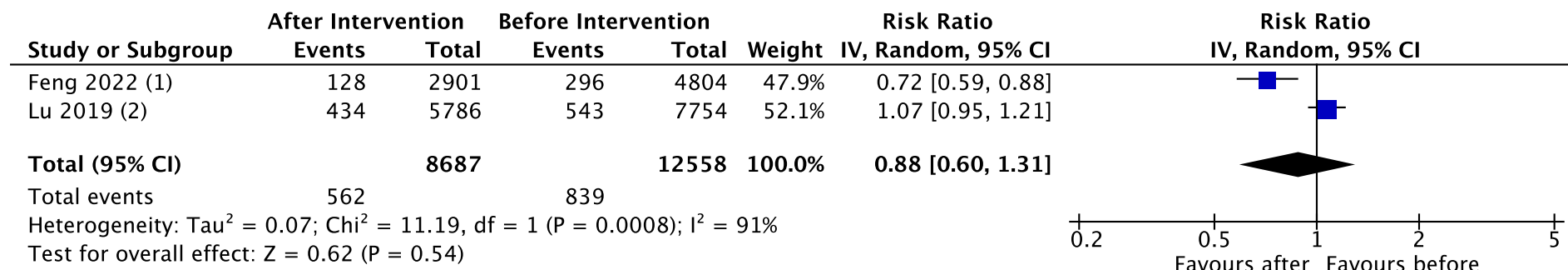


#### Footnotes

(1) Feng 2022 reported infants treated in  $\leq 5$  days for culture-negative sepsis

(2) Lu 2019 reported all infants treated for culture-negative sepsis

### Outcome: Pneumonia



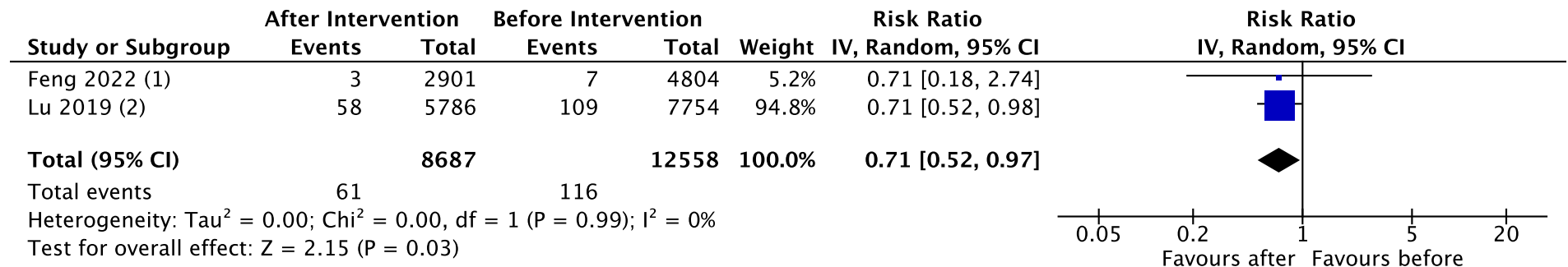
#### Footnotes

(1) Feng 2022 reported infants treated in  $\leq 5$  days for pneumonia

(2) Lu 2019 reported all infants treated for pneumonia

# Prevention and Treatment of Neonatal Infections in LMICs

## Outcome: Multidrug-resistant organism infection or colonization

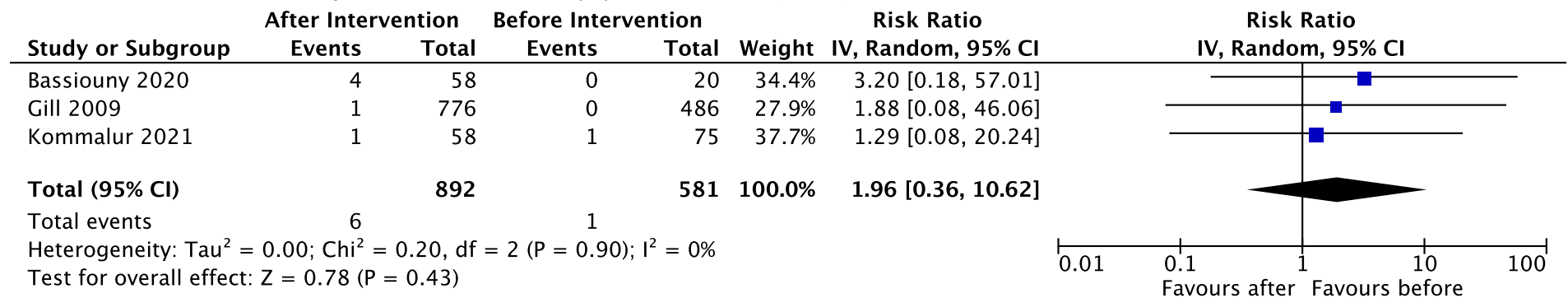


### Footnotes

(1) Feng 2022 reported multidrug-resistant organism infections

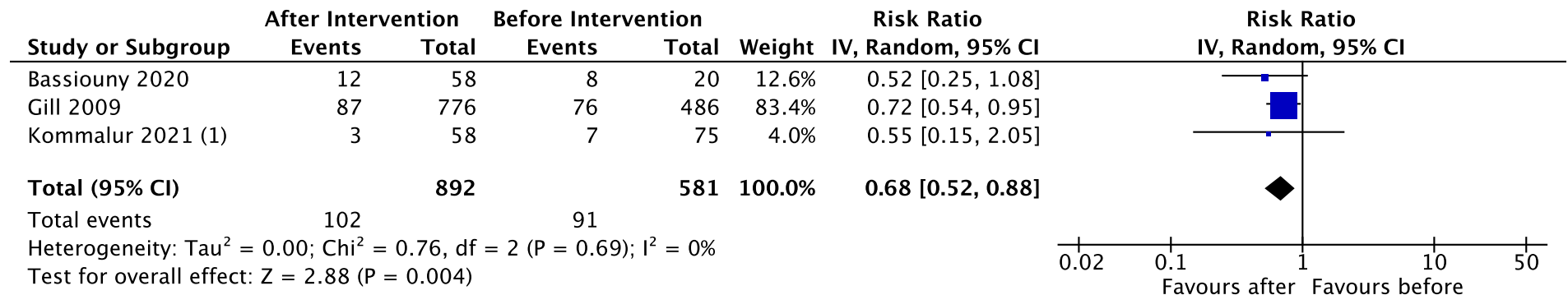
(2) Lu 2019 reported multidrug-resistant organism colonizations

## Outcome: Bloodstream isolates of methicillin-resistant *Staphylococcus aureus* (MRSA)



# Prevention and Treatment of Neonatal Infections in LMICs

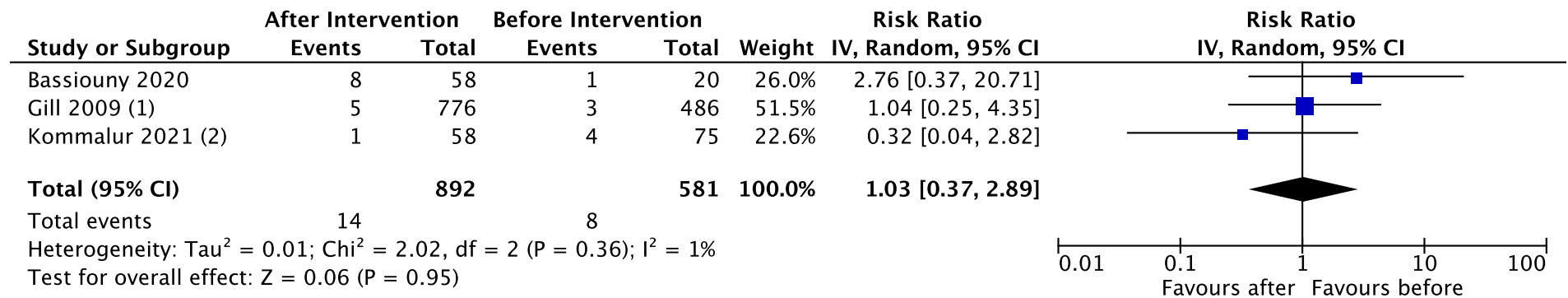
Outcome: Bloodstream isolates of *Klebsiella* spp.



## Footnotes

(1) Kommalar 2021 reported *Klebsiella pneumoniae* organisms

Outcome: Bloodstream isolates of *Acinetobacter* spp.



## Footnotes

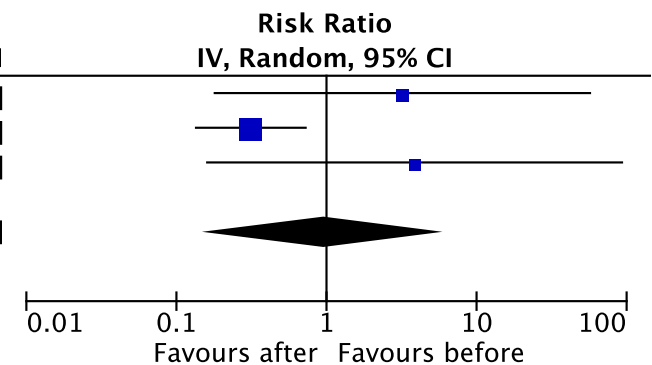
(1) Gill 2009 reported *Acinetobacter baumannii* organisms

(2) Kommalar 2021 reported *Acinetobacter baumannii* organisms

# Prevention and Treatment of Neonatal Infections in LMICs

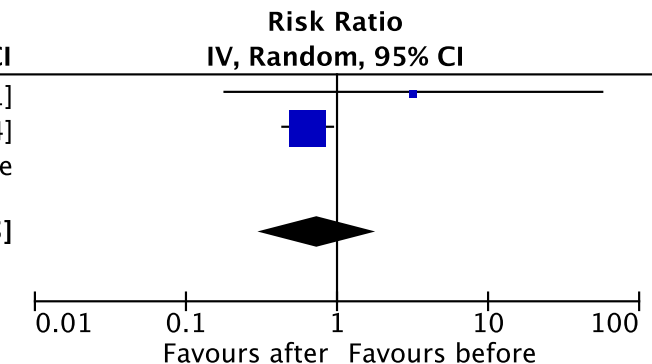
## Outcome: Bloodstream isolates of *Escherichia coli* (*E. coli*)

Study or Subgroup	After Intervention		Before Intervention		Weight	Risk Ratio IV, Random, 95% CI
	Events	Total	Events	Total		
Bassiouny 2020	4	58	0	20	24.6%	3.20 [0.18, 57.01]
Gill 2009	8	776	16	486	53.7%	0.31 [0.14, 0.73]
Kommalar 2021	1	58	0	75	21.7%	3.86 [0.16, 93.16]
<b>Total (95% CI)</b>		<b>892</b>		<b>581</b>	<b>100.0%</b>	<b>0.96 [0.15, 6.11]</b>
Total events	13		16			
Heterogeneity: $\tau^2 = 1.48$ ; $\chi^2 = 4.24$ , $df = 2$ ( $P = 0.12$ ); $I^2 = 53\%$						
Test for overall effect: $Z = 0.05$ ( $P = 0.96$ )						



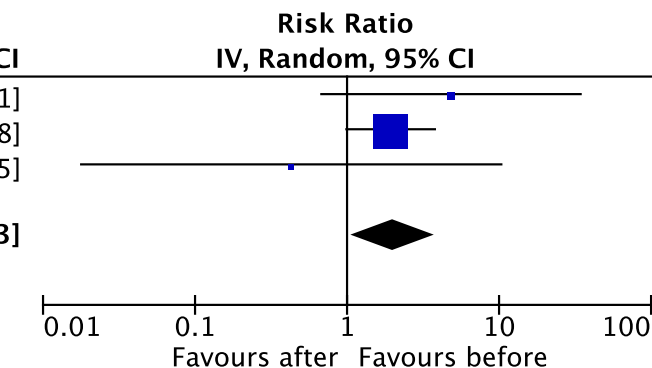
## Outcome: Bloodstream isolates of *Enterobacter* spp.

Study or Subgroup	After Intervention		Before Intervention		Weight	Risk Ratio IV, Random, 95% CI
	Events	Total	Events	Total		
Bassiouny 2020	4	58	0	20	9.2%	3.20 [0.18, 57.01]
Gill 2009	48	776	47	486	90.8%	0.64 [0.43, 0.94]
Kommalar 2021	0	58	0	75		Not estimable
<b>Total (95% CI)</b>		<b>892</b>		<b>581</b>	<b>100.0%</b>	<b>0.74 [0.30, 1.85]</b>
Total events	52		47			
Heterogeneity: $\tau^2 = 0.20$ ; $\chi^2 = 1.18$ , $df = 1$ ( $P = 0.28$ ); $I^2 = 15\%$						
Test for overall effect: $Z = 0.64$ ( $P = 0.52$ )						



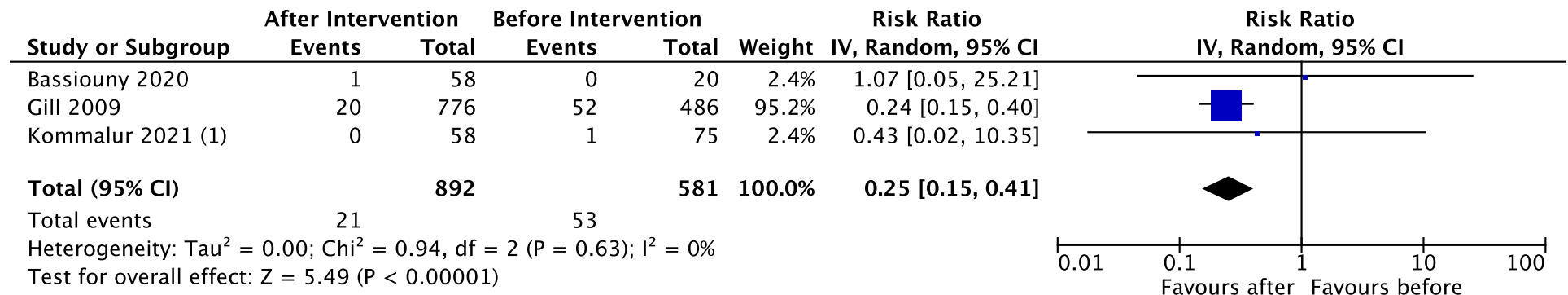
## Outcome: Bloodstream isolates of coagulase-negative staphylococci (CoNS)

Study or Subgroup	After Intervention		Before Intervention		Weight	Risk Ratio IV, Random, 95% CI
	Events	Total	Events	Total		
Bassiouny 2020	14	58	1	20	10.0%	4.83 [0.68, 34.41]
Gill 2009	34	776	11	486	86.1%	1.94 [0.99, 3.78]
Kommalar 2021	0	58	1	75	3.8%	0.43 [0.02, 10.35]
<b>Total (95% CI)</b>		<b>892</b>		<b>581</b>	<b>100.0%</b>	<b>2.00 [1.08, 3.73]</b>
Total events	48		13			
Heterogeneity: $\tau^2 = 0.00$ ; $\chi^2 = 1.68$ , $df = 2$ ( $P = 0.43$ ); $I^2 = 0\%$						
Test for overall effect: $Z = 2.19$ ( $P = 0.03$ )						



# Prevention and Treatment of Neonatal Infections in LMICs

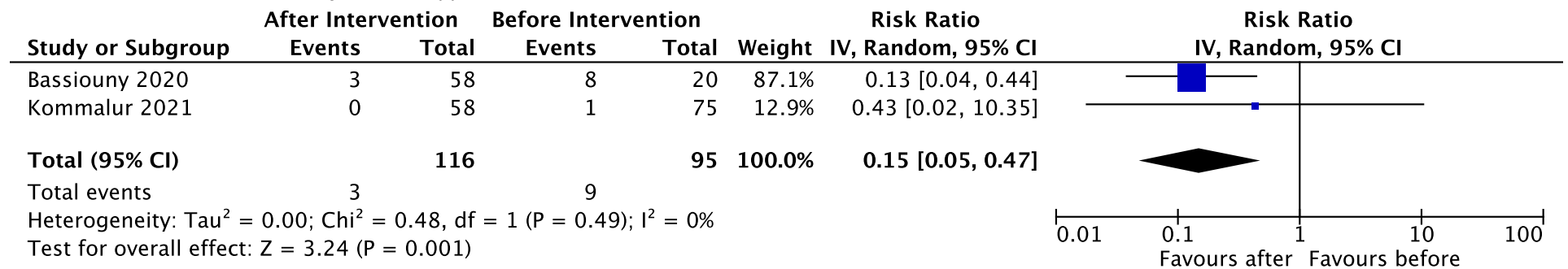
**Outcome:** Bloodstream isolates of *Pseudomonas* spp.



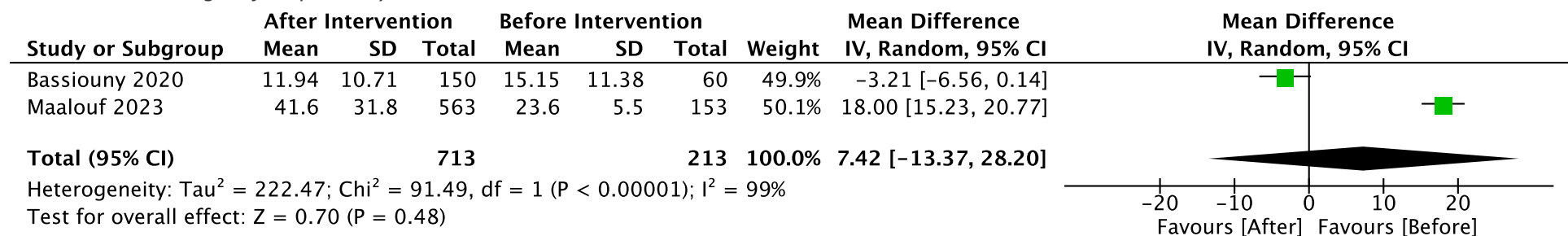
## Footnotes

(1) Kommalur 2021 reported *Pseudomonas aeruginosa* organisms

**Outcome:** Bloodstream isolates of *Candida* spp.

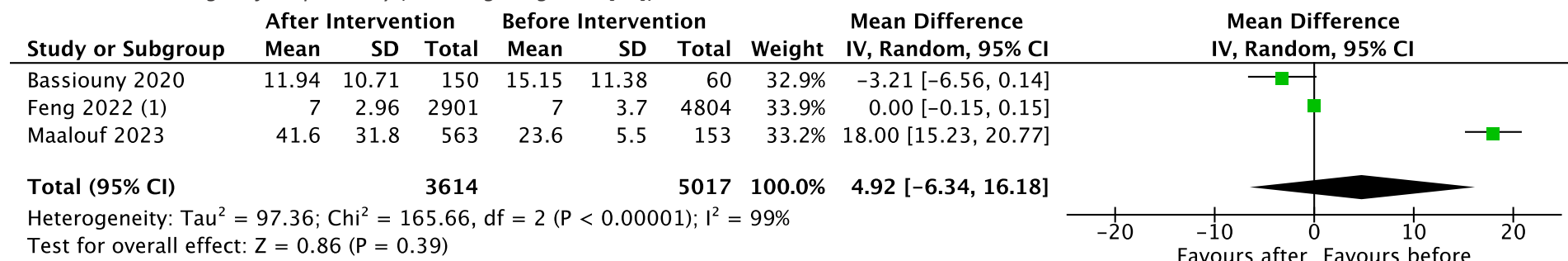


**Outcome:** Mean length of hospital stay



## Prevention and Treatment of Neonatal Infections in LMICs

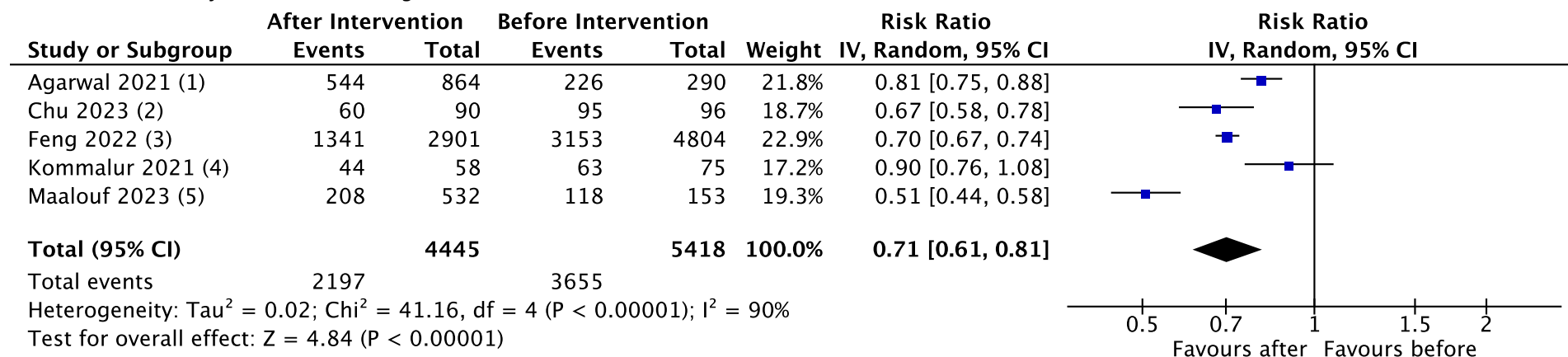
**Outcome:** Mean length of hospital stay (including Feng 2022 [13])



### Footnotes

(1) Feng 2022 expressed length of hospital stay as median and IQR. assuming the distribution of data is symmetrical, we estimated mean and SD

**Outcome:** Number of newborns receiving antibiotics



### Footnotes

(1) Agarwal 2021 reported neonates unexposed to antibiotics (from which the neonates exposed to antibiotics was derived)

(2) Chu 2023 reported proportion of early antibiotic usage

(3) Feng 2022 reported proportion of antibiotic exposure

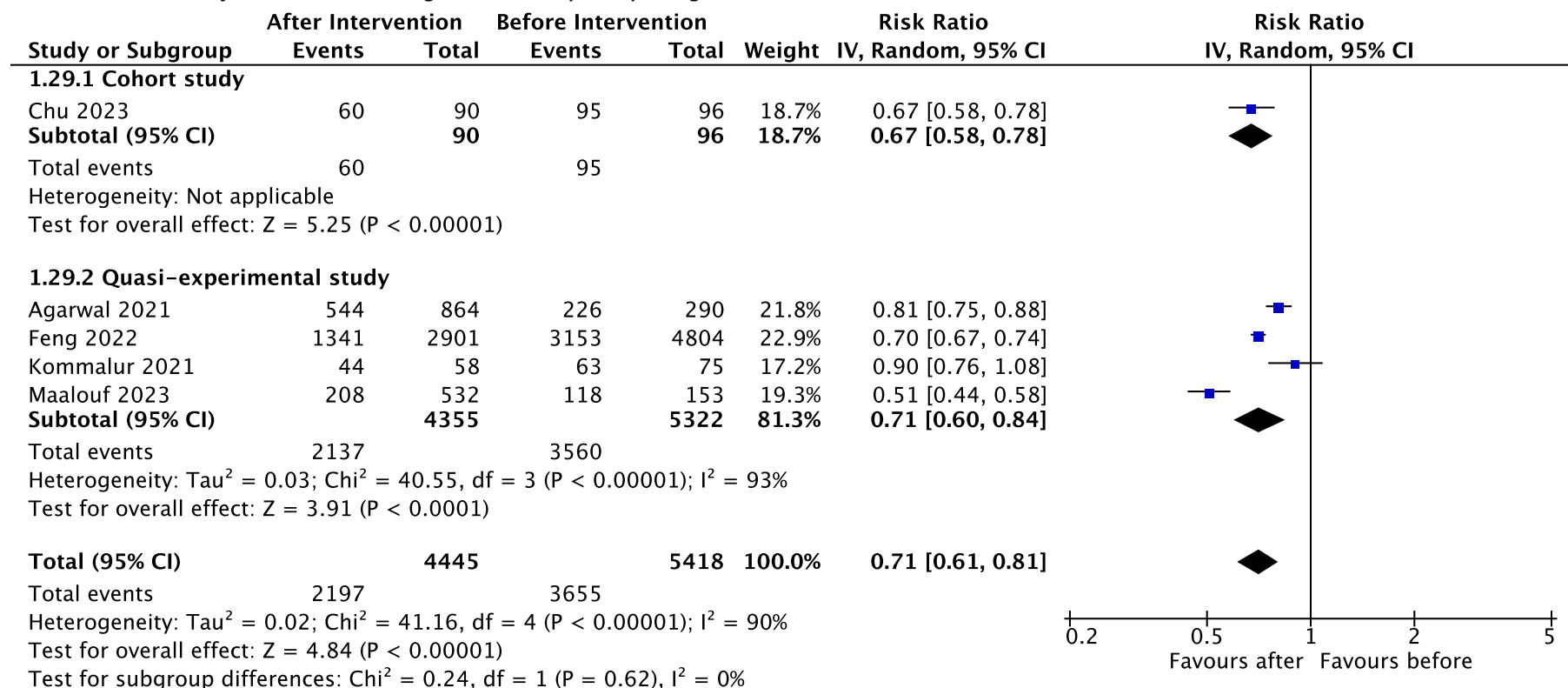
(4) Kommalar 2021 reported percentage of neonates with no antibiotics (from which neonates receiving antibiotics was derived)

(5) Maalouf 2023 reported proportion of neonates treated for early-onset sepsis

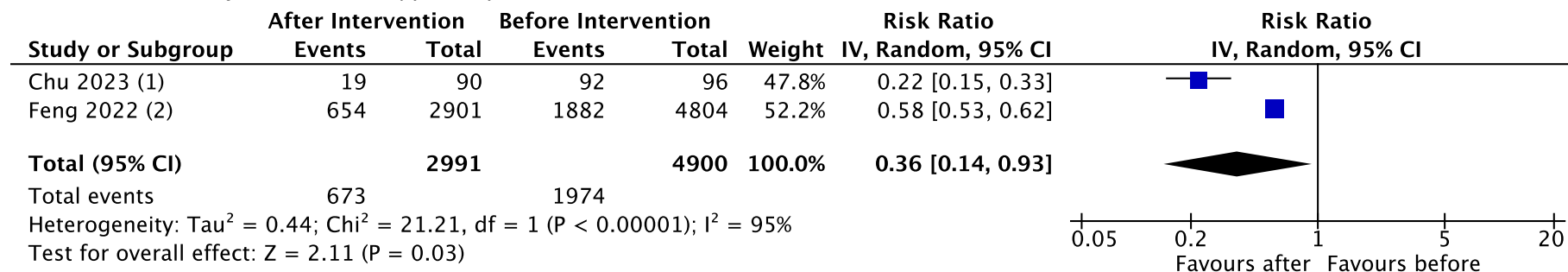


## Prevention and Treatment of Neonatal Infections in LMICs

**Outcome:** Number of newborns receiving antibiotics by study design



**Outcome:** Duration of antibiotic therapy >5 days



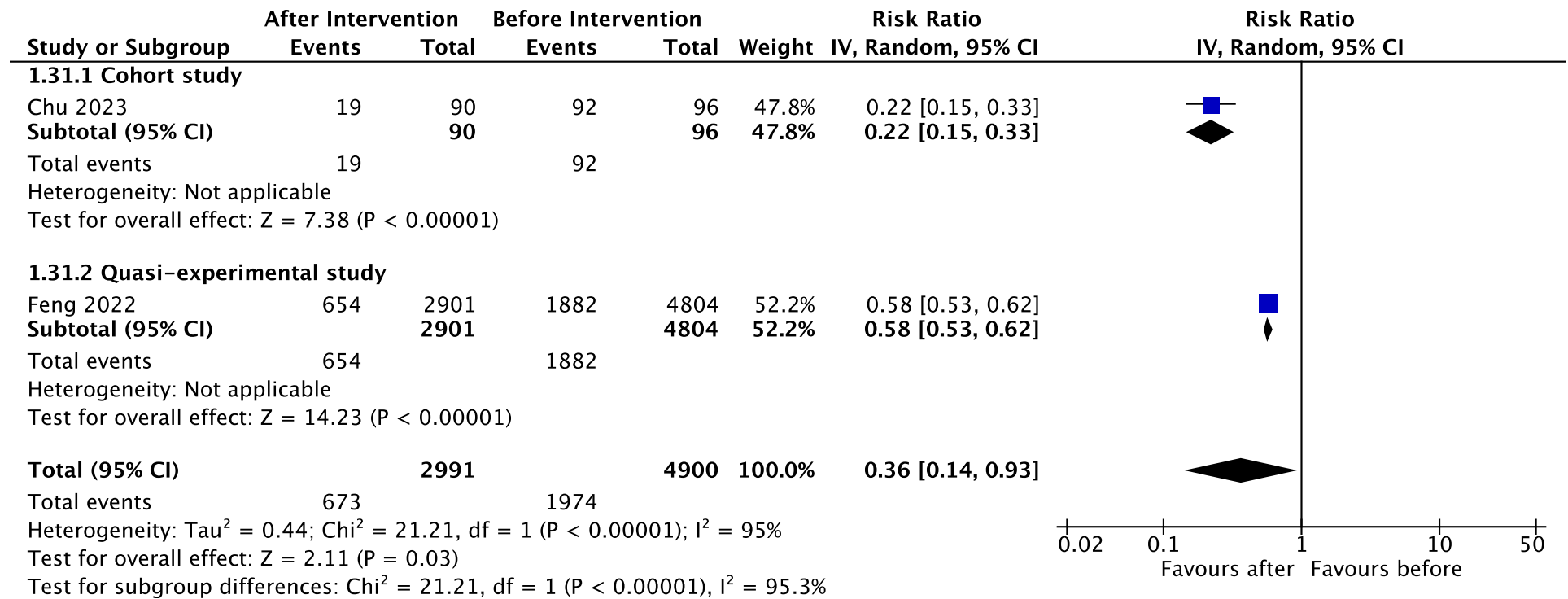
### Footnotes

(1) Chu 2023 reported the proportion of neonates treated with an initial antibiotic course >7 days

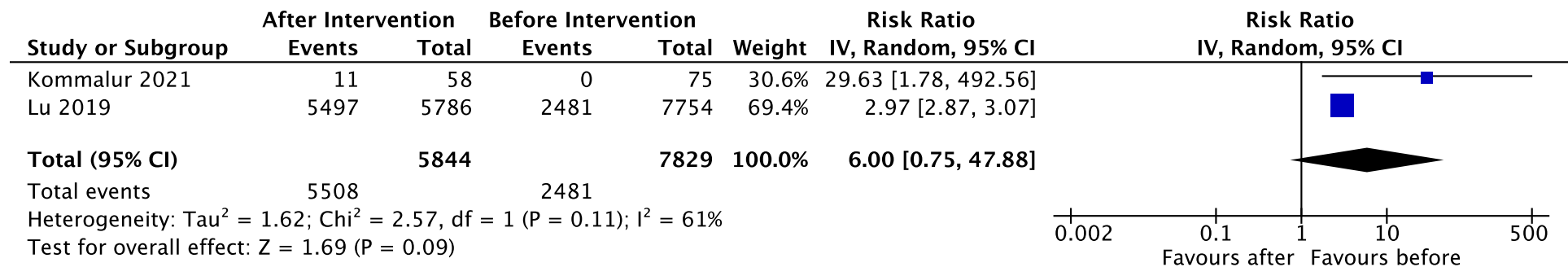
(2) Feng 2022 reported the proportion of neonates treated with a duration of therapy >5 days

# Prevention and Treatment of Neonatal Infections in LMICs

## Outcome: Duration of antibiotic therapy >5 days by study design



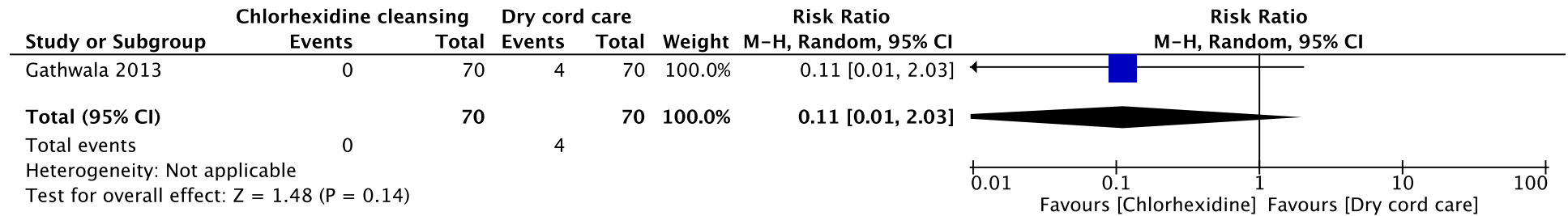
## Outcome: Neonates with antibiotics discontinued after 48 hours



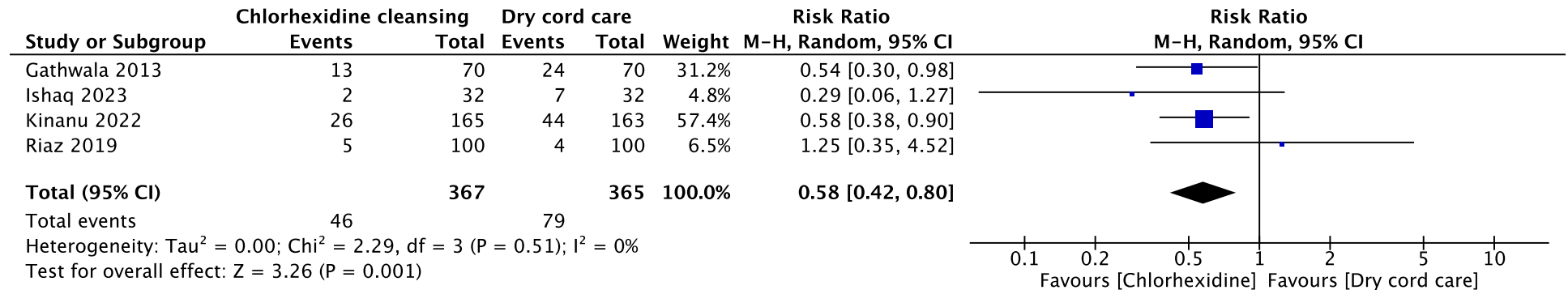
### 4.1.2. Chlorhexidine Cleansing

**Comparison:** Chlorhexidine umbilical cord cleansing versus dry cord care

**Outcome:** Neonatal mortality

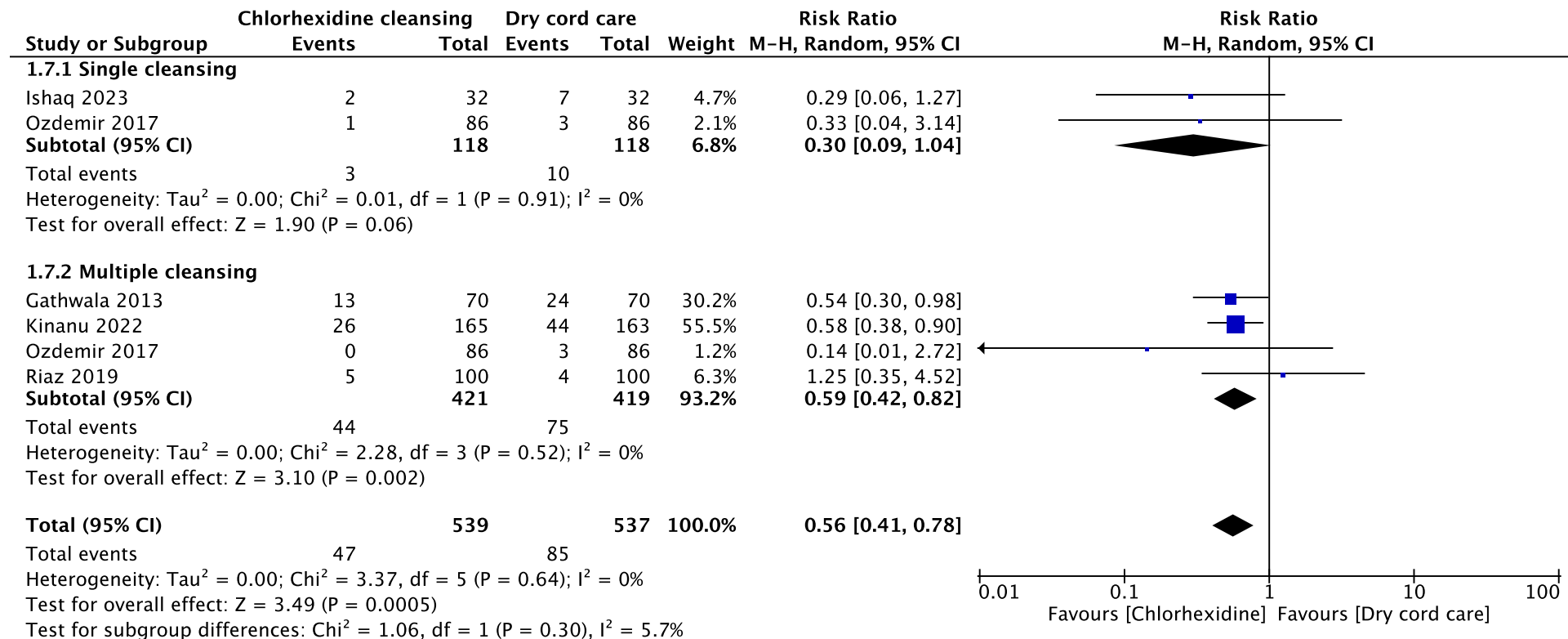


**Outcome:** Omphalitis



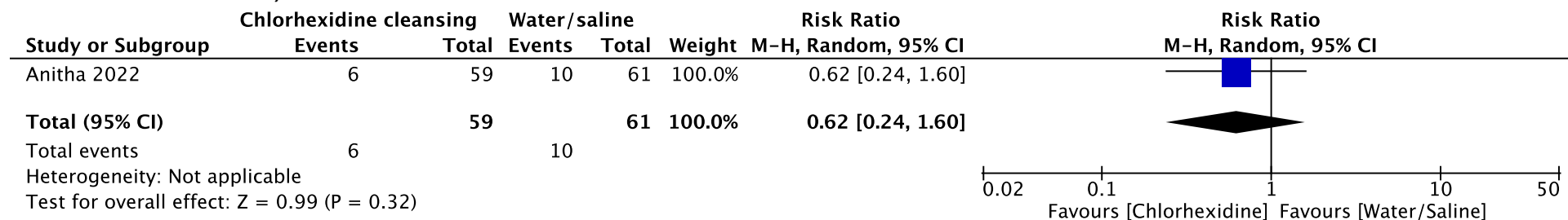
## Prevention and Treatment of Neonatal Infections in LMICs

### Outcome: Omphalitis by cleansing frequency



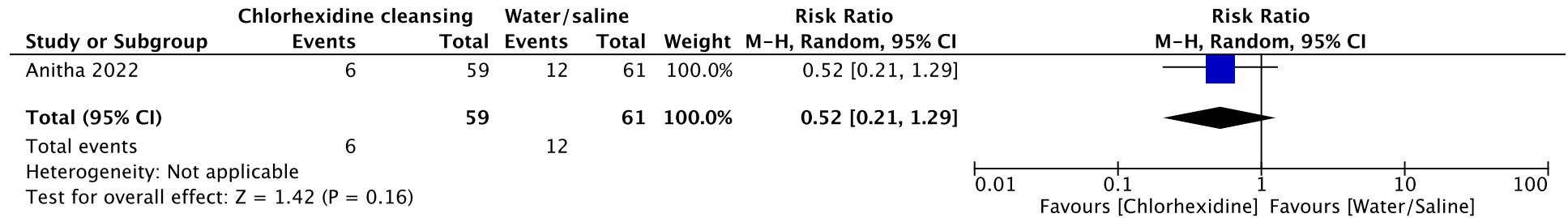
### Comparison: Chlorhexidine for whole-body cleansing versus water/saline

#### Outcome: Neonatal mortality



## Prevention and Treatment of Neonatal Infections in LMICs

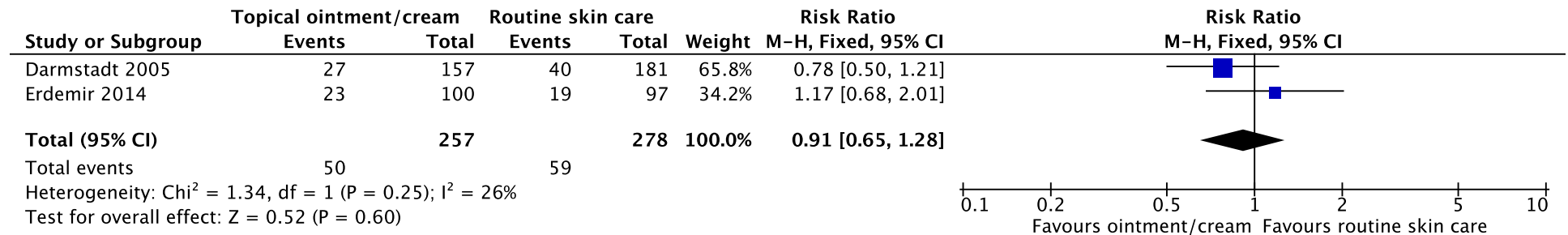
### Outcome: Bloodstream infection/sepsis



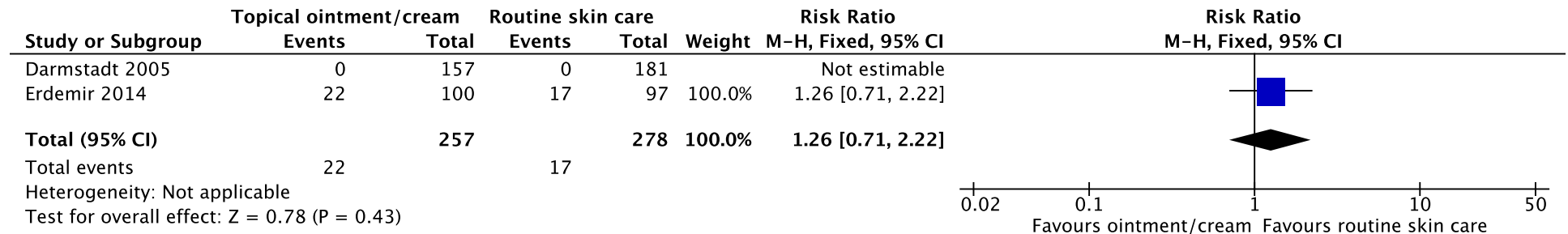
### 4.1.3. Topical Emollients

#### Comparison: Topical ointment/cream versus routine skin care in preterm neonates

#### Outcome: Invasive infection (any organism)

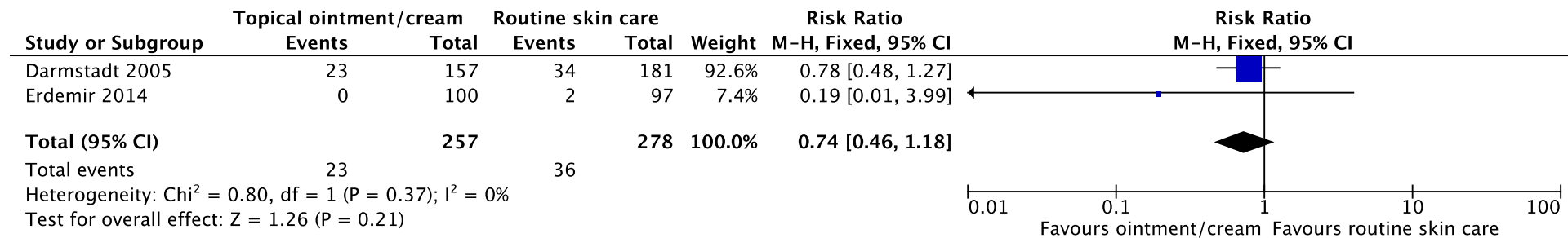


#### Outcome: Invasive infection (coagulase negative staphylococci)

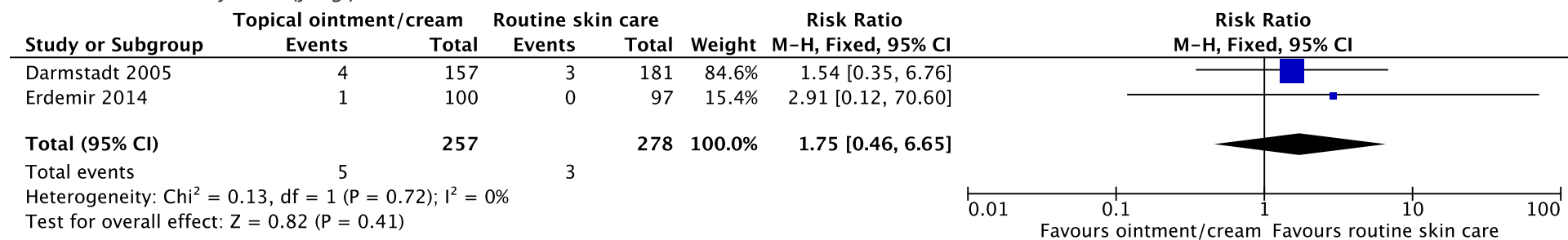


## Prevention and Treatment of Neonatal Infections in LMICs

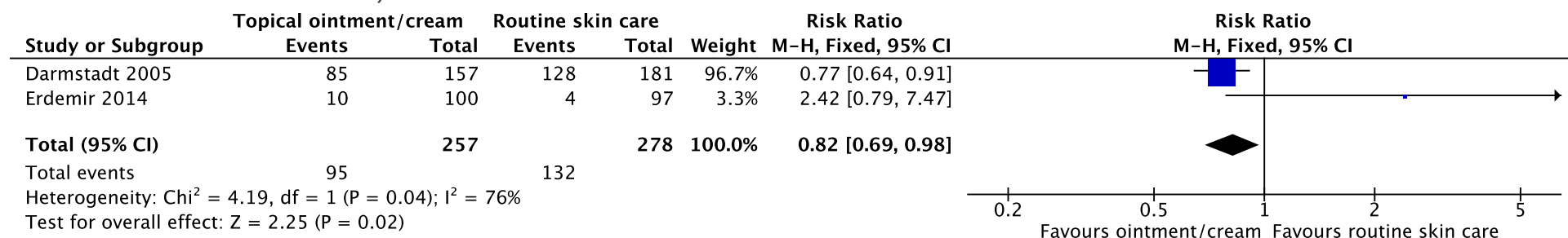
### Outcome: Invasive infection (other bacteria)



### Outcome: Invasive infection (fungi)

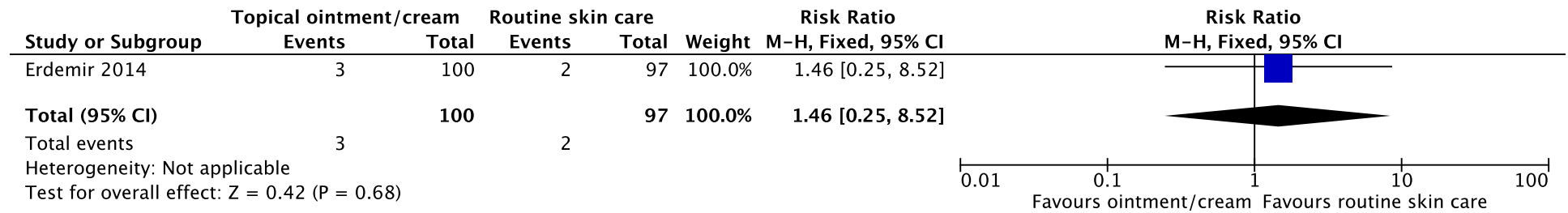


### Outcome: All-cause neonatal mortality



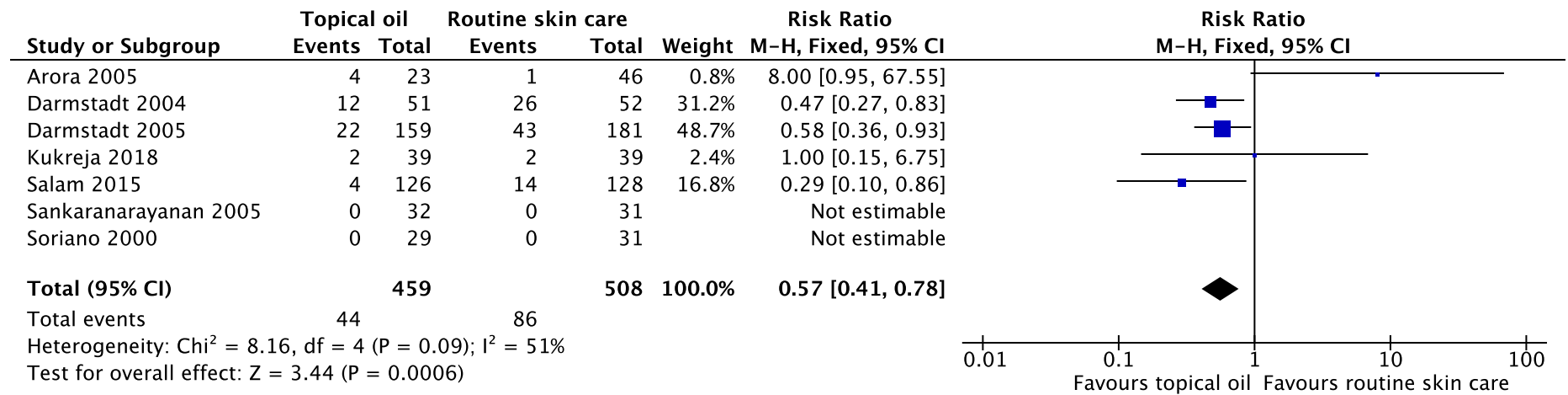
## Prevention and Treatment of Neonatal Infections in LMICs

### Outcome: Necrotizing enterocolitis



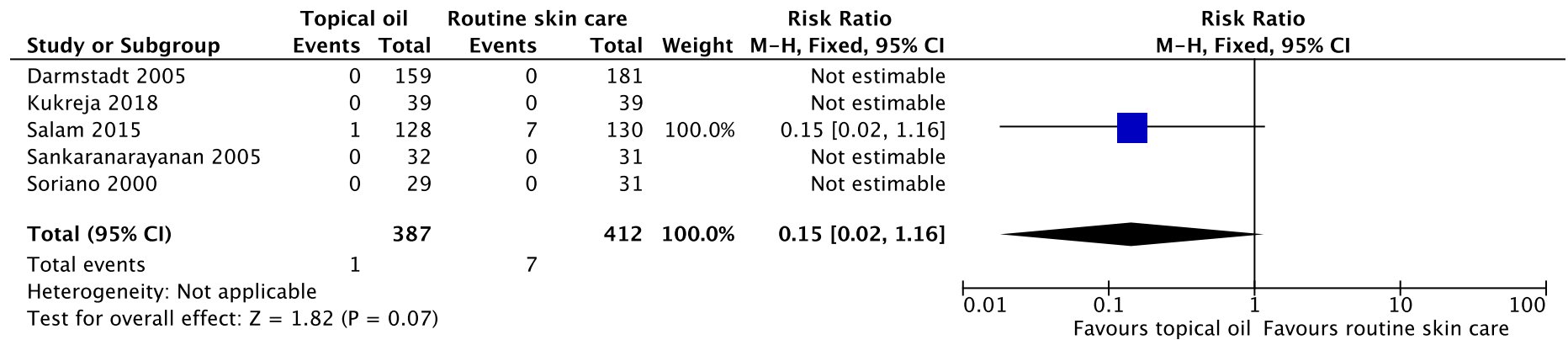
### Comparison: Topical oil versus routine skin care in preterm neonates

#### Outcome: Invasive infection (any organism)

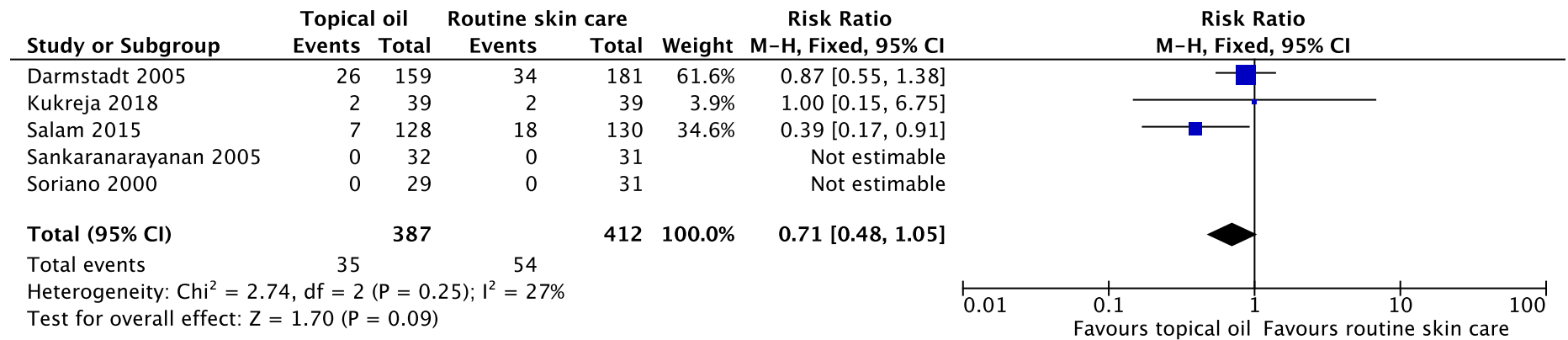


# Prevention and Treatment of Neonatal Infections in LMICs

**Outcome:** Invasive infection (*coagulase negative staphylococci*)



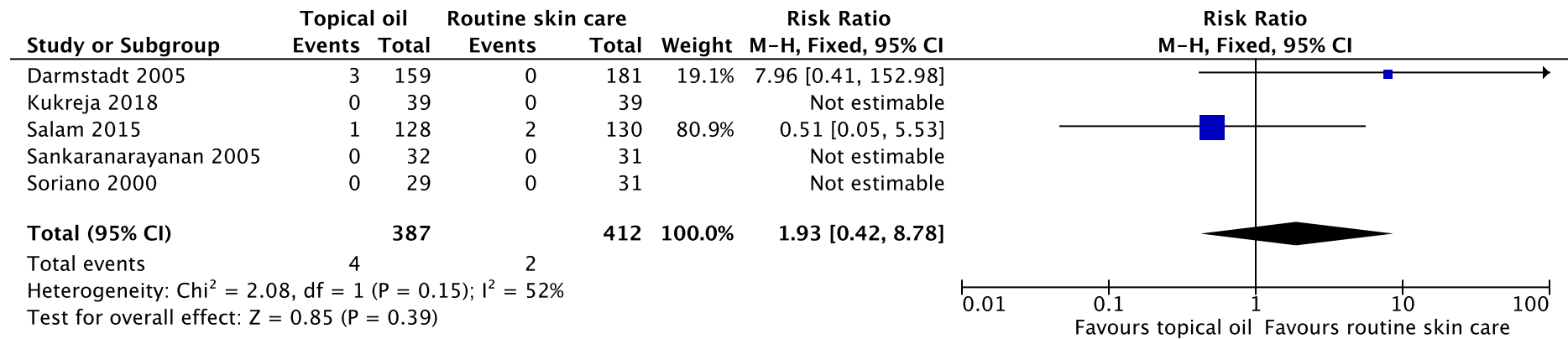
**Outcome:** Invasive infection (*other bacteria*)



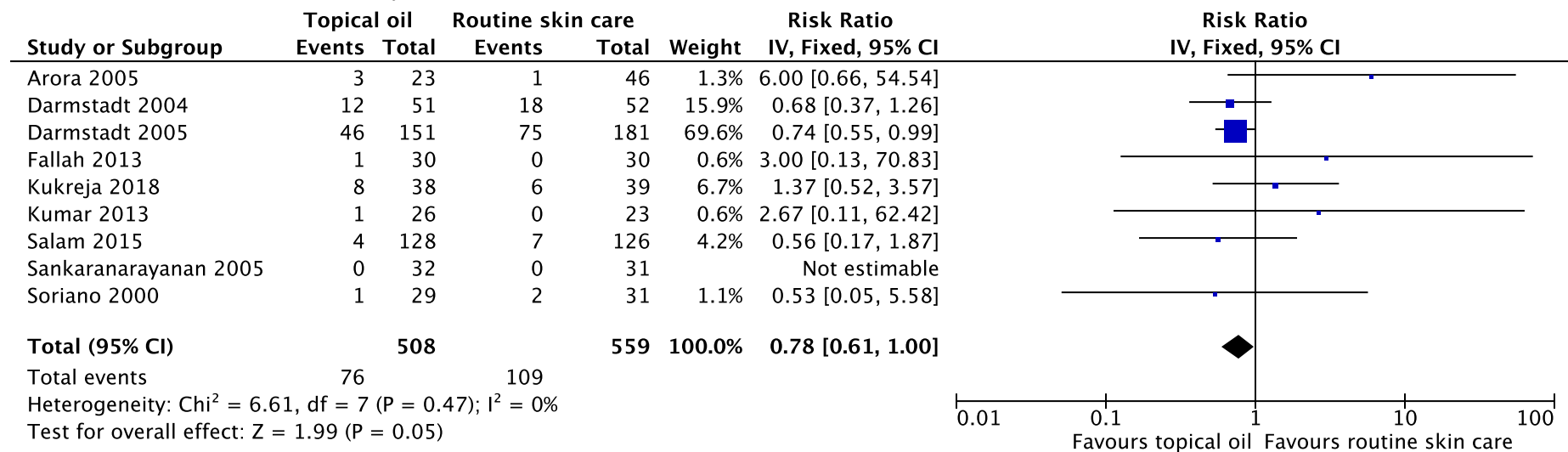


# Prevention and Treatment of Neonatal Infections in LMICs

## Outcome: Invasive infection (fungi)



## Outcome: All-cause neonatal mortality



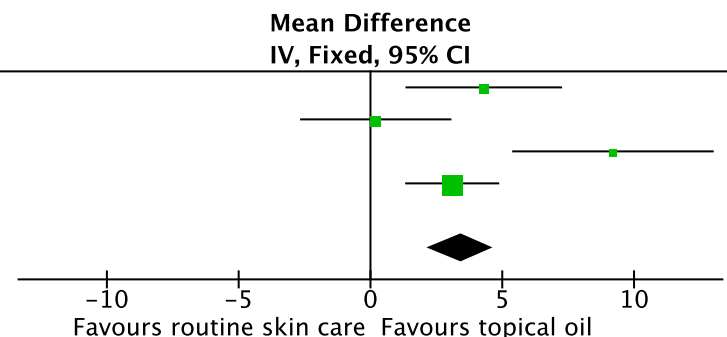
## Prevention and Treatment of Neonatal Infections in LMICs

### Outcome: Rate of weight gain (g/kg/day)

Study or Subgroup	Topical oil			Routine skin care			Weight	Mean Difference IV, Fixed, 95% CI
	Mean	SD	Total	Mean	SD	Total		
Fallah 2013	10.9	5.6	28	6.6	5.5	27	18.2%	4.30 [1.37, 7.23]
Farhat 2010	8	5.6	30	7.8	5.5	29	19.5%	0.20 [-2.63, 3.03]
Jabraeille 2016	16	7.7	42	6.8	10.1	44	10.9%	9.20 [5.41, 12.99]
Soriano 2000	18	3.3	29	14.9	3.6	31	51.4%	3.10 [1.35, 4.85]
<b>Total (95% CI)</b>			<b>129</b>			<b>131</b>	<b>100.0%</b>	<b>3.42 [2.17, 4.67]</b>

Heterogeneity:  $\chi^2 = 14.40$ ,  $df = 3$  ( $P = 0.002$ );  $I^2 = 79\%$

Test for overall effect:  $Z = 5.36$  ( $P < 0.00001$ )

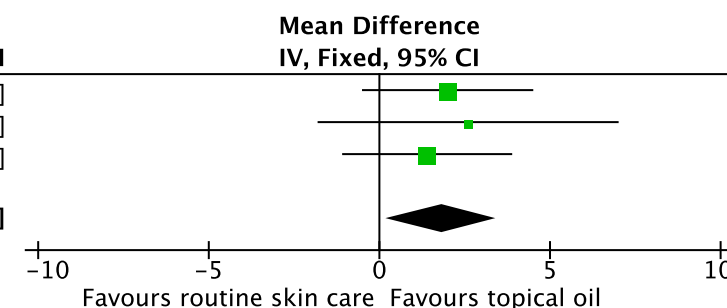


### Outcome: Change in crown-heel length (mm/week)

Study or Subgroup	Topical oil			Routine skin care			Weight	Mean Difference IV, Fixed, 95% CI	
	Mean	SD	Total	Mean	SD	Total			
Fallah 2013	8	2.5	28	6	6.1	27	42.8%	2.00 [-0.48, 4.48]	
Jabraeille 2016	10.3	10.1	33	7.7	8.4	37	13.7%	2.60 [-1.78, 6.98]	
Soriano 2000	8.4	2.5	29	7	6.5	31	43.5%	1.40 [-1.06, 3.86]	
Total (95% CI)			90				95	100.0%	1.82 [0.20, 3.44]

Heterogeneity:  $\chi^2 = 0.25$ ,  $df = 2$  ( $P = 0.88$ );  $I^2 = 0\%$

Test for overall effect:  $Z = 2.20$  ( $P = 0.03$ )

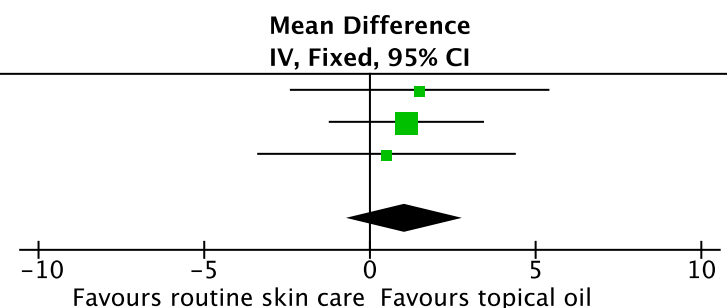


### Outcome: Change in circumference (mm/week)

Study or Subgroup	Topical oil			Routine skin care			Weight	Mean Difference IV, Fixed, 95% CI
	Mean	SD	Total	Mean	SD	Total		
Fallah 2013	5.5	7.4	28	4	7.3	27	20.7%	1.50 [-2.39, 5.39]
Jabraeille 2016	5.7	5.2	33	4.6	4.6	37	58.5%	1.10 [-1.21, 3.41]
Soriano 2000	7.7	7.5	29	7.2	7.8	31	20.8%	0.50 [-3.37, 4.37]
Total (95% CI)			90	95			100.0%	1.06 [-0.71, 2.83]

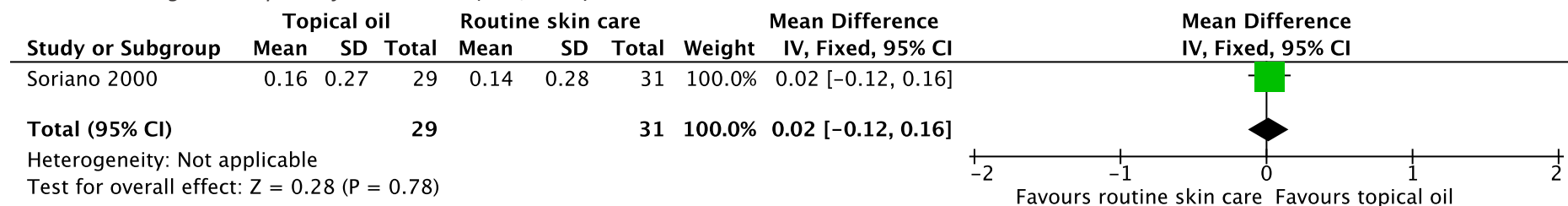
Heterogeneity:  $\chi^2 = 0.13$ ,  $df = 2$  ( $P = 0.94$ );  $I^2 = 0\%$

Test for overall effect:  $Z = 1.17$  ( $P = 0.24$ )



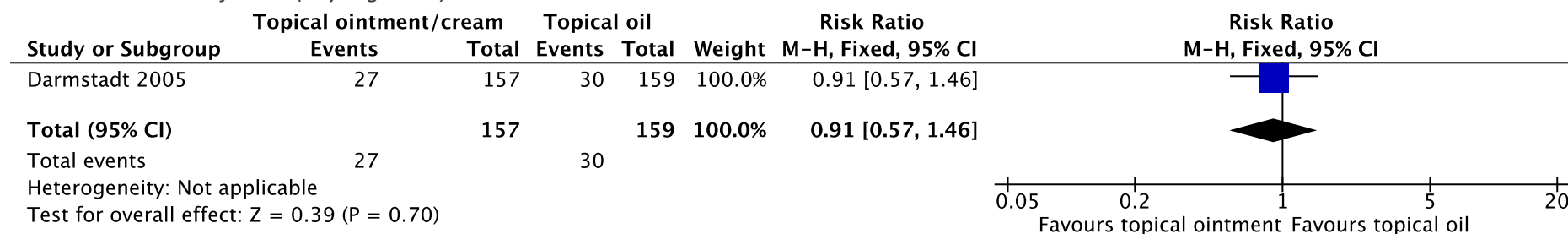
# Prevention and Treatment of Neonatal Infections in LMICs

## Outcome: Change in triceps skinfold thickness (mm/week)

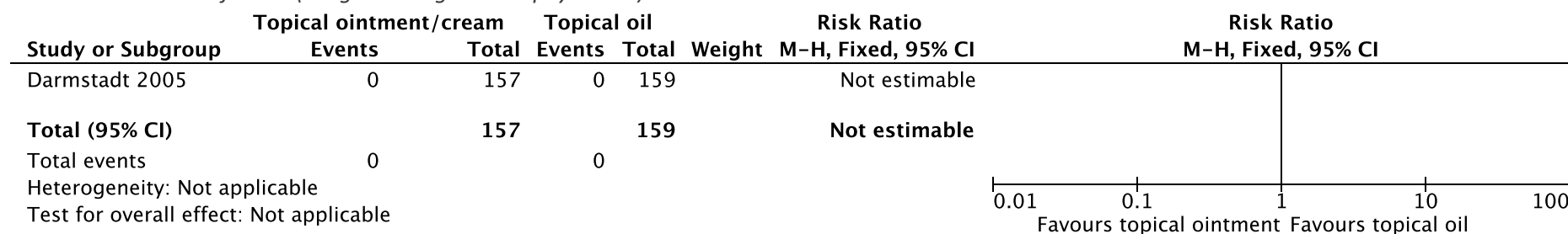


## Comparison: Topical ointment/cream versus topical oil in preterm neonates

### Outcome: Invasive infection (any organism)

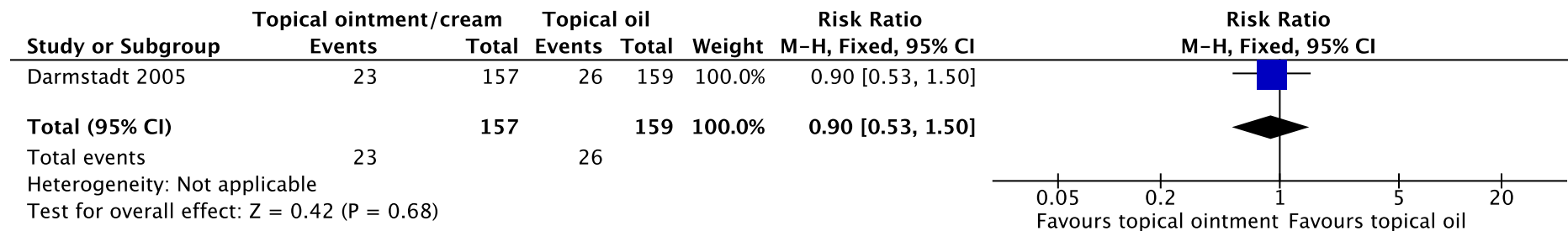


### Outcome: Invasive infection (coagulase negative staphylococci)

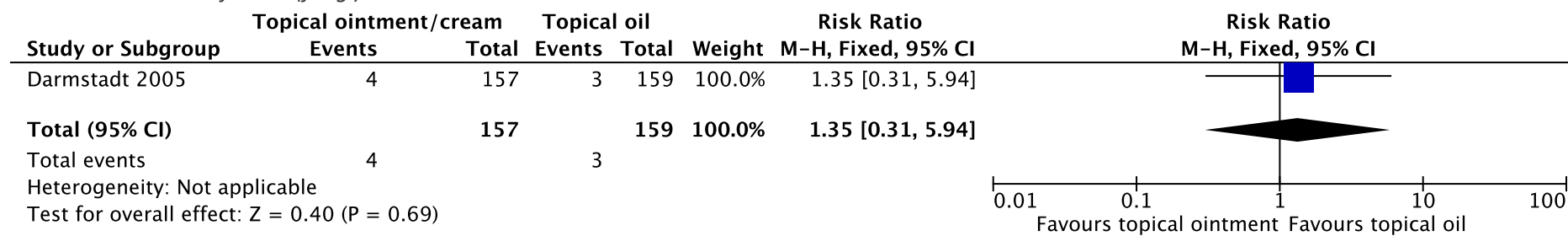


# Prevention and Treatment of Neonatal Infections in LMICs

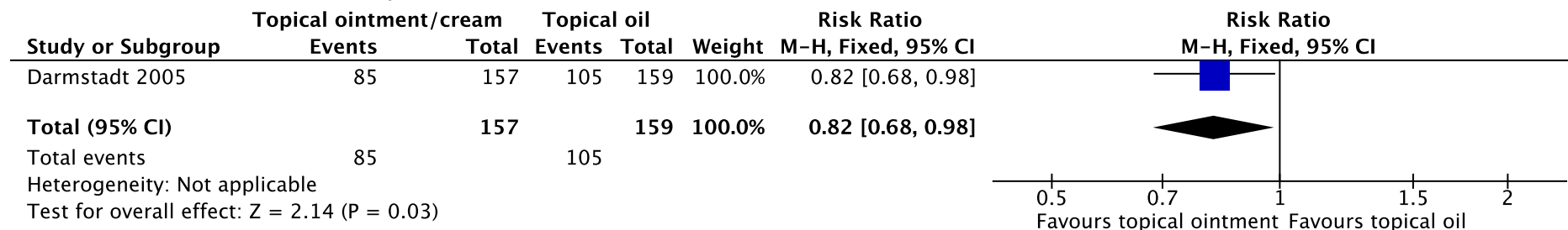
## Outcome: Invasive infection (other bacteria)



## Outcome: Invasive infection (fungi)



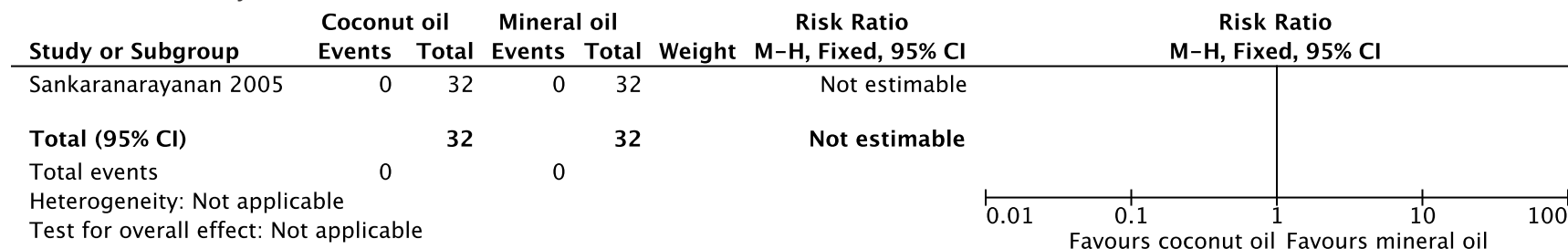
## Outcome: All-cause neonatal mortality



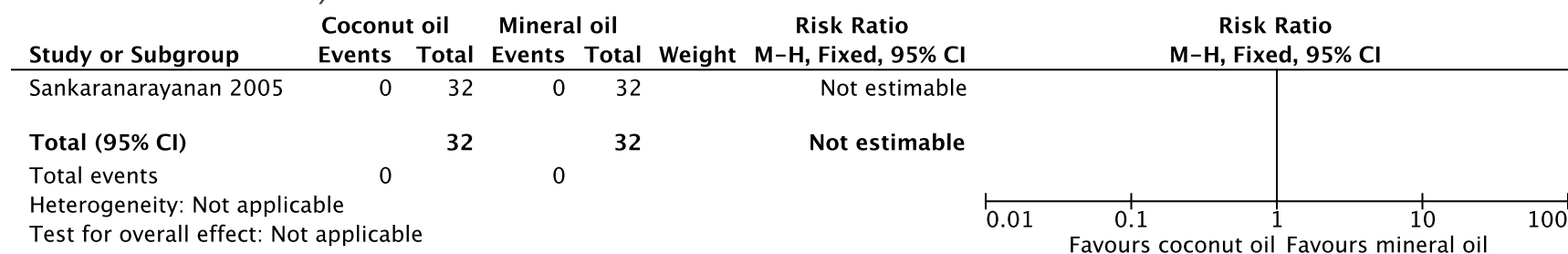
# *Prevention and Treatment of Neonatal Infections in LMICs*

**Comparison:** One topical oil (or combination) versus another oil (or combination)

**Outcome:** *Invasive infection*



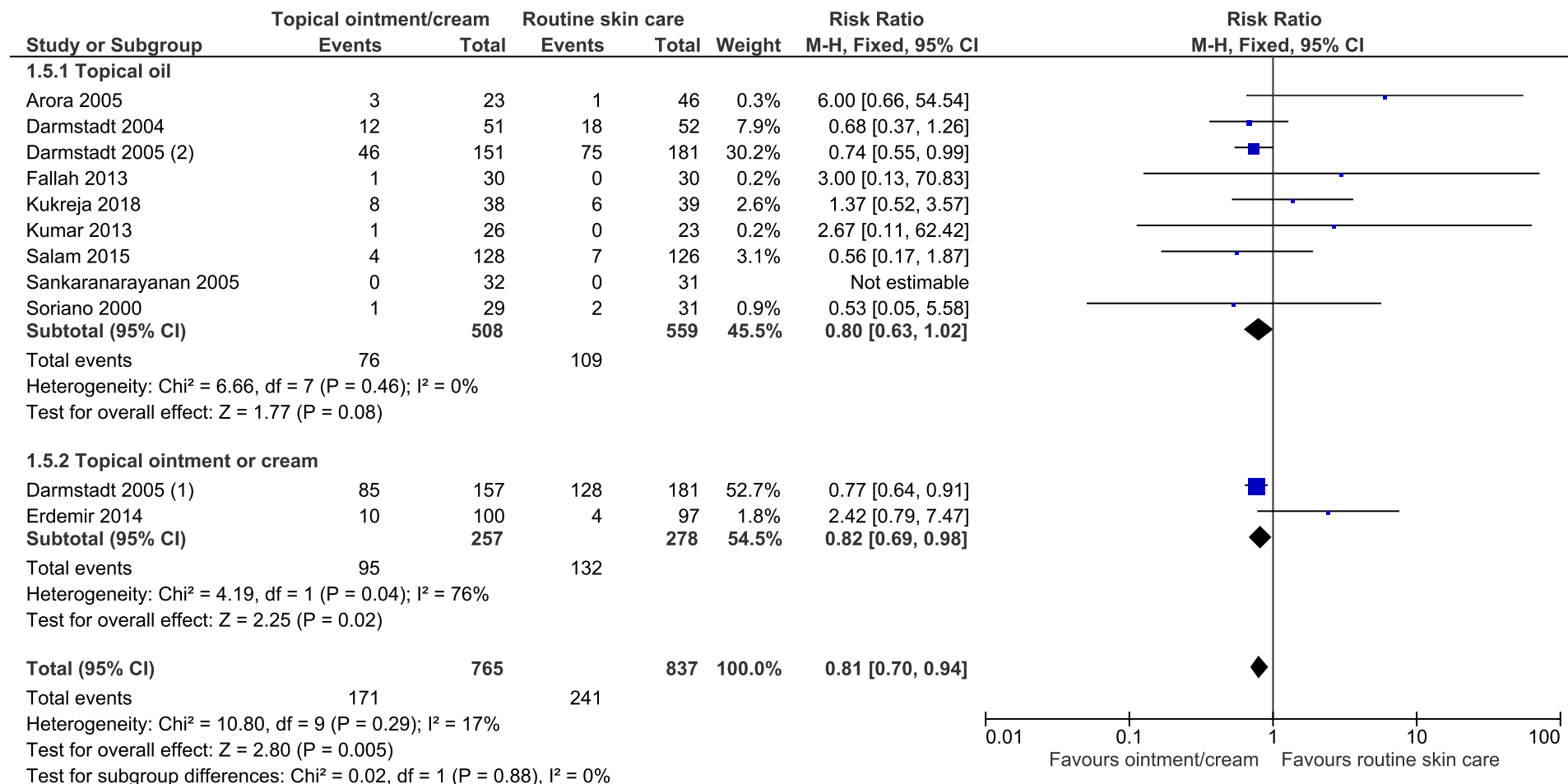
**Outcome:** *All-cause mortality*



# Prevention and Treatment of Neonatal Infections in LMICs

**Comparison:** Combined topical ointment/cream or oil versus routine skin care in preterm newborns

**Outcome:** All-cause neonatal mortality

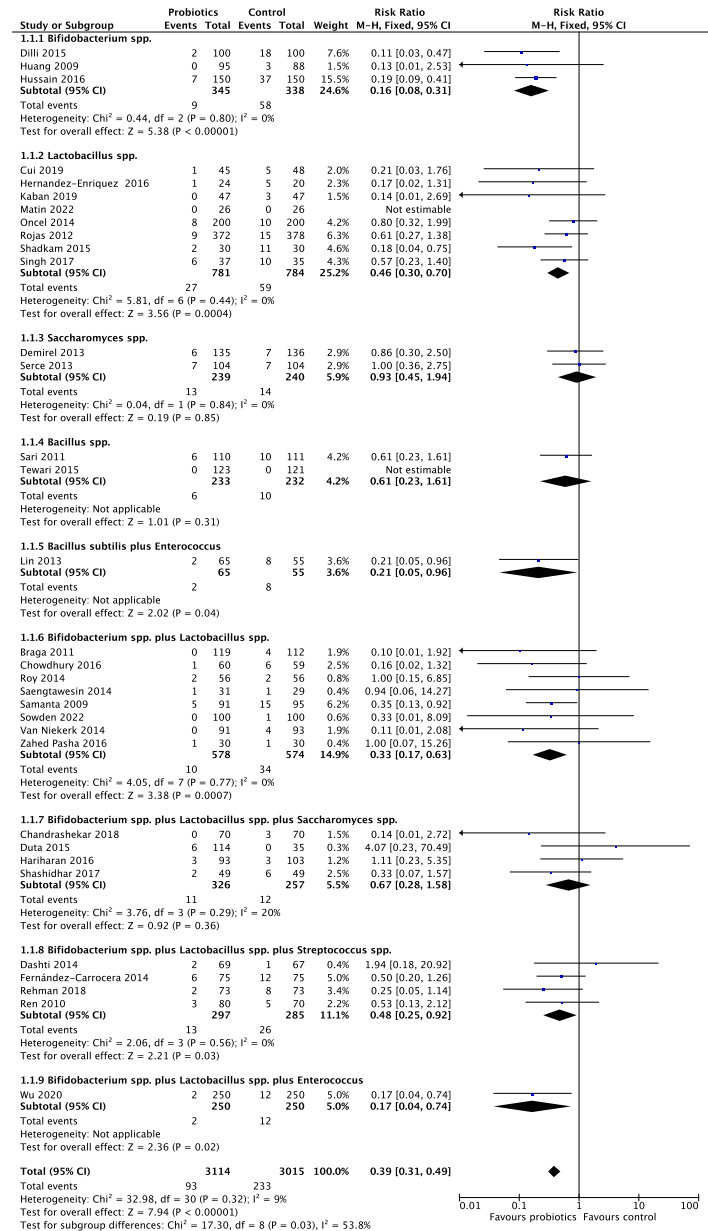


## Prevention and Treatment of Neonatal Infections in LMICs

### 4.1.4. Probiotics Supplementation

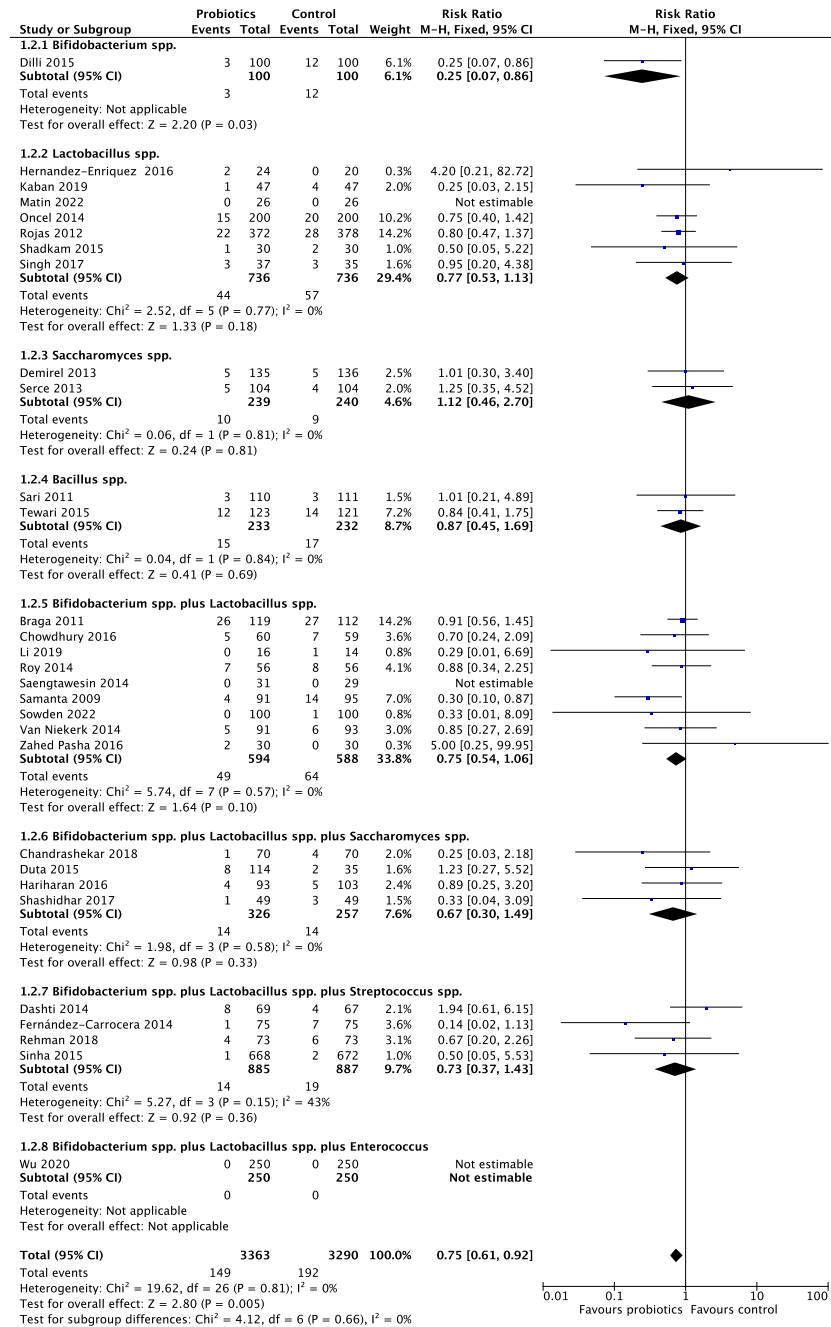
**Comparison:** Probiotics versus control in preterm newborns by probiotic type

**Outcome:** *Necrotizing enterocolitis*



# Prevention and Treatment of Neonatal Infections in LMICs

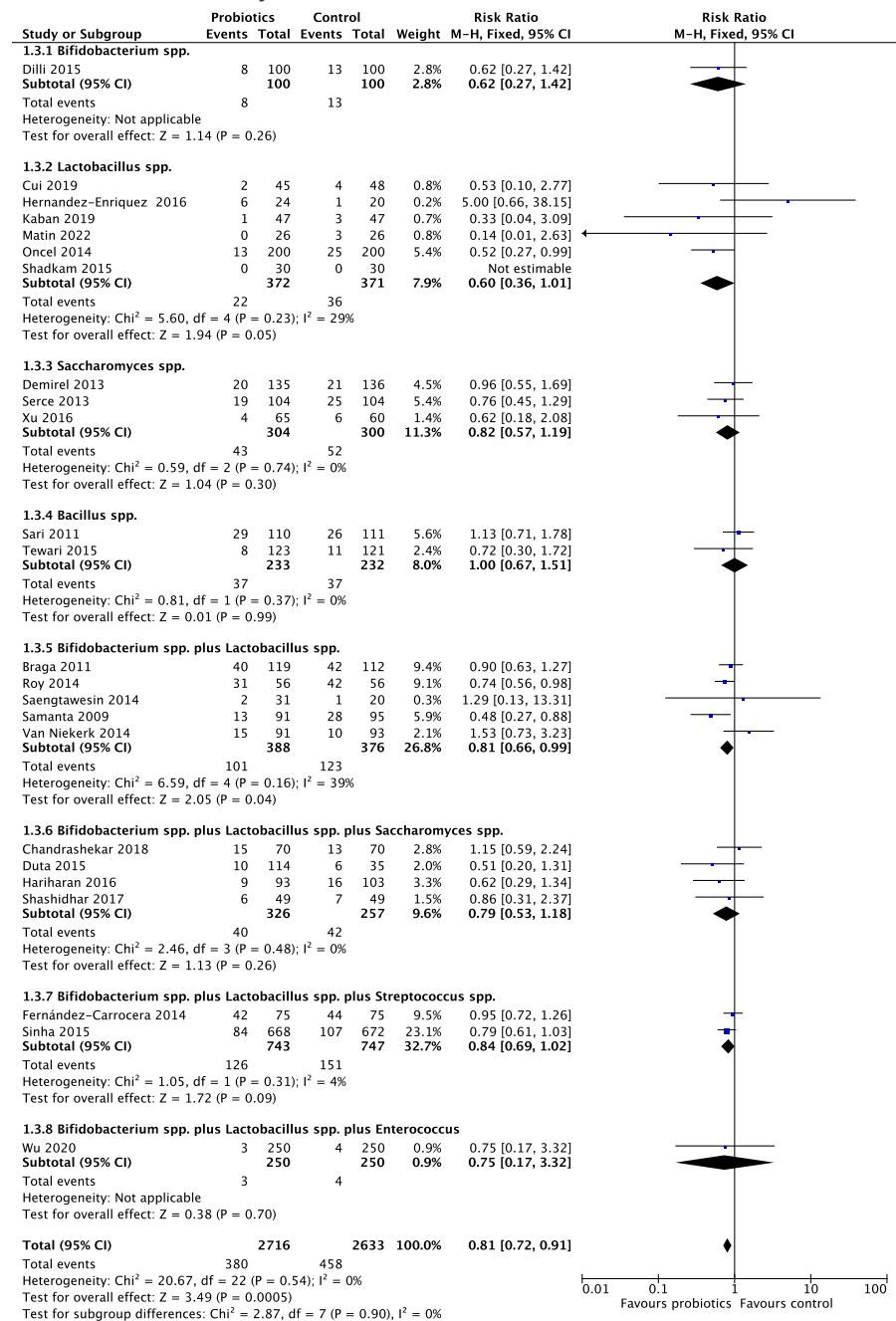
## Outcome: All-cause neonatal mortality





# Prevention and Treatment of Neonatal Infections in LMICs

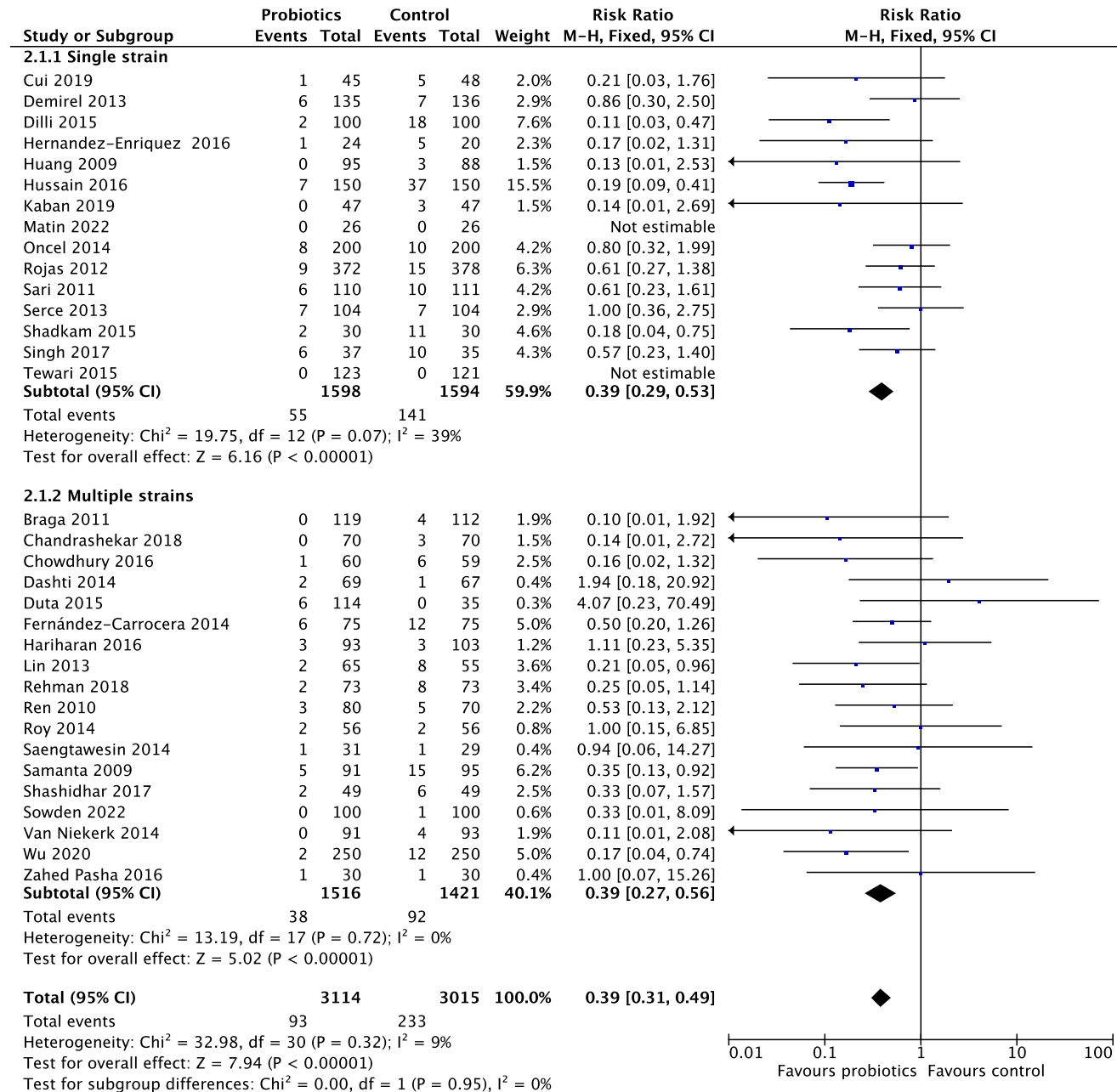
## Outcome: Invasive infection



## Prevention and Treatment of Neonatal Infections in LMICs

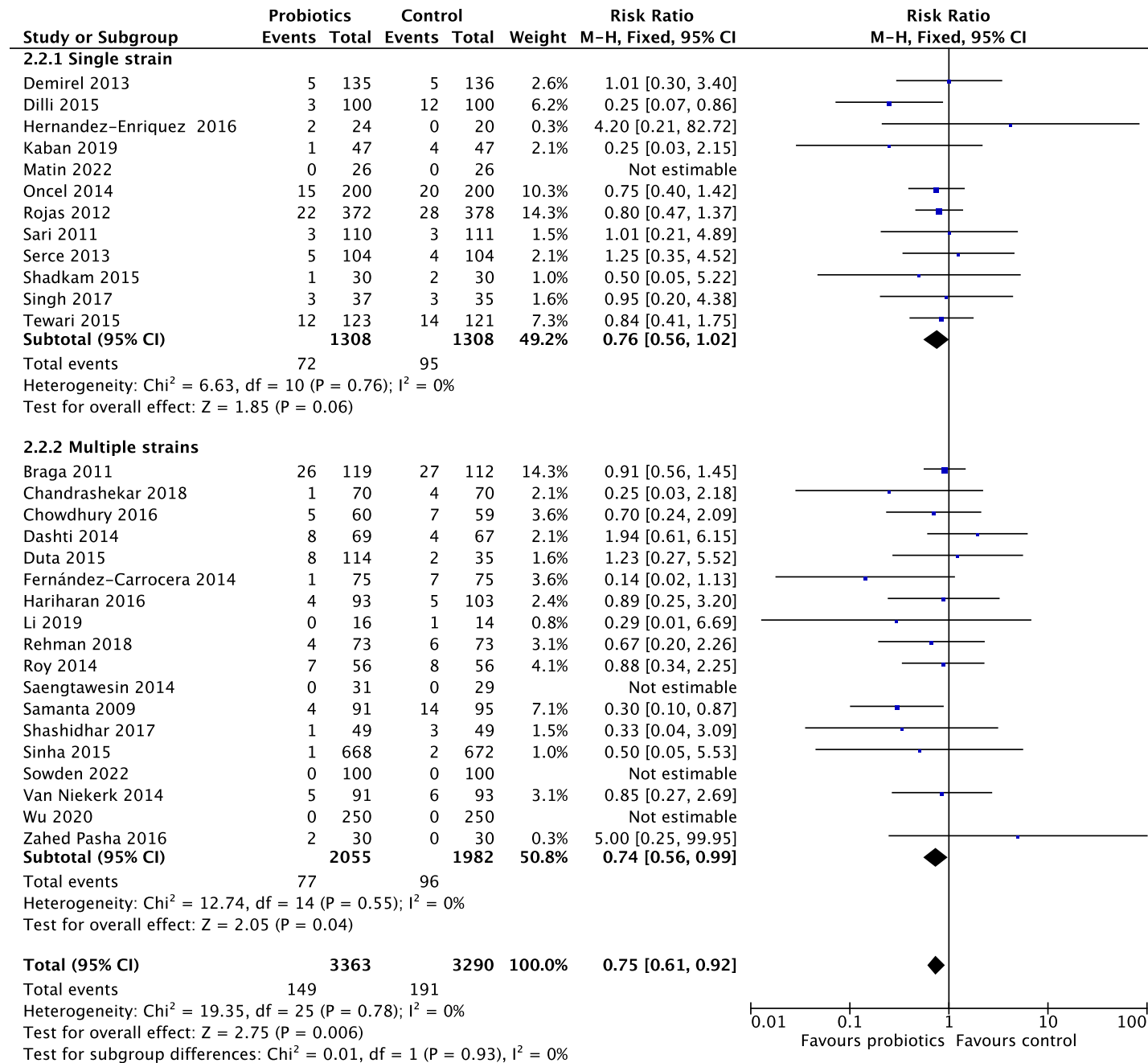
**Comparison:** Probiotics versus control in preterm newborns by probiotic strain type

**Outcome:** Necrotizing enterocolitis



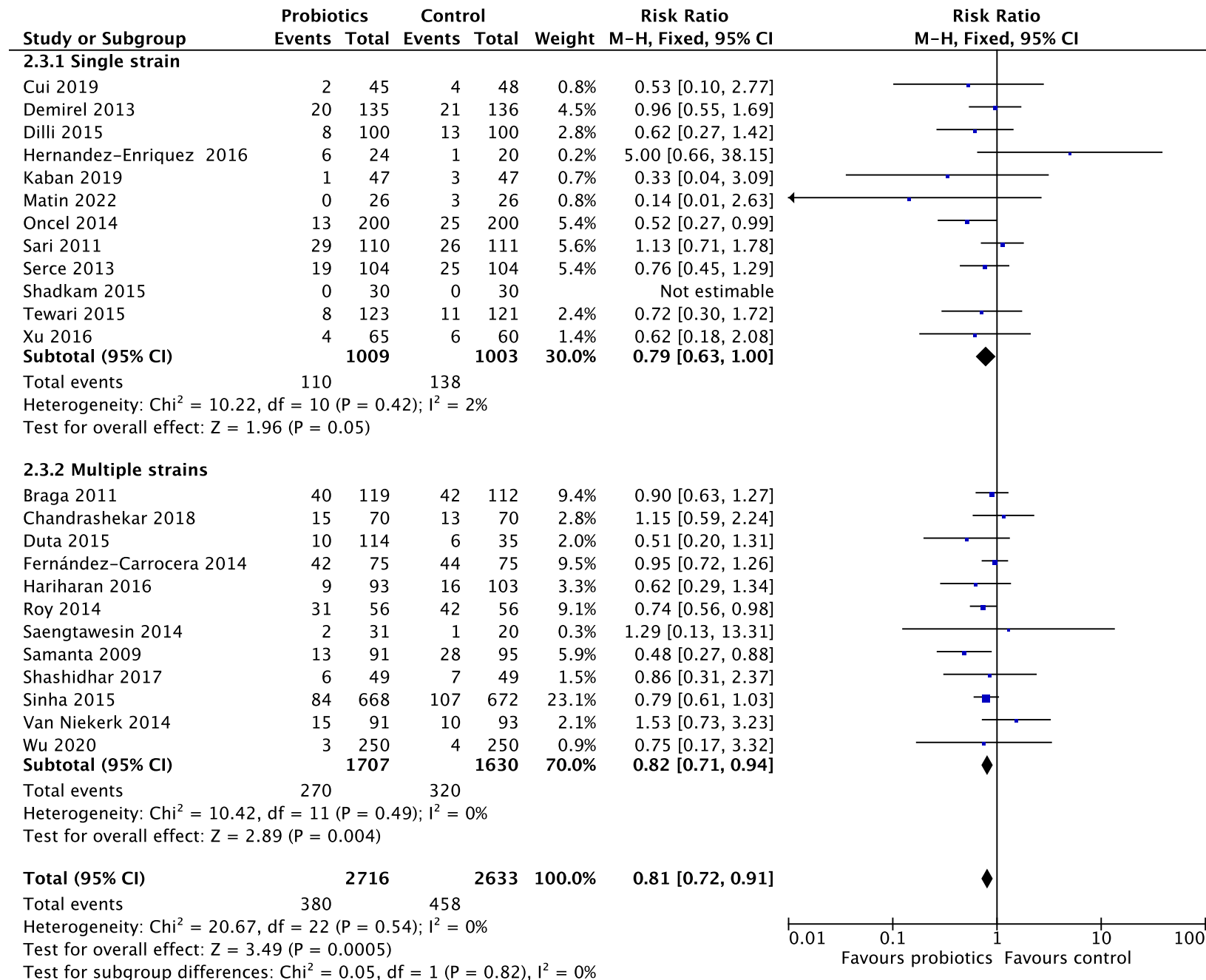
## Prevention and Treatment of Neonatal Infections in LMICs

### Outcome: All-cause neonatal mortality



## Prevention and Treatment of Neonatal Infections in LMICs

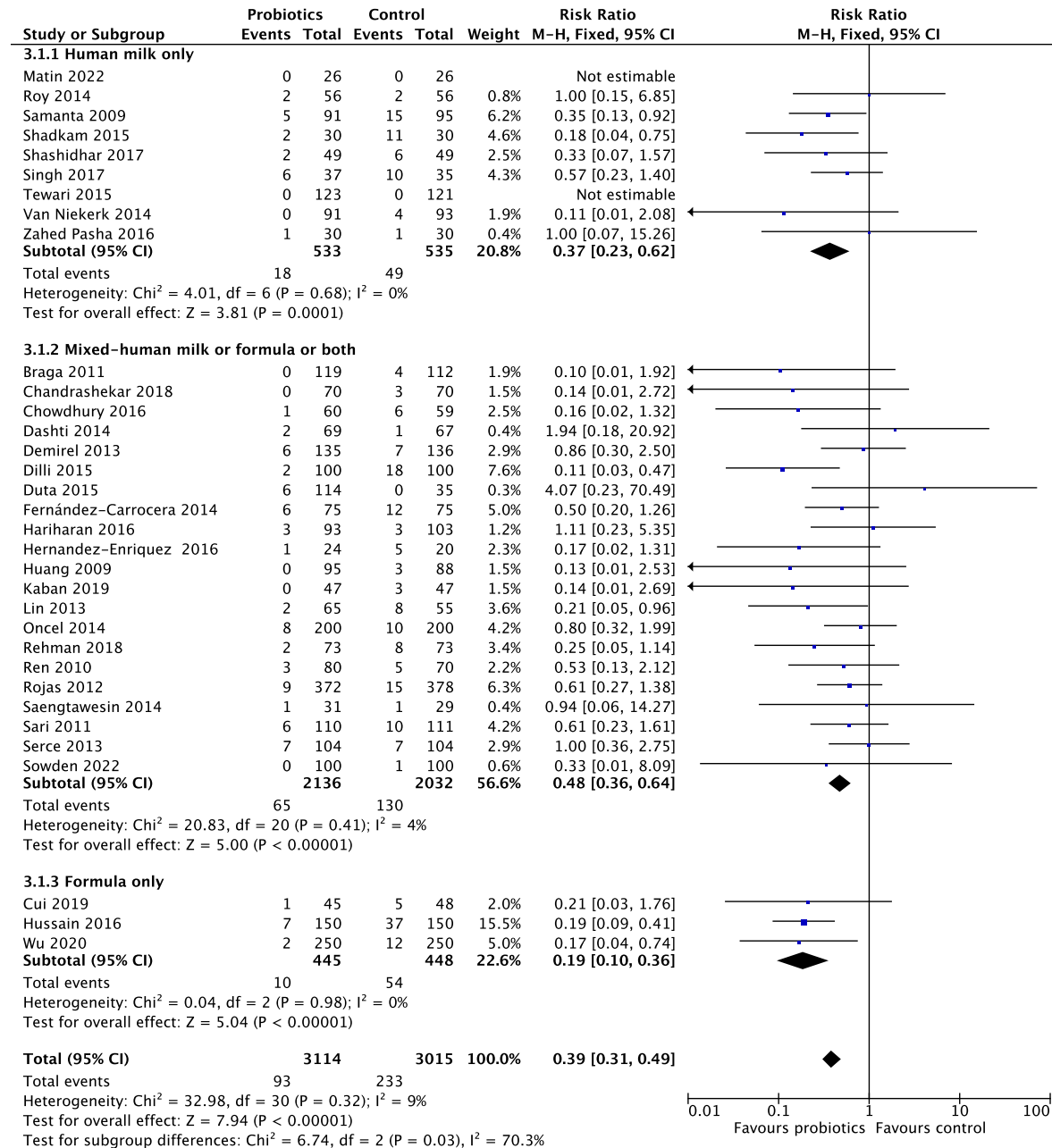
### Outcome: Invasive infection



## Prevention and Treatment of Neonatal Infections in LMICs

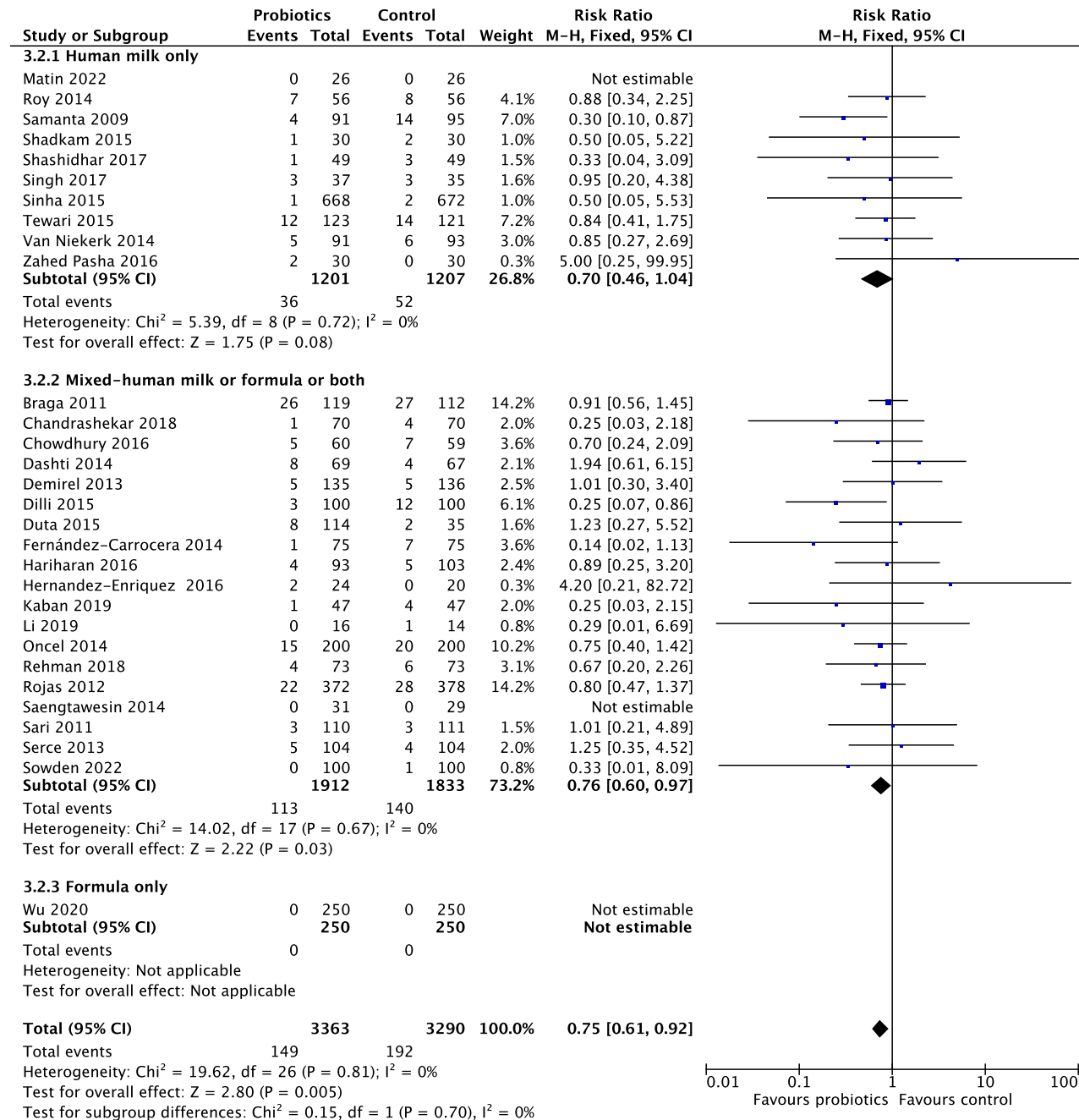
**Comparison:** Probiotics versus control in preterm newborns by feeding type

**Outcome:** Necrotizing enterocolitis



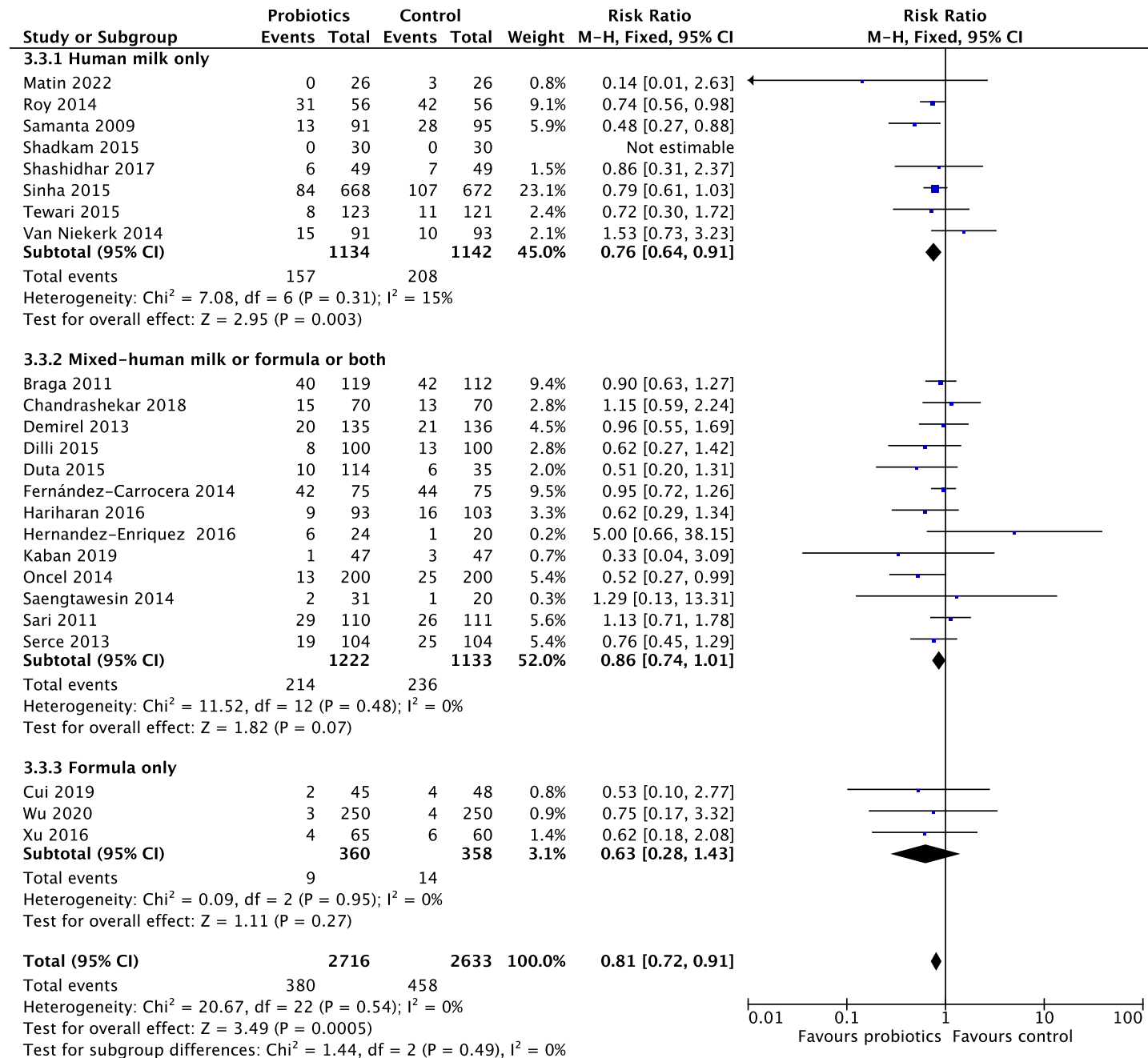
## Prevention and Treatment of Neonatal Infections in LMICs

### Outcome: All-cause neonatal mortality



## Prevention and Treatment of Neonatal Infections in LMICs

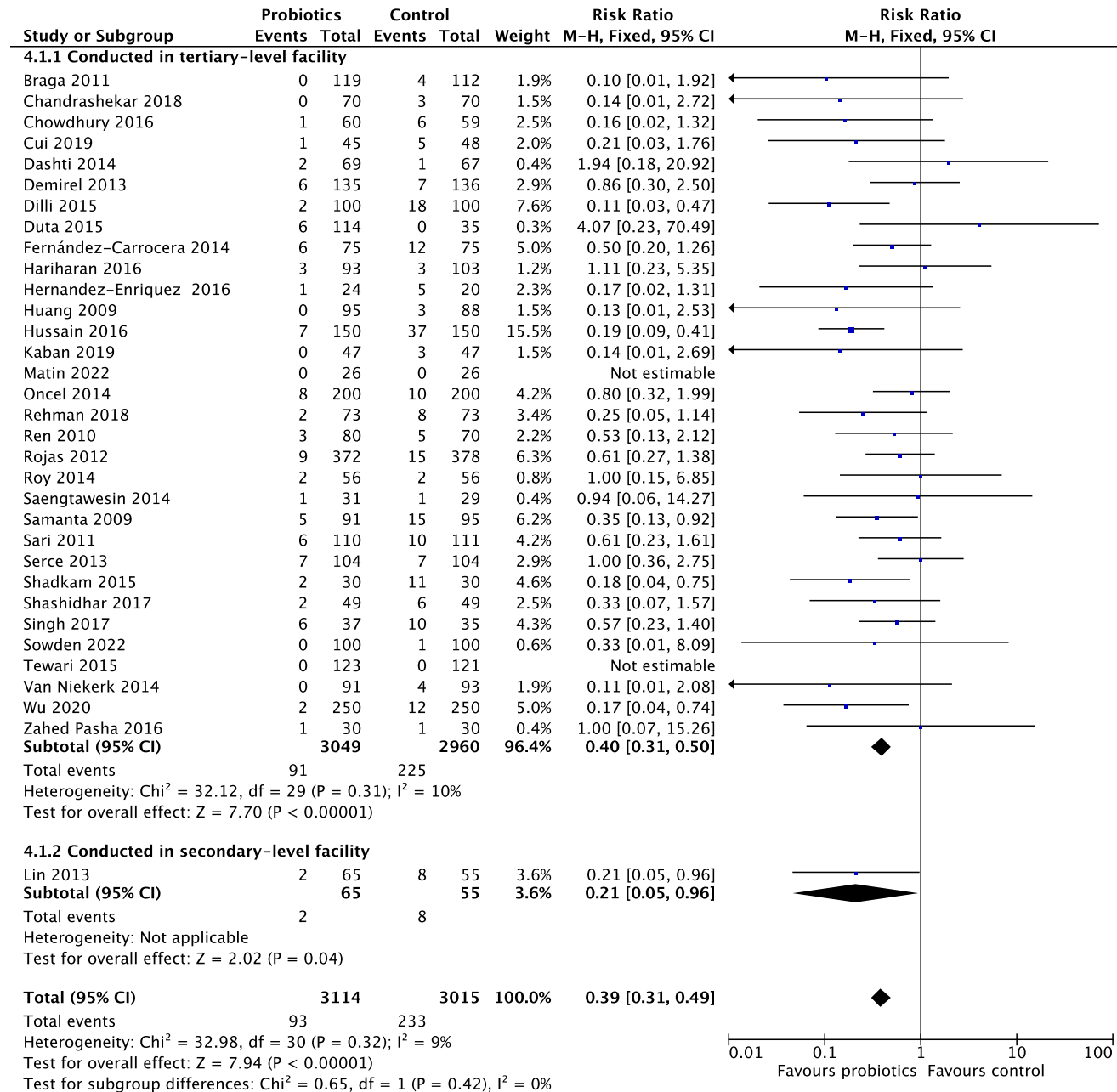
### Outcome: Invasive infection



## Prevention and Treatment of Neonatal Infections in LMICs

**Comparison:** Probiotics versus control in preterm newborns by facility level

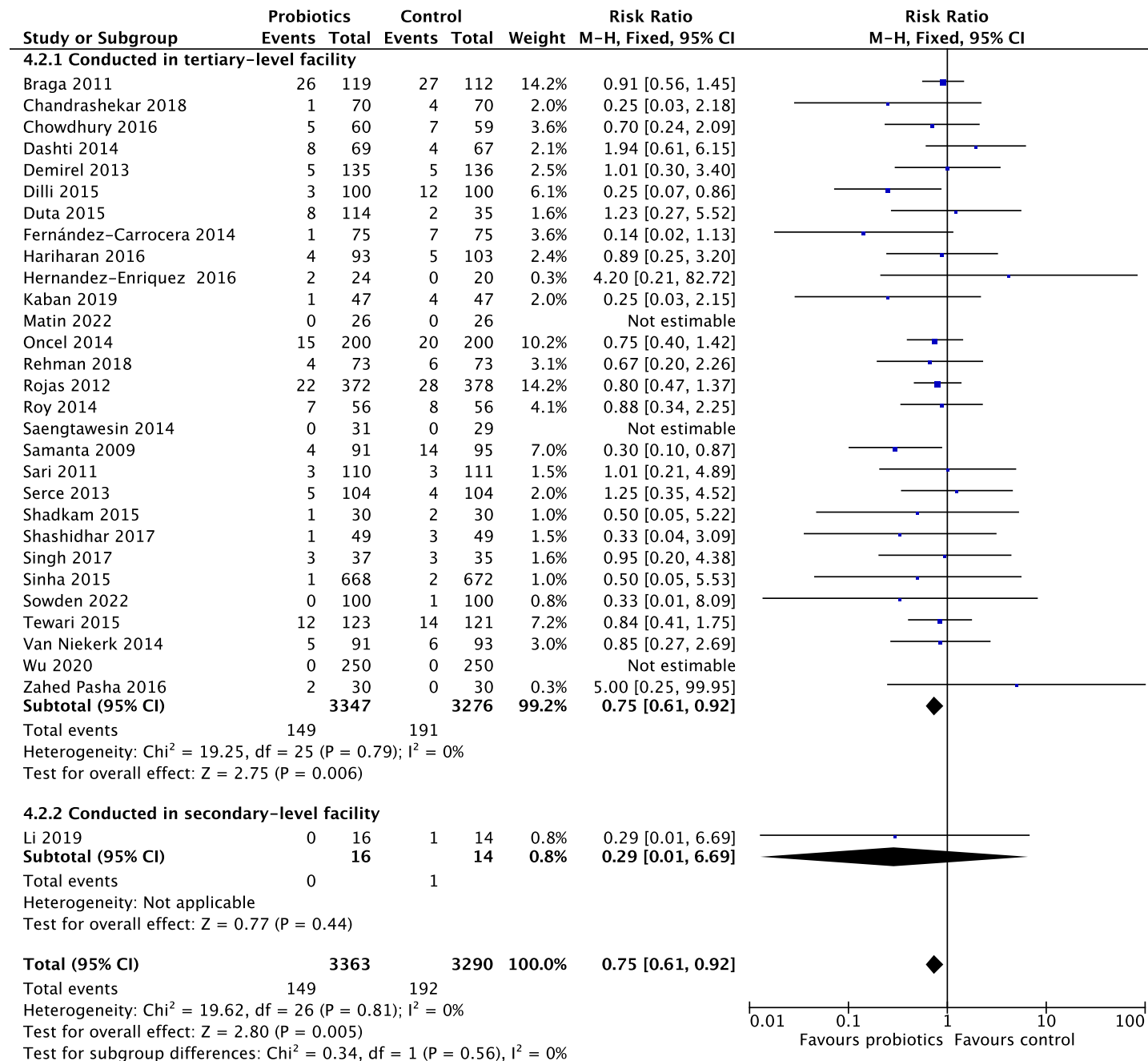
**Outcome:** Necrotizing enterocolitis





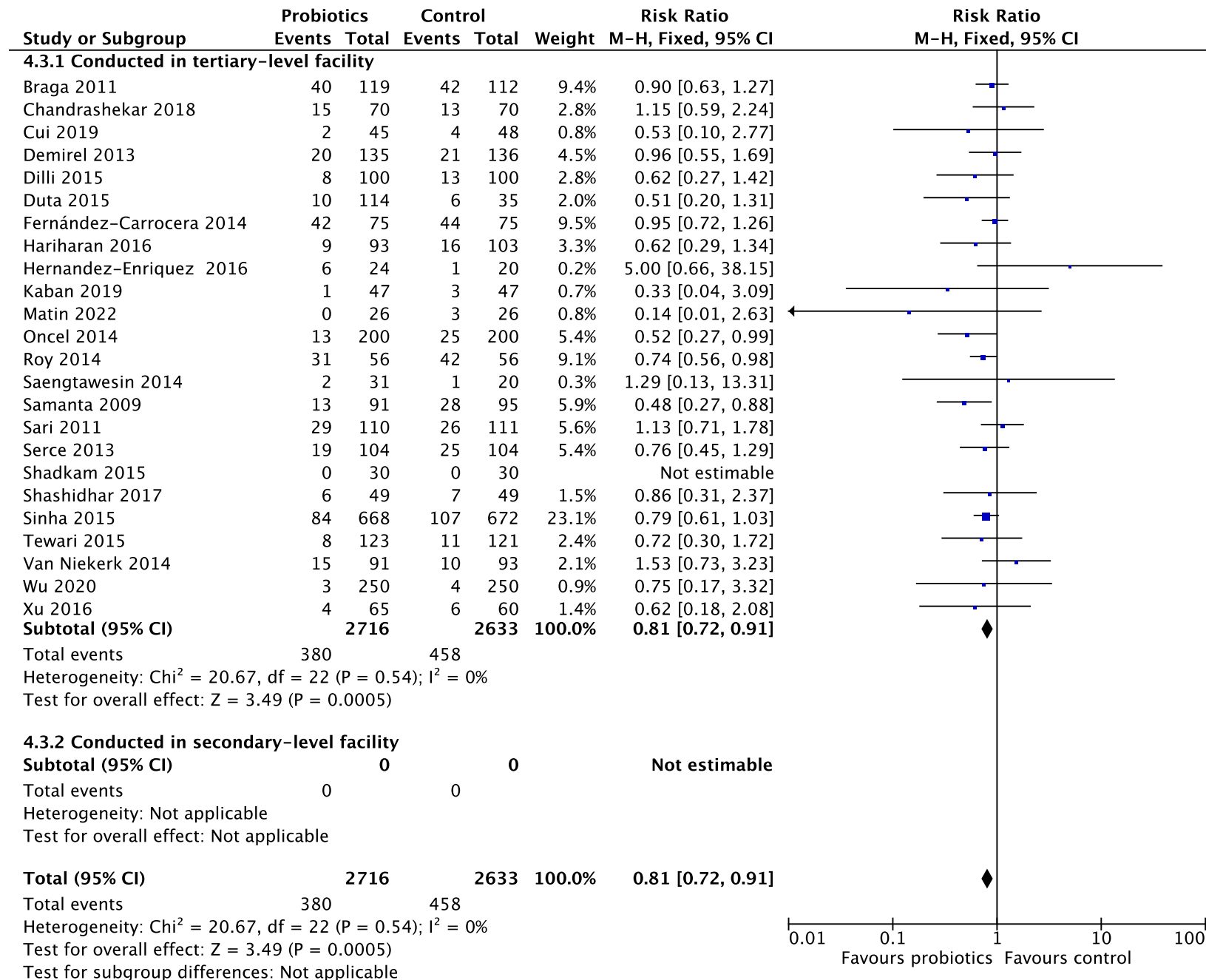
# Prevention and Treatment of Neonatal Infections in LMICs

## Outcome: All-cause neonatal mortality



# Prevention and Treatment of Neonatal Infections in LMICs

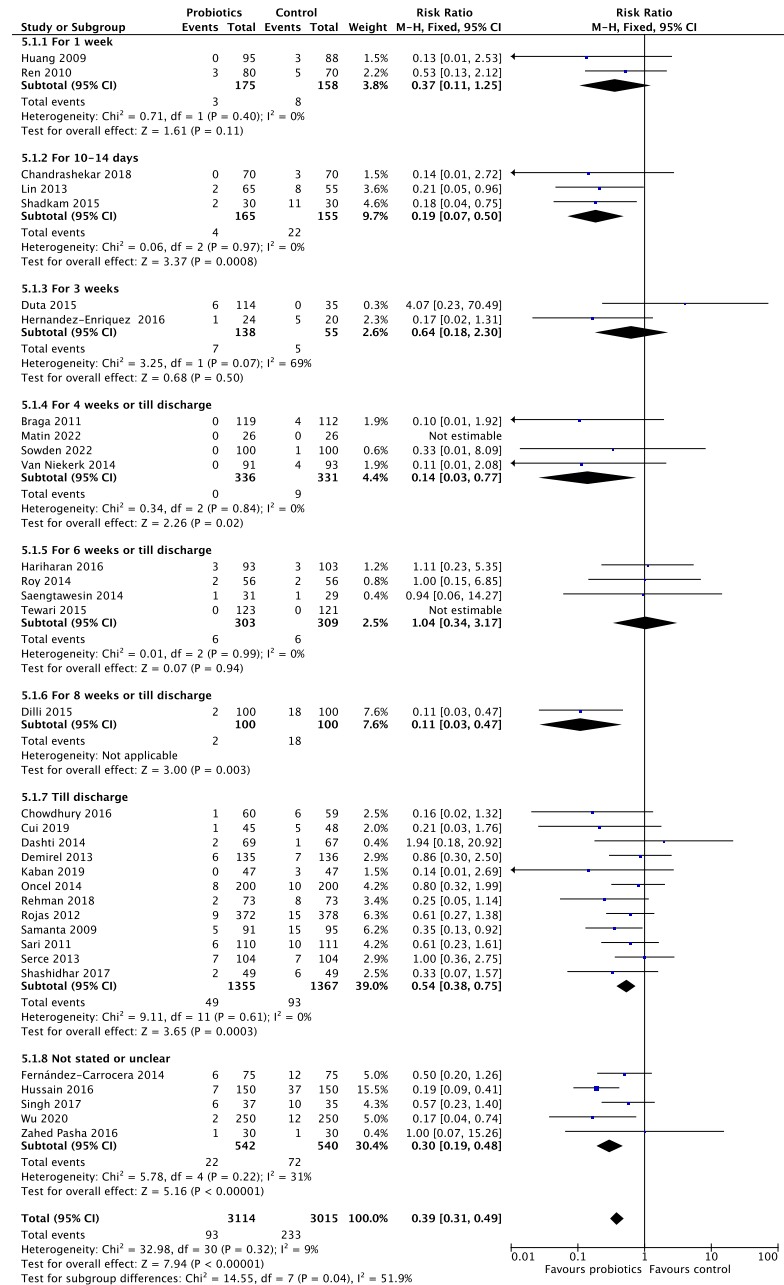
## Outcome: Invasive infection



## Prevention and Treatment of Neonatal Infections in LMICs

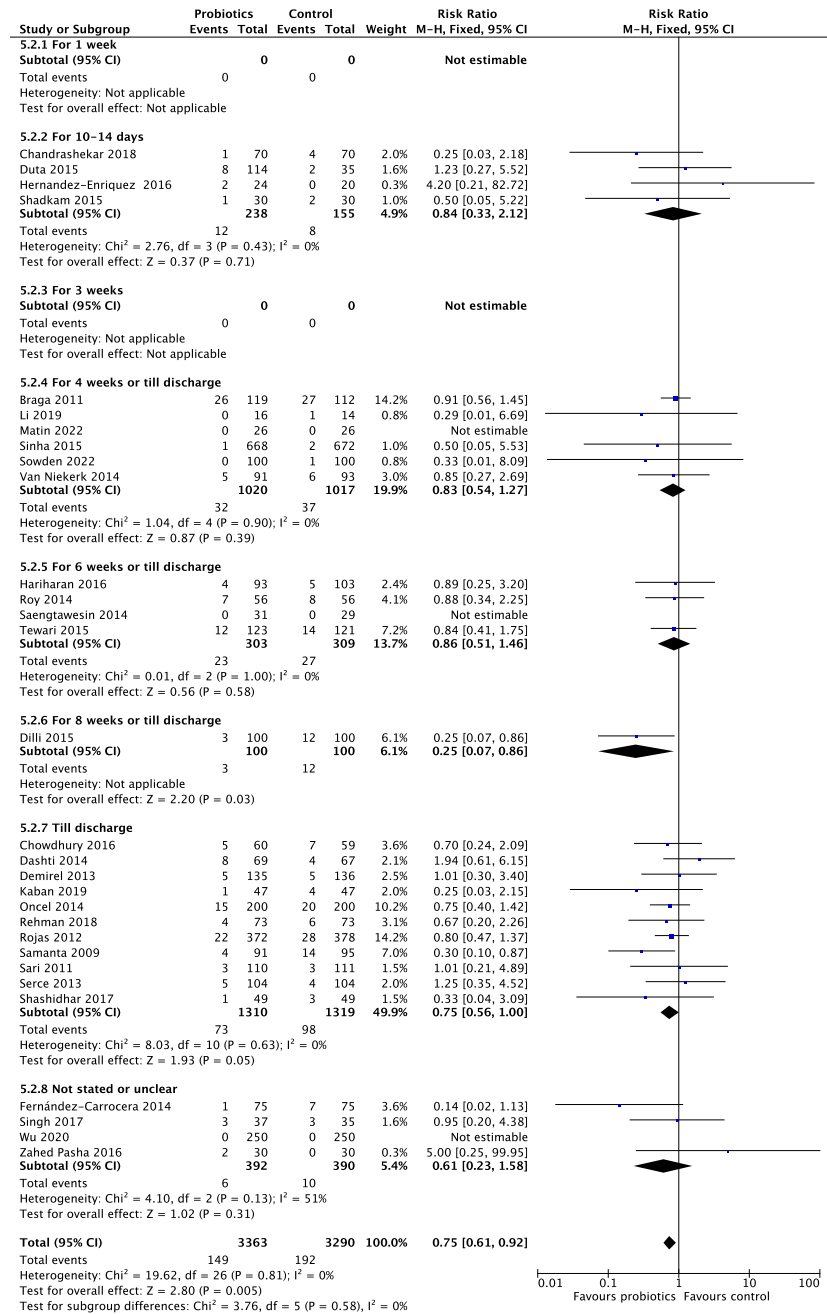
### Comparison: Probiotics versus control in preterm newborns by duration of intervention

#### Outcome: Necrotizing enterocolitis



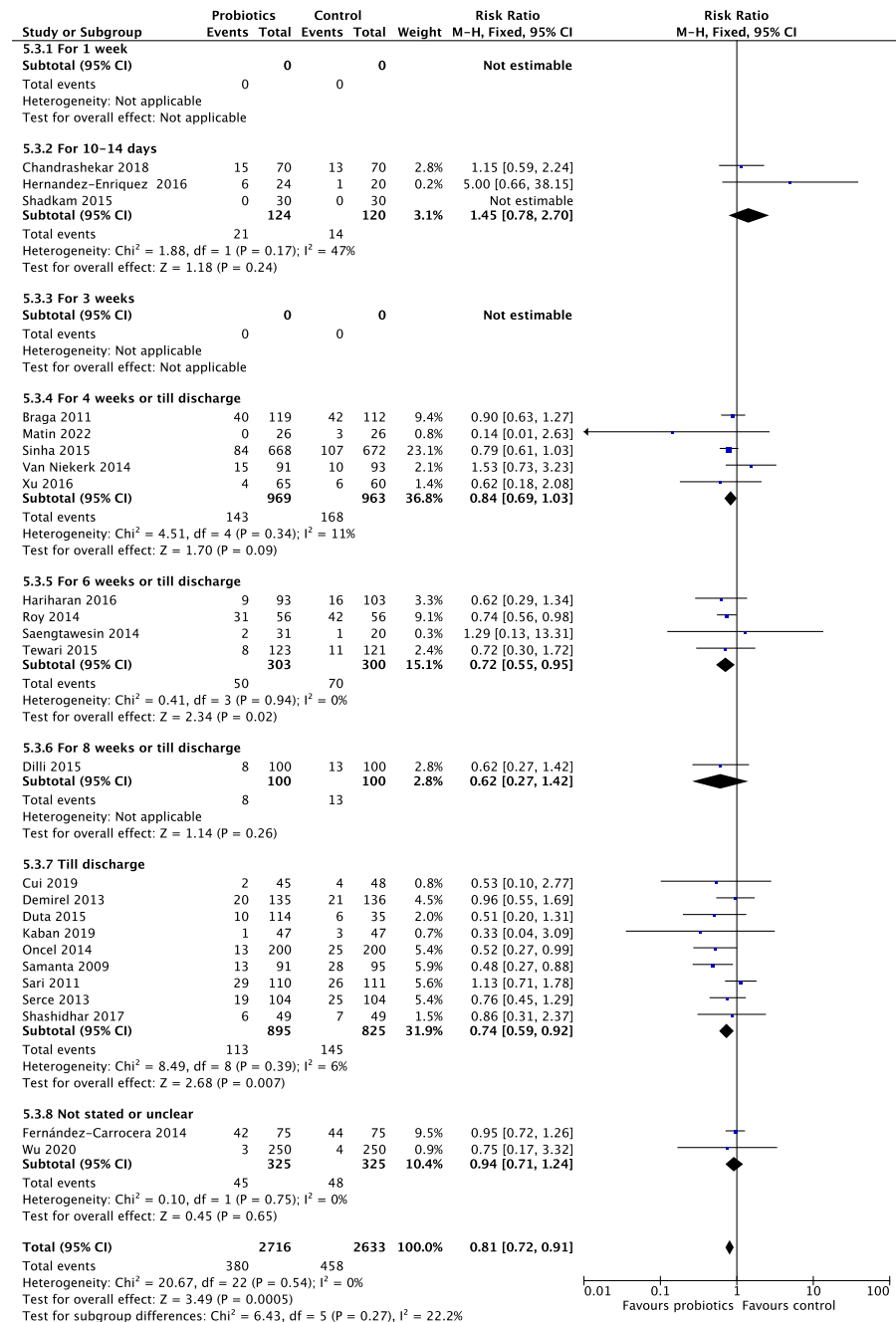
# Prevention and Treatment of Neonatal Infections in LMICs

## Outcome: All-cause neonatal mortality



# Prevention and Treatment of Neonatal Infections in LMICs

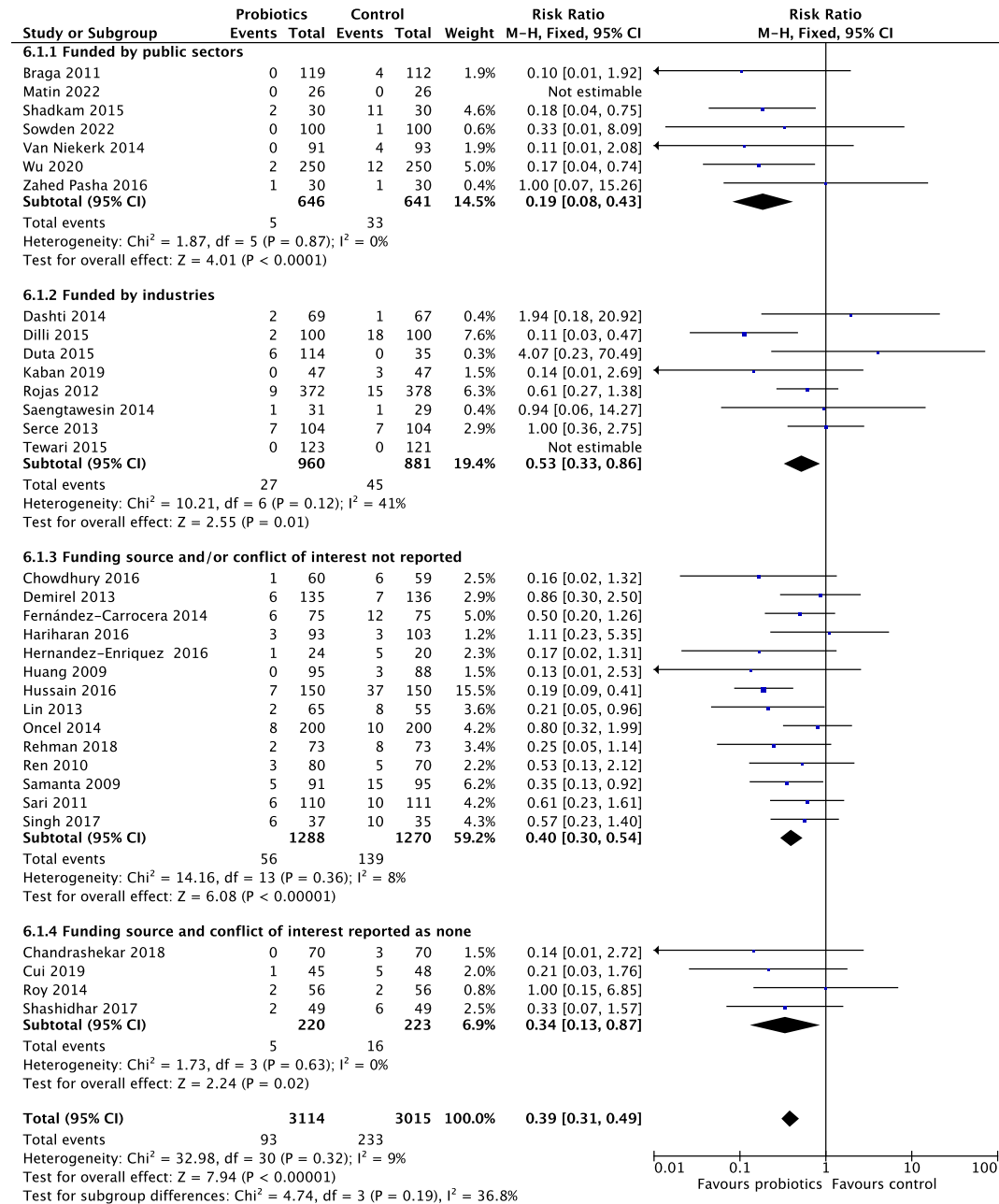
## Outcome: Invasive infection



## Prevention and Treatment of Neonatal Infections in LMICs

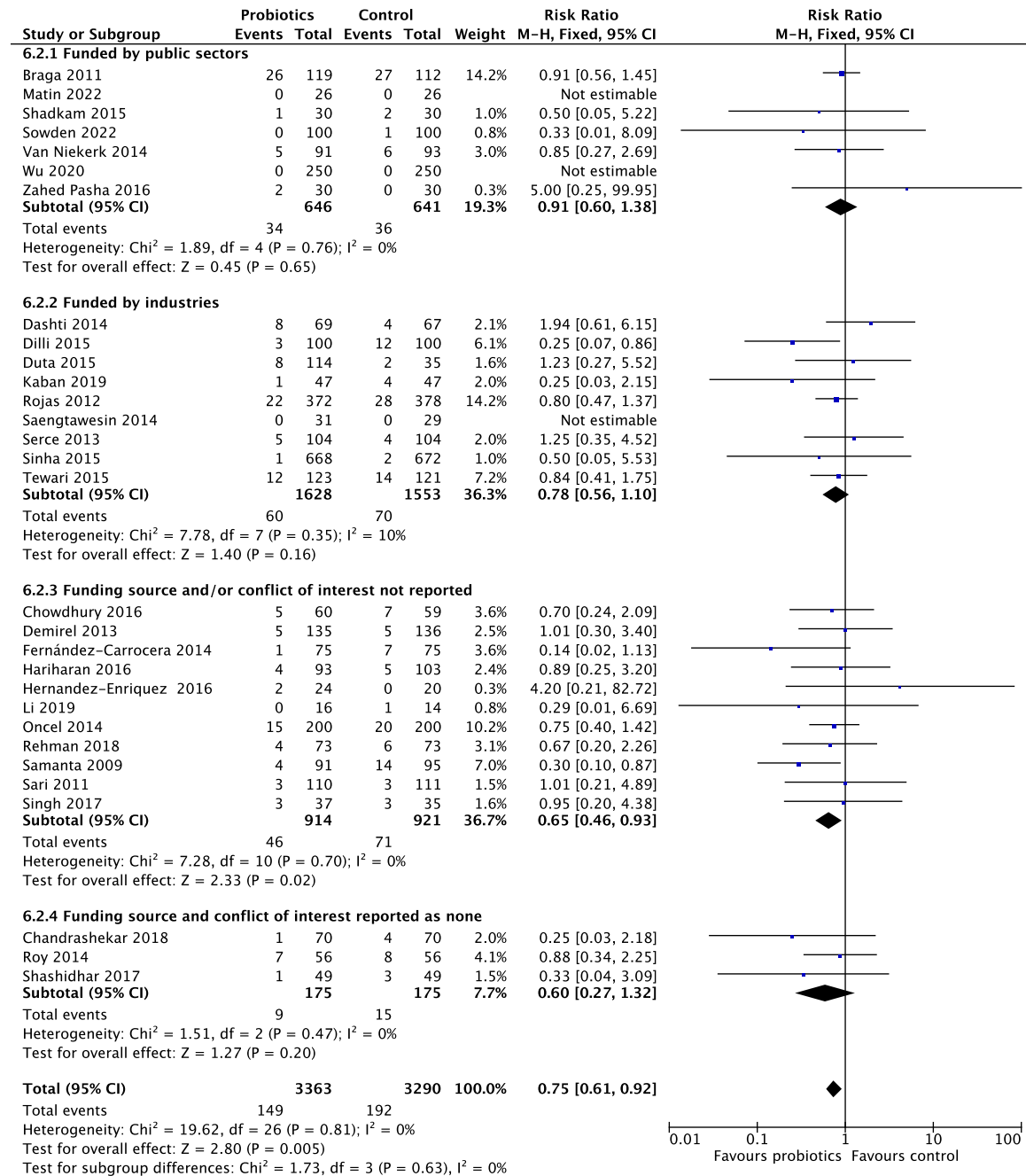
### Comparison: Probiotics versus control in preterm newborns by funding source

#### Outcome: Necrotizing enterocolitis



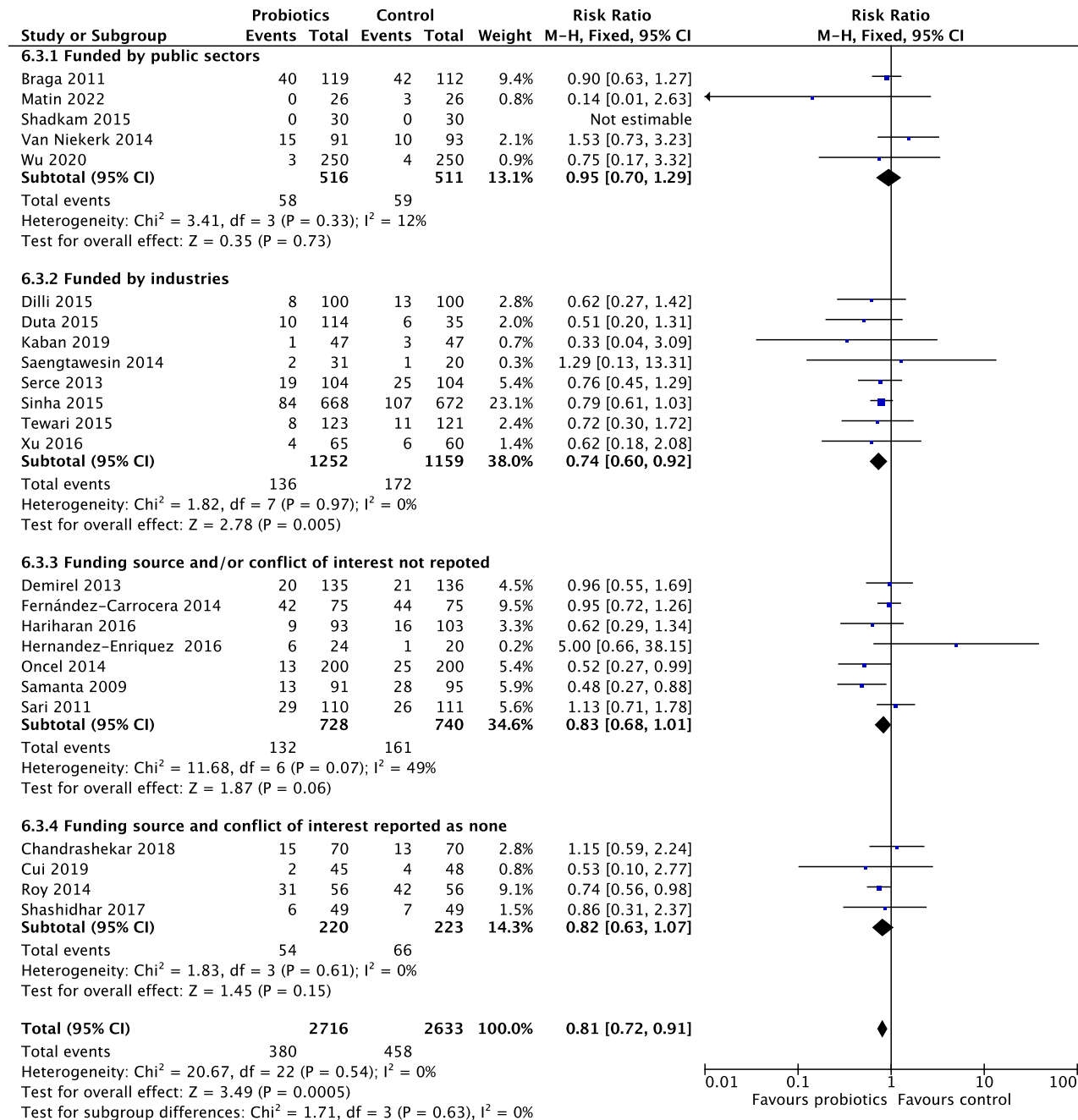
## Prevention and Treatment of Neonatal Infections in LMICs

### Outcome: All-cause neonatal mortality



## Prevention and Treatment of Neonatal Infections in LMICs

### Outcome: Invasive infection

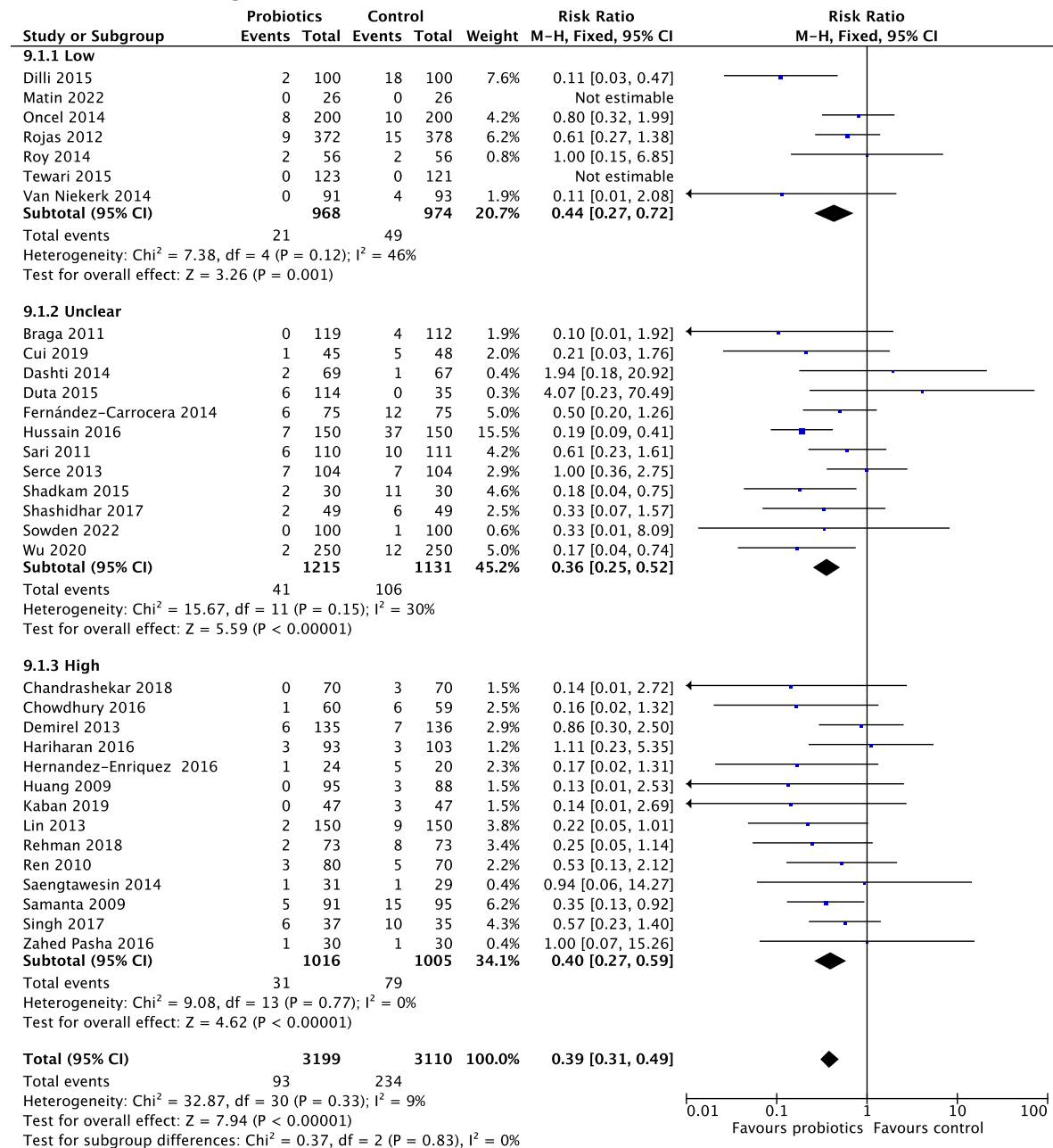




## Prevention and Treatment of Neonatal Infections in LMICs

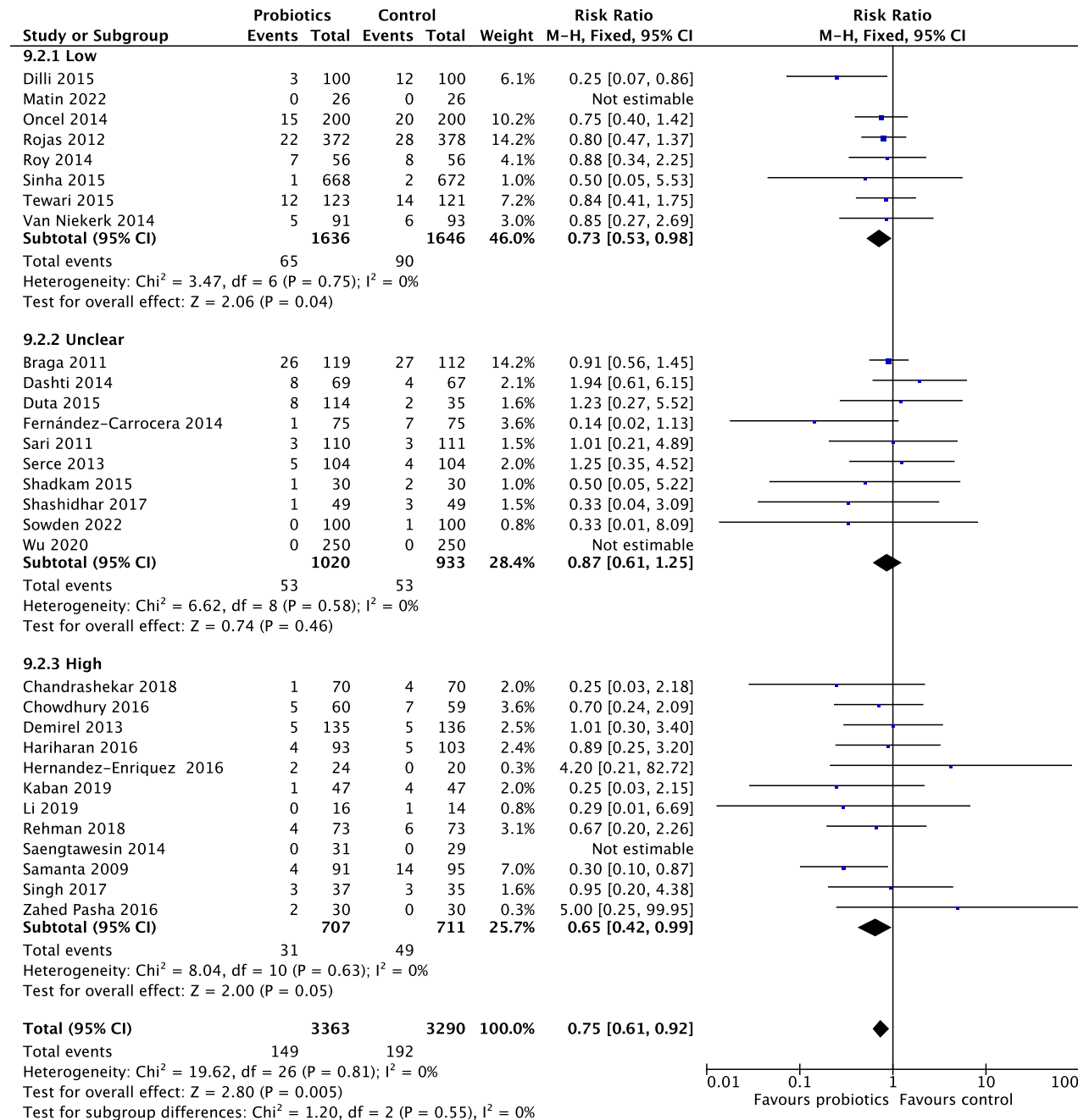
**Comparison:** Probiotics versus control in preterm newborns by risk of bias

**Outcome:** *Necrotizing enterocolitis*



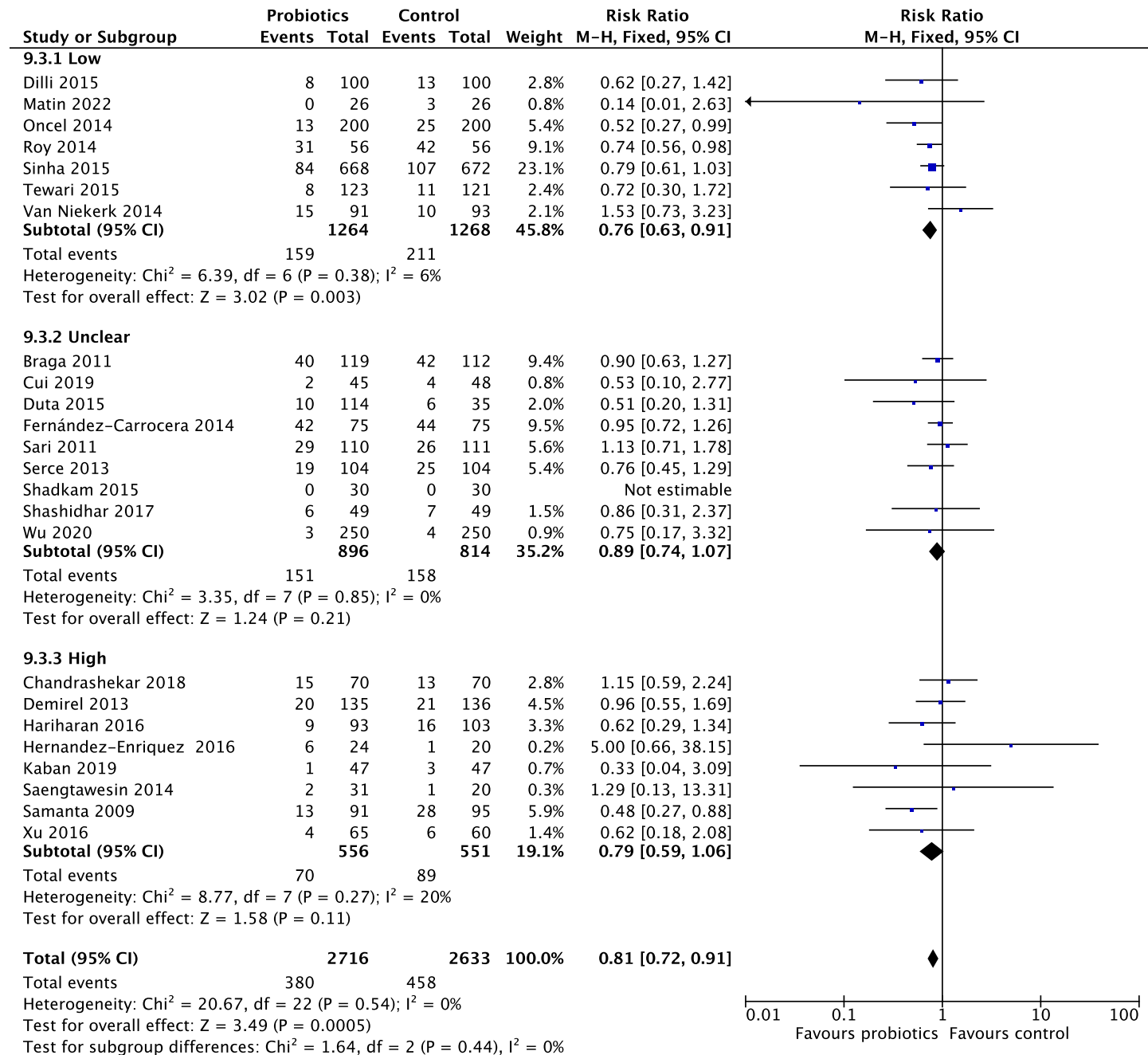
## Prevention and Treatment of Neonatal Infections in LMICs

### Outcome: All-cause neonatal mortality



## Prevention and Treatment of Neonatal Infections in LMICs

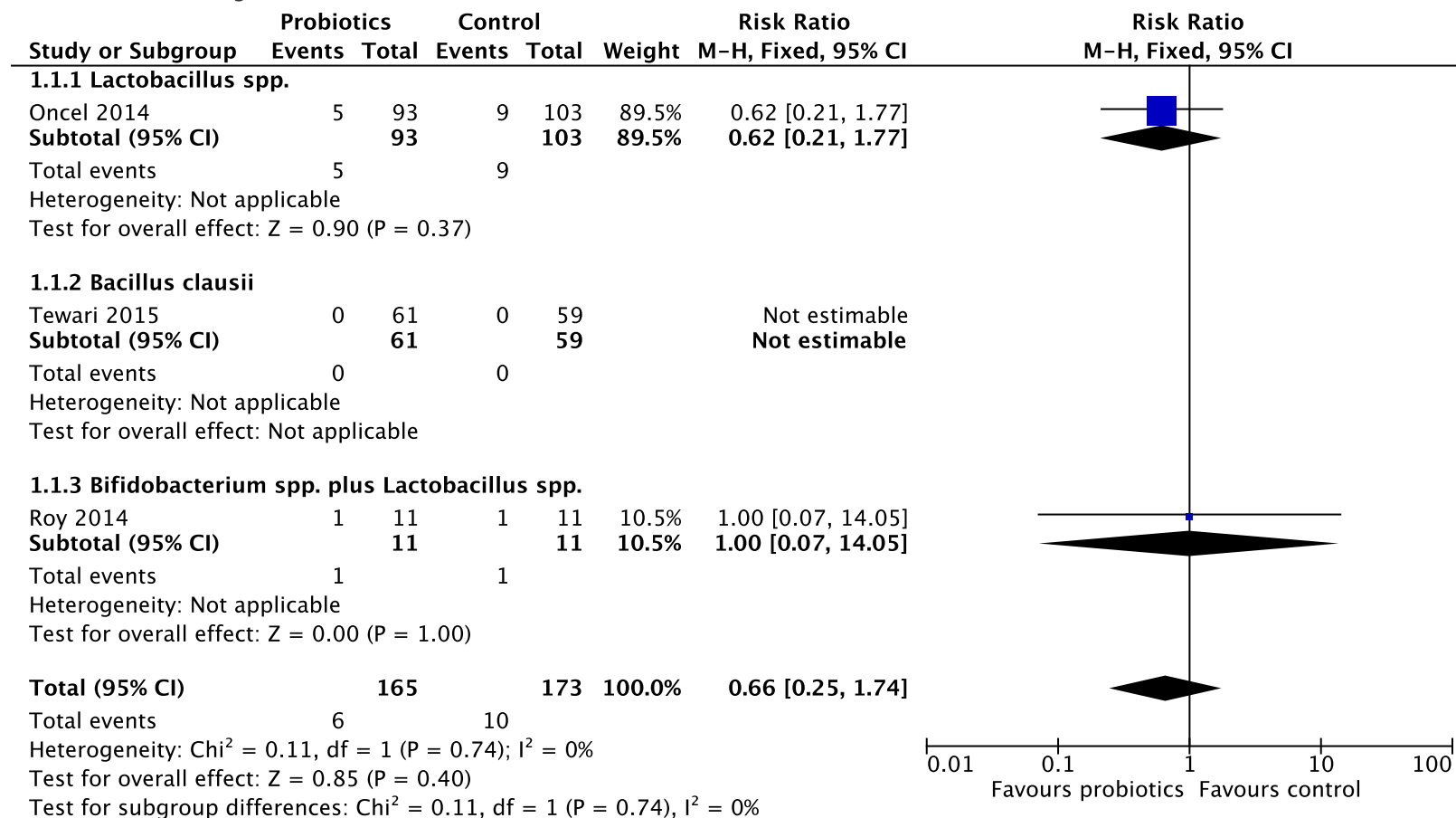
### Outcome: Invasive infection



# Prevention and Treatment of Neonatal Infections in LMICs

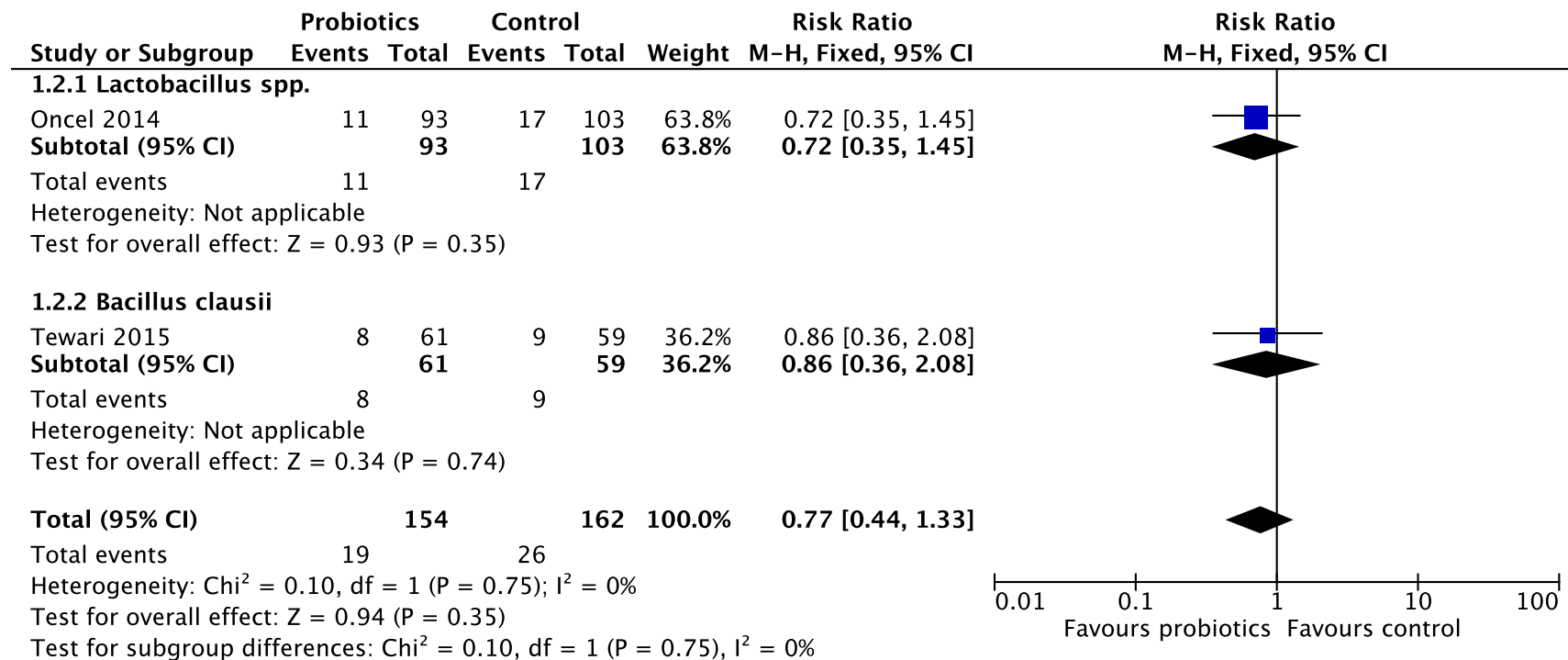
**Comparison:** Probiotics versus control in extremely preterm or ELBW newborns by probiotic type

**Outcome:** Necrotizing enterocolitis

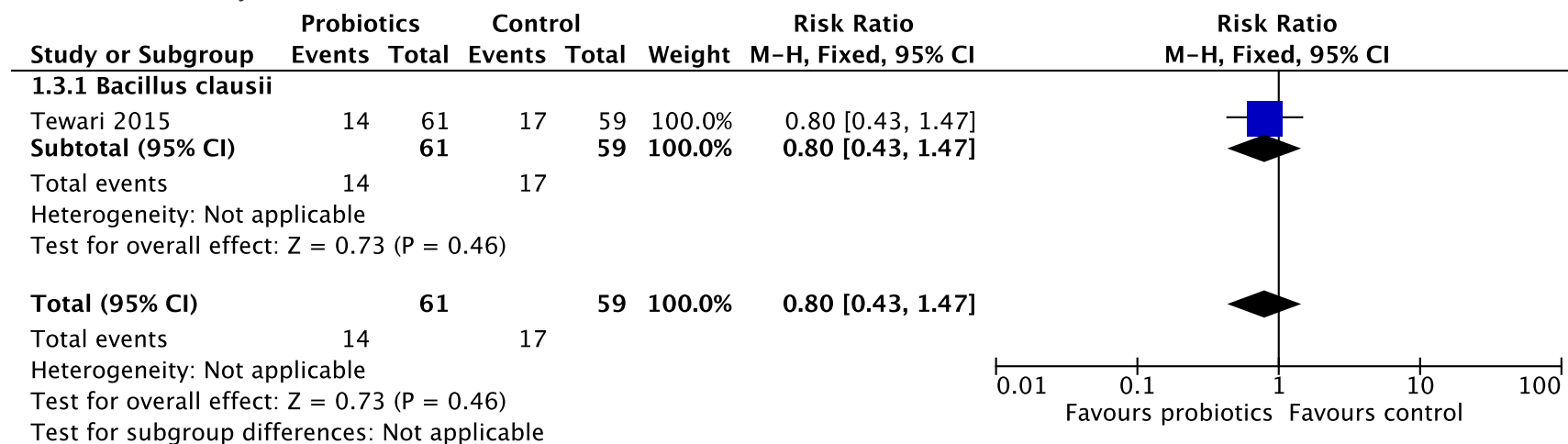


## Prevention and Treatment of Neonatal Infections in LMICs

### Outcome: All-cause mortality



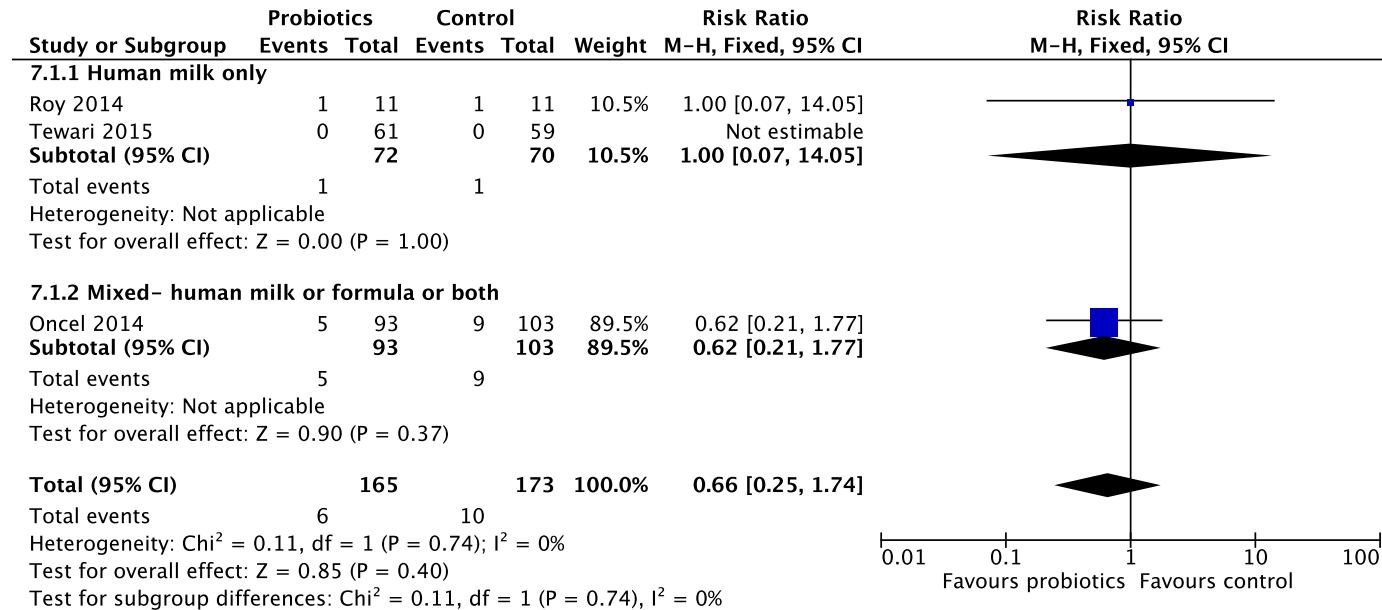
### Outcome: Invasive infection



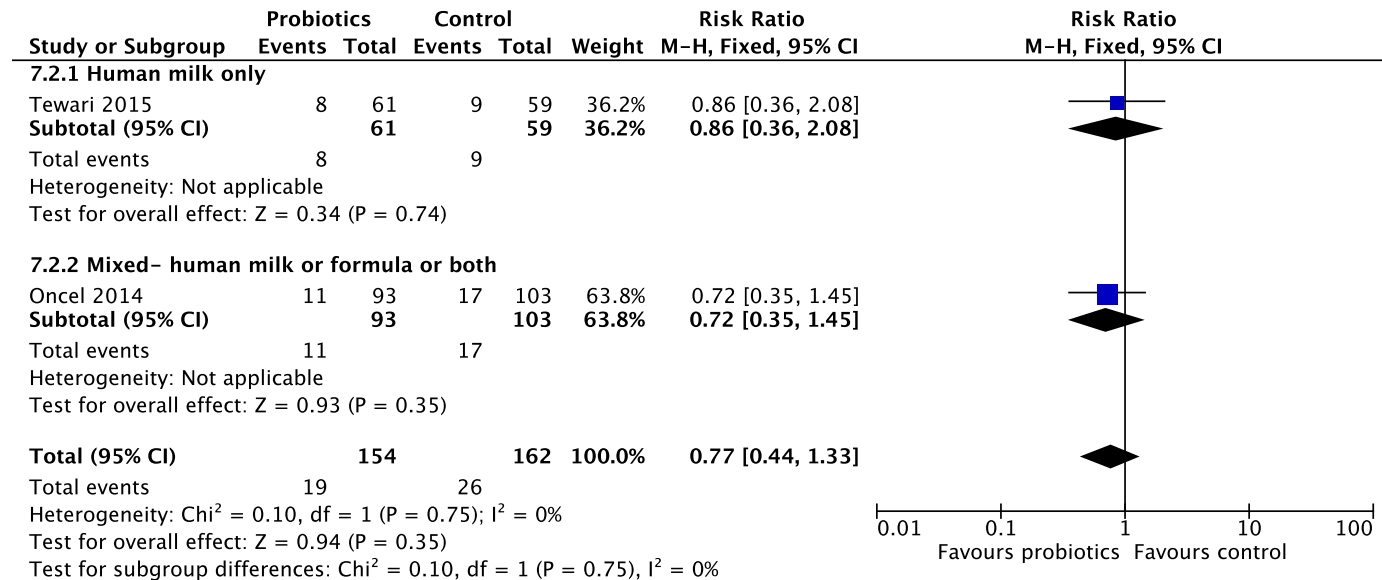
## Prevention and Treatment of Neonatal Infections in LMICs

**Comparison:** Probiotics versus control in extremely preterm or ELBW newborns by feeding type

**Outcome:** *Necrotizing enterocolitis*

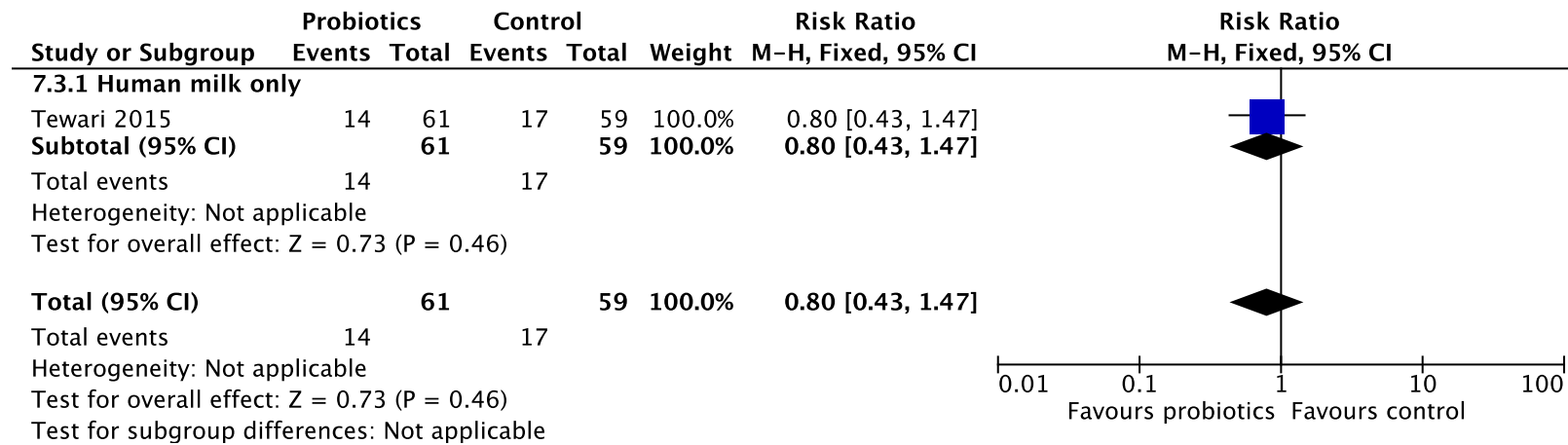


**Outcome:** *All-cause neonatal mortality*



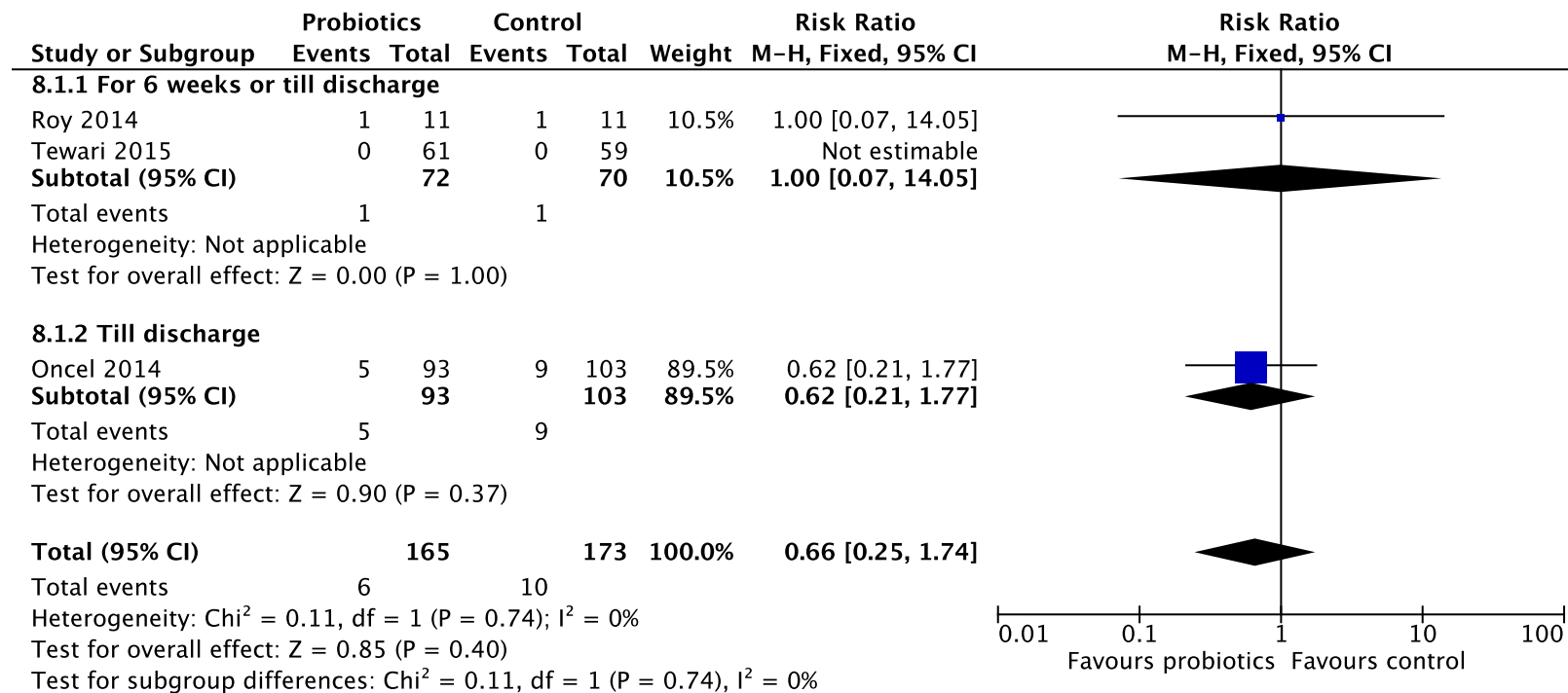
## Prevention and Treatment of Neonatal Infections in LMICs

### Outcome: Invasive infection



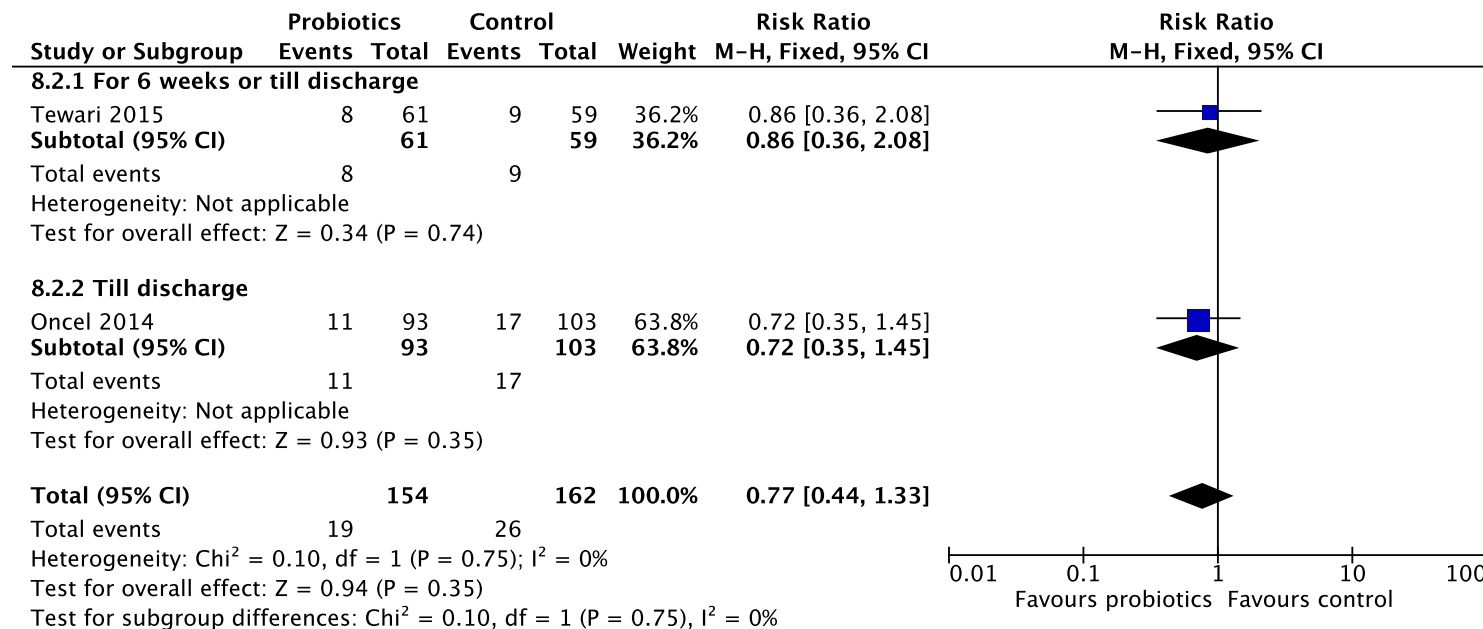
### Comparison: Probiotics versus control in extremely preterm or ELBW newborns by duration of intervention

#### Outcome: Necrotizing enterocolitis

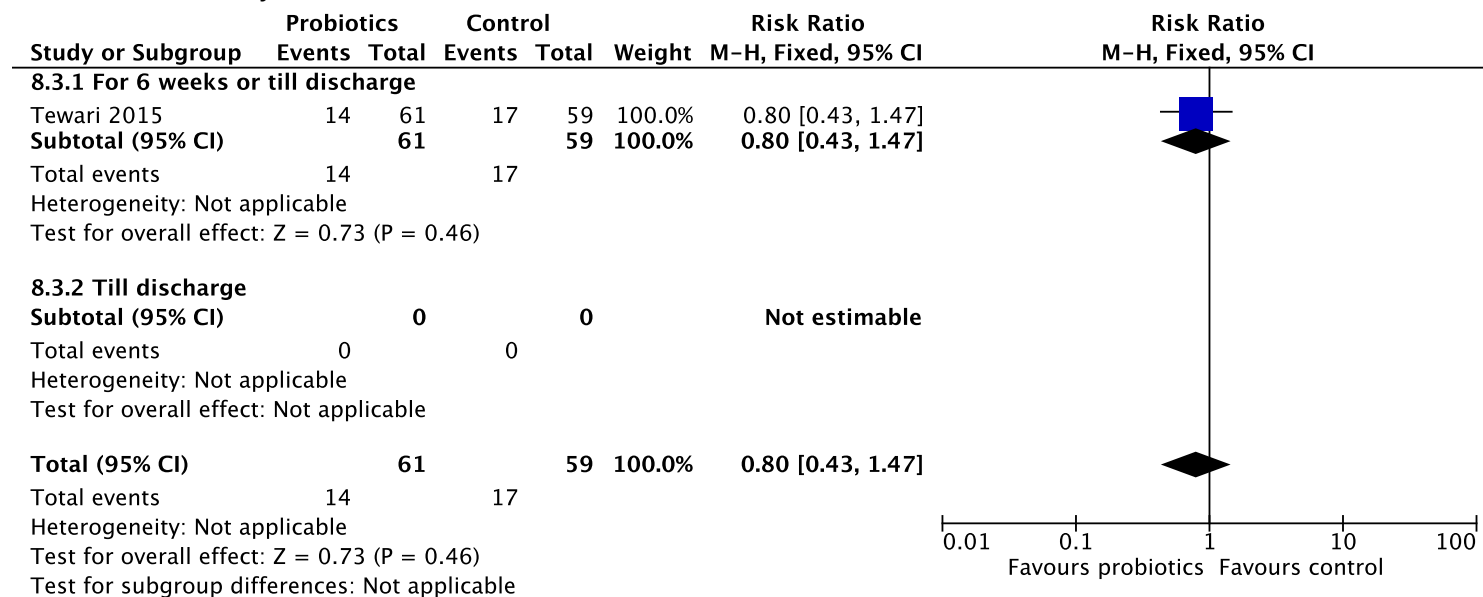


## Prevention and Treatment of Neonatal Infections in LMICs

### Outcome: All-cause neonatal mortality



### Outcome: Invasive infection

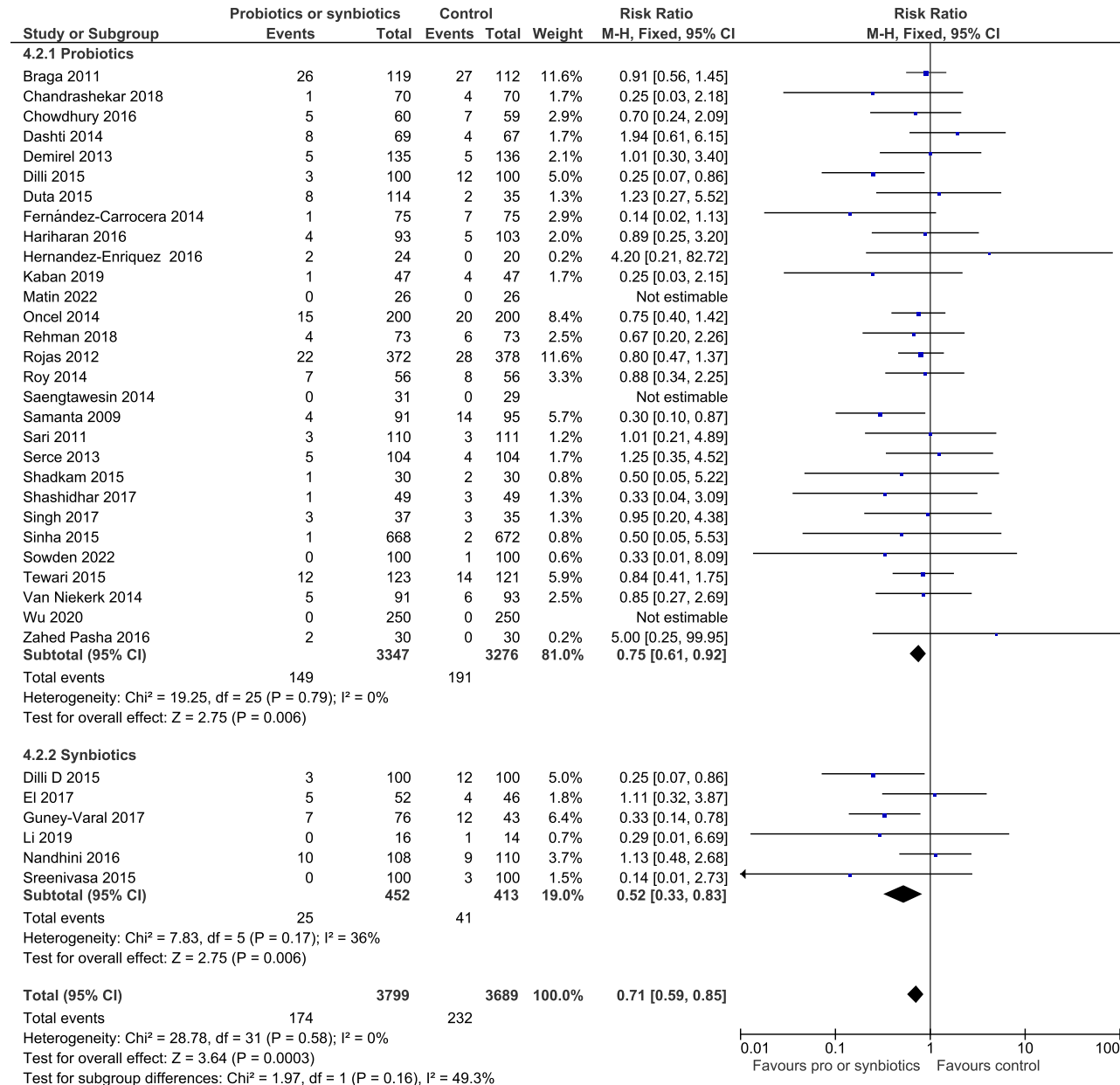




## Prevention and Treatment of Neonatal Infections in LMICs

**Comparison:** Combined probiotics or synbiotics versus control (i.e., probiotics with or without prebiotics versus control) in preterm/LBW and extremely preterm/ELBW newborns

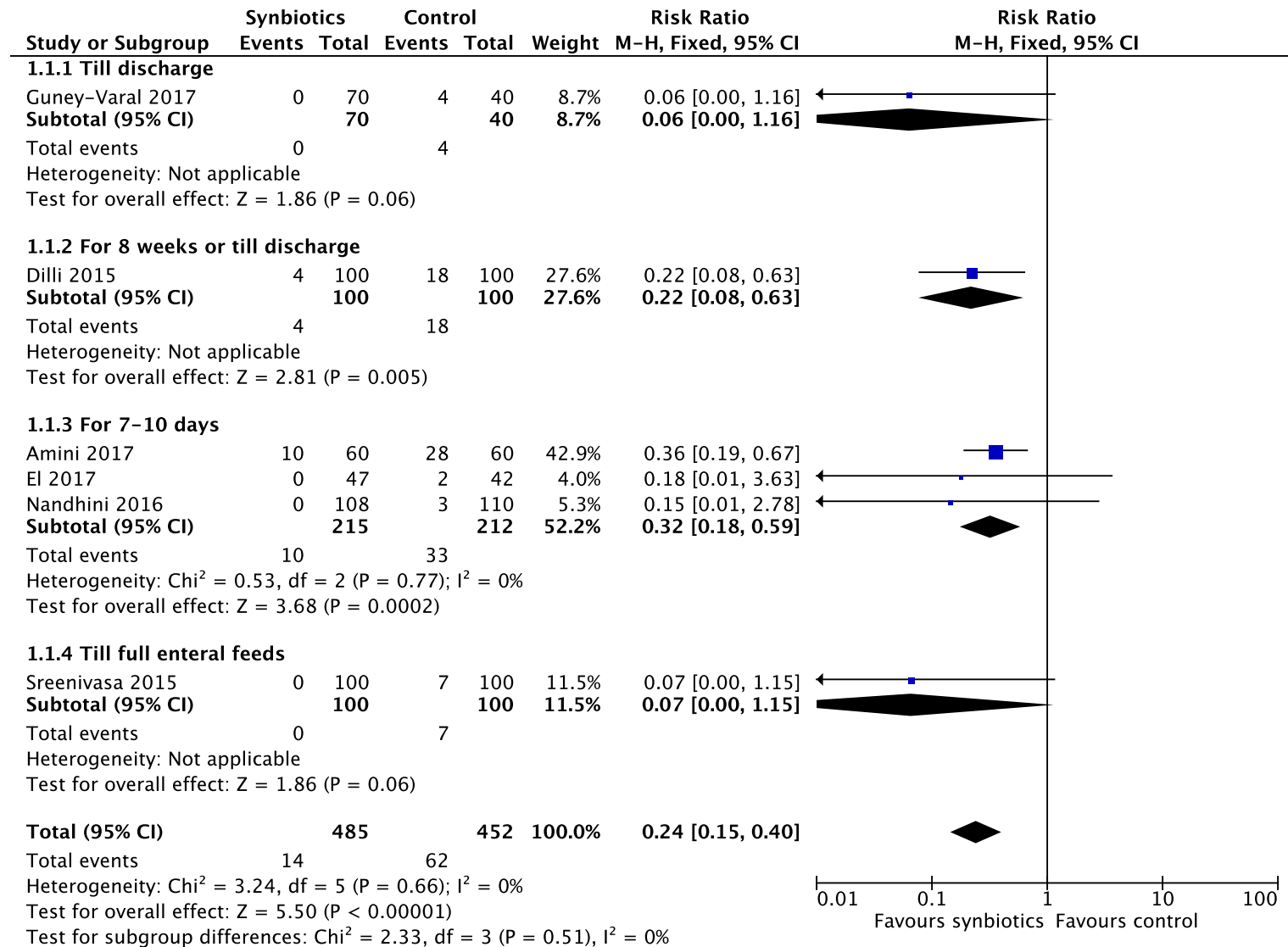
**Outcome:** All-cause neonatal mortality



### 4.1.5. Synbiotics Supplementation

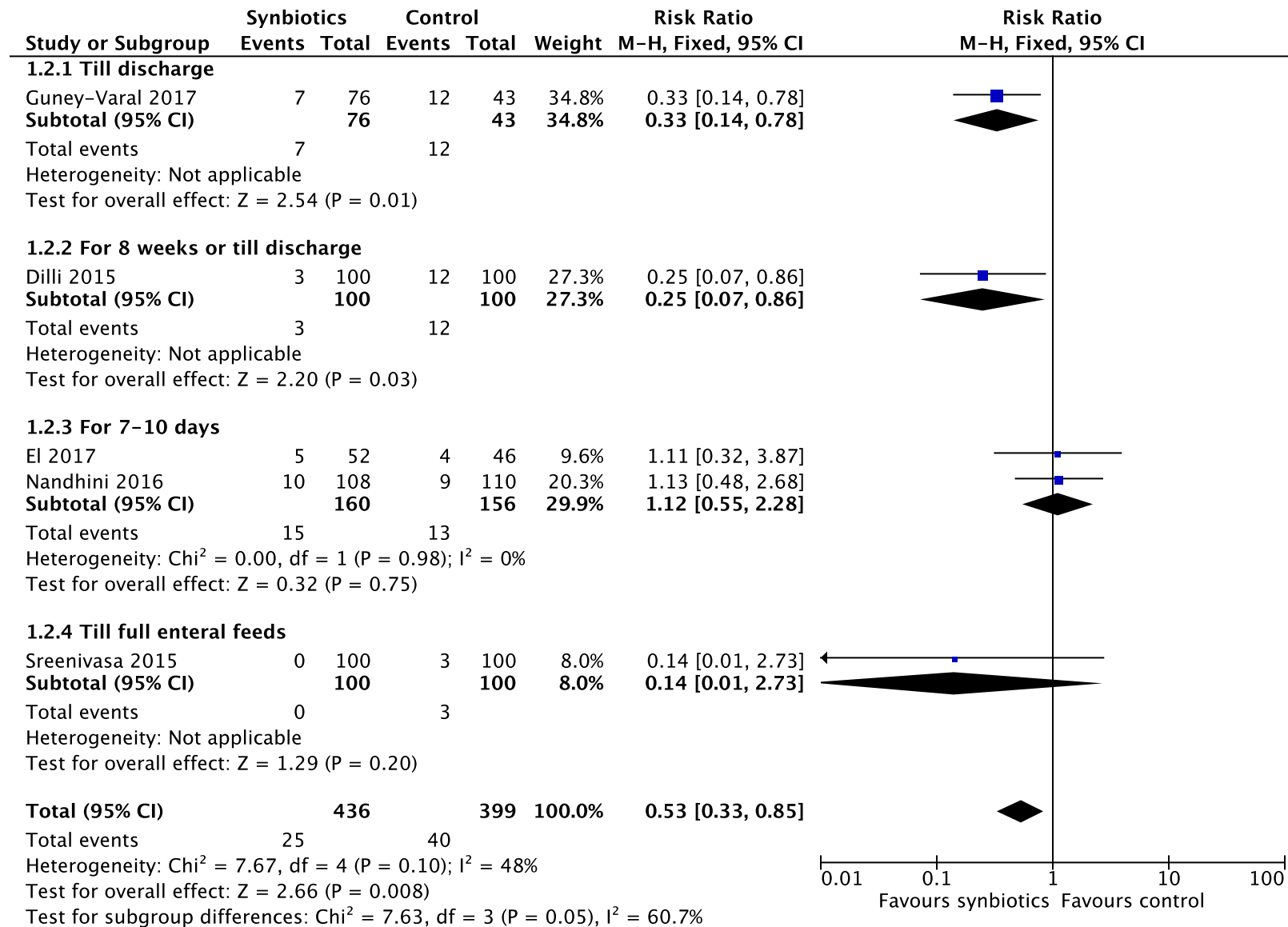
**Comparison:** Synbiotics versus control in preterm or LBW infants by the duration of intervention

**Outcome:** Necrotizing enterocolitis



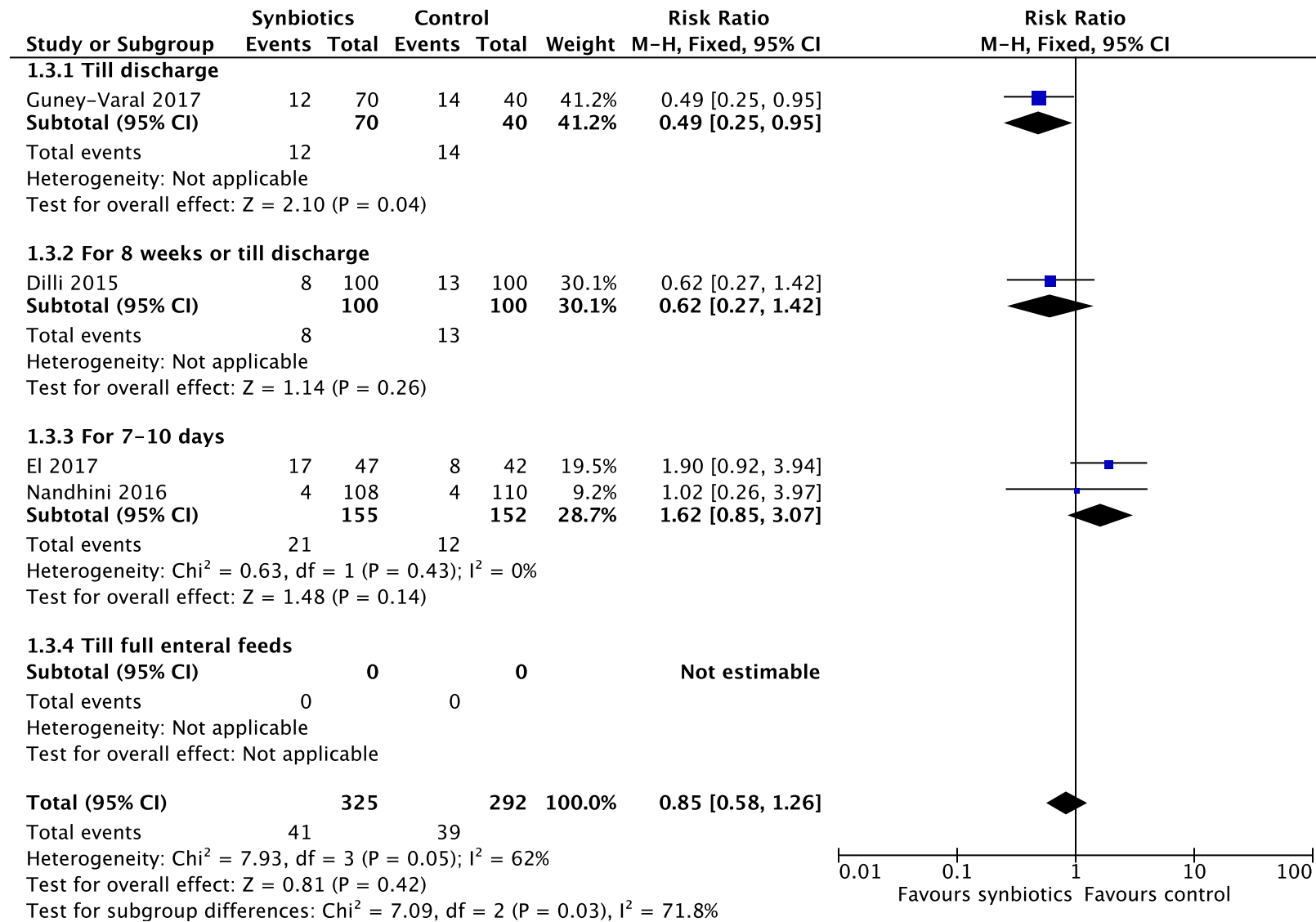
# Prevention and Treatment of Neonatal Infections in LMICs

Outcome: All-cause mortality till discharge



# Prevention and Treatment of Neonatal Infections in LMICs

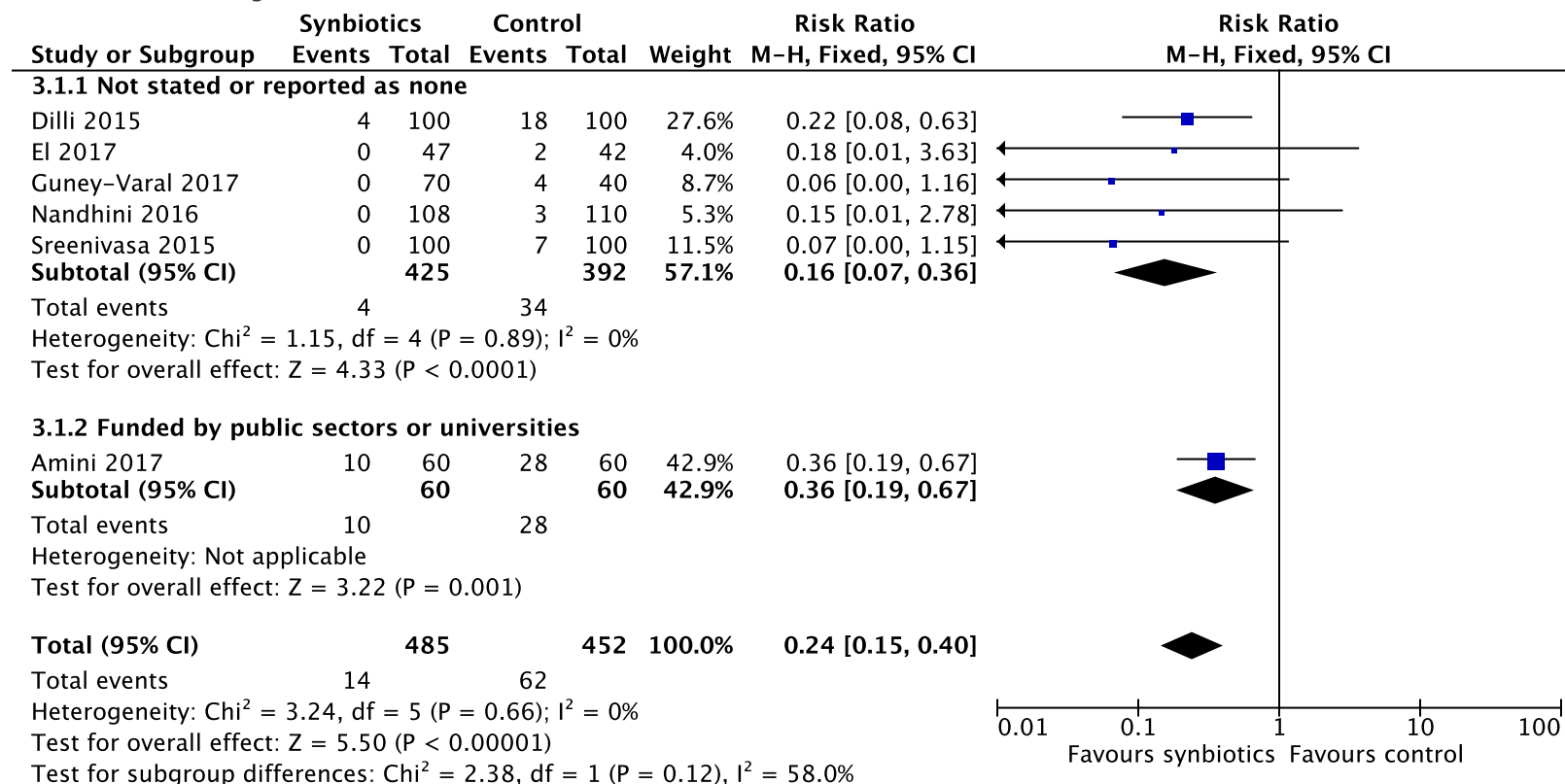
## Outcome: Invasive infection



# Prevention and Treatment of Neonatal Infections in LMICs

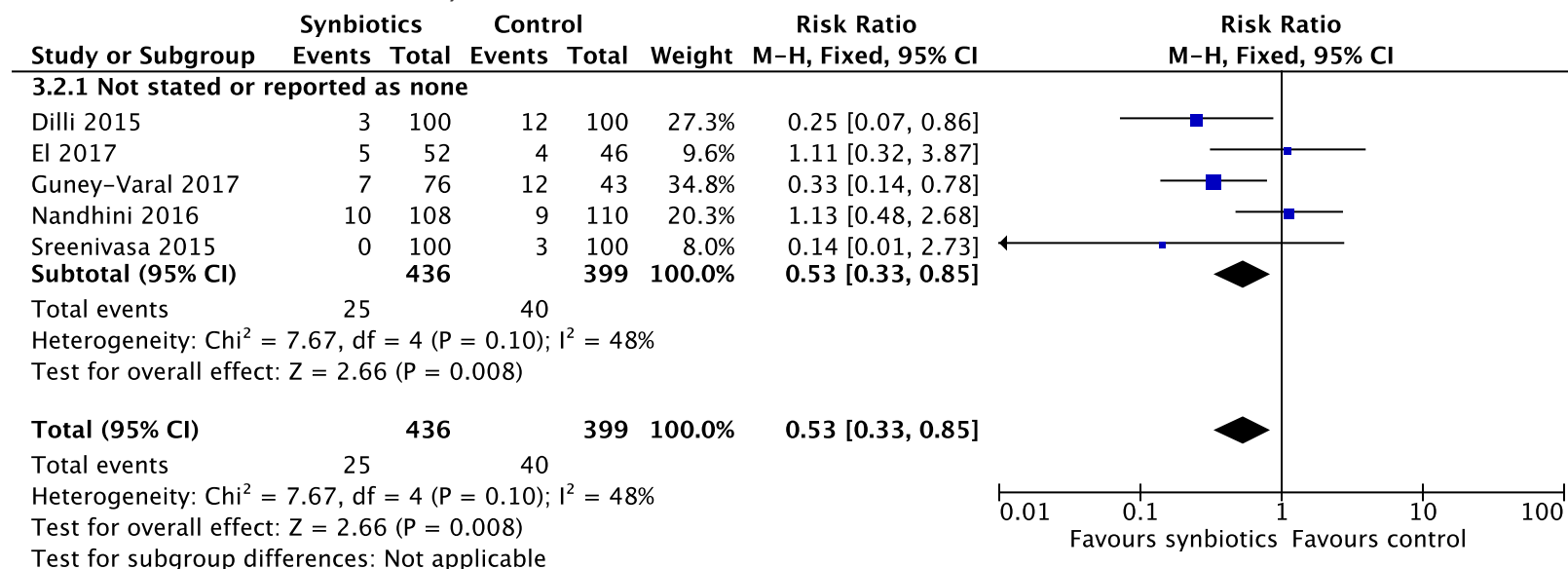
**Comparison:** Synbiotics versus control in preterm or LBW infants by funding source

**Outcome:** Necrotizing enterocolitis

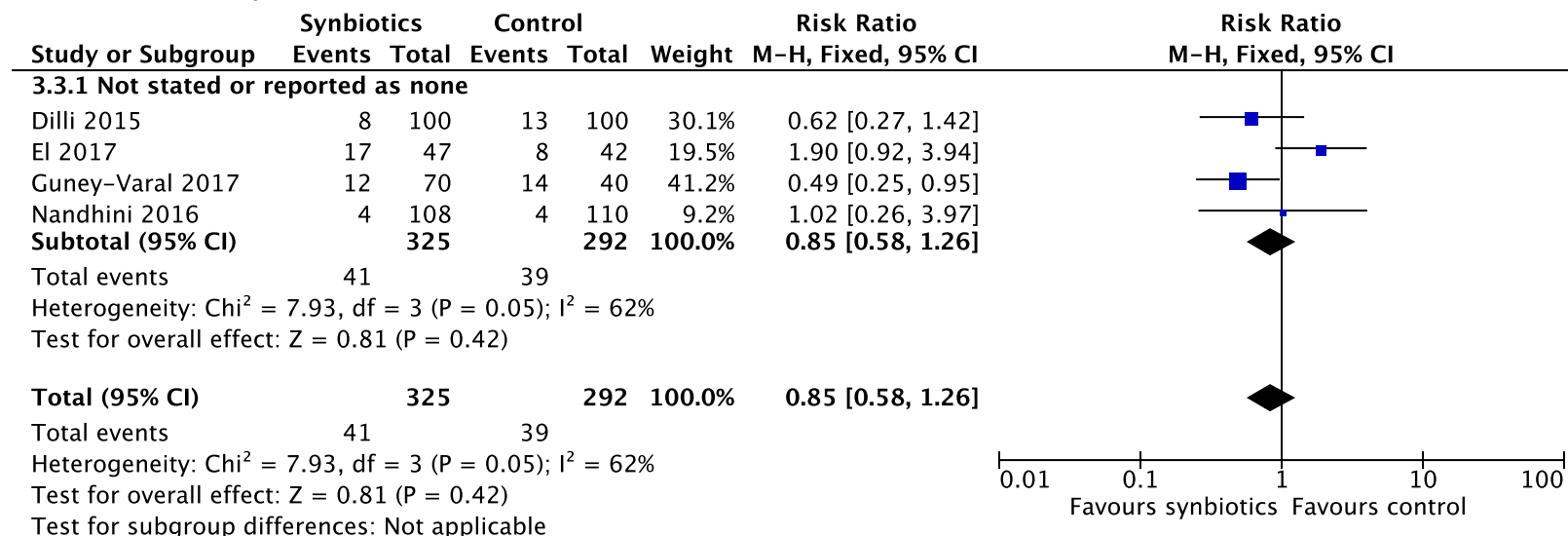


## Prevention and Treatment of Neonatal Infections in LMICs

### Outcome: All-cause neonatal mortality



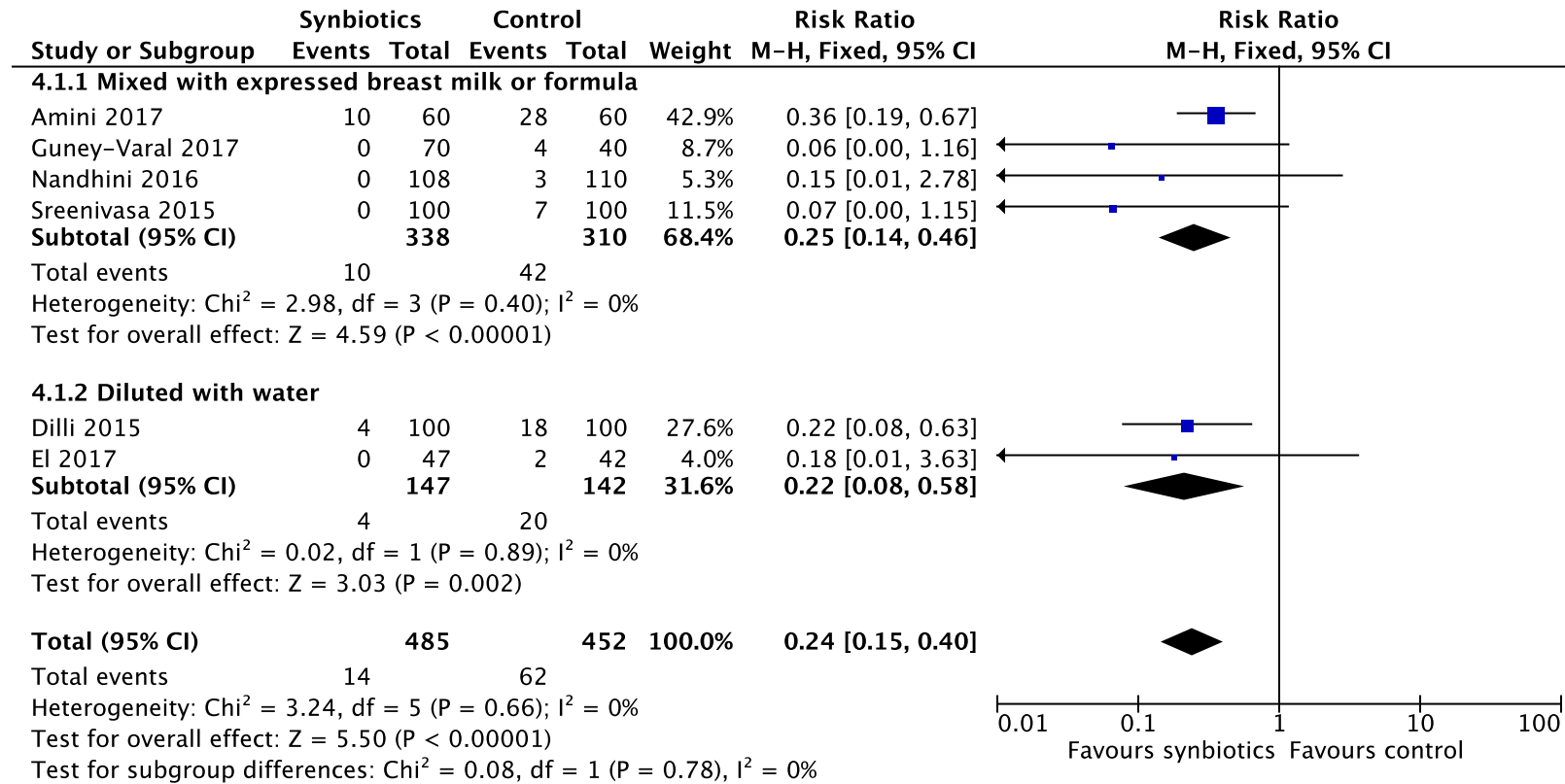
### Outcome: Invasive infection



## Prevention and Treatment of Neonatal Infections in LMICs

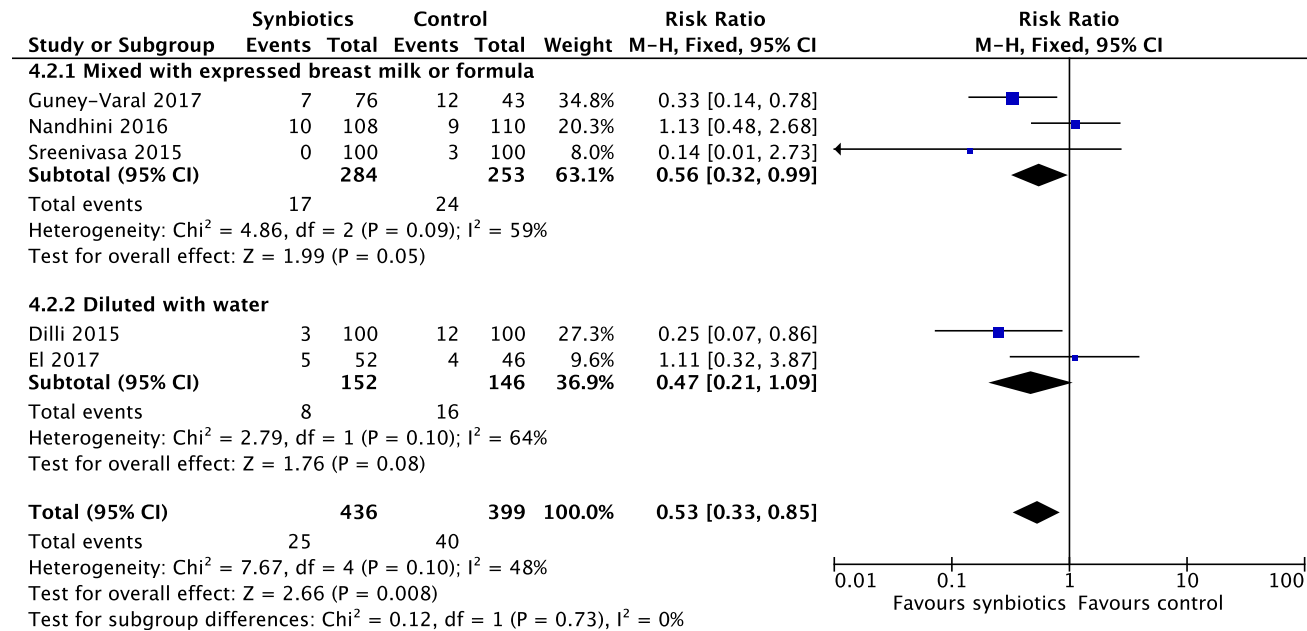
**Comparison:** Synbiotics versus control in preterm or LBW infants by synbiotics' volume

**Outcome:** Necrotizing enterocolitis

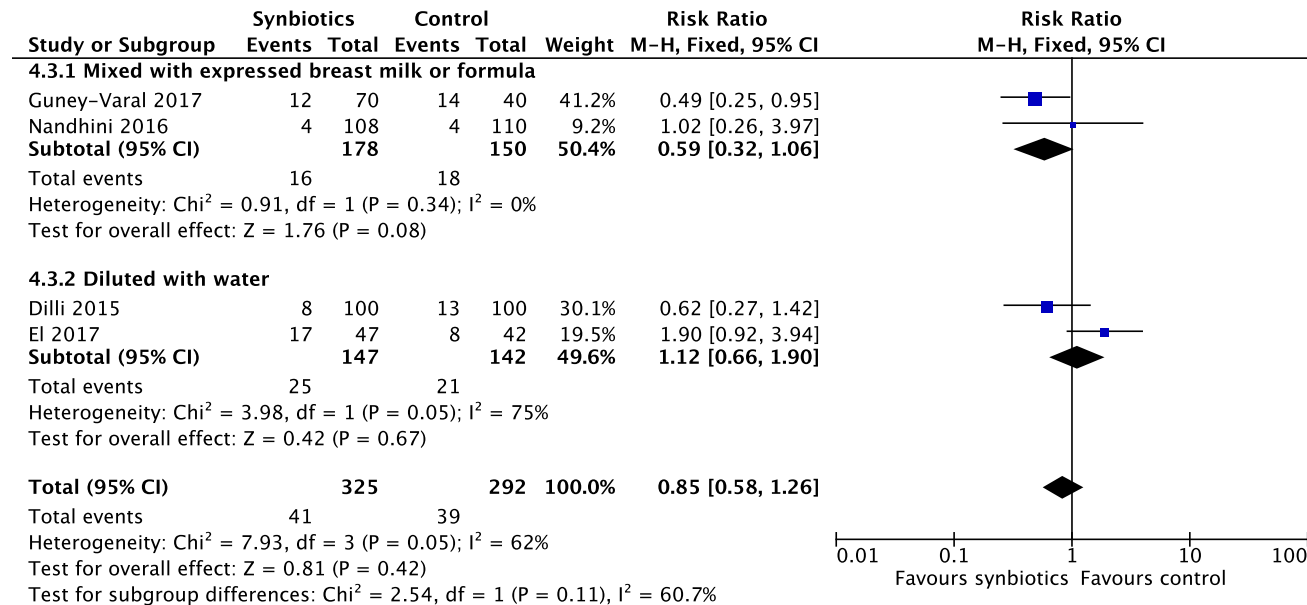


## Prevention and Treatment of Neonatal Infections in LMICs

### Outcome: All-cause neonatal mortality



### Outcome: Invasive infection

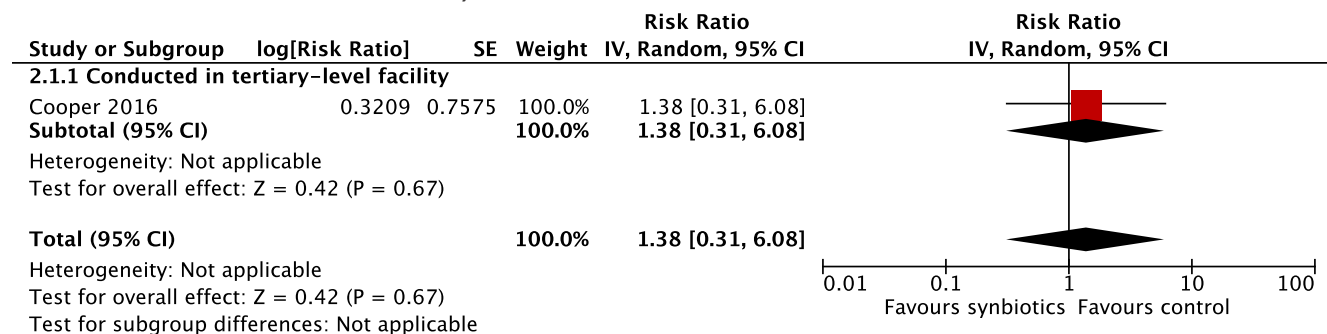




## Prevention and Treatment of Neonatal Infections in LMICs

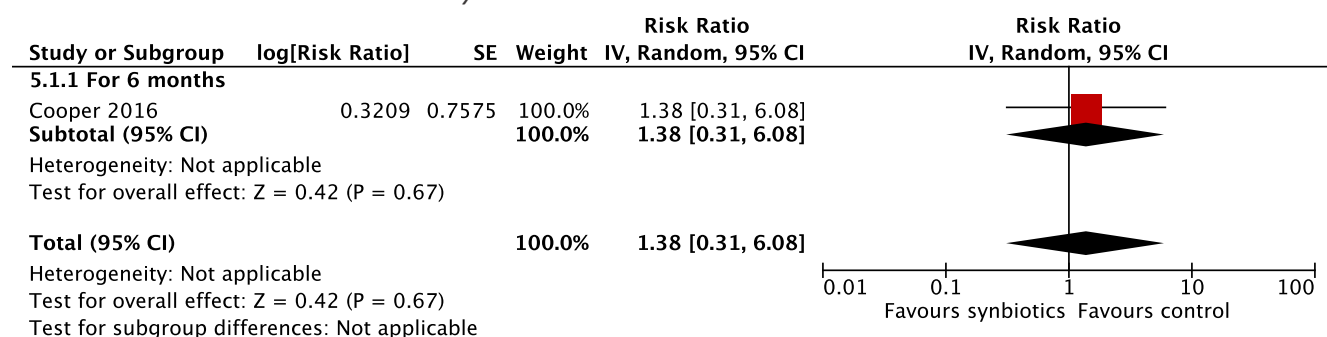
**Comparison:** Synbiotics versus control in term newborns by facility level

**Outcome:** All-cause neonatal mortality



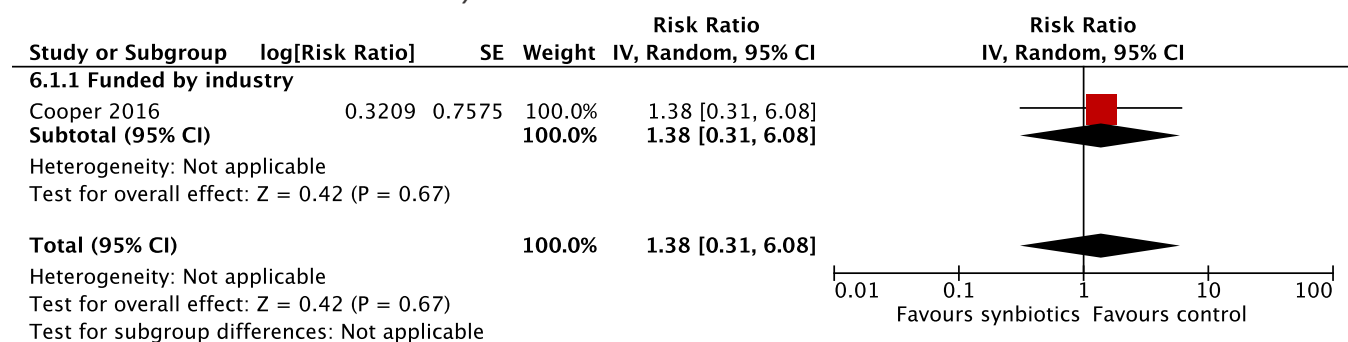
**Comparison:** Synbiotics versus control in term newborns by the duration of intervention

**Outcome:** All-cause neonatal mortality



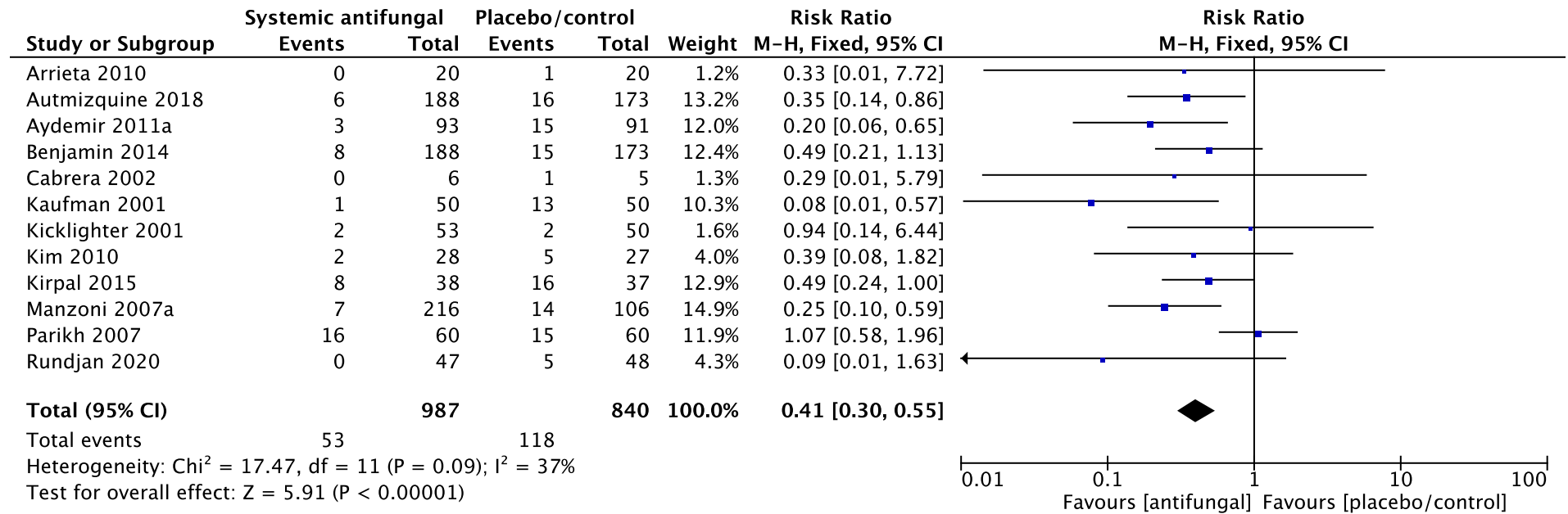
**Comparison:** Synbiotics versus control in term newborns by funding source

**Outcome:** All-cause neonatal mortality

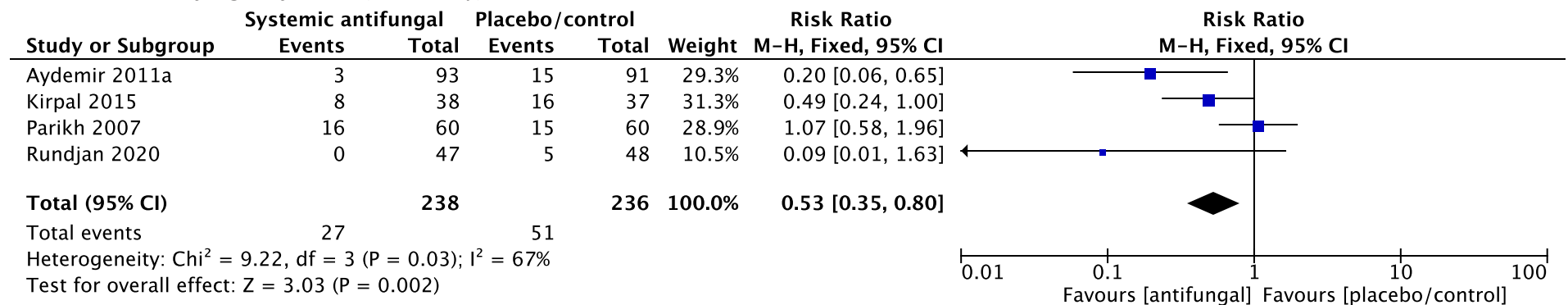


#### 4.1.6. Prophylactic Systemic Antifungal Agents

**Outcome:** Invasive fungal infections (Total)



**Outcome:** Invasive fungal infections (LMICs only)



## Prevention and Treatment of Neonatal Infections in LMICs

### Outcome: Neonatal mortality prior to hospital discharge (Total)

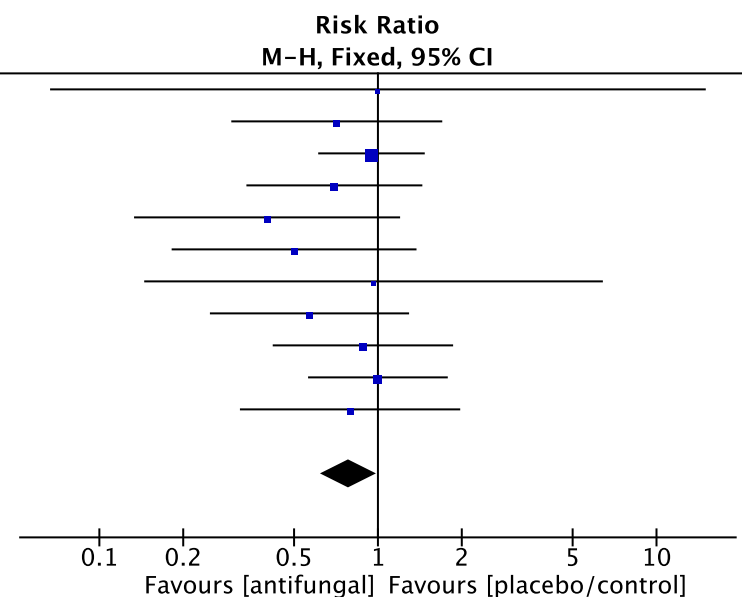
Study or Subgroup	Systemic antifungal		Placebo/control		Weight	Risk Ratio M-H, Fixed, 95% CI
	Events	Total	Events	Total		
Arrieta 2010	1	20	1	20	0.7%	1.00 [0.07, 14.90]
Aydemir 2011a	8	93	11	91	8.3%	0.71 [0.30, 1.69]
Benjamin 2014	34	188	33	173	25.7%	0.95 [0.62, 1.46]
Jannatdoust 2015	9	43	15	50	10.4%	0.70 [0.34, 1.43]
Kaufman 2001	4	50	10	50	7.5%	0.40 [0.13, 1.19]
Kicklighter 2001	5	53	10	53	7.5%	0.50 [0.18, 1.36]
Kim 2010	2	28	2	27	1.5%	0.96 [0.15, 6.37]
Kirpal 2015	7	38	12	37	9.1%	0.57 [0.25, 1.28]
Manzoni 2007a	18	216	10	106	10.0%	0.88 [0.42, 1.85]
Parikh 2007	17	60	17	60	12.7%	1.00 [0.57, 1.77]
Rundjan 2020	7	47	9	48	6.7%	0.79 [0.32, 1.96]

**Total (95% CI)** **836** **715** **100.0%** **0.78 [0.62, 0.99]**

Total events 112 130

Heterogeneity:  $\text{Chi}^2 = 4.61$ ,  $\text{df} = 10$  ( $P = 0.92$ );  $I^2 = 0\%$

Test for overall effect:  $Z = 2.06$  ( $P = 0.04$ )



### Outcome: Neonatal mortality prior to hospital discharge (LMICs only)

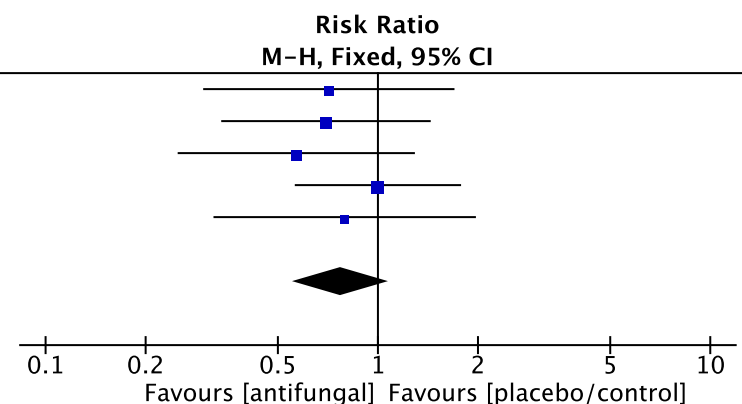
Study or Subgroup	Systemic antifungal		Placebo/control		Weight	Risk Ratio M-H, Fixed, 95% CI
	Events	Total	Events	Total		
Aydemir 2011a	8	93	11	91	17.6%	0.71 [0.30, 1.69]
Jannatdoust 2015	9	43	15	50	22.0%	0.70 [0.34, 1.43]
Kirpal 2015	7	38	12	37	19.3%	0.57 [0.25, 1.28]
Parikh 2007	17	60	17	60	27.0%	1.00 [0.57, 1.77]
Rundjan 2020	7	47	9	48	14.1%	0.79 [0.32, 1.96]

**Total (95% CI)** **281** **286** **100.0%** **0.77 [0.55, 1.07]**

Total events 48 64

Heterogeneity:  $\text{Chi}^2 = 1.45$ ,  $\text{df} = 4$  ( $P = 0.83$ );  $I^2 = 0\%$

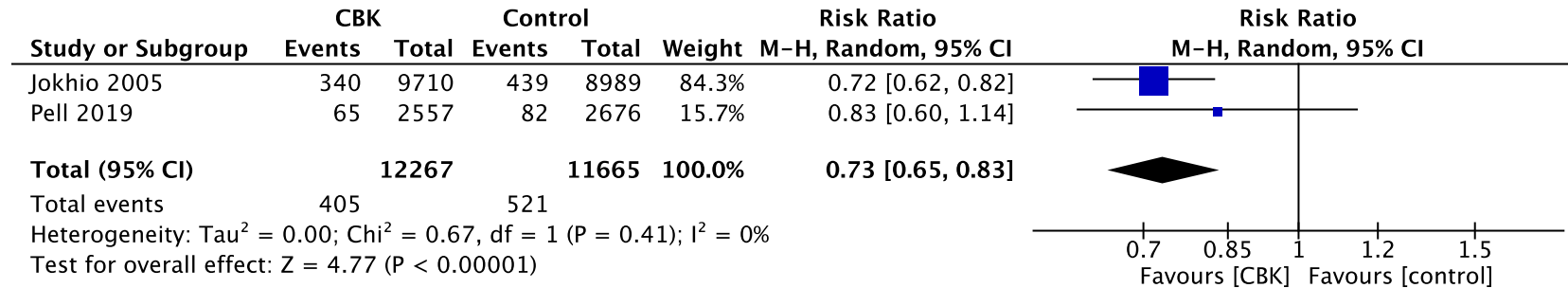
Test for overall effect:  $Z = 1.55$  ( $P = 0.12$ )



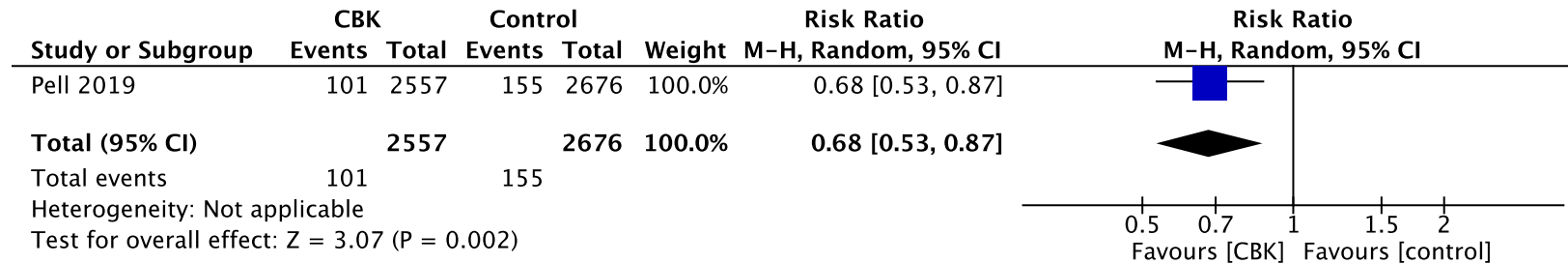
## 4.2 Mixed Level Forest Plots

### 4.2.1. Clean Birth Kits

Outcome: Neonatal mortality



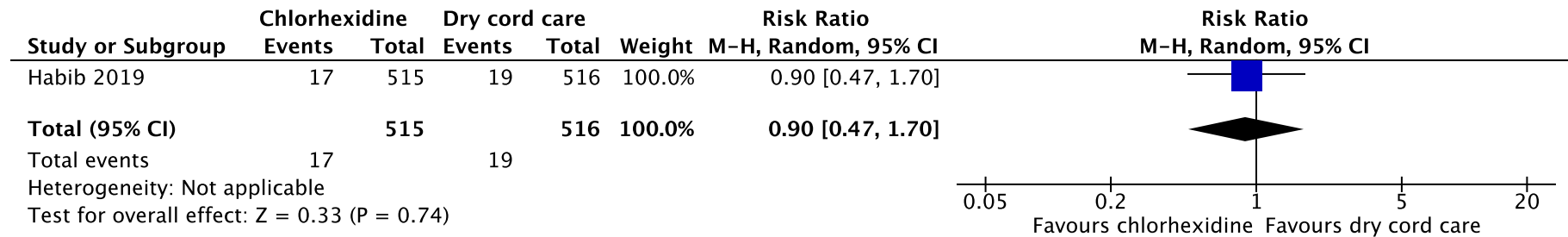
Outcome: Any omphalitis



### 4.2.2. Chlorhexidine Cleansing

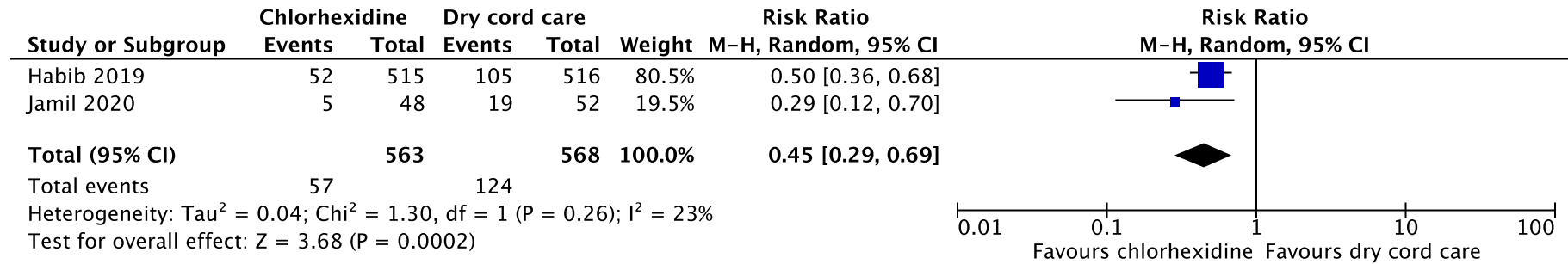
Comparison: Chlorhexidine umbilical cord cleansing versus dry cord care

Outcome: Neonatal mortality

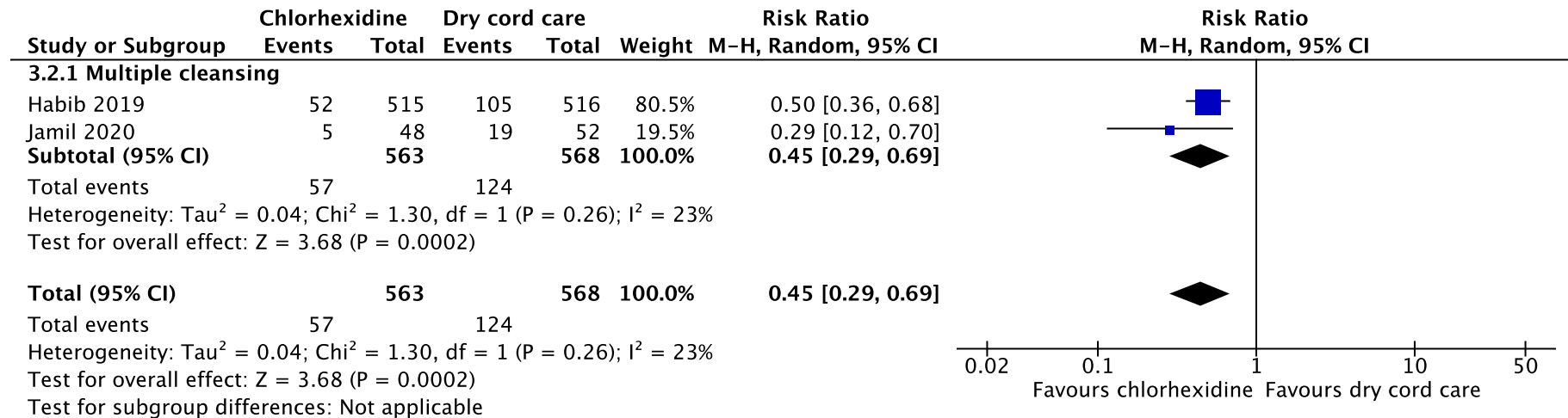


## Prevention and Treatment of Neonatal Infections in LMICs

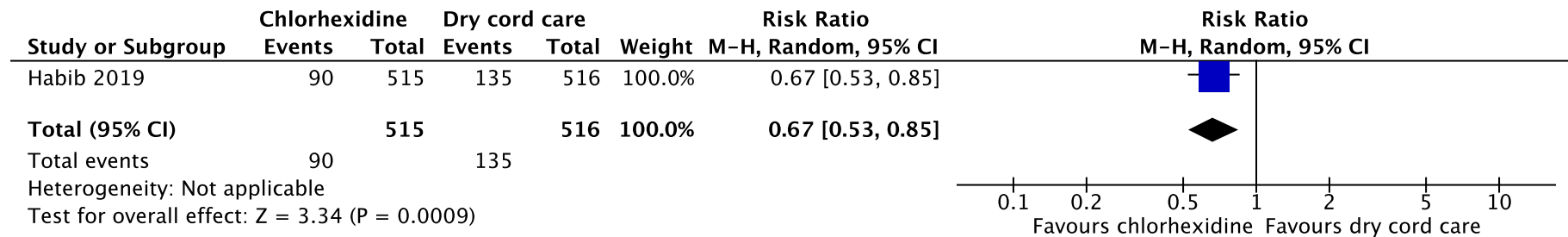
### Outcome: Omphalitis



### Outcome: Omphalitis by cleansing frequency



### Outcome: Bloodstream infection/sepsis



### 4.2.3. Topical Emollients

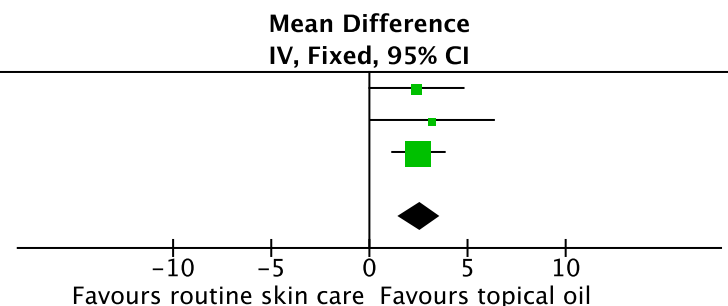
**Comparison:** Topical oil versus routine skin care in preterm neonates

**Outcome:** Rate of weight gain (g/kg/day)

Study or Subgroup	Topical oil			Routine skin care			Weight	Mean Difference IV, Fixed, 95% CI
	Mean	SD	Total	Mean	SD	Total		
Arora 2005	10.9	4.4	20	8.5	4.7	42	20.8%	2.40 [0.00, 4.80]
Kumar 2013	11.6	5.6	25	8.4	5.5	23	12.1%	3.20 [0.06, 6.34]
Sankaranarayanan 2005	11	2.6	32	8.5	2.8	31	67.1%	2.50 [1.16, 3.84]
<b>Total (95% CI)</b>			<b>77</b>			<b>96</b>	<b>100.0%</b>	<b>2.56 [1.47, 3.66]</b>

Heterogeneity:  $\chi^2 = 0.18$ ,  $df = 2$  ( $P = 0.91$ );  $I^2 = 0\%$

Test for overall effect:  $Z = 4.60$  ( $P < 0.00001$ )

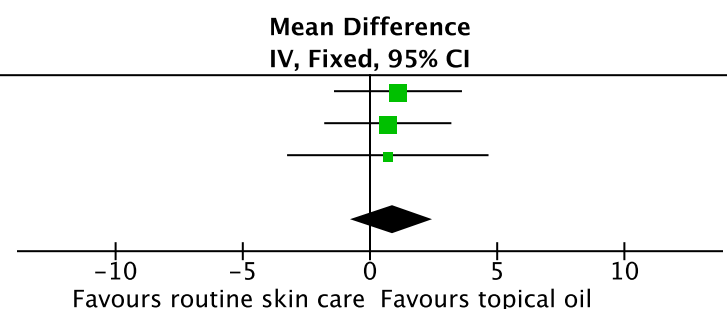


**Outcome:** Change in crown-heel length (mm/week)

Study or Subgroup	Topical oil			Routine skin care			Weight	Mean Difference IV, Fixed, 95% CI
	Mean	SD	Total	Mean	SD	Total		
Arora 2005	7.5	2.1	20	6.4	7.6	42	41.5%	1.10 [-1.38, 3.58]
Kumar 2013	6.5	2.3	25	5.8	5.6	23	42.0%	0.70 [-1.76, 3.16]
Sankaranarayanan 2005	6.3	6.8	32	5.6	8.9	31	16.5%	0.70 [-3.22, 4.62]
<b>Total (95% CI)</b>			<b>77</b>			<b>96</b>	<b>100.0%</b>	<b>0.87 [-0.73, 2.46]</b>

Heterogeneity:  $\chi^2 = 0.06$ ,  $df = 2$  ( $P = 0.97$ );  $I^2 = 0\%$

Test for overall effect:  $Z = 1.06$  ( $P = 0.29$ )

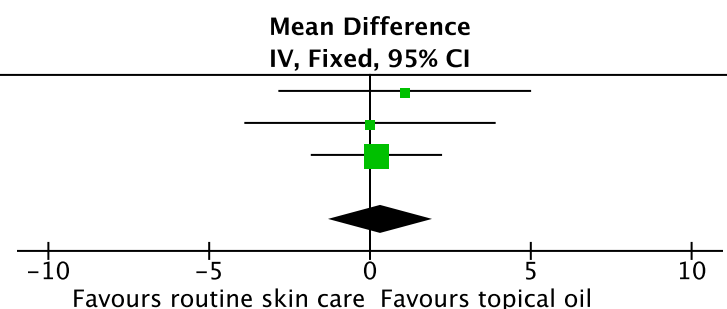


**Outcome:** Change in circumference (mm/week)

Study or Subgroup	Topical oil			Routine skin care			Weight	Mean Difference IV, Fixed, 95% CI
	Mean	SD	Total	Mean	SD	Total		
Arora 2005	7.2	6.3	20	6.12	9.1	42	17.3%	1.08 [-2.82, 4.98]
Kumar 2013	6	7	25	6	6.7	23	17.5%	0.00 [-3.88, 3.88]
Sankaranarayanan 2005	4.9	2.8	32	4.7	5	31	65.2%	0.20 [-1.81, 2.21]
<b>Total (95% CI)</b>			<b>77</b>			<b>96</b>	<b>100.0%</b>	<b>0.32 [-1.30, 1.94]</b>

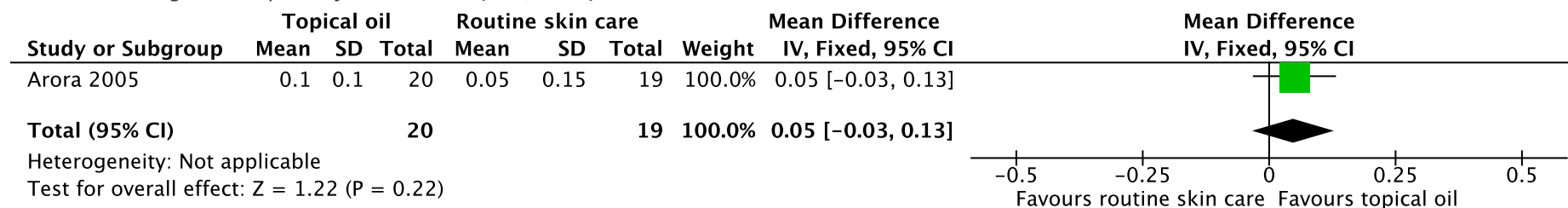
Heterogeneity:  $\chi^2 = 0.19$ ,  $df = 2$  ( $P = 0.91$ );  $I^2 = 0\%$

Test for overall effect:  $Z = 0.38$  ( $P = 0.70$ )



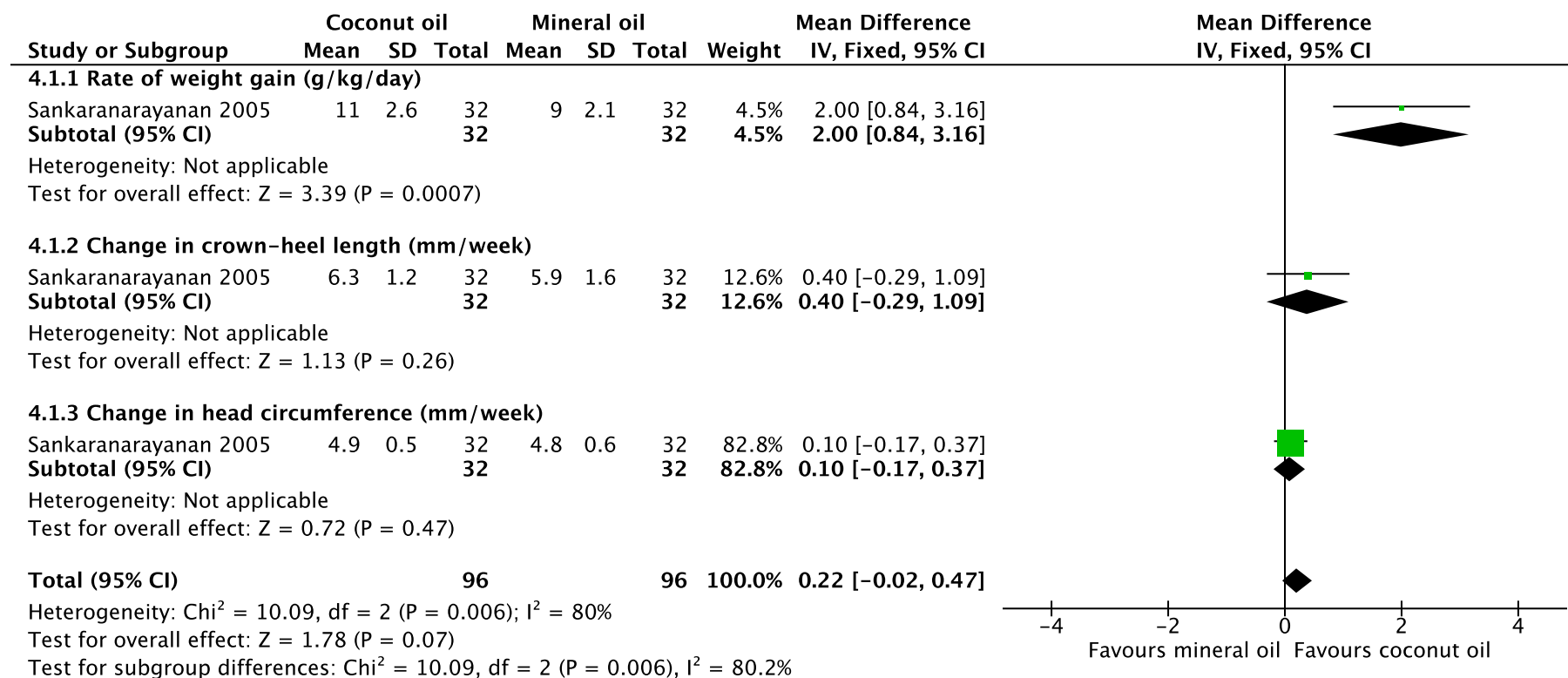
## Prevention and Treatment of Neonatal Infections in LMICs

### Outcome: Change in triceps skinfold thickness (mm/week)



### Comparison: One topical oil (or combination) versus another oil (or combination)

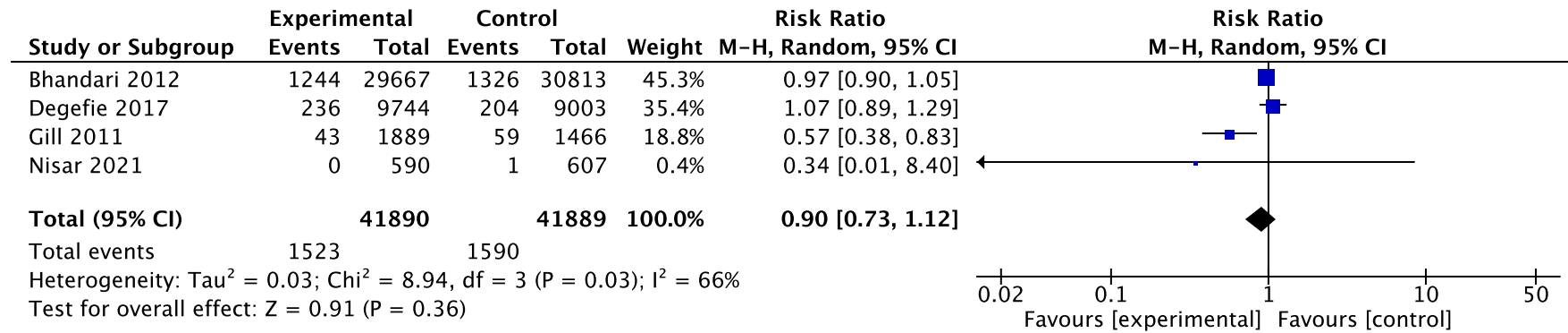
#### Outcome: Growth



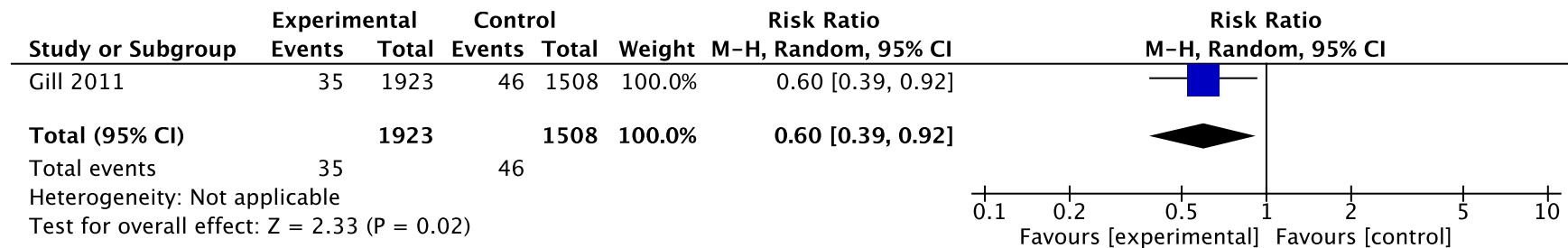
#### 4.2.4. Mixed Setting Antibiotic Delivery for PSBIs

**Comparison:** Home-based & primary facility-based antibiotic delivery versus standard care (i.e., hospital referral)

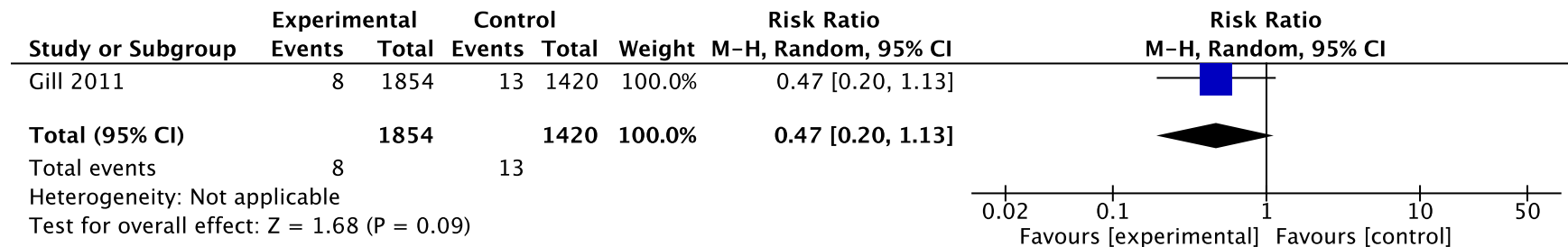
**Outcome:** All-cause neonatal mortality



**Outcome:** Early neonatal mortality



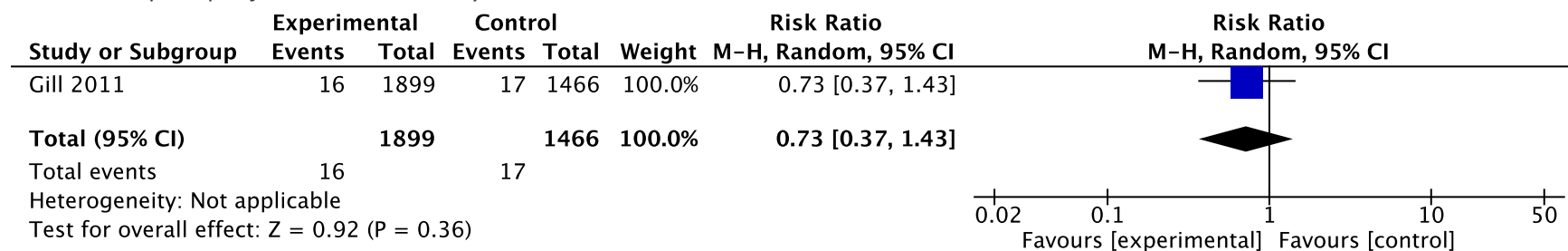
**Outcome:** Late neonatal mortality





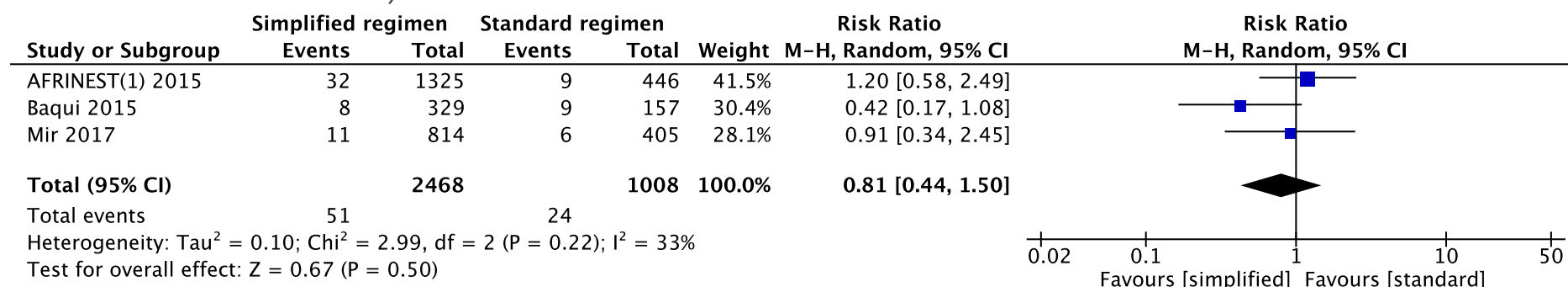
## Prevention and Treatment of Neonatal Infections in LMICs

### Outcome: Sepsis-specific neonatal mortality

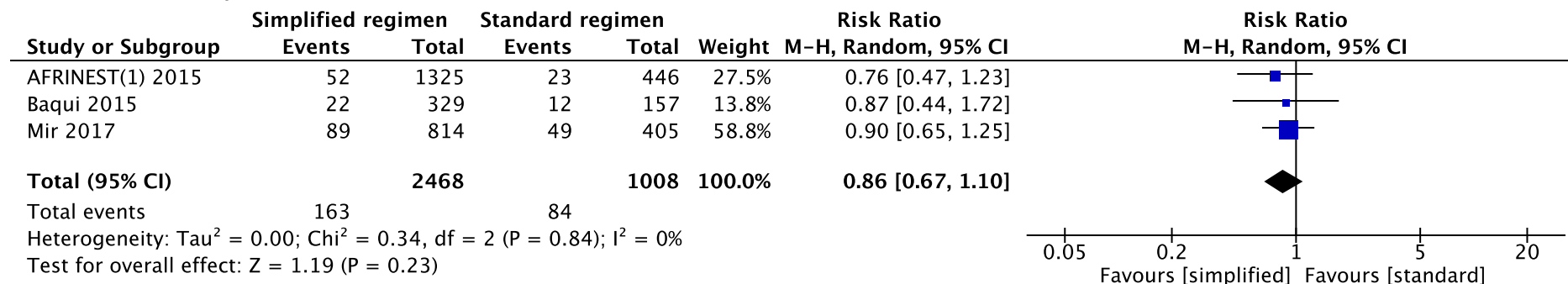


### Comparison: Simplified antibiotic regimens versus standard antibiotic regimens

#### Outcome: All-cause neonatal mortality

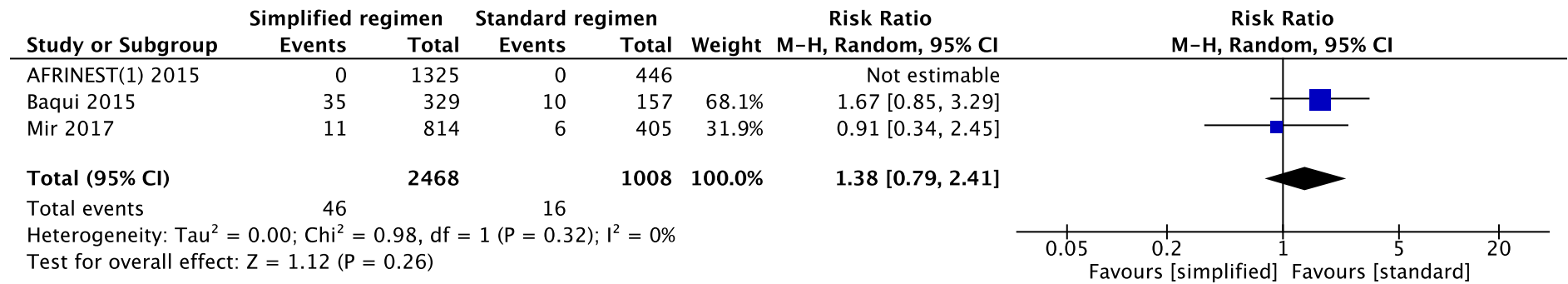


#### Outcome: Treatment failure



## Prevention and Treatment of Neonatal Infections in LMICs

### Outcome: Adverse effects

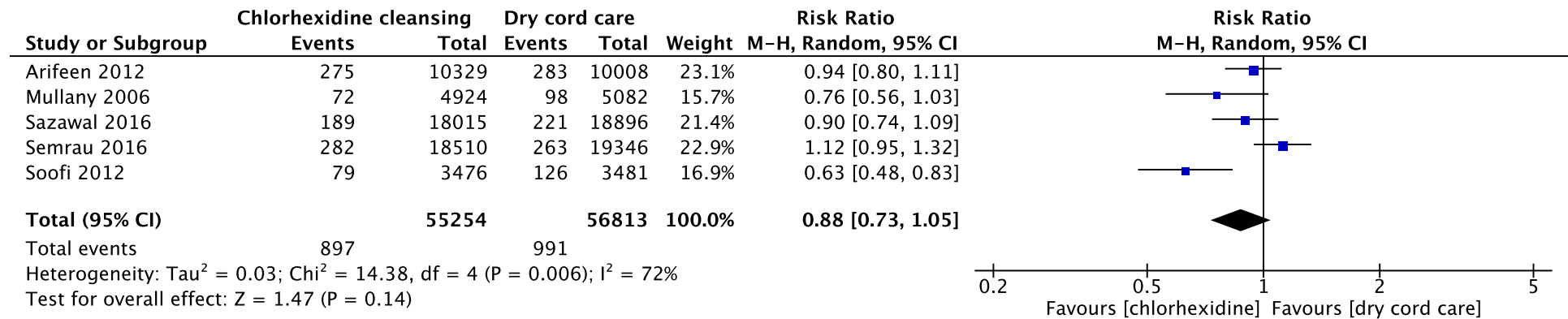


## 4.3 Community Level Forest Plots

### 4.3.1. Chlorhexidine Cleansing

**Comparison:** Chlorhexidine umbilical cord cleansing versus dry cord care

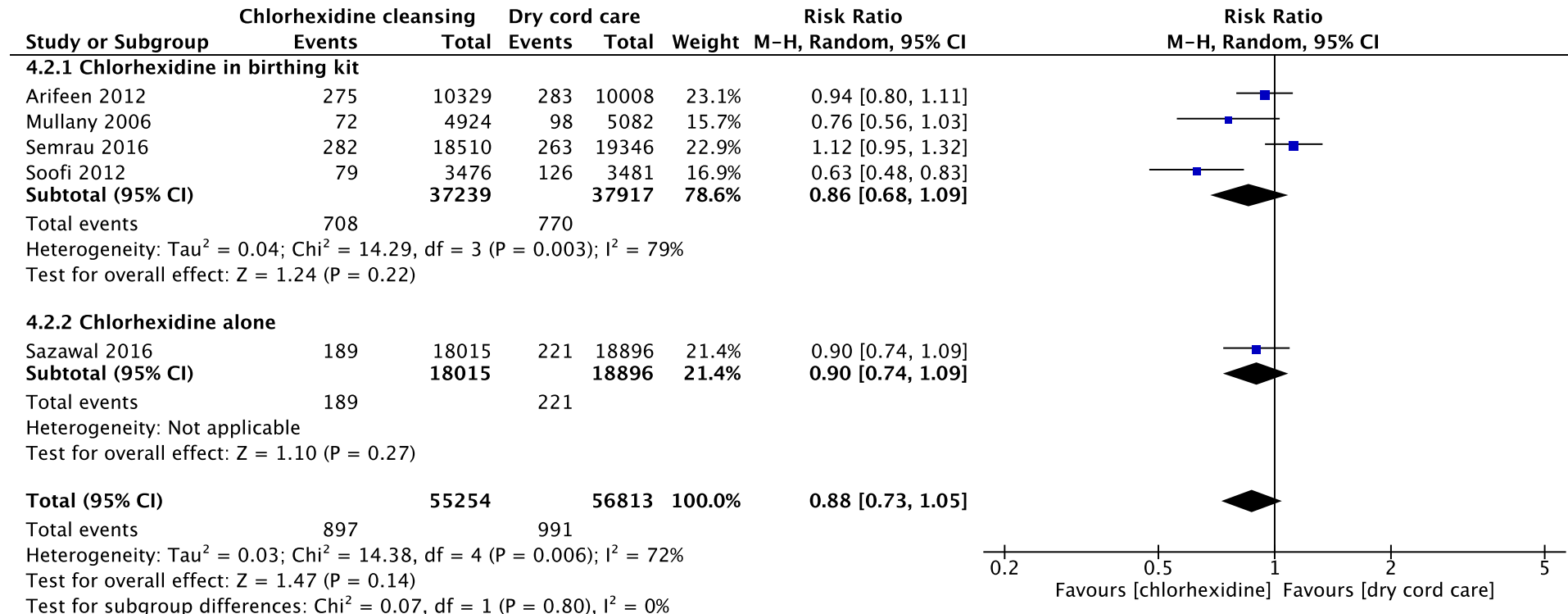
**Outcome:** Neonatal mortality



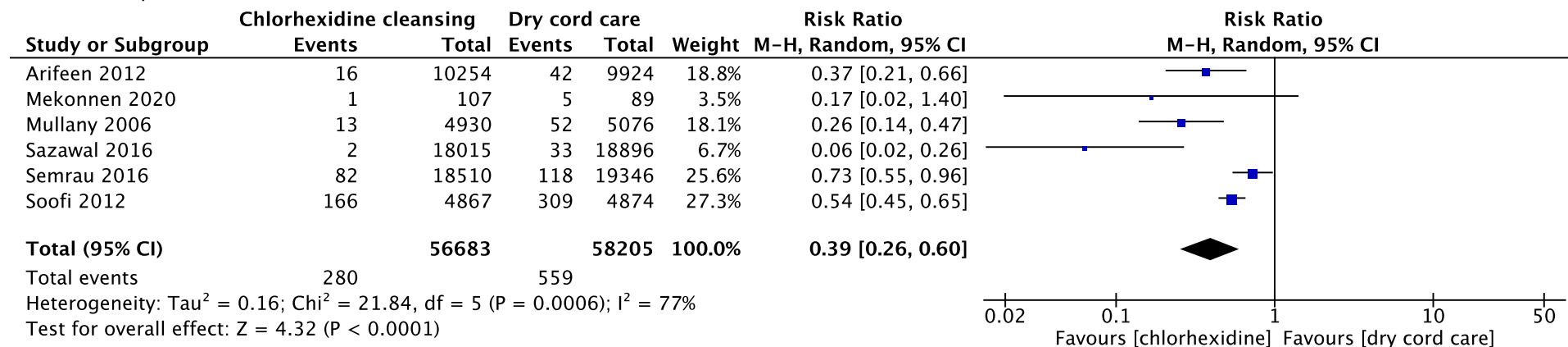
## Prevention and Treatment of Neonatal Infections in LMICs

### Subgroup Analysis: Chlorhexidine alone versus chlorhexidine in clean birth kits

#### Outcome: Neonatal mortality

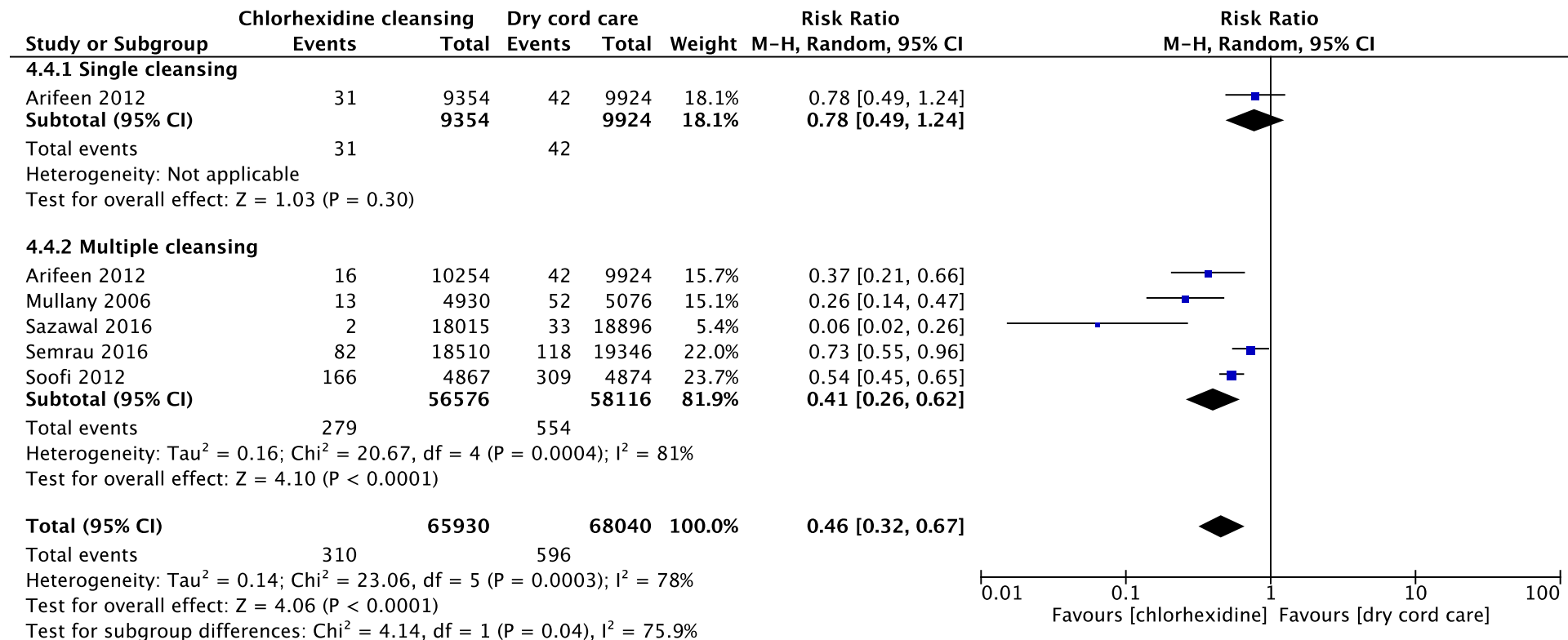


#### Outcome: Omphalitis



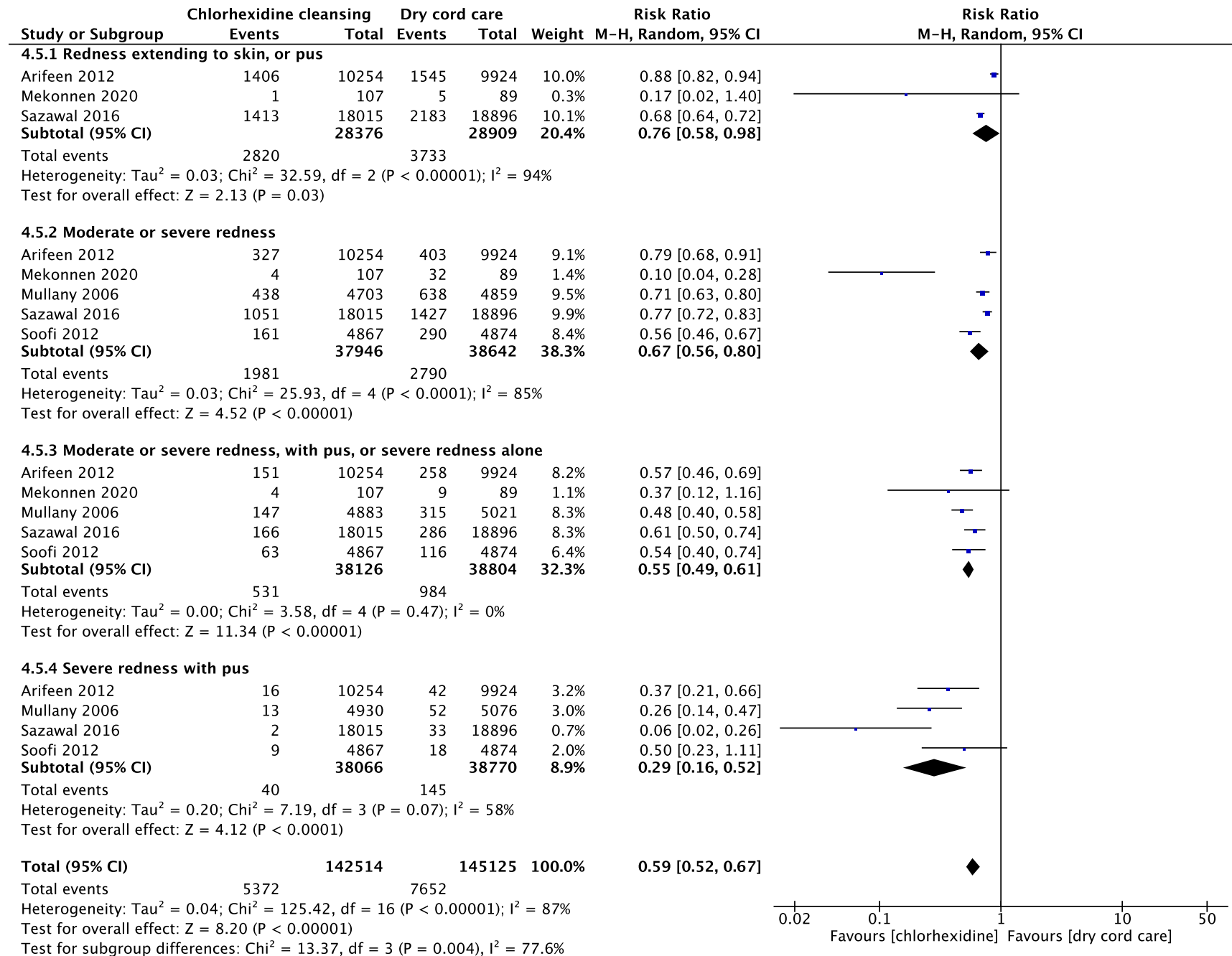
## Prevention and Treatment of Neonatal Infections in LMICs

### Outcome: Omphalitis by cleansing frequency



## Prevention and Treatment of Neonatal Infections in LMICs

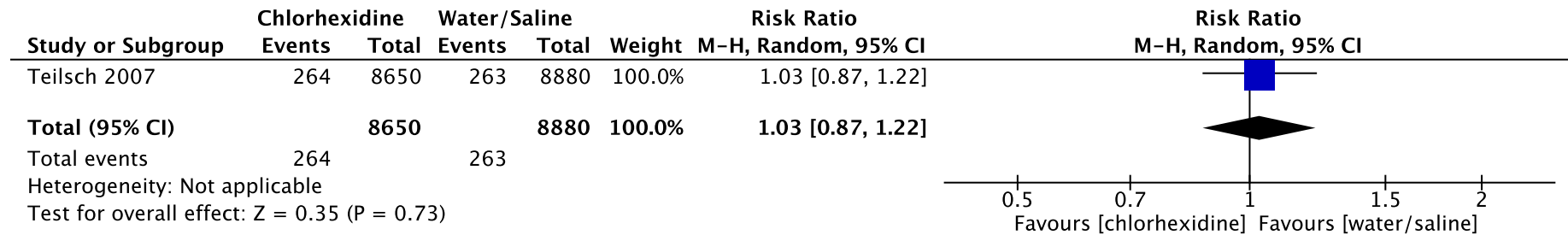
### Outcome: Omphalitis by severity



### Prevention and Treatment of Neonatal Infections in LMICs

**Comparison:** Chlorhexidine whole-body cleansing versus water/saline

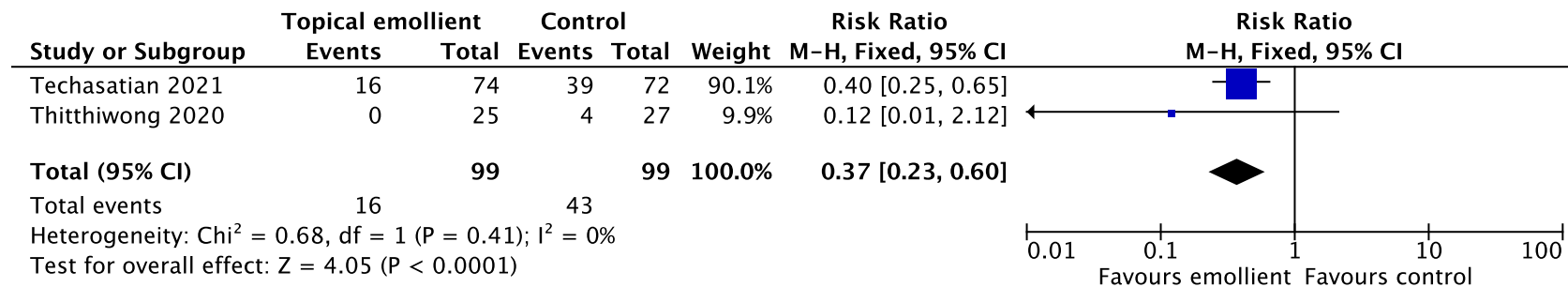
**Outcome:** Neonatal mortality



### 4.3.2. Topical Emollients

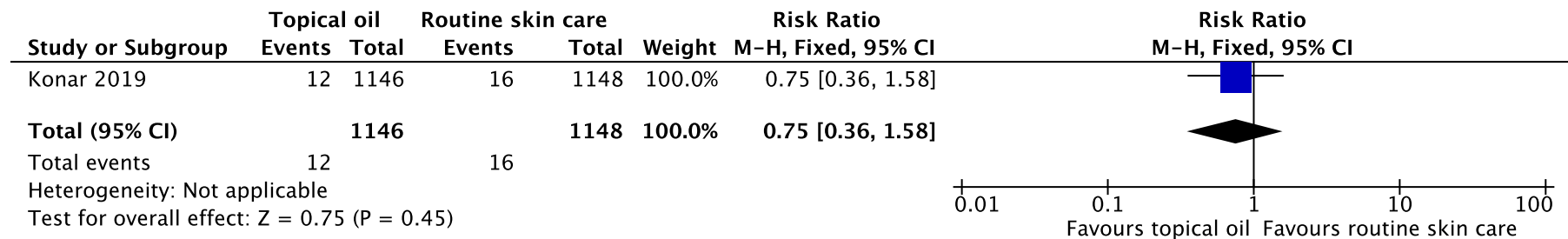
**Comparison:** Topical emollient versus routine skin care in term neonates

**Outcome:** Atopic dermatitis



**Comparison:** Topical oil versus routine skin care in preterm neonates

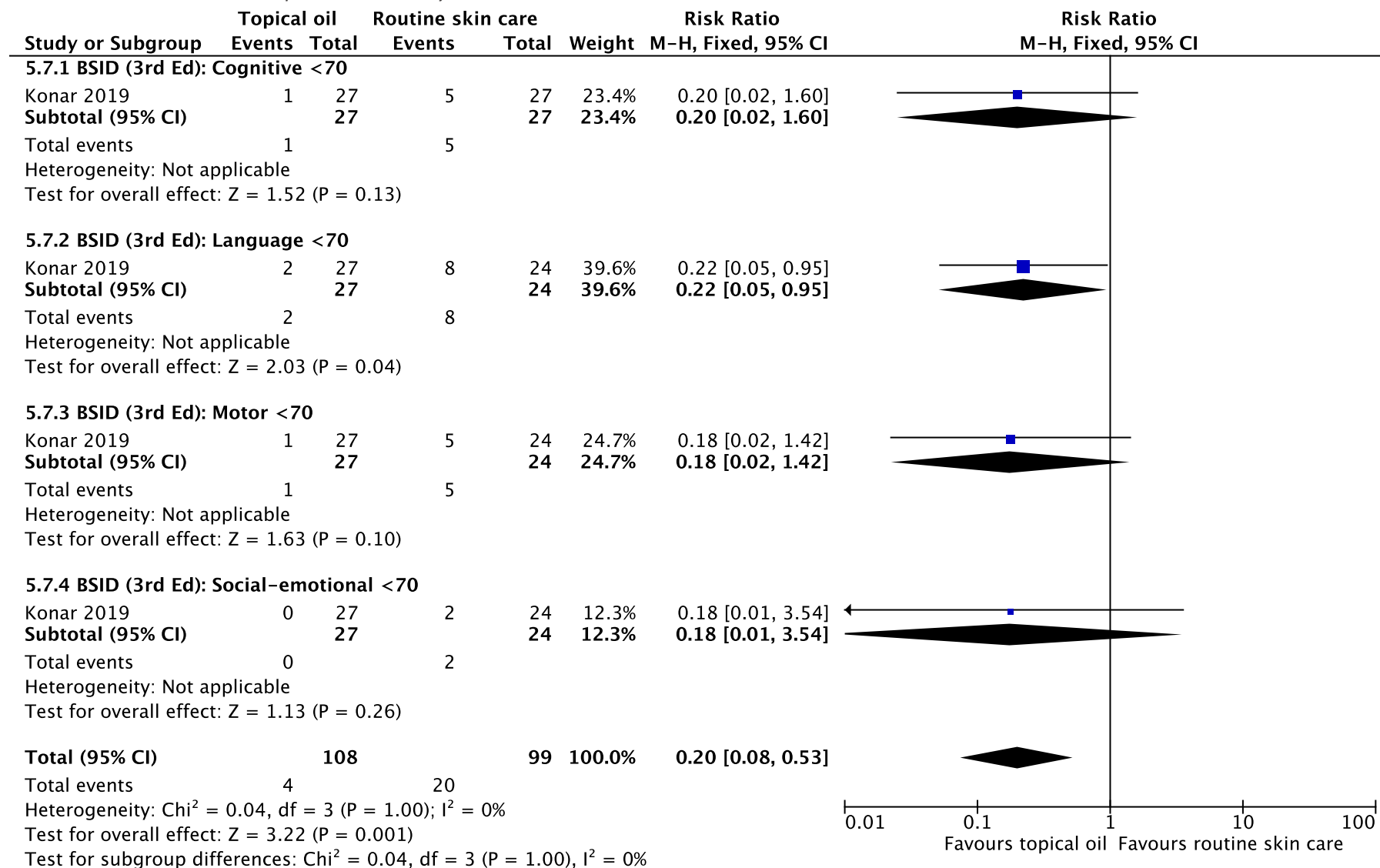
**Outcome:** Invasive infection (any organism)



## Prevention and Treatment of Neonatal Infections in LMICs

**Comparison:** Topical oil versus routine skin care in preterm neonates

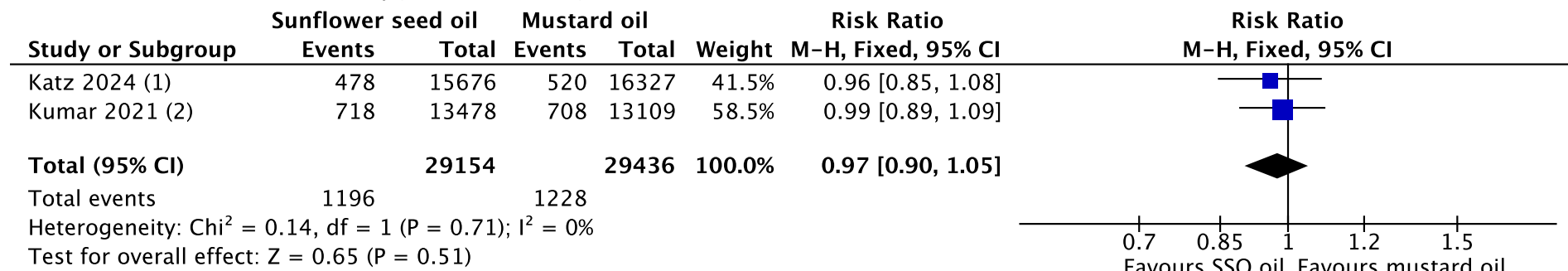
**Outcome:** Severe neurodevelopmental disability



# Prevention and Treatment of Neonatal Infections in LMICs

**Comparison:** Sunflower seed oil versus mustard oil in mixed term and preterm newborns

**Outcome:** All-cause neonatal mortality (intention-to-treat)

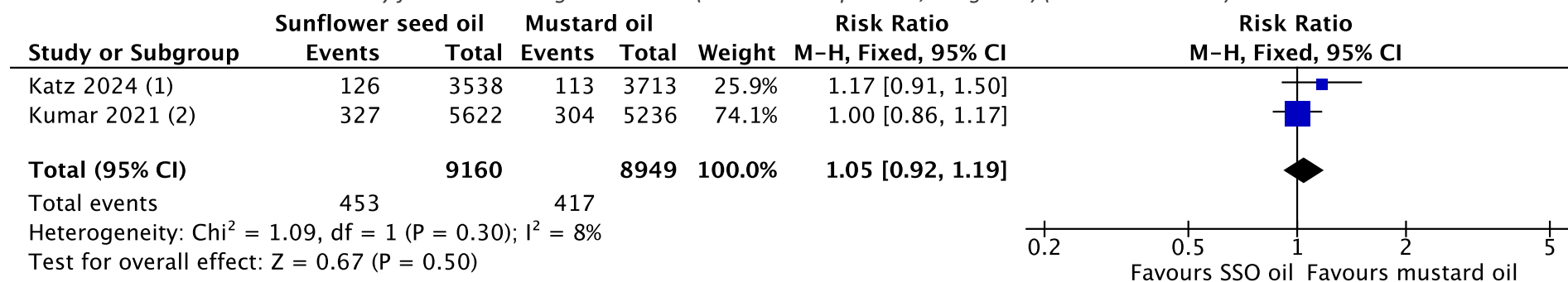


## Footnotes

(1) Intention-to-treat analysis

(2) Intention-to-treat analysis

**Outcome:** All-cause neonatal mortality for low birthweight newborns (less than or equal to 2,500 grams) (intention-to-treat)



## Footnotes

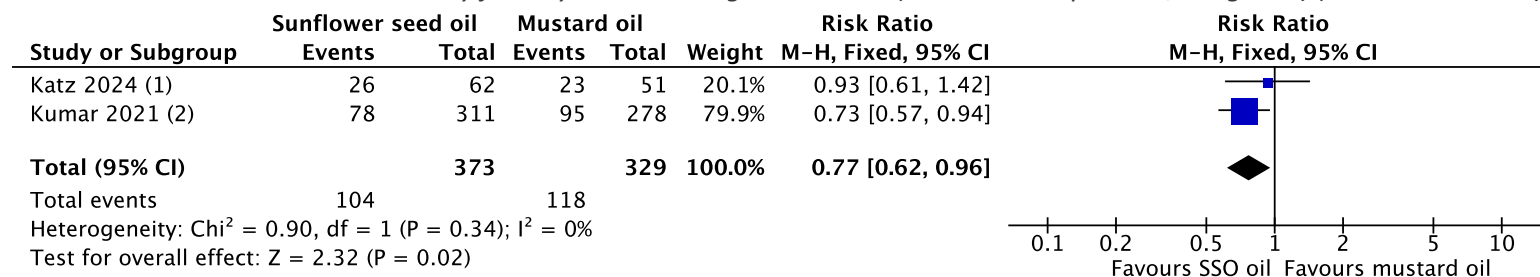
(1) newborns <2500 grams; intention-to-treat analysis

(2) newborns  $\leq 2500$  grams; intention-to-treat analysis



## Prevention and Treatment of Neonatal Infections in LMICs

**Outcome:** All-cause neonatal mortality for very low birthweight newborns (less than or equal to 1,500 grams) (intention-to-treat)

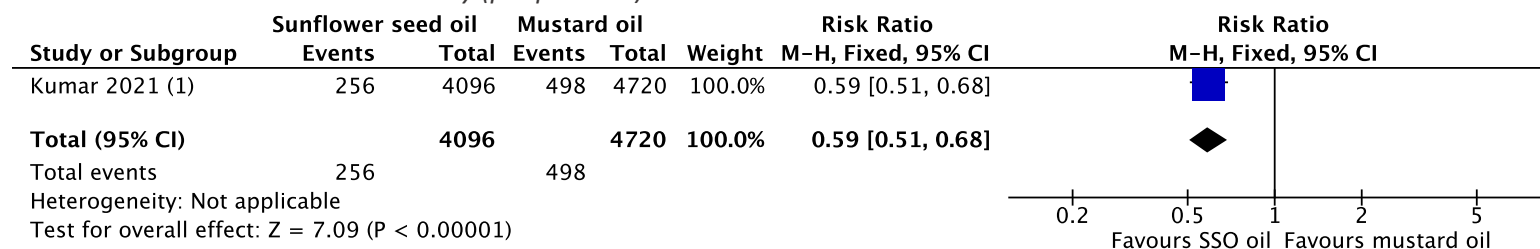


### Footnotes

(1) newborns <1500 grams; intention-to-treat analysis

(2) newborns  $\leq 1500$  grams; intention-to-treat analysis

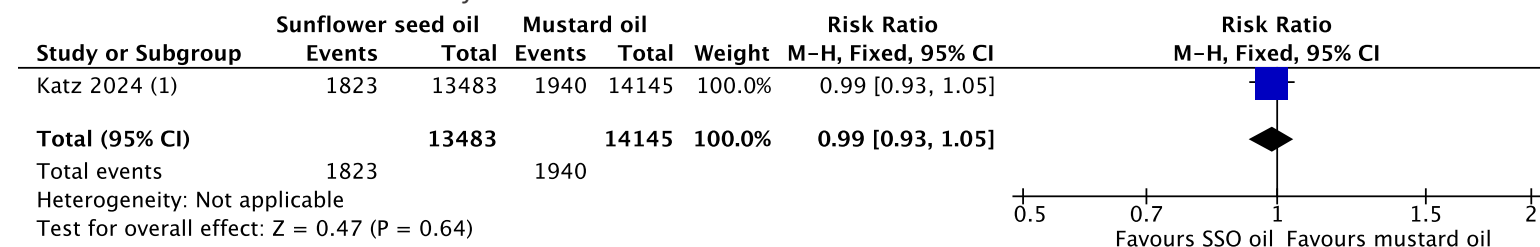
**Outcome:** All-cause neonatal mortality (per protocol)



### Footnotes

(1) Per protocol analysis

**Outcome:** Possible serious bacterial infections



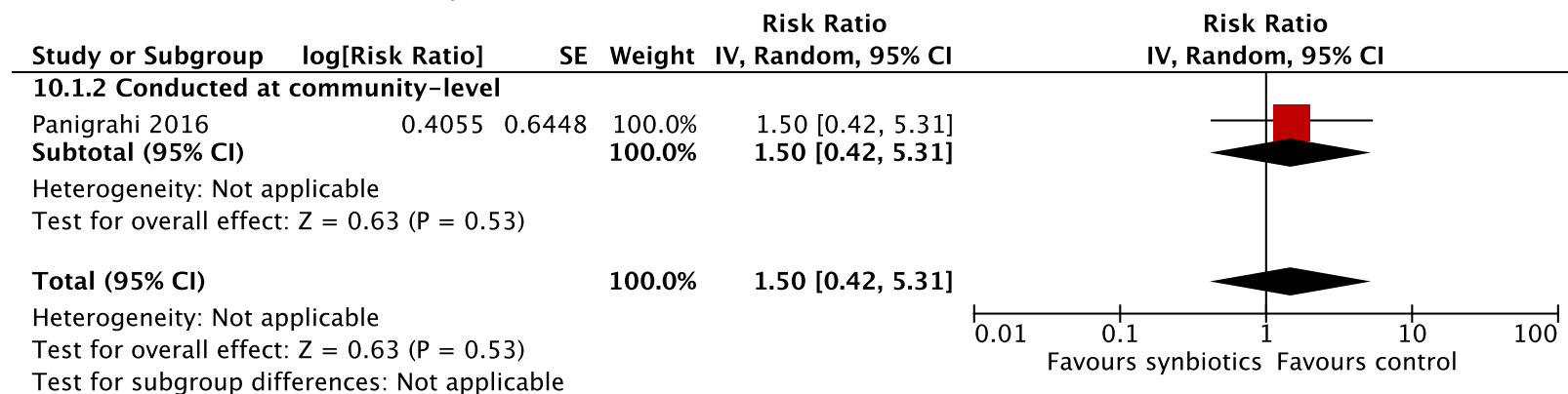
### Footnotes

(1) Intention-to-treat analysis

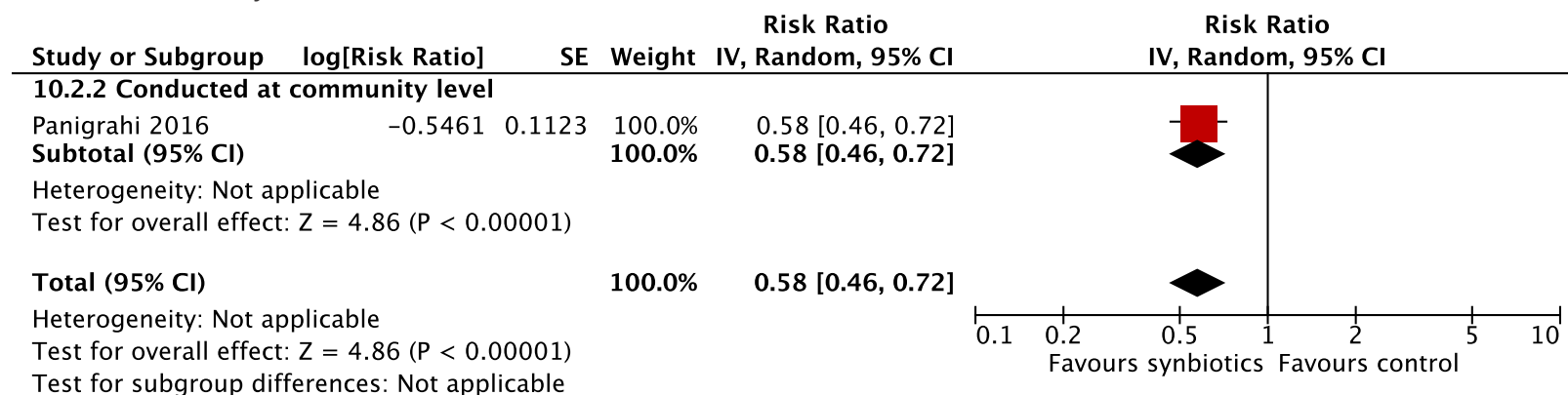
### 4.3.3. Synbiotics Supplementation

**Comparison:** Synbiotics versus control in term newborns

**Outcome:** All-cause neonatal mortality



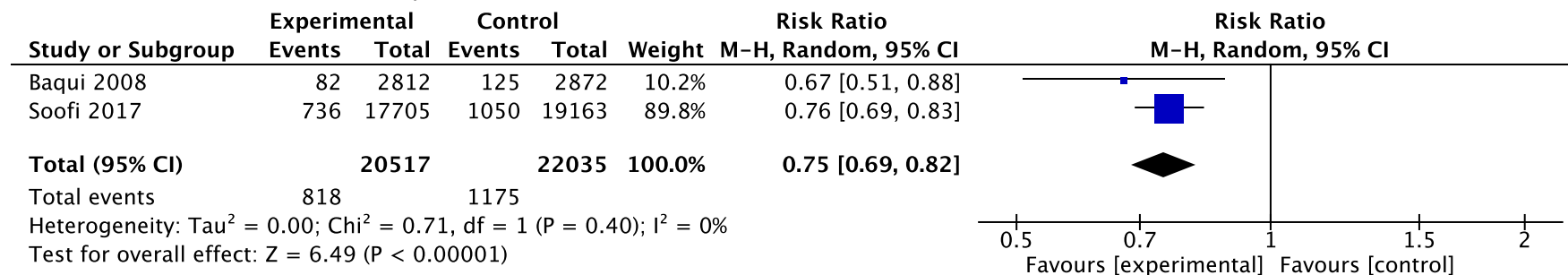
**Outcome:** Invasive infection



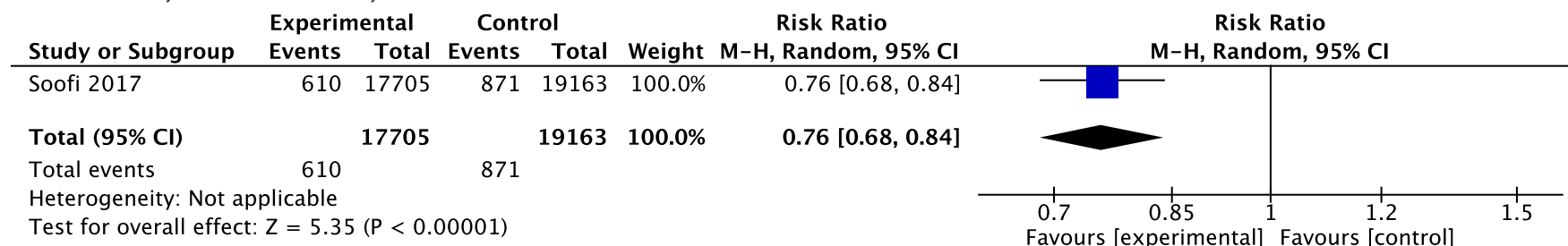
#### 4.3.4. Community-Based Antibiotic Delivery for PSBIs

**Comparison:** Community-based antibiotic delivery versus standard care (i.e., hospital referral)

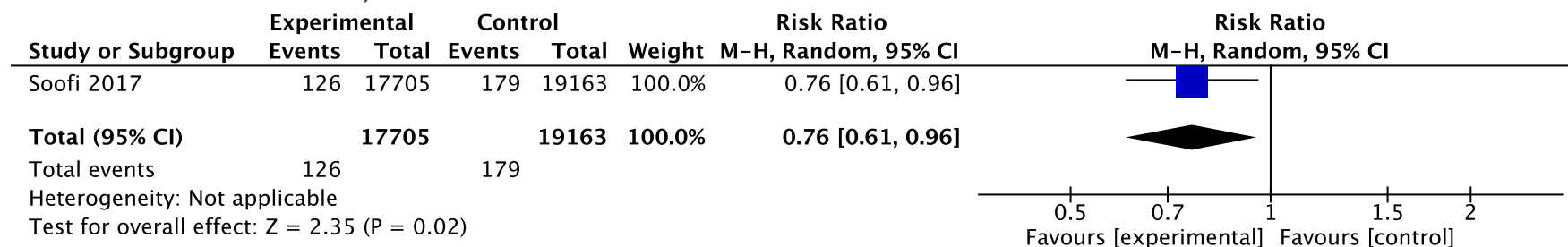
**Outcome:** All-cause neonatal mortality



**Outcome:** Early neonatal mortality

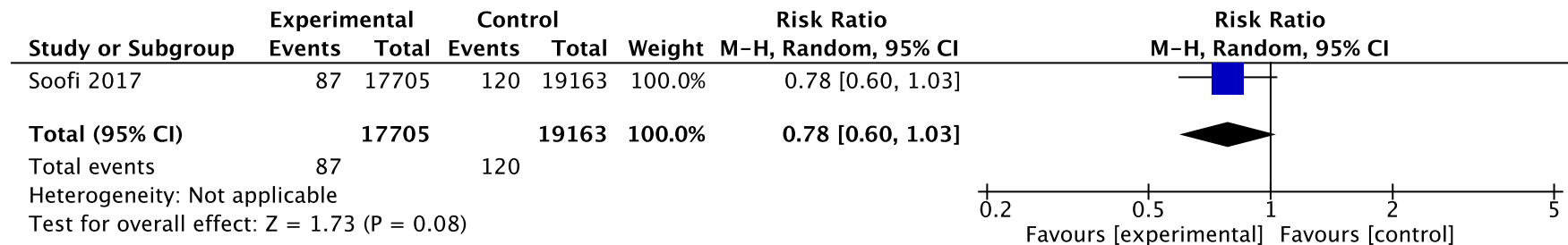


**Outcome:** Late neonatal mortality



## Prevention and Treatment of Neonatal Infections in LMICs

### Outcome: Sepsis-specific neonatal mortality



## Appendix 5: Prophylactic Systemic Antifungal Agents Background, Methods, Results, and Discussion

### Background

Yeast are naturally occurring on the skin and in the genitourinary tract and are transmitted vertically from mother to baby or horizontally within the hospital environment as a consequence of inadequate hand hygiene and IPC practices [14-17]; however, when colonizing yeast enter the newborn's bloodstream, severe systemic multi-organ infections can occur [18] with clinical presentations that are indistinguishable from invasive bacterial infections [10, 19]. To prevent systemic fungal infection, antifungal prophylaxis is frequently used, particularly for very preterm (<32 weeks' gestation) and very low birth weight (VLBW, <1500 grams) infants who are at greatest risk of fungemia due to their need for often lengthy hospitalization, surgeries, catheterization or mechanical ventilation, and prior or ongoing antibiotic therapy [10, 15, 20]. The most pervasive newborn nosocomial fungal infections are caused by *Candida* species [21], and prophylactic antifungal agents such as fluconazole, are normally the first choice for high-risk neonates, with amphotericin B commonly prescribed to treat invasive candidiasis [16]. Although invasive candidiasis is primarily diagnosed with blood culture, this test lacks sensitivity and high rates of false negative tests can hinder appropriate and timely antifungal treatment [14, 17, 22, 23]. There are also challenges in isolating higher than normal blood volumes and at greater frequency than normal to detect both the presence of infection and its clearance over time [16, 23, 24]. Because systemic antifungal infection is difficult to diagnose and therefore treat in a timely manner, there has been increased reliance on antifungal prophylaxis but gaps remain in the literature regarding its effect on mortality, morbidity, and its impact on the development of antifungal resistance [10] which is rising globally among *Candida auris*, *C. parapsilosis*, and *C. krusei* [14, 17, 21].

### Methods

The review on prophylactic systemic antifungals searched Cochrane Central Register of Controlled Trials (CENTRAL), MEDLINE, EMBASE, and CINAHL for randomized or quasi-randomized controlled trials pertaining to the effect of prophylactic systemic antifungal therapy versus control or placebo or another

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antifungal agent or regimen on primary outcomes of confirmed invasive fungal infection and mortality prior to hospital discharge in very preterm or VLBW infants [10].

We re-ran the search in the same databases for relevant trials published after the review's final search date of May 2015, and identified three new trials whose evidence was synthesized with ten trials from the existing review. For this topic, by technical advisory group (TAG) recommendation, we leveraged data from HIC contexts, recognizing the cost of the intervention and that in many LMICs newborns may not survive long enough to develop secondary fungal infections. To compare HIC and LMIC combined estimates with LMIC-only estimates, we disaggregated LMIC studies to evaluate the effectiveness of prophylactic systemic antifungals in low-resource settings. All trials were conducted in tertiary care facilities with eight trials conducted in HICs and five trials, two new and three existing trials, conducted in LMICs.

## Results

In treatment of suspected fungal infections in very preterm and very low birth weight (VLBW) newborns from high- and low-income facility-based settings, prophylactic systemic antifungal agents reduced the risk of invasive fungal infections by 59% (95% CI 45-70%) and mortality risk prior to hospital discharge by 22% (95% CI 1-38%), when compared to control or placebo. In very preterm and VLBW newborns from LMICs alone, prophylactic systemic antifungals reduced the risk of invasive fungal infections by 47% (95% CI 20-65%), but had no significant effect on mortality prior to hospital discharge (see *Appendix 7.1.6.*), when compared to control or placebo.

**Table 4** Effect estimates for prophylactic systemic antifungal agents treat suspected neonatal infections in facility settings.

Prophylactic systemic antifungal agents						
Comparison	Population	Outcome	Subgroup	No. of studies (No. of participants)	Effect estimate (95% CI)	Heterogeneity (I <sup>2</sup> )
Prophylactic systemic antifungals vs. control or placebo	Very preterm or VLBW neonates	Invasive fungal infection	Total*	12 (1,827)	RR 0.41 (0.30, 0.55)	37%
Prophylactic systemic antifungals vs. control or placebo	Very preterm or VLBW neonates	Invasive fungal infection	Studies conducted in LMICs only	4 (474)	RR 0.53 (0.35, 0.80)	67%

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<b>Prophylactic systemic antifungals vs. control or placebo</b>	Very preterm or VLBW neonates	Neonatal mortality prior to hospital discharge	Total*	11 (1,551)	<b>RR 0.78</b> (0.62, 0.99)	0%
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VLW, very low birth weight; **bolded effect estimates are statistically significant ( $p < 0.05$ )**

\*Leveraged HIC data to produce an HIC and LMIC combined estimate.

### Discussion

Prophylactic systemic antifungal agents were strongly effective in reducing the risk of invasive fungal infections but less effective in reducing the risk of neonatal mortality prior to hospital discharge when used in a high-resource settings for treatment of suspected fungal infections in very preterm and VLBW newborns. Comparatively, we found that systemic antifungal prophylaxis reduced the risk of invasive fungal infections but had no effect on mortality prior to hospital discharge in very preterm and VLBW newborns from LMICs. Similarly, the 2015 Cochrane review [10], which included trials at all income levels, found a statistically significant reduction in the risk of invasive fungal infection only, with no difference in mortality prior to discharge between treatment and control groups. Considerations that must be addressed in LMIC implementation include improving antifungal drug availability and ensuring laboratory diagnostic capacity for fungal infections [25]. In the absence of such resources, stricter attention to modifiable risk factors for nosocomial fungal infections such as the use of broad-spectrum antibiotics and central venous catheters are recommended to decrease fungal infection incidence [14]. More LMIC-based research is needed to evaluate the safety and effectiveness of this intervention, as well as considerations including cost-effectiveness, and barriers and facilitators to implementation, to further elucidate the viability of this intervention in LMICs.

## REFERENCES

- 1 Fitzgerald FC, Zingg W, Chimhini G, Chimhuya S, Wittmann S, Brotherton H, et al. The Impact of Interventions to Prevent Neonatal Healthcare-associated Infections in Low- and Middle-income Countries: A Systematic Review. *Pediatr Infect Dis J*. 2022;41(3S):S26-S35.
- 2 Lassi ZS, Fisher Z, Andraweera P, Cummins A, Roberts CT. Effectiveness of birthing kits for clean childbirth: a systematic review. *Int Health*. 2020;12(1):3-10.
- 3 Zhou J, Mei L, Chen S. Effect of chlorhexidine cleansing on healthcare-associated infections in neonates: a systematic review and meta-analysis. *Arch Dis Child Fetal Neonatal Ed*. 2022;107(4):398-407.
- 4 WHO. WHO recommendations on maternal and newborn care for a positive postnatal experience. Geneva: World Health Organization; 2022.
- 5 Cleminson J, McGuire W. Topical emollient for preventing infection in preterm infants. *Cochrane Database Syst Rev*. 2021;5(5):CD001150.
- 6 Priyadarshi M, Balachander B, Gupta S, Sankar MJ. Topical emollient application in term healthy newborns: A systematic review. *J Glob Health*. 2022;12:12002.
- 7 Sharif S, Meader N, Oddie SJ, Rojas-Reyes MX, McGuire W. Probiotics to prevent necrotising enterocolitis in very preterm or very low birth weight infants. *Cochrane Database Syst Rev*. 2020;10(10):CD005496.
- 8 Imdad A, Rehman F, Davis E, Attia S, Ranjit D, Surin GS, et al. Effect of Synthetic Vitamin A and Probiotics Supplementation for Prevention of Morbidity and Mortality during the Neonatal Period. A Systematic Review and Meta-Analysis of Studies from Low- and Middle-Income Countries. *Nutrients*. 2020;12(3).
- 9 Sharif S, Heath PT, Oddie SJ, McGuire W. Synbiotics to prevent necrotising enterocolitis in very preterm or very low birth weight infants. *Cochrane Database Syst Rev*. 2022;3(3):CD014067.
- 10 Cleminson J, Austin N, McGuire W. Prophylactic systemic antifungal agents to prevent mortality and morbidity in very low birth weight infants. *Cochrane Database Syst Rev*. 2015;2015(10):CD003850.
- 11 Duby J, Lassi ZS, Bhutta ZA. Community-based antibiotic delivery for possible serious bacterial infections in neonates in low- and middle-income countries. *Cochrane Database Syst Rev*. 2019;4(4):CD007646.
- 12 Thomas D, Sharma A, Sankar MJ. Probiotics for the prevention of mortality and sepsis in preterm very low birth weight neonates from low- and middle-income countries: a Bayesian network meta-analysis. *Front Nutr*. 2023;10:1133293.
- 13 Feng K, He Y, Liu W, Zhang X, Song P, Hua Z. Evaluation of antibiotic stewardship among near-term and term infants admitted to a neonatal unit. *Eur J Pediatr*. 2023;182(1):245-54.
- 14 Kilpatrick R, Scarrow E, Hornik C, Greenberg RG. Neonatal invasive candidiasis: updates on clinical management and prevention. *Lancet Child Adolesc Health*. 2022;6(1):60-70.
- 15 Ferrando G, Castagnola E. Prophylaxis of Invasive Fungal Infection in Neonates: A Narrative Review for Practical Purposes. *J Fungi (Basel)*. 2023;9(2).
- 16 Camacho-Gonzalez A, Spearman PW, Stoll BJ. Neonatal infectious diseases: evaluation of neonatal sepsis. *Pediatr Clin North Am*. 2013;60(2):367-89.
- 17 Suleyman G, Alangaden GJ. Nosocomial Fungal Infections: Epidemiology, Infection Control, and Prevention. *Infect Dis Clin North Am*. 2021;35(4):1027-53.
- 18 Weimer KED, Smith PB, Puia-Dumitrescu M, Aleem S. Invasive fungal infections in neonates: a review. *Pediatr Res*. 2022;91(2):404-12.
- 19 Ng PC. Systemic fungal infections in neonates. *Archives of Disease in Childhood*. 1994;71:130-5.
- 20 Huang D, Li H, Lin Y, Lin J, Li C, Kuang Y, et al. Antibiotic-induced depletion of *Clostridium* species increases the risk of secondary fungal infections in preterm infants. *Front Cell Infect Microbiol*. 2022;12:981823.
- 21 Cook A, Ferreras-Antolin L, Adhisivam B, Ballot D, Berkley JA, Bernaschi P, et al. Neonatal invasive candidiasis in low- and middle-income countries: Data from the NeoOBS study. *Med Mycol*. 2023;61(3).
- 22 Bassetti M, Azoulay E, Kullberg BJ, Ruhnke M, Shoham S, Vazquez J, et al. EORTC/MSGERC Definitions of Invasive Fungal Diseases: Summary of Activities of the Intensive Care Unit Working Group. *Clin Infect Dis*. 2021;72(Suppl 2):S121-S7.

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23 Hsieh E, Smith PB, Jacqz-Aigrain E, Kaguelidou F, Cohen-Wolkowicz M, Manzoni P, et al. Neonatal fungal infections: when to treat? *Early Hum Dev.* 2012;88 Suppl 2(Suppl 2):S6-S10.

24 Clancy CJ, Nguyen MH. Finding the "missing 50%" of invasive candidiasis: how nonculture diagnostics will improve understanding of disease spectrum and transform patient care. *Clin Infect Dis.* 2013;56(9):1284-92.

25 Driemeyer C, Falci DR, Oladele RO, Bongomin F, Ocansey BK, Govender NP, et al. The current state of clinical mycology in Africa: a European Confederation of Medical Mycology and International Society for Human and Animal Mycology survey. *Lancet Microbe.* 2022;3(6):e464-e70.