was to determine the immediate and long-term impact of introduction of low-cost guidelines on neonatal mortality in a low-income setting.

Methods Neonatal mortality was audited for three months prior to the intervention. The intervention consisted of guidelines developed using a literature review and experience from local doctors, nurses and a visiting paediatrician. The guidelines focused on four areas: (i) ensuring all babies requiring oxygen, antibiotics or fluids were cared for on the neonatal unit, (ii) separating infants with infections from premature infants, improving hand washing techniques and teaching parents to perform observations thus reducing cross contamination, (iii) using antibiotic regimens based on microbiology data and lower thresholds to start antibiotic treatment, (iv) acutely unwell infants were not enterally fed and nasogastric tubes were for premature or neurologically compromised infants. The guidelines were disseminated at a ward meeting at the end of the audit and implemented with ongoing ward based teaching. Mortality was re-audited for the three-month period immediately post implementation. The audit was repeated at the same period of the year three years and six years post intervention.

Results Pre-intervention there were 79 neonatal deaths in the three months with 137 admissions to the neonatal unit (0.58 deaths per admission). Forty-nine neonatal deaths occurred in the three months post intervention with 187 admissions to the neonatal unit (0.26 deaths per admission) (p<0.001). Three years post intervention there were 60 neonatal deaths and 233 admissions to the neonatal unit (0.26 deaths per admission), six years post intervention, there were 53 neonatal deaths and 315 admissions to the neonatal unit (0.17 deaths per admission, p<0.001).

Conclusion These data demonstrate it was possible to produce a sustained reduction in hospital neonatal mortality in Western Uganda.

Background/Aims World Child Cancer has created twinning partnerships with developing oncology services in low-middle income countries (LMICs) to support improvement of services for children with cancer. Central to success for these is the creation of effective shared-care networks not just single centre support. There is a dearth of good literature on network development. Our aim was to create an ideal model.

Methods The model was developed through learning from a 3 year UK Government(DFID) funded programme in Ghana and Bangladesh in which new shared care units were created and from lessons shared from other WCC-funded programmes in Myanmar and the Philippines. A 2 dayworkshop was held, focussing on lessons learnt from paediatricians representing networks in different stages of development to identify key elements and steps necessary to optimise planning.

Results The over-arching proposed themes for the model were need for; excellent, regular communication between the centres; twinning partnerships and funding. A successful shared-care network must have a strong hub hospital at its centre with at least one fully trained paediatric oncologist and a committed multi-disciplinary team. The hub (referral) centre must have dedicated space/beds, develop treatment guidelines and protocols and provide training for the staff populating the satellite units. Shared-care centres must be strategically chosen based on population demography and accessibility, create development plans and service provision to replicate the hub centre as close as resources allow... Collaborative working and good communication, using the same treatment protocols, developing two-way referral systems and sharing successes and any failures are essential. Sustainable development is ensured.