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PART 1:

Journal Name:	International Journal of TROPICAL DISEASE & Health
Manuscript Number:	2013_IJTDH_4985
Title of the Manuscript:	PATTERN OF NEONATAL MORTALITY IN A TERTIARY HEALTH FACILITY IN UMUAHIA, SOUTH EAST, NIGERIA
Type of the Article	Research paper

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PART 2: Review Comments

	Reviewer's comment	Author's comment (if agreed with reviewer, correct the manuscript and highlight that part in the manuscript. It is mandatory that authors should write his/her feedback here)
<u>Compulsory</u> REVISION comments	1. The Introduction does not present an evidence-based review of the possible intervention to reduce neonatal death. Neonatal resuscitation is not in the list of simple actions/care but it is more effective than early treatment of infections and other interventions listed. Reference 10 was published before the data on resuscitation trials were published in Pediatrics, and Perlman J in Pediatrics papers). Essential newborn care (ENC) is also very effective and proven by a large trial (Cario WA, NEJM). Indeed, both interventions have a much larger effect than the obstetric interventions mentioned. High level of evidence trials should be addressed better in the introduction not put in the Discussion. 2. The demographic characteristics provided are limited. A table using a rather standard format of reporting a cohort should be provided instead. This table should include livebirths and deaths (allowing comparison), birth weights (the most important predictor of death), sex (making Figures 2 and 3 unnecessary), and inborn/outborn death, facility birth, method of delivery, duration of hospitalization, and other baseline demographics. 3. The current Table II is the only one that is acceptable. Data on Table I are not needed in the manuscript unless mortality was seasonal. Timing of death can be stated in the results. A table is not needed.	[1]. The introduction section has been updated to incorporate references on neonatal resuscitation: Adequate training and retraining of personnel involved in deliveries with provisions of equipment required for neonatal resuscitation of newborns with intra-partum asphyxia has shown a significant decrease in deaths attributable to birth asphyxia.^{10,14,15} See references 14 & 15: 14. Carlo WA, McClure EM, Chomba E, Chakraborty H, Hartwell T, Harris H, Lincetto O, Wright LL. Newborn care training for midwives and neonatal and perinatal mortality rate in a developing country. Pediatrics 2010; 126(5): e1064-e1071.

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	4. Most of the results stated in the Results section should be included in the demographic characteristic table suggested. 5. The methods do not address the process for assigning cause of death. The person making the diagnosis and the algorithm used to classify death should be stated. For example, if a premature baby had birth asphyxia, was the cause of death prematurity or asphyxia? 6. The definitions for the cause of death should be mentioned unless it is obvious, for example what criteria had to be met to classify a death as due to asphyxia? 7. Data on whether this is a population-based study or not are not provided. It this one of several referral hospitals in the region.	15. Perlman JM, Wyllie J, Kattwinkel J, Atkins DL, Chameldes L, Hazinski MF, Morley C, Richmond S, Simon WM, Singhal N, Szyld E, Tamura M, Velaphi S. Neonatal resuscitation: 2010 International Consensus on cardiopulmonary Resuscitation and emergency cardiovascular Care Science with Treatment recommendation. 2013copyright, American Academy of Pediatrics [2]. Table 1has been modified in line with the suggestions (SOCIODEMOGRAPHICS). [4]. Already done as shown in the new Table 1 (results). [5]. Standard case definitions were used to assign admitting diagnoses/cause of death. Usually the registrar on call receives the babies as they present while
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		the diagnosis at death is finally assigned by the unit consultant. [6]. This is contained in the materials and methods section: Babies born before 37 completed weeks of gestation are generally regarded as preterm delivery while birth asphyxia is defined as history of failure or delayed onset of spontaneous respiration after birth or 5 minutes APGAR score < 7, or history of delayed cry or need for resuscitation for > 10 minutes in full term babies.^{18,19} Usually the registrar on duty admits and first assesses the presenting newborn and is subsequently reviewed by a senior registrar and the supervising consultant. See Materials and Methods sub- section on page 5 lines 16-19. [7]. The study was conducted at the
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		federal Medical Centre Umuahia, Abia State, South East Nigeria. It is a tertiary referral hospital. See Materials and methods page 5 lines 3-9.: The Centre serves as a major referral centre for patients from within AbiaState and also some surrounding states of Imo and Rivers. The newborn babies basically are referred in house from the Department of Obstetrics and Gynecology and out-born (those babies born before arrival to the hospital). The NBSCU has three sections: for inborn (delivered in FMC, Umuahia), out-born (referrals) and an isolation section for very ill-newborns all geared towards reduction of cross infection within the nursery. About 1500 deliveries are recorded annually in the Centre.
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<u>Minor</u> REVISION comments	Age of admission has not been analyzed as a covariate for death.	
<u>Optional/General</u> comments		