Defining ‘N’ in RMNCAH - 
Every Newborn Action Plan Country Planning and Costing 
Toolkit and User Guide

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Acknowledgements

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Defining ‘N’ in RMNCAH - Every Newborn Action Plan Country Planning and Costing Toolkit and User Guide

Purpose of this user guide
This user guide was designed to support countries in applying the available planning and costing tools to develop national newborn action plans.

It brings together the wealth of knowledge that exists in fore-runner countries, to make examples and lessons learned available to all countries aspiring to strengthen the newborn component in their RMNCAH plans. It is intended for use by all those engaged with planning and costing newborn health activities, such as health planners, health managers, and technical experts in maternal and newborn health.

Why now?

Partners recognized the need to provide more guidance for a harmonized and evidence-based approach to planning and costing newborn health activities in countries. This document hopes to fill this gap, by offering practical guidance to apply the available tools. It is intended to complement other sources of support, for example technical assistance available from country, regional and HQ offices of UN agencies, or from other international and national organizations involved in this work. A list of generic RMNCAH tools can be accessed at [http://www.everywomaneverychild.org/h6-toolkit](http://www.everywomaneverychild.org/h6-toolkit), a tool kit to support implementation of the UN Secretary-General’s Global Strategy for Women’s, Children’s and Adolescents’ Health, including many of the tools presented in this user guide. In addition, the Healthy Newborn Network ([http://www.healthynewbornnetwork.org/](http://www.healthynewbornnetwork.org/)) is an online community that seeks to address knowledge gaps in newborn health, and contains a wealth of information and resources, including examples of plans, reports, articles and tools, among others. Countries are invited to continue documenting and sharing experiences on this platform.

How can this guide help you?

Countries can draw on the examples presented, ranging from experiences in holding national consultations on newborn health, to strategies for prioritizing activities in plans, to advice for costing and developing an investment case. Particular focus is on guiding evidence-based planning, setting targets and prioritizing strategies for equity focused approaches.

While the Global Every Newborn Action Plan provides a roadmap and platform for the reduction of preventable newborn mortality, this user guide provides real life examples and practical suggestions for developing and costing national plans. It is not intended to be prescriptive, and recognizes that each country is at different stages on the path to improving newborn health. Instead it offers multiple examples, inviting users to consider options that are most helpful to address the current challenges.

How is the guide structured?

Following brief introductions to each of the tools available for planning and costing newborn action plans, it presents experiences from countries such as best practices and success factors, but also challenges they faced and strategies they adopted to overcome them.

The following chapters cover all key processes required for developing newborn action plans. The materials can be read sequentially, however given the richness of each chapter countries may select to read only those chapters that address current needs, as some aspects of plan development may have already been covered. Users can therefore focus on one step of action plan development at a time, and read the corresponding chapter in this user guide. Countries are further invited to view the steps as part of an iterative process, where different components inform each other.
Defining ‘N’ in RMNCAH - Every Newborn Action Plan Country Planning and Costing

I. Purpose of this user guide

ENAP national milestones:

Global health experts agree that to reach every woman and newborn baby, particularly addressing the equity and quality gaps for care around the time of birth, requires country-led, data driven processes to assess and sharpen national health plans.

Since the 1990s, under 5 and maternal mortality has been halved as a result of efforts guided by the Millennium Development Goals (MDGs). However, reductions in neonatal mortality have lagged behind progress made for maternal and under 5 mortality rates. Specifically, neonatal mortality has reduced at an annual rate of 2%, compared to 2.4% reduction in deaths among children under 5, and a 2.6% reduction of maternal deaths. In addition, over 2.6 million yearly stillbirths are reducing at an even slower rate (at 1% annually).

The international community has recognized the urgent need to address the unfinished agenda of the MDGs in respect to newborn mortality and stillbirths. A large portion of this burden is preventable and solutions exist to address the main causes of newborn death. In fact, more than 80% of such deaths results from three preventable and treatable conditions: complications associated with prematurity, intra-partum related deaths, and neonatal infections.

In this context, the Every Newborn Action Plan (ENAP) was endorsed in 2014 through a World Health Assembly resolution to guide countries on the path to improving newborn health, and eliminating preventable deaths among mothers and newborns. The plan sets out a clear vision to achieve this objective by 2035, with intermediate milestones for countries to follow as they progress towards this goal.

A key national milestone by 2020 is to develop national plans and strategies with strengthened newborn care component. Plans should be costed, equity-focused, and present clear targets for neonatal mortality rate and stillbirth rate. Some countries may choose to develop standalone newborn plans while others may decide to integrate and strengthen the component of newborn health in plans for maternal and/or child health. Either approach can work as long as newborn health is given adequate attention. The 10 proposed core indicators for monitoring progress are:

1. Impact:
   - Maternal mortality ratio;
   - Stillbirth rate;
   - Neonatal mortality rate.

2. Coverage: care for all mothers and newborns:
   - Skilled attendant at birth;
   - Exclusive breastfeeding for 6 months;
   - Early postnatal care for mothers and babies.

3. Coverage: complications and extra care:
   - Antenatal corticosteroid use;
   - Newborn resuscitation;
   - Kangaroo mother care, feeding support;
   - Treatment of neonatal sepsis.

As of 2017, these indicators are under validation and refinement by an ENAP metrics group, and countries will be guided on further developments accordingly. A feasibility assessment (2017) of 15 proposed quality of maternal and newborn care indicators, conducted in 963 facilities in 10 Asian and African countries, also revealed the need to refine these indicators or strengthen sources and methods of data collection to be applied in real-world settings.

Trends indicate that countries are advancing in their efforts to develop national and subnational plans that address newborn health, either as standalone documents or as part of wider RMNCAH documents. Building on this momentum, this user guide can help to further accelerate progress so that mothers and newborns everywhere receive high quality care when they need it.

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Defining ‘N’ in RMNCAH - Every Newborn Action Plan Country Planning and Costing Toolkit and User Guide

Purpose of this user guide

NATIONAL LEVEL

2035 COVERAGE TARGETS ASSESSMENT:
Universal coverage for all packages

2030 COVERAGE TARGETS ASSESSMENT:
Achieve Sustainable Development Goals

2025 COVERAGE TARGETS ASSESSMENT: 2020 COVERAGE TARGETS ASSESSMENT:
1. Care at birth: 95% of births receive quality care
2. Care of small and sick newborn:
   >75% kangaroo mother care;
   >75% sepsis management;
   comprehensive neonatal intensive care: country-specific targets
3. Community care:
   95% of births 90% coverage for postnatal care; 50% exclusive breastfeeding at 6 months

2020 COVERAGE TARGETS ASSESSMENT: 2020 COVERAGE TARGETS ASSESSMENT:
1. Care at birth: 90% of births receive quality care
2. Care of small and sick newborn:
   >50% kangaroo mother care;
   >50% sepsis management;
   comprehensive neonatal intensive care: country-specific targets
3. Community care: 20% increase in postnatal care

NATIONAL MILESTONES BY 2020

• National plans: Review and sharpen national strategies, policies, and guidelines for RMNCAH in line with the goals, targets, and indicators in Every Newborn action plan, including clear focus on care around the time of birth and small or sick newborn care.
• Data: Count every newborn by improving and using programmatic coverage data and equity, quality gap assessments. Institutionalise civil registration and vital statistics, adapt and use a minimum perinatal dataset, implement maternal/perinatal death surveillance and response.
• Quality: Adopt Every Mother Every Newborn Quality Initiative standards of quality and indicators for assessing quality of maternal/newborn care at all levels of health system; and ensure access to essential commodities for RMNCAH.
• Investment: Develop or integrate costed human resources for health strategy into RMNCAH plans, ensure sufficient financial resources are allocated.
• Health workers: Ensure the training, deployment, and support of health workers, in particular midwifery personnel, nurses, and community health workers.
• Innovation and research: Develop, adapt, and promote access to devices and commodities to improve care for mothers and newborn babies around the time of birth; and agree on, disseminate, and invest in a prioritized and coordinated research agenda for improving preterm and newborn health outcomes. Particular focus is needed for stillbirths, who have been left out and left behind.
• Engagement: Involve communities, civil society representatives, and other stakeholders to harness the power of individuals, families, and communities ensuring access and coverage of essential maternal and newborn care.
• Parent voices, champions: Shift social norms so that it is no longer acceptable for babies to die needlessly, just as it has become unacceptable for women to die giving birth

Meeting the health needs of newborns in countries requires the dedication and commitment of different health professionals, including policy-makers, health planners, and staff delivering essential health services, among others. It calls for multi-stakeholder collaborations, financial and human resources, timely planning, and a focus on both processes and results. It requires integration with efforts across the continuum of care for maternal and child health, including family planning. Rigorous monitoring and evaluation processes should further both inform and follow these efforts, for example to evaluate the quantity, allocation and quality of human resources, a crucial element of newborn health initiatives. While the path to realise all of these elements may be challenging, in an increasingly global public health landscape there are ample sources of support that countries can draw on in this journey. These include for example planning and costing tools available in the public domain, as well as networks and forums for knowledge exchanges and sharing of best practices. Moreover, a growing body of evidence emerging in countries demonstrates that strategic efforts to improve newborn health lead to successful outcomes, even amid challenging circumstances and starting points.

Indeed trends over the past three years (2014-2016 period) show countries have made significant progress in planning and costing for newborn health. By the end of 2016, 24 out of 51 countries reporting to the global ENAP mechanism had finalized their newborn plans, while 18 countries had established both stand-alone and RMNCAH plans with a strengthened newborn component. 31 countries were found to have sharpened existing RMNCAH plans. This data is encouraging, representing more than a two-fold increase from 2015 to 2016 in the number of countries with such plans. In addition, 33 out of 51 countries with a newborn action plan or a strengthened RMNCAH plan were found to have defined a target for NMR (only 10 out of 51 having a SBR target). Finally, 16 out of 51 countries had included specific activities for achieving ENAP milestones and scaling-up of newborn-specific interventions in RMNCAH. These trends reflect the increased recognition of newborn health as an area calling for urgent action. The ENAP Country Progress Tracking Report 2016 can be accessed at: https://www.dropbox.com/sh/cfm7o2si6aws32n/AACgHXnRJNQN1OxF45ju6nta?dl=0

Regarding human resources availability, large variations exist between countries in terms of numbers of health workers, with many low- and middle-income countries reporting workforce-to-population ratios lower than internationally recognized thresholds (figure 1 on the next page). In particular midwives are a vital part of the health workforce, and if fully qualified and working within a functioning health system they can provide 87% of the essential care needed for women and children.
newborns. About half of high burden countries have strengthened their national capacities to use available data on the midwifery workforce and many have conducted in-depth national workforce assessments to support the development of their national human resources for health plan. There has been substantial progress, however huge global shortages remain. For example a 2013 assessment in India revealed that while much progress has been made to fill human resources gaps in the country, half of sick newborn care units did not meet the recommended nurse to bed ratio of 1:1.2 and doctor to bed ratio of 1:1.77. Global projections to 2030 estimate that an additional 18 million health workers will be needed to address the requirements of the SDGs.

**Figure 1**
Mapping of 74 countries based on the established health worker density thresholds, most recent available year

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**Source:** Pozo-Martin et al 2017


7 Manpreet Khurmi, *Two-Year Progress of Special Newborn care units in India. 2014, Child Health Division, MoHFW*; https://www.researchgate.net/publication/266021509_Two_years_progress_report_of_SN-CUs_in_India

HUMAN RESOURCES AND SICK NEWBORN CARE IN INDIA

India made concerted efforts to address sick newborn care. As of 2015 the Government established 602 Special Newborn Care Units (SNCUs) at district and tertiary care hospitals to strengthen care for sick, premature and low birthweight newborns.

Adequate human resources have been central to functioning SNCUs. Each SNCUs is equipped with 12 to 20 bed units, four trained doctors and 10 to 12 staff nurses providing services to sick newborns 24 hours a day / seven days a week. The SNCUs offer specialized care at birth including resuscitation of asphyxiated newborns, sick newborn care and routine postnatal care, and provide follow up services of high risk newborns as well as immunization and referral services.

These efforts were strengthened by the roll out of a facility based newborn care operational guide (2011), a maternal and newborn health toolkit on quality of care (2013), and a facility based newborn care training package (2014). Quality standards for district hospitals (DHs), community health centers and primary care centers were also disseminated under the national quality assurance framework. An online monitoring system further records information on care in the SNCUs, which as of 2016 has been scaled up to 550 SNCUs.

The National Rural Health Mission (NRHM) has targeted human resources gaps by approving recruitment of medical officers, specialists, auxiliary nurse midwives, staff nurses, AYUSH (traditional medicine) doctors in states on a contractual basis. A focus area has been developing the skills of doctors at strategically located facilities, for example by providing training in emergency obstetric care, lifesaving anaesthesia skills and laparoscopic surgery.

As a result of these initiatives, between 2008 and 2015 neonatal mortality declined from 35 to 28 per 1000 live births, an annual rate of reduction of 3.3%. Intensified efforts are still needed to reach the recommended nurse to bed ratio of 1:1.2 and doctor to bed ratio of 1:1.4 in half of facilities, and to address the lack of lab technicians in some locations.

Table 1

<table>
<thead>
<tr>
<th>Newborn services at various levels of facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Newborn care corner</strong> (at all Delivery Points)</td>
</tr>
<tr>
<td>Care of normal newborn</td>
</tr>
</tbody>
</table>

Source: Ministry of Health and Family Welfare, India.

So how have countries approached this critical area of work, and specifically what steps have they taken in the development of plans that aim to improve newborn health? The next chapters in this guide present examples and options for approaching the key components of national newborn action plans based on ENAP, as well as sources of support available for each. While each country may take a different approach, those who completed the process highlight a number of activities conducive to developing a newborn health plan. The following will be discussed more in detail in this guide, and should be considered as a basis for consultative processes and technical discussions to advance the newborn health agenda:

- Situation analysis / desk review: to assess the degree to which countries’ health systems are prepared to deliver health services and interventions for newborn health.
- Bottleneck analysis: to analyse health system bottlenecks and challenges preventing the scale-up of high-impact, cost-effective interventions for newborns.
- Prioritization of activities: to decide which activities should be given highest priority in efforts to improve newborn health.
- Equity analysis: to identify health disparities between the most marginalized population groups and the better-off in countries, and to target health plans based on these insights. The aim of an equity analysis is to develop plans that can target and reduce such health disparities.
- Monitoring and evaluation framework: to help track progress on newborn health in countries, take stock of and address existing gaps in future efforts.
- Costing: to develop financing scenarios, and to assess health investment needs in countries to support budgeting and financing of newborn health plans. Assessment of costs should be an integral aspect of newborn health planning processes.
- Investment case development: to identify the improvements in newborn health that a country envisions, and a prioritized set of investments required to achieve these results. It should focus on efficiency and prioritizing the evidence-based, high-impact interventions that equitably reduce morbidity and mortality. The investment case can guide and attract financing from international development partners, including national governments.

In addition to the available tools and resources addressed in this guide, there are also global mechanisms aimed at strengthening countries’ capacities to improve health for women, children, including newborns, and adolescents. These mechanisms are briefly outlined below.

First, the Global Health Partnership H6 is a collaboration started in 2008 between six UN organizations (UNAIDS, UNFPA, UNICEF, WHO, UN Women and the World Bank) to support high-burden countries in their efforts to improve the survival, health, and well-being of every woman, newborn, child, and adolescent. The partnership’s approach is to strengthen countries’ health systems and improve health services for these groups, especially in places where they are dying from preventable causes. In 2016 H6 renewed its efforts in response to the UN Secretary-General’s call to action to accelerate progress towards the health Sustainable Development Goals, and in light of commitments made under the UN Secretary-General’s Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030).

Second, the newly formed Global Financing Facility (GFF) is a key financing mechanism that supports country-led efforts to improve the health of women, children, and adolescents. This platform also supports the United Nations Secretary-General’s Global Strategy for Women’s, Children’s and Adolescents’ Health, supported by the Every Woman Every Child global movement. Housed at the World Bank, this multi-stakeholder partnership takes a country-centred approach, and aims to strengthen health systems to deliver on the full spectrum of the RMNCAH agenda, working towards Universal Health Coverage. It benefits from the unique strengths and contributions of financing bodies (e.g. the donor community), technical experts (e.g. UN agencies), community organizations (e.g. faith-based organizations), and the private sector. Under the GFF funding mechanisms, countries have the opportunity to sharpen their health plans and include detailed costing components and investment cases for newborn health. Countries that have received support from GFF

15 H6 Partnership: https://h6partners.wordpress.com/
16 H6: Harnessing the collective strengths of the UN system to reach every woman, child and adolescent: http://www.who.int/life-course/partners/h4/en/
17 The Global Financing Facility: https://www.globalfinancingfacility.org/
include for example Tanzania and Uganda. More details on the GFF mechanisms are available at: [www.globalfinancingfacility.org](http://www.globalfinancingfacility.org)

Third, the Every Woman Every Child (EWEC) global movement mobilizes international and national action by governments, multilaterals, the private sector and civil society to address the major health challenges facing women, children and adolescents around the world. It serves as a powerful advocacy mechanisms that has generated national commitments for newborn health from public and private sector actors, strengthening accountability towards newborn health. More details on EWEC can be found at: [http://www.everywomaneverychild.org/](http://www.everywomaneverychild.org/)

While the focus of this user guide is the development of newborn action plans, these resources may also be relevant for subsequent stages of a country’s programming cycle, such as plan implementation, and monitoring and evaluation for input to the next planning phase.

**Methods**

Under the guidance of the maternal and newborn health team (UNICEF HQ), this user guide was developed based on information gathered by a consultant through key informant interviews with experts involved in newborn action plan development. Interviews were conducted in March-April 2017 with a total of 18 experts from: UNICEF regional and country offices, WHO, UNFPA, Save the Children, independent consultants who supported planning and costing processes in countries, and government officials from ministries of health. Participants were invited to contribute based on their expertise in the field of maternal and newborn health, and in particular their involvement with ENAP development and tools.

The interviews were guided by 13 questions (included in annex 7) and focused on the interviewees’ particular area of expertise. Participants shared about their experience in developing newborn action plans in countries, as well as challenges, recommendations and lessons learned in applying the available ENAP tools.

Information collected during the interview process was included in this user guide to enable dissemination of valuable lessons learned to stakeholders engaged in newborn action plan development. To strengthen the data collection process the consultant further reviewed resources available online such as articles, reports, strategies and plans on newborn health.

Prior to finalization, a draft of the user guide was shared with all participants and other key newborn health experts for their review and comments in order to validate its contents and provide an opportunity for further refinement of the document.
Country experiences of defining “N” in RMNCAH; pathways to develop country plans
As countries embark on the path to improving the health of newborns, they are faced with multiple decisions. There is no single formula that can or should be applied rigidly, as each context calls for different solutions and countries have invariably taken different approaches to move the newborn health agenda forward.

For example, in developing newborn action plans countries are faced with the choice to develop such plans as standalone documents or as part of a wider (e.g. RMNCAH) plan. While the goal of improving the health of newborns may be achieved through either of these approaches, countries should decide what is most suitable in light of the existing health systems structure, health planning cycles, Ministry-level policy recommendations, and other factors. Moreover, decisions have to be taken concerning technical and budgetary issues, timelines, and when and how to involve different stakeholder groups. While approaches vary according to local circumstances, this guide offers options and experiences from countries for readers to reflect on what strategies might work best in their respective public health context.

Case study 1: Ghana

In Ghana the National Newborn Health Strategy and Action Plan (2014-2018) was developed in line with the global ENAP, adapted to the country context and aligned to the existing RMNCAH plan. It includes specific targets for newborn mortality reduction, and for increasing the proportion of deliveries conducted by skilled birth attendants. The table on the next page illustrates key milestones on the path to developing this plan in Ghana.

The roadmap for Ghana highlights a process inclusive of multiple stakeholders, and a progressive shift toward a more equitable policy environment, marked by consultations, participation in international conferences, and capacity building workshops to identify and address the key bottlenecks to quality maternal and newborn care. This process, along with support and guidance from the global ENAP stakeholders, ultimately led to the development of the National Newborn Action Plan, which was launched in 2014. This was followed by further resource mobilization efforts.

Key elements which facilitated the development of Ghana’s newborn action plan were: multi-actor collaboration, timely involvement of key stakeholders to build consensus and create ownership of the process, as well as long lasting partnership; engagement of champions in key fora (e.g. MoH, professional societies, faith-based organizations, the media, celebrities, as well as the private sector).

With regards to the adaptation of the ENAP guidance to the country requirements, this was done by grouping the proposed newborn activities under the strategic objectives of the existing RMNCAH strategy. This helped to more easily integrate the activities into the existing health planning structure of the Ministry of Health. This approach also enabled adapting the newborn plans according to the specific technical language used in the RMNCAH strategy. Having said this, the team ensured that all global ENAP components were retained in this exercise, so that while the format of the plan was tailored to Ghana’s existing planning structure, all key activities recommended by ENAP were adequately included.

**Key lesson learned:** whether developed as a standalone document or integrated into wider plans, the newborn heath plan should capture all key components of the global ENAP (i.e. strategic objectives, core indicators, milestones and targets). In addition, when developing an integrated newborn plan as part of a wider plan (e.g. an RMNCAH plan), it is essential that the newborn dimension retain its integrity, for example by including specific newborn targets and indicators.


Table 2: Key activities to accelerate progress in newborn health from 2011 to 2015

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
<th>Details</th>
</tr>
</thead>
</table>
| First National Newborn Stakeholders meeting | 2011 | • First National Newborn Stakeholders’ meeting held.  
• National newborn committee established.  
• Specific community- and facility-based newborn care interventions started in Northern Regions. |
| National Newborn Consultation of Stakeholders, Accra | July 2012 | • The Ministry of Health and a multistakeholder Working Group developed a National Road Map for newborn health with clear milestones to be achieved to strengthen newborn programming. Over time this group evolved into the Newborn Care Sub-committee.  
• Each region developed an annual newborn plan under the leadership of the Newborn Care Sub-committee. |
| National Newborn Action Plan increases access to free maternity care | 2014 | The National Health Insurance Scheme registered 1,500,324 extremely poor people across the country to access free health care, an increase from 320,000 in 2012. This free access to health services includes maternity and delivery services in National Health Insurance Agency accredited institutions. |

Case study 2: Myanmar

Myanmar set out to draft an Every Newborn Action Plan (2014-2020), however when the country developed the National Strategic Plan for Newborn and Child Health Development (2016-2018) it was decided to integrate the newborn plan into this broader strategic plan. This shift emerged to avoid duplications between the separate strategic plans of different programmes of the Ministry of Health, working instead towards increased coordination between technical areas. The transition from one plan to the other was facilitated by the fact that both followed a similar structure, based on the key health systems building blocks.

Importantly, while newborn health was integrated into the broader child health and development plan, the newborn component maintained its integrity and is distinct from the child health section. Further, all indicators from the newborn draft plan were transferred to the newborn and child health action plan (with the exception of one, included in the maternal and reproductive health strategic plan).

The benefits of the newly developed National Strategic Plan for Newborn and Child Health Development spanned beyond the fact that it facilitated coordination among technical departments within the ministry of health. Such an integrated plan was also found to better align to existing training packages, which are delivered jointly for newborn and child health, as well as better reflecting the work performed by frontline health service providers, who in many cases are responsible to care for newborns as well as children.

Below are key milestones in Myanmar’s path to improving newborn health:

- High-level political commitment to newborn health: starting in 2010, political changes resulted in improved leadership and funding for the health sector, including newborn health.
- Increased collaboration between national leaders and partners: the Ministry of Health engaged with global maternal and newborn health initiatives to strengthen national plans and programmes to deliver on commitments. Key activities are cited in the table below.

| Table 3: Government commitments to global maternal and newborn health initiative |
|---------------------------------|--------------------------------------------------------------------------------------------------|
| **A Promise Renewed (2012)**    | The national government committed to identifying and tracking five-year benchmarks for maternal, newborn and child survival, with the goal of reducing newborn deaths to 16 per 1,000 by 2018. |
| **Newborn Readiness Benchmarking (2013)** | An analysis was conducted to assess the readiness to scale-up newborn care using the Scale-up Readiness Benchmarks tool developed by Save the Children that outlines 27 benchmarks that measure the degree to which health systems and national programmes are prepared to deliver interventions for newborn survival at scale. |
| **Bottleneck Analysis in support of Every Newborn (2013)** | In 2013, Myanmar joined the process in support of the global Every Newborn Action Plan and undertook a bottleneck analysis. The exercise identified bottlenecks to the scale-up of quality care which provided critical information for development of a national plan. |
| **The National Newborn and Child Health and Development Strategic Plan 2015-2018 (2014)** | A Newborn Action Plan was developed following the guidance in the global Every Newborn Action Plan, and WHO and UNICEF Regional Action Plan. This was integrated with the new Child Health Plan, and The Newborn and Child Health and Development Strategic Plan was launched and costed. |

In light of data gaps at the country level on different newborn health indicators, the targets in the newborn action plan were developed based on expert opinion and consensus through a multi-stakeholder forum (including representatives from the public health community, medical services, paediatricians, obstetrician and gynaecologists, and development partners).

The Government is further planning to scale-up newborn care to all townships in the health system (330 townships), who are responsible for planning and implementing health services down to the lowest administrative unit, the village or urban ward. In this context, a standardized package of newborn care is to be rolled out in a phased approach in all townships over five years. This initiative will further be strengthened through efforts to increase the volume and competencies of health care workers skilled in maternal and newborn care.

Key lesson learned: setting up a multi-stakeholder forum can be instrumental in setting targets for newborn health, especially in cases where essential data is lacking and targets have to be decided based on expert opinion. In Myanmar, target setting could advance based on the guidance of such experts, including from the Ministry of Health, paediatric association, civil society, universities conducting medical research, and midwives who provide the services at subnational level.

Case study 3: Iraq

Iraq developed the Every Newborn Action Plan 2016-2020 amid a challenging security environment which has impacted heavily on the health care sector\(^{18}\). Despite the difficult political context, the ministry of health decided to address newborn health challenges, such as the shortage of staff and infrastructure, and the absence of neonatal care units in districts and remote areas. The approach involved:

- A bottleneck analysis workshop (2015) involving 64 experts, with technical presentations and working group discussions to identify bottlenecks to improved newborn care, a plenary session to reach consensus on priorities, and proposed actions to address them. To sustain the momentum, a working group to support the development of the national action plan was established.
- A situation analysis based on a comprehensive desk review, health services facility assessments (using WHO health facility checklist, and the Every Mother Every Newborn standards tools - tailored to the Iraq context), and an Emergency Obstetric Care Needs assessment\(^{19}\). This step took place over a three month period and revealed gaps in provision of essential newborn care services and quality of care, as well as other maternal and newborn interventions, especially in underserved areas.
- Consultative stakeholder meetings, which took a highly participative approach to propose standards for improved quality of care and newborn care services. Consensus was reached on targets for reduction of NMR and stillbirths rate at both the national and subnational level in the 7 Governorates included in the plan.
- Development of Every Newborn Action Plans at both national and subnational level. Engaged stakeholders also had the opportunity to build capacities to conduct health facility assessments, and to implement WHO’s quality of care standards.

One of the key guiding principles underpinning the newborn action plan is integration. This means that the country envisions newborn health as inextricably linked to women’s health across the life course, as captured through the integrated RMNCAH approach taken by the ministry of health. To facilitate integration, relevant directorates and departments of the ministry of health coordinate work towards common goals. In this spirit, the country developed a standalone newborn plan, which was however fully integrated in the broader national strategic RMNCAH action plan 2016-2020 developed by the ministry of health in collaboration with WHO, UNICEF and UNFPA. In addition, to target efforts the team focused on areas at the subnational level (governorates) that had previously been assessed, in order to build on the results of such assessments.

Challenges and lessons learned:

- Initially stakeholder had to be persuaded that a situation analysis was required. The team approached this by emphasising that the plan should be adequately informed by the country context, and in addition it offered participants the tools and knowledge to build capacity for quality improvement. This led to a shift in perspective as the concerned staff saw this work as an opportunity to build capacities, and as a result proactively contributed to the process.
- Estimating projected reductions in NMR was challenging in a country affected by an ongoing conflict situation. As a solution, the team consulted with many experts to arrive at the best approach for a country affected by this high level of uncertainty. In particular, the plan’s future implementers who understood the challenges at the facility level, were actively involved in the discussions.

\(^{19}\) Emergency Obstetric and Newborn Assessment. UNFPA, UNICEF, Averting Maternal Death and Disability Program (AMDD), Ministry of Health Iraq (2014).
Key recommendations for developing a newborn action plan

The following suggestions and key success factors were shared by key informants involved in the process of developing newborn action plans:

• Ensure Government leadership and ownership which is critical and a foremost requirement of the process. Other stakeholders may work to raise awareness on the issue of newborn health among government officials, however the work should be spearheaded by the relevant department and ministry(ies).

• Professional associations, development partners and civil society are key players for supporting ENAP discussions in a country.

• Establish close collaboration with policy makers to support the process. Embedding the discussions in the ongoing political and administrative environment is important to avail the existing opportunities.

• Create a technical body within the ministry, for example a core working group or technical advisory group (TAG) under the ministry of health, to enable efficient planning processes at all levels (sub-national, national, regional, global) as well as support and monitor plan implementation. This group is ideally not large in number, but its members should have decision-making authority to take the lead on newborn health. A RMNCAH technical advisory group or a partners forum may already exist which can be given the responsibility.

• Define a timeframe for action, with roles and responsibilities among the technical working group members clearly set out in order to sustain momentum. Distribution of responsibilities among partners promotes a wider ownership.

• Facilitate a process for a national consultative meeting for newborn health. This is an essential step to ensure buy-in from all relevant stakeholders (from health and other sectors). It should be inclusive and time-permitting feature consultations at both national and sub-national levels, as well as participation from bilateral groups.

In addition to following the strategic objectives in the global ENAP, it is advisable that actions in the newborn plan align with countries’ existing reproductive, maternal, child, and adolescent health strategic objectives. Such alignment has the advantage that newborn actions can be linked and implemented with related activities for the mother and older child, and are therefore less likely to be overlooked. While country-specific adaptation for newborn plans is necessary, no component of the global ENAP should be missed.

It is also recommended that the newborn action plan be aligned to the country’s overall health strategic plan to ensure it receives adequate attention and follow-up. It is also helpful if newborn health has a high priority in the national strategic plan, for example by integrating newborn health objectives.

It is helpful to note the level of the health system where interventions can be implemented (this also helps with budget calculations). An example of such a mapping exercise can be found in annex 8. To be comprehensive interventions should include, beyond basic essential newborn care, neonatal resuscitation, care of preterm and low birth weight babies and management of neonatal infections (including prevention and treatment). Prevention of infection has received increasing attention as the linkages between infections and neonatal mortality are better understood.

Engage a consultant with strong technical knowledge, analytical and writing skills to help develop the newborn action plan and relevant policy briefs. It would be helpful if this person has some knowledge of the clinical aspects of newborn health, gained for example through engagement with country-based paediatricians. They should also possess strong communication skills to create the necessary momentum for plan development and implementation, and to effectively present the plan to policy-makers and donors to get their support.

Finally when the draft plan is ready, it is useful to hold a workshop (e.g. 2 days) involving key stakeholders to review and reach consensus on the proposed document.
Examples of regional plans and initiatives
In recent years newborn health initiatives have also emerged at the regional level. These include for example:

- The **ENAP Task Force for the Western and Central Africa Region (WCAR)**: the region has among the highest rates in newborn mortality, while reduction has been slow and coverage of key newborn health interventions has also been low. To address this situation, and as an outcome of the ENAP forum in November 2016, partners decided to set up a ENAP task force for WCAR to enhance coordination on newborn health at regional and national level in Western and Central Africa. The mechanism has three main objectives: 1. to coordinate technical support to countries; 2. to monitor progress at country level; 3. to share information at regional and national level (e.g. regarding events, conferences). The task force’s first meeting in spring 2017 is an opportunity to develop a joint regional action plan to take the newborn health agenda forward.

- The **Maternal, Newborn, and Child Health Muskoka Initiative**: this initiative was launched in 2010 at the Muskoka G8 Summit, and initially committed to mobilizing $5 billion of funding towards maternal, newborn and child health over the 2010-2015 period. It focuses on strengthening health systems in countries and enabling the delivery of key interventions along the continuum of care from pre-pregnancy to childhood. With strong implications for newborn health, priorities for action include: antenatal care; attended childbirth; post-partum care; sexual and reproductive health care and services, including family planning; health education; prevention and treatment of HIV/AIDS, malaria and devastating childhood diseases; immunizations; basic nutrition; and access to safe drinking water and sanitation. Funding can be distributed through bilateral, multilateral, or civil society channels, as long as it is explicitly directed at fulfilling the Muskoka Initiative to improve MNCH.

- The **WHO South East Asia Regional Technical Advisory Group (SEAR-TAG)**: this group of RMNCAH technical experts was constituted in 2015 to provide guidance to national governments, implementing partners and other stakeholders to accelerate reduction in newborn, child and maternal mortality in the region. The first meeting in India (2015) focused on understanding priorities, challenges and high impact approaches for reducing newborn mortality. Key areas examined included: expanding coverage of essential interventions and reaching the unreached, improving quality of care, engaging communities and improving accountability towards the health of women, newborns and children. The second SEAR-TAG meeting in 2017 will review progress on newborn mortality reduction, and further focus on adolescent health.

- The **Action Plan for Healthy Newborn Infants in the Western Pacific Region (2014–2020)**: this plan (2014) was developed to reduce the high number of newborn deaths that still persist in the western pacific region. Based on consultations with technical experts, representatives from ministries of health and academia, as well as nongovernmental organizations (NGOs), WHO and UNICEF, it suggests evidence-based actions that governments and development
partners can take to improve newborn infant health, in line with the Every Newborn: An Action Plan To End Preventable Deaths (WHO/UNICEF, 2014). The strategic focus of the regional action plan is on scale-up of simple and cost-effective interventions, with a focus on birth and the first three days of life, which can have a significant impact on preventing newborn mortality. Key recommendations include ensuring adoption and implementation of early essential newborn care (EENC), and providing overall quality of care at this critical time. The region already made progress on EENC, as evidenced by the outcomes of benchmark monitoring efforts started in 2013 for 8 priority countries. Benchmarks to assess EENC scale-up readiness included: the presence of a situation analysis, costed action plans, clinical protocols, EENC technical working groups, an EENC focal point in the ministry of health, and the country having completed consensus building workshops. Progress was made in many areas (e.g. situation analysis, action plans, costing, clinical protocols, among others), while more support was needed to expedite progress in areas such as consensus building, and engaging EENC stakeholders and champions.

**Action Plan for Healthy Newborn Infants in the Western Pacific Region (2014–2020)**


**Benchmarks for Preparing to Scale-up Early Essential Newborn Care (2013-2014) for Western Pacific Region Priority countries.**

*WHO Western Pacific Region, UNICEF.*

*Available at: [https://www.dropbox.com/sh/cfm7o2si6aws32n/AACgHXnRJNJQN1OxF45ju6nta?dl=0](https://www.dropbox.com/sh/cfm7o2si6aws32n/AACgHXnRJNJQN1OxF45ju6nta?dl=0)*
V

Situation analysis tools: country examples and lessons learnt
Analysing the situation of newborn health in countries, and assessing health systems’ readiness to provide quality care, are essential first steps in effective action plan development. A situation or landscape analysis helps to understand advances and gaps in efforts to improve newborn health. It involves consulting existing and new data sources to describe trends in morbidity and mortality among mothers and newborns, and on coverage and quality of service provision. Where possible such analyses should examine disaggregated data in order to describe health disparities among different groups, to better inform equity analyses and approaches.

Several options exist for developing a situation analysis:

- **Desk review, interviews, health facility visits:** an initial review of available documents (e.g. academic literature, policies, legislations, strategies, plans) can provide a good understanding of a country’s situation in relation to newborn health, and its readiness to address existing gaps. Key stakeholder interviews (e.g. with health managers, or health workers), as well as observations during site visits (e.g. to facilities) can further enrich this information. This method was followed for a study completed in Indonesia, the Lao People’s Democratic Republic (PDR) and the Philippines, which aimed to conduct a comprehensive, equity-focused newborn care assessment and explore options to improve newborn survival. The document review phase was complemented by interviews and health facility visits to assess services and care for newborns, and the researchers triangulated findings to obtain a comprehensive picture of newborns’ health status, the policy and health system context for newborn care, and the equity situation regarding newborn survival. This exercise was essential to identify areas requiring attention, such as leadership and governance, quality of care and inequities in newborn care.

- **Review newborn care standards and services by levels of care:** the initial desk review and health facility visits should explore the national standards for essential newborn care and services rendered at each level of the health service delivery point. This will provide important information as an input for the planning and costing exercises. Many countries have clearly defined facilities for provision of basic and comprehensive emergency obstetric care and signal functions. This detail is often missing for the newborn services. Nepal’s newborn strategy has defined the services for each level, as shown in Figure 2 on the next page.


• Similarly see example from South Africa in the table on the next page. It is important to highlight that the country plans double the number of beds for Kangaroo Mother Care for each sick newborn care bed, so the sick newborn care units include KMC as an integral feature.

### Table 4: Levels of Newborn Care Health Services Delivery Place

<table>
<thead>
<tr>
<th>Home and community level</th>
<th>First level of Care</th>
<th>Second level of Care</th>
<th>Tertiary Level of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Care (RC)</td>
<td>Standard Inpatient Care (SIC):</td>
<td>High Care (HI)</td>
<td>Intensive Care (IC)</td>
</tr>
<tr>
<td>Home and community level</td>
<td>for babies with: Low Apgar score, Congenital abnormalities Low birth weight 1000 &gt;1500 GA 32-36 weeks, Birth weight &gt;4000grams, Meconium staining PSBI and Jaundice</td>
<td>for babies with: Birth weight &lt;1500grams Gestational age &gt;32 weeks Encephalopathy Meconium aspiration Septicaemia/ meningitis Recurrent apnoea Moderate &amp; severe respiratory distress Convulsions Sever jaundice Simple surgical procedures</td>
<td>for babies with: Need for ventilation Complex surgical procedure Persistent hypoglycaemia Cardiovascular problems Multisystem problems Requiring specialist intervention e.g ambiguous genitalia</td>
</tr>
<tr>
<td>Care Provided</td>
<td>Apgar score Basic newborn resuscitation Initiation of breast feeding at birth and Further support, Emergency care before referral Vitamin K, eye care, immunisation, cord care, measurement, Examination of newborn Care to baby whose mother has HIV, TB or syphilis Skin to skin care and KMC</td>
<td>In addition to routine care: Maintenance of thermoneutral environment, Oxygen administration and monitoring, Glucose monitoring and correcting abnormality</td>
<td>In addition to other NC: IPPV and advanced respiratory support TPN Arterial cauterization Therapeutic cooling Advanced neurological care</td>
</tr>
</tbody>
</table>

**Source:** Norms and standards for essential neonatal care in South Africa. Limpopo Initiative for Newborn Care.

Finally, the table in annex 8 provides an example of newborn health interventions mapped against health systems levels for Ghana.
Benchmarks were developed by Save the Children’s Saving Newborn Lives Programme to assess scale-up readiness and the degree to which health systems and national programmes are prepared to deliver interventions for newborn survival. A list of 27 benchmarks helps to assess status and changes in national readiness to implement newborn care interventions, and covers issues such as: agenda setting (e.g. having a national newborn survival needs assessment); policy formulation (e.g. the national essential drugs list includes injectable antibiotics at primary care level); and policy implementation (e.g. standards for care of sick newborns exist at district hospital level). For more information see: Benchmarks to measure readiness to integrate and scale up newborn survival interventions at https://doi.org/10.1093/heapol/czs046.

The approach was used by UNICEF Regional Office for East Asia and the Pacific (EAPRO) for a situation assessment for newborn survival in the region. This information was very useful for the development of country plans and shaping of the WHO-UNICEF Healthy Newborn Plan. See the examples of country profiles developed:

- Maternal and newborn health – country profiles from Asia and the Pacific. UNICEF 2013. Profiles for Cambodia, China, Indonesia, Democratic People’s Republic of Korea, Laos, Myanmar, Mongolia, Philippines, Timor-Leste, Vanuatu, Viet Nam are available at: https://www.dropbox.com/sh/ cfm7o2si6aws32n/AACgHXnRJNQ10xF45ju6nta?dl=0

- A Situation Analysis Guide was developed by Save the Children to support with newborn health planning. It provides a structure for developing a national situation analysis for newborn health, assisting countries to determine where to focus to achieve impact at scale. It invites users to describe the status of newborn health in the country, to examine coverage of interventions and reasons for low coverage, and describe current policy and financial allocations for newborn health, as well as key partners involved. Proposed steps for the situation analysis include a desk review, consultations with key informants, discussions with strategic partners, and review of health facility data.

Available at: https://www.dropbox.com/sh/ cfm7o2si6aws32n/AACgHXnRJNQ10xF45ju6nta?dl=0

- As part of a Landscape Analysis of Life-Saving Reproductive, Maternal, Newborn and Child Health Interventions and Commodities, a Rapid Assessment of Life-saving Interventions and Commodities (RAIC) tool is available to conduct a rapid review of RMNCH programmes and related commodities. It helps to collect information on country profiles and health systems, covering both programme-specific and commodity-specific modules that help assess national RMNCH plans and programmes. It includes one module on newborn health.

- The District planning tool for maternal and newborn health strategy implementation (WHO, 2011) offers a framework to plan and implement maternal and newborn health (MNH) services at the district level. It includes a technical overview on prevalence and causes of maternal and newborn death and disability; highlights strategic directions for improving maternal and newborn health and the key 10 steps required for the proposed district planning framework for MNH, including a situation analysis. Link: http://apps.who.int/iris/bitstream/10665/44503/1/9789241500975_eng.pdf

- Existing country assessments may also provide key information for a newborn health situation analysis. They may not focus specifically on newborn health, but can give an overview of a country’s progress on development goals, or in respect to its international human rights commitments. Such documents include for example government reports or evaluations, national academic publications, interagency Common Country Assessments (CCAs), Joint Assessments of National Health Strategies (JANS), or other publications by civil society, human rights bodies, or UN agencies. Some of these documents may include a section on maternal and newborn health.

In addition, assessments directly concerning newborn health may exist in countries. For example in 2016 Bangladesh, Ghana and Tanzania conducted baseline assessments of quality of care for maternal and newborn care. These studies examined the status of facility readiness, of the quality of maternal and newborn care both from provider and client perspectives, and the status of documentation of records. Mixed method approaches were used, including surveys, structured observation in facilities, interviews with managers, health care staff and service users. They revealed gaps in quality of care related to human resources (Bangladesh), lacking or poor water and sanitation in facilities (Ghana, Tanzania), poor hand washing practices and weak record keeping (Tanzania), among other issues. These findings could help to identify appropriate interventions to improve the quality of care in targeted health facilities. In another example from Iraq, the outcomes of an emergency obstetric care assessment were used as an entry point for the situation analysis.

- **Evaluation of “Every Mother Every Newborn” quality improvement initiative: A quasi-experimental study. Baseline Assessment Report 2016.** International Centre for Diarrhoeal Disease Research, Bangladesh (icddr,b). Available at: https://www.dropbox.com/sh/cfm7o2si6aws32n/AACgHxNRJQN1OxF45ju6nta?dl=0


Additional tools and resources for a comprehensive situation analysis:

- **Countdown to 2030 for Reproductive, Maternal, Newborn, Child, and Adolescent Health and Nutrition.** Presents country profiles with demographic measures of maternal and newborn survival, coverage rates for priority interventions, as well as data for selected equity, policy, health systems, and financing indicators. http://countdown2030.org/country-profiles

- **UNICEF Data: Monitoring the Situation of Children and Women** is a portal with reliable and open data and analysis on the situation of children and women worldwide, based on information collected through the Multiple Cluster Indicator Surveys (MICS). It is accessible at: https://data.unicef.org/

- **Maternal and Newborn Health Disparities Country Profiles, UNICEF.** These statistical profiles present current levels of key impact, service delivery and coverage interventions for mothers and newborns with a wide array of disaggregation including residence, household wealth, mother’s age, mother’s education and sub-regional levels. https://data.unicef.org/resources/maternal-newborn-health-disparities-country-profiles/


- **UNICEF Guidance on Conducting a Situation Analysis of Children’s and Women’s Rights.** UNICEF, 2012. This tool guides users in conducting situation analyses with a focus on children’s and women’s rights.
Country examples of situation analyses:


Other examples of country newborn situation analyses can be found on the Healthy Newborn Network website at the link [http://www.healthynewbornnetwork.org/?s=situation+analysis](http://www.healthynewbornnetwork.org/?s=situation+analysis)

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**COUNTRY EXAMPLE: SITUATION ANALYSIS IN BANGLADESH**

In light of policy shifts and increasing national interest in newborn health, Bangladesh completed a comprehensive situation analysis of newborn health in 2014. Its aim was to assess the policy environment, service coverage, and identifying existing gaps.

It was set up as a collaborative effort among the Ministry of Health and Family Welfare, professional associations, development partners, and NGOs, and involved the following steps: review and analysis of literature, documents and tools; primary data collection (qualitative and quantitative); and stakeholder interviews.

The team developed a survey to collect information from healthcare facilities and the community, which was pretested before finalization and implementation by trained field staff. This was complemented by in-depth stakeholder interviews and focus groups among sampled facilities and communities. Together the literature review, surveys, and interviews formed the basis of this situation analysis report.

Findings revealed weaknesses in essential newborn care and postnatal care services, and called for increased attention to facility preparedness to implement newborn health interventions.

The situation analysis, complemented by a bottleneck analysis, informed the draft national Every Newborn Action Plan.

**Bangladesh National Newborn Health Situation Analysis Report 2014. Ministry of Health and Family Welfare.**

Challenges:

- Persuading the relevant stakeholders that a comprehensive situation analysis is necessary may be challenging in some cases, for example if stakeholders feel they already possess the relevant information. Country teams can address this by highlighting the benefits of a comprehensive situation analysis that is informed by multiple data sources, and most recently collected data.

- In the context of facility based situation assessments, a lack of awareness and training on record keeping limited the documents available for review. To address this limitation, research teams focused on recent information (e.g. past three months or one year), and relied on routine records such as from health management information system (HIMS), as well as complementing the available information with key informant interviews and direct observations of facilities.

Recommendations for conducting a successful situation analysis:

- An accurate situation analysis is the first step towards successful action plan development. It should be given adequate time and attention, as it lays the foundation for the next steps and the ultimate development of a plan that is relevant, evidence-based and responds to the country situation.

- Ensure that stakeholders involved carry out an in-depth analysis, not just a description of the situation in countries. For example, a country may experience insufficient human resources, or a lack of drug supplies – however, these may be the visible manifestations of issues underlying the health system as a whole. The action plan development should address the root causes of challenges.

- The situation analysis is an opportunity to ask difficult questions and to reflect on the effectiveness (or lack thereof) of past initiatives, especially if significant resources have been invested towards specific objectives over time, and have failed to achieve the desired impacts. A rigorous situation analysis can help to consider the effectiveness of current approaches.

- It may be helpful to consult examples of existing situation analyses from other countries, or to identify consultants who have experience with this process who can support.

- Once the desk review and data collection are completed, the findings should be presented in a format considered most effective to influence national policy and planning discourses.
Defining ‘N’ in RMNCAH – Every Newborn Action Plan Country Planning and Costing Toolkit and User Guide

VI

Bottleneck analysis tool: country examples and lessons learnt
Closely linked to the situation analysis, another component of the global ENAP process is to understand the challenges of scaling-up newborn interventions. To this end, a bottleneck analysis can help to identify the barriers that prevent newborns and mothers from receiving adequate health interventions and services. Analysing and addressing such bottlenecks at the health-system level can therefore help to accelerate scale-up of interventions with the goal of achieving high quality and equitable coverage of care for newborns.27

Global health experts agree that identifying and addressing bottlenecks is essential to plan and implement actions that can accelerate progress. A 2014 study examined health system bottlenecks for scaling up intervention packages to reduce neonatal deaths and improve essential maternal and newborn health care in eight of the 13 countries with the most neonatal deaths27. Common barriers were found across countries, related to health workforce, financing and service delivery, and specifically pertaining to interventions for the prevention and management of preterm births, inpatient supportive care of ill and small newborn babies, management of severe infections, and kangaroo mother care. The same study examined enabling factors in fast progressing countries, such as strategies to address health workforce shortages or to remove financial barriers.

In this context, UNICEF and partners developed a tool to support countries to identify bottlenecks and solutions to scale-up newborn care, particularly high-impact and cost-effective interventions for newborns. The tool is structured around the 7 health system building blocks28, and can help to identify critical interventions29 to provide basic care for all newborns and mothers, and to prevent and treat the three main causes of neonatal mortality: complications from prematurity, intrapartum-related including asphyxia, and newborn infections. Finally, the tool is designed to help users identify potential strategies and solutions for the priority bottlenecks.

Tool to support countries to identify bottlenecks and solutions to scale-up newborn care. UNICEF, 2013.

The bottleneck analysis can build on the information collected in the situation analysis. While the situation analysis can take place through desk-research and data gathering ahead of stakeholder meetings, the bottleneck analysis is in many cases completed through a dedicated workshop. Participants are organized into groups examining different topic areas using tracer interventions, which is followed by a plenary discussion to agree on bottlenecks and priority areas.

28 Health system building blocks: leadership and governance; health financing; health work force; essential medical products and technologies; health services; health information systems; community ownership and partnership. Source: Tool to support countries to identify bottlenecks and solutions to scale-up newborn care, 2013. UNICEF.
29 Critical newborn health interventions:
1. Management of preterm birth (focus on antenatal corticosteroids)
2. Skilled care at birth (focus on the use of the partograph)
3. Basic Emergency Obstetric Care (focus on assisted vaginal delivery)
4. Comprehensive Emergency Obstetric Care (focus on caesarean section)
5. Basic Newborn Care (focus on cleanliness including cord care, warmth, and feeding)
6. Neonatal resuscitation
7. Kangaroo mother care (focus on skin to skin, breastfeeding and feeding support for premature and small babies)
8. Treatment of severe infections (focus on using injectable antibiotics)
9. Inpatient supportive care for sick and small newborns (focus on IV fluids/feeding support and safe oxygen)

Source: Tool to support countries to identify bottlenecks and solutions to scale-up newborn care, 2013.
Country experience in applying the bottleneck analysis: focus on Myanmar.


Under the leadership of the ministry of health, Myanmar reviewed the situation of newborn health to identify specific bottlenecks and solutions to scale up key high impact newborn health interventions. The team conducted a literature review on maternal and neonatal health, in addition to key informant interviews, focus group discussions, field visits to selected townships, and clinical observations at health facilities. These steps helped to gain a better understanding of the country context, as well as to validate findings from the desk review.

Table 5:
Distribution of groups working on various components of the MNH bottleneck analysis tool

<table>
<thead>
<tr>
<th>Groups</th>
<th>Component/ Intervention</th>
<th>Scope</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1</td>
<td>Preterm/ low-birth weight</td>
<td>Management of pre-term birth, (focus on antenatal corticosteroids (dexamethasone), Kangaroo mother care (focus on skin to skin), breastfeeding and feeding support for premature and small babies</td>
</tr>
<tr>
<td>Group 2</td>
<td>Normal delivery (including management of asphyxia)</td>
<td>Appropriate care at delivery (focus on proper use of partograph (for decision-making), Neonatal resuscitation</td>
</tr>
<tr>
<td>Group 3</td>
<td>Managing complications of childbirth and the postnatal period</td>
<td>Basic Emergency Obstetric Care (focus on assisted vaginal delivery); Comprehensive Emergency Obstetric care (focus on caesarean section and blood); Inpatient supportive care (focus on IV fluids/feeding support and safe oxygen, for sick and small newborns).</td>
</tr>
<tr>
<td>Group 4</td>
<td>Normal postnatal care (immediate and beyond)</td>
<td>Basic Newborn Care (focus on cleanliness/cord care, warmth, and feeding at health facility and in the home), Influencing household practices (e.g breastfeeding)</td>
</tr>
<tr>
<td>Group 5</td>
<td>Prevention and Treatment of Infection</td>
<td>Prevention opportunities during pregnancy (e.g. ITNS, TT), Treatment of severe infections (focus on using injectable antibiotics)</td>
</tr>
<tr>
<td>Group 6</td>
<td>Group 6 - Cross cutting and systems-related issues</td>
<td>Health Systems building blocks and other cross cutting issues</td>
</tr>
</tbody>
</table>

A key benefit of the workshop was that following the bottleneck analysis process, awareness of newborn health issues was greatly raised among key stakeholders and decision-makers, so that newborn could be given more emphasis in the country. The government further recognized closing the equity gap and achieving universal coverage and equity in maternal and newborn health as the underlying principle guiding this work. The stakeholder workshop to develop the Myanmar newborn action plan happened 3 months after the BNA workshop. This helped keeping the momentum and following-up with same stakeholders.

Other country examples:

- In **Nepal**, the bottleneck analysis was used as an advocacy mechanism during the newborn national consultative meeting. At this event many participants from different constituencies raised similar concerns on newborn health, providing a unique opportunity to draw the government’s attention to important issues. For example, the view that out of pocket expenditures were too high, and that sick newborn care should be free of cost emerged very strongly in the bottleneck analysis discussions. Civil society, providers, experts, professional bodies and other partners thus voiced a unified message about barriers to improved newborn health. As a result the government included newborn health into the annual plan. The team recommends bringing together a large group to complete the bottleneck analysis, to establish shared ownership of the process.

- **Ethiopia** conducted a barrier analysis to understand poor uptake of newborn care services in the community. The study sought to identify demand- and supply-side barriers to uptake of integrated community case management (iCCM) and community based newborn care (CBNC) services. Despite investments in these services, service utilization of iCCM and CBNC had been low. Qualitative data was collected through in-depth interviews and focus groups with primary caretakers of children under five, health care workers, religious and community leaders. Identified barriers included: on the demand side, lack of awareness of services, preference for traditional remedies, and perceived low quality of services; on the supply side, drug shortages, service interruption, and lack of physical access. Proposed solutions to address these included awareness-raising of available services (e.g. through targeted health education campaigns), close collaboration with health centres to promote post-natal care, and addressing service interruptions. Bottleneck analyses can thus help to understand barriers to service uptake, and inform improvement efforts.

**Optimizing the Health Extension Program to Increase Integrated Community Case Management of Childhood Illness Service Utilization in Ethiopia. Overview of findings from a study to examine barriers to uptake of service. PATH**

Available at: https://www.dropbox.com/sh/cfm7o2si6aws32n/AACgHXnRJNQ1OxF45ju6nta?dl=0

- **Viet Nam** completed a comprehensive bottleneck analysis (BNA) in 2013 to address disparities on maternal and child health care indicators, and the slow reduction of neonatal deaths in the country. Led by the ministry of health in collaboration with UNICEF, WHO and NGOs, its objective was to identify barriers to scale-up of key newborn health interventions. The BNA tool was applied both at provincial and national level to gather key information. This was followed by a national workshop to verify, synthesize and reach consensus on findings, attended by 50 participants from the ministry of health, hospitals, professional health associations, international NGOs and UN organizations, as well as representatives from provinces. Finally the ministry of health convened a technical working group to finalize the BNA report, including recommended priority areas for action related to each of the health systems building blocks.

**Bottlenecks and solutions to scale-up newborn care in Viet Nam. 2013 Ministry of Health.**

Available at: https://www.dropbox.com/sh/cfm7o2si6aws32n/AACgHXnRJNQ1OxF45ju6nta?dl=0

- In selected countries in the East Asia and Pacific Region, the BNA shed light on the following barriers to scale up of newborn health interventions:

  - Indonesia: inequities in coverage of facility based deliveries and C-sections, gaps in HMIS; data on newborn interventions, lack of perinatal audits at scale.
• Timor-Leste: geographic and financial barriers to facility deliveries and care-seeking for obstetric complications, shortage of midwives and skills-gap on newborn care, lack of trust in health facilities, and presence of harmful cultural practices.

• Bottleneck assessments in Afghanistan, Bangladesh, India, Nepal and Pakistan highlighted common health system constraints related to workforce (lack of skilled midwives and nurses), financing (limited funding specifically focused on newborns), and insufficient scale-up. Pakistan and Afghanistan specifically presented constraints in scale up of KMC. The highest number of bottlenecks related to prevention and management of preterm births, provision of quality care for small / sick babies, and management of severe infections.

Summary Bottlenecks Assessment
Afghanistan, Bangladesh, India, Nepal and Pakistan

Common Health system constraints are found in all these high burden countries
• Workforce—Lack of competent healthcare workers, especially skilled midwives and nurses
• Financing—limited funding specifically focused on newborns
• Insufficient Scale up

Context-specific constraints, where despite similar health systems a particular intervention faces differing bottlenecks to scale up eg KMC with high perceived challenges in South Asia (Pakistan and Afghanistan). Social norms for Skilled birth attendance (female health provider)

Intervention specific findings – those with the most bottlenecks
• Preventing/managing preterm births
• Providing quality in patient care for small/sick babies
• Management of severe infections

Quality and Equity Gaps .... for care around birth
• Universal resolve to reach every woman and every newborn
• Increase investment, medicines and health workers, with the skills, and autonomy to provide the right care for every woman and every newborn bab
The figure below presents the outcomes of a health system bottleneck assessment for care around birth and care of small and sick newborns in high-burden countries. (green = 1-3 countries, pink = 4-5 countries, purple = 6-8 countries):
• The report of a bottleneck analysis workshop to identify barriers for improving neonatal health care held in Iraq in 2015 is available at: https://www.dropbox.com/sh/cfm7o2si6aws32n/AACgHXnRJNQN10xF45ju6nta?dl=0

The BNA tool applied in these examples supported preparation of equity focused newborn health plans, anchored in the health systems strengthening approach.

Challenges:

• One country reported difficulties in workshop participants understanding what was required to identify bottlenecks to scale-up interventions. A good understanding of the methodology is needed to identify the right bottlenecks for the country situation. In this case, the workshop team revisited the bottlenecks with participants in order to arrive at accurate conclusions. To prevent such challenges, especially in cases of large groups conducting a bottleneck analysis (one country convened over 200 participants) it is important that a strong facilitator is charged with conveying the purpose and requirements of the exercise. This may call for a number of facilitators to ensure every group receives guidance.

Recommendations for optimizing the bottleneck analysis:

• Ahead of the workshop, provide guidance on the information that will be requested (e.g. through a questionnaire or workshop guide shared in advance). This gives group facilitators time to collect relevant documents and data, prepare concept notes, and reflect on key lessons learned as a basis for productive engagement in the discussions. They can also identify key informants and an effort should be made to invite those key informants.

• Arrange an off-site workshop location (e.g. away from the workplace), to ensure participants dedicate full attention to the topic of discussion, and giving an opportunity to “think outside of the box”. Split same department colleagues in different groups to avoid hierarchy and domination of discussions by a few participants. In addition, there should be a balanced representation of participant voices to ensure all issues are considered.

• Plan for participatory data reviews and discussions, organizing workshop participants into working groups addressing different aspects of newborn health. For example, groups could discuss key bottlenecks for each health system building block per intervention, and propose solutions to overcome them for the priority interventions (see table above from Myanmar example).

• The tool requires preparation, a participatory and inclusive methodology and organization of a 2 day stakeholder workshop. However if applied correctly it can bring to light important newborn health issues, and pave the way for new courses of action that may not have been considered before. Countries who completed the exercise shared that it was an extremely useful exercise, and that the ensuing report was well received by stakeholders. Countries who were fore-runners for national plan development were also the ones which had undertaken BNA exercise that led to more engagement and partner consensus mobilizing action.

• An essential step in the bottleneck analysis is the validation of results and of suggested solutions. This should take place through a plenary session with all participants, with the goal to reach consensus on the best actions to address the bottlenecks.

• The information gained by use of the tool can also be used for advocacy purposes and to raise awareness on newborn health issues. It can help to document examples and build an evidence-base on barriers and solutions as identified by a wide stakeholder-base, which can be shared with decision-makers at the ministerial level.

• Countries can develop protocols and guidance on how to apply the tool in the specific country context, taking into account structural, logistical or other specificities. One country shared about developing guidance to apply the tool at the subnational level first, to ensure a standardized approach would be followed across the country. This guidance
document could for example outline the type of experts required to conduct a bottleneck analysis, how discussion groups should be formed, how to engage facilitators for this work, and timelines and expected outcomes for this process.
Prioritization of activities at national and subnational level
In developing newborn action plans, countries need to take the difficult yet essential decision of which activities to prioritize. Given finite resources, prioritization can help to allocate funds strategically and ensure that investments of human and financial resources are based on a considered plan, with a view to long term solutions for newborn health that consider the health system as a whole. Below follow selected country examples for prioritizing activities, both at national and sub-national level.

National level:

• For Nepal, setting priorities in newborn action plans was tightly linked to having completed a thorough bottleneck analysis. The team found that correctly identifying bottlenecks to improved newborn health helped to prioritise and select interventions to address these barriers, which led to more relevant action plans. Given the format of this group work, it was crucial to engage a strong facilitator to manage the discussions and to ensure the analysis was sufficiently in-depth to arrive at the root causes of issues. Moreover, the stakeholders responsible for action plan development, such as a technical advisory group (TAG), conducted several rounds of consultative meetings to agree on actions. Therefore countries can expect the prioritization of activities to be an iterative process, with several meetings over a period of time, to reach consensus and to ensure that identified actions help to achieve the plan’s objectives. While a large number of actions may be proposed along the way, priorities were set based on the evidence of bottlenecks requiring most urgent attention.

• Nigeria used a classification system to identify the most pressing bottlenecks, which helped to prioritize actions in the newborn action plan. The country analyzed key bottlenecks preventing scale-up of newborn interventions, and classified them as “good”, “needs some improvements”, “needs major improvements” or “inadequate.” Concerned stakeholders then recommended solutions for each high priority bottleneck, which helped to define priority actions in the country’s ENAP. In addition, priority actions were linked to the 10 health system areas31 prioritized by the country. To aid implementation, the plan specifies the role of different constituency groups for each action, including for: government policy-makers, international development partners, donors and foundations, the private sector, NGOs and community organizations, academic and research institutions, and health professionals.

• In Ghana, priorities for the newborn action plan were aligned to the strategic directions in the country’s existing RMNCAH plan. This approach helped to link newborn activities to existing RMNCAH initiatives, therefore creating synergies between the plans. To reach consensus on priority actions, a two day workshop was held with relevant stakeholders to review the preliminary draft of the newborn strategy, and to agree on priorities.

• In Tanzania, where newborn health is part of a wider RMNCAH plan, the ministry had sought to prioritize and scale interventions to improve maternal and newborn health as part of the 2008-2015 plan to accelerate reduction of maternal, newborn and child deaths32. The priorities for the next action plan for 2016-


Subnational level:

- **In India**, a country with a decentralized planning system, prioritization of activities for newborn health involved mechanisms at both national and subnational levels. As a large country with 36 separate administrative units at the subnational level, each with its own health officials, successful prioritization of activities required effective coordination between the central government and the subnational state level. In this context, the development of an overarching national level ENAP helped to guide plan development in each state. At the same time, priority setting was relegated to the subnational level to allow plans to be tailored, so that states developed specific action plans based on individual situation analyses. This flexibility enabled the adoption of innovative approaches in states, which in turn increased flexibility at the district level. Having said this, funding for each state in India is largely dependent on a central government scheme, whereby states depend on national guidelines but are offered flexibility to implement plans based on local contexts. To effectively coordinate newborn action plan efforts in this decentralized system, the ministry of health and family welfare appointed a focal point to steer the technical work and drive consensus among numerous stakeholders. The national level ENAP was developed over a 6-months period, and featured consultations with stakeholders at the subnational level to ensure the document was endorsed by all. Thanks to this process, the country now presents a high level of ownership of the national ENAP, with states proactively developing ENAPs at the subnational level. To prioritize interventions in the national ENAP, the country held numerous scientific and technical discussions to ensure that decisions were founded on a robust evidence-base. Such technical sessions involved government representatives, eminent academic experts and other relevant partners.

**Key lessons learned:** India presents different needs across regions, and a high number of subnational actors. The scale of the work presented challenges for coordinating and reaching consensus among a high number of stakeholders. However key to success was strong leadership at the national level, spearheaded by a technical group within the ministry of health. Their proactive engagement was crucial to ensure that the plan developed would be viable over time. The team emphasised this work was far from a “one man show”, and rather benefited from active engagement of partners at national, subnational and the district level. Finally, the emerging global movement for newborn health provided additional opportunities for knowledge exchange and support.

- **Pakistan**, where prioritization of activities also takes place at subnational level, emphasised the need to involve experts at the district level in the process. This allowed stakeholders to develop ownership of decisions, a crucial element for success during the implementation phase. A specific example illustrates the importance of this approach: the government at the national and provincial levels had determined that in a particular district maternal and child health should be prioritized. However, the district health officer involved in the discussion shared that the most pressing issue in the community were also other safety and public health concerns which had impact on access to facilities. These concerns were factored into recommendations to respond to the local needs. This example shows that in efforts to define and advance the newborn
health agenda, it is essential to gain the input from actors at all levels, including those who understand the local context best such as district and community health officers. This can help to prevent challenges during the implementation phase.

The country further completed a thorough bottleneck analysis to identify provincial needs and barriers to scale-up newborn interventions. In 2013, the country held provincial consultations for scaling-up newborn programmes, so that each province could identify bottlenecks and challenges in their newborn health system. In the same year a national consultation was organized to consolidate findings and recommendations from provinces, and to coordinate efforts among national stakeholders. The main bottlenecks identified included lack of health care personnel, lack of supplies and equipment, over-complicated procedures, and cultural practices. Findings from the bottleneck analysis in the province of Punjab are highlighted in the table below.

<table>
<thead>
<tr>
<th>Table 6: Newborn bottleneck analysis for Punjab province</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intervention</strong></td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>Skilled care at birth</td>
</tr>
<tr>
<td>Basic emergency obstetric care</td>
</tr>
<tr>
<td>Comprehensive emergency obstetric care</td>
</tr>
<tr>
<td>Basic newborn care</td>
</tr>
<tr>
<td>Management of preterm birth</td>
</tr>
<tr>
<td>Neonatal resuscitation</td>
</tr>
<tr>
<td>Kangaroo Mother Care</td>
</tr>
<tr>
<td>Treatment of severe infections</td>
</tr>
<tr>
<td>Inpatient care for sick and small babies</td>
</tr>
</tbody>
</table>

**Key**
- Minor bottlenecks
- Significant bottleneck
- Very major bottleneck
- Incomplete data

Priority setting to improve newborn health in Punjab was based on these findings, which led the province to focus on leadership, governance and health financing for newborn programmes, especially in the treatment of severe infections, introducing Kangaroo Mother Care, implementing neonatal resuscitation when needed and providing inpatient care for small and preterm babies. Punjab has since spearheaded introduction of high-impact interventions, tailoring implementation strategies to local needs and leading efforts to reach rural populations with the greatest deprivation. The province could accelerate progress towards newborn survival by targeting cost-effective and lifesaving interventions, such as capacity-building of Lady Health Workers (LHWs) and community-based midwives in the administration of chlorhexidine for cord care, and training in Kangaroo Mother Care (KMC).

**Indonesia** emphasised the need to clearly communicate national level priorities on newborn health to the subnational level, to support subnational priority setting and planning efforts. The country set priorities in the national ENAP based on a bottleneck analysis process, while provinces developed individual newborn health action plans based on a district problem solving approach focused on monitoring for results. The country thus approached newborn health tailored to the needs of each district, with guidance from the national ENAP. In efforts to align subnational plan development with the central ENAP, the central ministry consulted provinces to ensure the ENAP document was understandable, and to encourage its integration in provincial plans. The team also developed a short action plan outlining the 5 critical interventions for newborn survival[^34], and these are now captured routinely in subnational plans, although more work is required to ensure they are implemented in facilities.

**Key lessons learned:** some regions in Indonesia advanced more than others in adopting national ENAP guidelines, which called for increased capacity building and support in areas lagging behind. However staff shortages limited the length of training possible in those regions, so the country recommends having clear guidelines and frameworks to encourage adoption of priority interventions. Finally, as the causes of newborn death can vary by region[^35], countries can expect that priority interventions in subnational plans vary accordingly.

**Challenges:**

- To set priorities for newborn health some countries faced difficulties in reaching agreement between different administrative units. This was especially pronounced in decentralized systems operating at central and state levels. As a way forward, country teams referred to existing government commitments such as those found in RMNCAH strategies. For a country facing a similar situation, it is further advisable to:
  - Bring stakeholders on board from the beginning, and set up a strong advisory group within the ministry that can influence financial decisions.
  - Ensure that decision-making processes are documented. One country shared that decisions captured in official meeting minutes would not be easily overlooked, and carry more weight for being implemented. Therefore creating a platform for documenting decisions (e.g. a task force or advisory group) is recommended.
  - Consider priority setting is not a one time job, it calls for robust monitoring and evaluation, and mid-term review processes in order to assess progress and gaps, and inform future priorities. These steps should be an integral part of the process, especially during the planning phases. This should be clearly articulated among all stakeholders involved.

[^34]: 5 critical interventions for newborn survival:
- resuscitation for asphyxia;
- antibiotics for infections;
- kangaroo mother care;
- initiation of breastfeeding;
- antenatal corticosteroids for premature babies.

[^35]: Indonesia’s Demographic Health Survey (2012) provides data for perinatal mortality by region.
Recommendations for prioritization of newborn health activities (national and subnational levels):

- Criteria for prioritisation should be explicit and based on data from situation analysis, bottleneck analysis, results from resource mapping, equity analysis, scenario analysis and other exercises mentioned in this guide, and consultations with different stakeholders including the communities.

- It is helpful if the same experts involved in developing the national health strategy also contribute to the newborn and child health plan. Ethiopia shared how this continuity helped to reach consensus on priorities, as the same decision-makers were involved in both processes. Further, the government officials managing newborn and child health should be in a position to influence other health systems stakeholders about the importance of newborn health. Once it is recognized as a priority for the ministry, then resource mobilization, infrastructure support, training support will more easily align. This in turn allows newborn health programs and units to develop a detailed action plan, which ideally emanates from the overarching ministry of health strategic plan. In summary, alignment and a common agenda are key to success.

- Prioritization is in many cases driven by limited funds, but it can also help to cost plans that would otherwise be too large in scope to cost, given available time and resources. For example Bangladesh presented a very comprehensive ENAP document covering a 5 year period, so that prioritization of actions was essential to complete the costing exercise. The team organized a 3 day workshop with key stakeholders to develop a detailed breakdown of costs for the prioritized interventions, as well as a yearly scale-up plan, thereby successfully completing costing of the ENAP (using the OneHealth tool).

- Costing tools such as the Lives Saved Tool (LiST) can help to set priorities for newborn health, and ensure that plans are cost-effective. Uganda reported that this tool was instrumental to prioritize interventions, by displaying the impact of each intervention scaled up to different coverage levels, and to see which would yield the best results in mortality reduction.

“Without LiST and OneHealth tool it would be very difficult for the country to cost and prioritize interventions.” LiST and OneHealth user, Uganda.
STRATEGIES AND RESOURCES FOR NEWBORN HEALTH PLANNING

Geographic information system (GIS) mapping

To plan effectively for newborn health, and to develop action plans that fit local contexts, Bangladesh used GIS mapping to locate the number of maternal and newborn deaths, and to identify the areas of highest need. The Maternal and Perinatal Death Surveillance and Response (MPDSR) system works through the health system, and captures maternal, neonatal deaths and still births from the community and facility level. Mapping of deaths helps to identify vulnerable areas for prioritizing interventions, supporting health managers to prepare local and targeted action plans.

In another example from Pakistan, GIS mapping has been used to identify family planning services available in communities, in order to understand distribution patterns. The mapping revealed that the lady health workers and private clinics able to perform this work were mostly concentrated around main roads, therefore leaving remote rural areas with limited access to such services. The insights gained from this mapping exercise could therefore help to address the coverage gaps for service provision in under-served areas.

Maternal and newborn health disparity country profiles
These statistical profiles, developed by UNICEF, are helpful to locate areas of highest need and to adapt plans accordingly. They present the causes of neonatal mortality, current levels of key impact, service delivery and coverage interventions for mothers and newborns with a wide array of disaggregation including residence, household wealth, mother’s age, mother’s education and sub-regional levels. The profiles were developed for the 25 ENAP priority countries, and can be found at: https://data.unicef.org/resources/maternal-newborn-health-disparities-country-profiles/

Finally, rationalization of human resources is increasingly recognized as an important approach to adequately plan for newborn health. This requires examining the composition of health teams available in facilities, and addressing gaps for certain professional categories. For example, if a district health centre is equipped with an obstetrician that can perform caesarean delivery, but lacks an anaesthesiologist to enable this work, this gap has significant implications for the provision of care in that location. Strategic placements of human resources require that health planners have an overview of available resources, and ensure that all required professionals are available in a given location. Thus rationalization of HR distribution can ensure 24/7 provision of key maternal and newborn care services in some priority facilities in a district. Mapping of human resources to ensure a complete workforce for the health of mothers and newborns is especially important for planning efforts in de-centralized health systems.
When planning and prioritizing newborn health activities, countries face the challenge of how best to address disparities in health as a part of this process. In addition to the tools presented in previous chapters, EQUIST helps to develop plans based on equity principles. It brings together into one platform all possible interventions, and taking into account the available fiscal space can project scenarios to advance newborn health agendas while reducing inequities in health.

Health disparities may occur based on geography, socio-economic status, gender, or other factors. They may not be visible when progress towards health targets is based on national averages, however in the context of the sustainable development goals (SDGs), the global health community is increasingly aware of the need to measure and address persisting inequalities.

For example a recent systematic assessment of bottlenecks to essential maternal and newborn health care in countries with the most neonatal deaths\(^{36}\) revealed significant inequities in coverage for the most effective interventions. An example from Egypt (figure below) illustrates disparities across provinces due to inequities in coverage of RMNCAH interventions.

**Figure 4**

Inequity in causes of NNMR in Egypt

Excess under five deaths due to inequity of RMNCAH intervention coverage, by Governorates

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Seven provinces account for majority of excess deaths due to inequity in coverage, major inequity reside in newborn causes.

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**Source:** DHS 2014, Calculation using LIST tool.

The EQUIST tool was developed to reduce disparities between the most marginalized mothers and children under 5, and the better-off. It supports equity-based analyses, highlighting for example low performing areas based on a defined population, and selected newborn health indicators. Countries can apply EQUIST to build scenarios for costing and lives saved, which can be presented to relevant ministries for consideration and to focus resources based on the evidence.

EQUIST invites users to adopt a step-wise approach, based on a sound theory of change, and entails: defining and understanding priority populations, as well as priority health issues among these groups; selecting priority interventions while considering the bottlenecks affecting their delivery; developing strategies to address the causes of the bottlenecks, and estimating the costs and impacts of these strategies. The tool can therefore effectively support decision-making processes and planning for scale-up of newborn health interventions.

EQUIST is unique in that it helps to define strategies and plans that are truly equity-focused. Beyond identifying health disparities, it enables comparison of different intervention scenarios by estimating the impact and cost-effectiveness of selected high-impact interventions. It calculates impact as reductions in morbidity and mortality among the most vulnerable women and children under 5, or reductions in health disparities. This is achieved when the gap between the most deprived and the better-off in a particular region or country is narrowed. The tool incorporated the Lives Saved Tool (LiST), which quantifies the number of lives saved and the associated cost based on implementation of different strategies.

In practical terms, EQUIST can be used to:

- conduct a bottleneck analysis and distinguish program-level issues (e.g. lack of capacity to conduct an intervention) from system-level issues (e.g. a lack of providers);
- understand the expected impact of interventions (e.g. number of deaths averted), which can help to communicate highly technical information to a broader audience, e.g. policy settings;
- compare different scenarios as part of an iterative policy making process; the tool allows to compare outcomes of different investment models, and costed activities.

Depending on countries’ requirements EQUIST can be used for different purposes: to conduct a situation analysis, to prioritize bottlenecks, to analyse and compare scenarios and make decisions during action plan development.

Key links:

- EQUIST site: http://equist.info
- Additional resources: http://equist.info/en/pages/resources

Country experiences with applying EQUIST:

- Bangladesh: http://equist.info/files/general_files/EQUIST_Bangladesh_Presentation.pptx
- Sudan: http://equist.info/files/general_files/EQUIST_Sudan_Presentation.pptx

37 EQUIST offers a stepwise logical approach:

1. Define priority populations
2. Prioritize health issues among targeted population
3. Prioritize interventions to address those issues, and that currently have low effective coverage
4. Identify challenges or bottlenecks that disrupt service delivery for the most deprived, and that cause the low coverage
5. Understand the root causes of bottlenecks within a population
6. Select strategies to address the causes of the bottlenecks
7. Assess expected impacts and cost-effectiveness of the strategies

In Cameroon, EQUIST helped to develop the RMNCAH plan, in particular through enabling a strong situation and bottleneck analysis. The team used the stepwise approach to identify priority populations, the key health problems affecting them, and conducted an in-depth analysis to identify bottlenecks and strategies to address them. Subsequently, the team determined the cost effectiveness of each strategy by projecting possible scenarios for priority themes and regions. The development of the RMNCH strategy was funded by the Global Financing Facility (GFF), which encouraged using EQUIST to conduct a situation analysis. LIST was further used to project scenarios, and OneHealth was used to develop the investment case for neonatal child health. The prioritization process using EQUIST in Cameroon is described in the Global Financing Facility Annual Report (2016-2017) available at: https://www.globalfinancingfacility.org/sites/gff_new/files/documents/GFF-Annual-Report-2016-2017.pdf

While EQUIST is frequently applied at the national level, in Bangladesh UNICEF is supporting application of EQUIST to identify priority interventions for maternal and newborn health in 15 remote low performing districts. While the availability of data has been reported as the most challenging aspect, the team is validating the data in all the districts and planning a workshop to finalize costing scenarios.

Challenges:

- Data requirements for the tool has been flagged by countries as a challenging area (e.g. for interventions coverage). Acknowledgement of data gaps is in itself an important outcome of applying EQUIST, and can initiate processes to make that data accessible over time. In many countries a large portion of the data is not disaggregated (e.g. by rural/urban settings, wealth quintiles) or is not available at the subnational level. When all available data sources have been exhausted and gaps remain, country teams have reported relying on the opinions of experts to complete the planning exercise, based on a consensus process.

- One country stressed the role of experts with experience in programming and planning at the country level to successfully apply the tool. Without such contextual in-depth knowledge, the resulting scenarios and country profiles may not reflect the situation on the ground, especially when data gaps require a number of assumptions to be made in order to conduct the exercise. A key lesson learned is that completing EQUIST is a group effort, and should involve staff who know the country well.

- Another challenge raised by countries relates to the scarcity of experts who are able to apply EQUIST independently. One country reported having local staff trained to use the tool, but at the time of application for planning purposes they requested a staff member from an international NGO to lead the process. A possible solution in this scenario is to pair the person in charge of applying the tool with an EQUIST expert who could support and guide as required, or setting up online training to this end.

Recommendations for applying EQUIST:

- Engaging with different thematic groups is helpful when implementing EQUIST, specifically to discuss both program-specific and system-specific issues. Inclusion of experts on the health systems building blocks is recommended.

- EQUIST is populated with preloaded information, however users are strongly encouraged to validate the existing data. As much as possible, all available information should be reviewed and analysed prior to the policy discussions.

- Set up a strong team who can support the process with relevant expertise. The tool is an instrument and does not in itself provide solutions. Instead it offers models and scenarios that users should carefully reflect on. Local experts should therefore be involved who bring knowledge of country issues, so that the analysis is based on contextual insights. Regional experts may also provide complementary information.
• Ensure representation of the perspectives of target populations and communities, for example by collecting qualitative data through interviews, focus groups etc. This information can provide a rich context for understanding the quantitative data, and ensure meaningful analysis.

• At the district level, EQUIST can also be used as a management tool to regularly appraise bottlenecks and ways to address them, and to develop equity-focused plans.

• Following application of the tool, the team should ensure that the resulting strategy or plan is implemented, and that interventions are monitored and assessed over time. Country teams can use the evidence-base and scenarios in EQUIST to create momentum and attract resources for this work.

• In addition to relying on funds from international donors, it is important to foster national ownership and leadership to leverage internal funds. Actively involving government stakeholders from the beginning is essential to this end.

In terms of timelines for applying EQUIST, countries can expect to invest (as a minimum, also subject to anticipated scope of work):

• 1, 2 weeks to collect and review available data;
• 1 week (approximately) for policy discussions. This includes an initial stakeholder orientation to the tools, and time dedicated to prioritize bottlenecks and strategies to address them. This should be an iterative process with several rounds of consultations, given that perspectives may change based on available evidence;
• 2-3 weeks to refine the intervention strategies, again based on further policy discussions; it may involve a wider stakeholder base, and can lead to the initial drafting of an action plan;
• this will be followed by a longer process in order to gain further support for the plan, and to put into place the organizational requirements and political support for its endorsement and implementation.
The Lives Saved Tool (LiST) is widely accepted by the global health community as an excellent tool for forecasting the health impacts associated with scaling up health interventions on maternal, newborn and child health, and stillbirths. It can therefore support countries to set adequate targets in newborn action plans.

The tool works as a model to identify high-impact interventions by projecting the mortality reductions that can be achieved based on different coverage targets. It calculates the number of maternal and newborn deaths averted under various scenarios, offering planners and decision-makers an evidence-based approach to set targets. LiST is based on:

- Demographic data: from demographic projections and estimates;
- Causes of death: from WHO estimates or preferably based on local data sources;
- Coverage levels for key health interventions across the continuum of care;
- Health status indicators for national or subnational settings;
- Effectiveness estimates for interventions from the latest scientific reviews and literature.

Based on this information, the model estimates the effectiveness of increased coverage of interventions on neonatal, child and maternal mortality. Mortality reductions or “lives saved” can be attributed proportionally to specific interventions as they are scaled up. As of 2017, LiST costing provides the option to differentiate between services delivery costs (e.g. via community, outreach, clinic, and hospital-level care), and above service delivery i.e. program costs. Countries have found LiST very useful to support development of newborn action plans, and to examine which interventions would have the greatest impact.

The Lives Saved Tool (LiST) is available at: http://livessavedtool.org/

Training resources for LiST: http://livessavedtool.org/training

Country experiences:

- **Nepal** engaged a wider stakeholder group to optimize application of the LiST tool and identify targets and indicators for the national ENAP. To this end, the technical advisory group supporting the ministry of health brought in the expertise of statisticians, monitoring and evaluation specialists, and technical experts in newborn health. The team found application of LiST a thorough process, resulting in evidence-based targets. To start, coverage of interventions for 2015 were set as a baseline (derived from DHS and MICS). Coverage targets for 2035 were then set for each intervention. LiST projected scenarios for NMR, SBR and MM based on the scale up of interventions according to selected targets. One challenge shared by the team was that progress towards reaching the targets was perceived to be minimal as per LiST calculations, despite significant investments to scale-up interventions; secondly, the tool limited the degree of ambition for the targets (e.g. it suggested an NMR of 11, when the team had initially planned to set it below 10 by 2035). Having said this, the team decided to adhere to the indicators and targets proposed by LiST, given that it offered a path for an evidence-based approach that would lead to sustainable results over time. Countries facing a similar situation are advised to potentially revisit the tool to ensure the high-impact interventions were selected, targeting areas of highest need.

- **Uganda** shared that LiST was essential to prioritize and refocus interventions, and to set targets at a national level for newborn health. It helped to estimate the impact of scaling up interventions on mortality, and to quantify the potential effectiveness of interventions. In this context, LiST was used for the strategic planning processes and to model various scenarios. One challenge
encountered in applying the tool involved the lack of quality data. The team relied mainly on national demographic health survey data (DHIS), which however presented gaps. As a solution, the team used household (HH) survey data from the national bureau of statistics. The current 2016 RMNCAH plan is therefore based on data collected in 2011, which is the most recent year of available HH survey data. Having said this, new 2016 data has recently become available so the team is equipped to revise the targets and baselines accordingly. Overall LiST was very helpful in prioritising high impact interventions for RMNCAH, based on their effectiveness in saving lives of women and newborns.

- **Ethiopia** used LiST to create three scenarios for scale-up of interventions, based on three possible levels of resource availability: a base, medium, and optimal scenario. The optimal scenario assumed that most required resources for scale-up would be available over a 5 year period, making acceleration towards universal health coverage (UHC) possible. The other projected scenarios assumed limitations in the available resources, and therefore anticipated maintenance of the status quo, or a delay in reaching specific targets. In this context, LiST was helpful to estimate options and propose targets for each of these funding scenarios.

**Challenges:**

- Lack of human resources for applying LiST in countries. To overcome this challenge, countries have gained support from regional offices from relevant UN agencies, or have enrolled staff (e.g. from the ministry, or from a local research institution) in relevant training sessions. In addition, expertise may be available in countries but not necessarily shared among key stakeholders. On this subject, international organizations such as UN agencies and NGOs are encouraged to support each other as well as local entities in applying the tools. Advancing the newborn health agenda is most successful when it is viewed as a collaborative effort, with expertise shared towards common goals.

**Recommendations for applying the LiST tool:**

- LiST is best applied in conjunction with complementary tools such as OneHealth and EQUIST, to which it is linked. This allows countries to gain a broad vision for proposed targets and intervention scenarios, with associated break down of costs. For example one country used LiST as part of EQUIST application, as it helped to provide models for scale-up, scenarios in terms of lives saved, and to illustrate the cost-effectiveness of interventions. OneHealth was subsequently used to develop an investment case for advancing newborn health in the country.

- The tool also includes interventions not directly relating to newborn health, for example related to water, sanitation and hygiene (WASH) or to the different health systems building blocks. LiST can recommend prioritizing broader health systems interventions, which may be indispensable for actions on newborn health to succeed.

- Increments in lives saved shown by the tool will depend on factors such as which interventions are selected, and targeted locations. For effective use of the tool, teams should consider the interventions and areas where the most impact can be achieved. EQUIST, as well as the available health disparity profiles can also highlight areas of need, for example with high concentrations of maternal and newborn mortality (available at: [https://data.unicef.org/resources/maternal-newborn-health-disparities-country-profiles/](https://data.unicef.org/resources/maternal-newborn-health-disparities-country-profiles/)).

- To support teams in applying LiST, countries can consider collaborating with academic institutions or research centres with expertise in using the tool. One such capacity building hub was created in collaboration with Makarere University in Uganda. LiST aligns with the University’s works on maternal and newborn health, and a course has been organized on LiST in collaboration with the Johns Hopkins Bloomberg School of Public Health. Countries can collaborate to set up similar regional hubs for capacity development.
Options for training support are also available on the LiST website: http://www.livesavedtool.org/training.

- Some countries have sought external support to apply LiST, for example from international consultants or agencies. This might be helpful, however it is recommended in parallel to also strengthen skills in countries, for example by pairing an international expert with a country representative. This approach has multiple benefits. First, it can ensure that outcomes of LiST are better understood, given that the process of arriving at results has been followed from the start. This background knowledge may be essential when proposed options are presented to decision-makers. Second, it can help to build internal country capacity for future applications of the tool.
Defining ‘N’ in RMNCAH - Every Newborn Action Plan Country Planning and Costing Toolkit and User Guide X.

Monitoring and Evaluation Framework
A key component of a robust ENAP is the presence of a comprehensive monitoring and evaluation (M&E) framework. This can highlight progress achieved as a result of interventions, in terms of key newborn health indicators and coverage levels across geographic areas. A sound M&E methodology can help stakeholders take stock of the effectiveness of interventions, to help strengthen those that are on track, or refocus those not leading to anticipated results. Monitoring and evaluating action plans can not only help to assess the impact of activities, but helps to identify remaining challenges and actions required to accelerate progress. Ultimately, such efforts can enhance accountability towards commitments for improving the health of mothers and newborns. In addition, countries who actively engage in M&E activities strengthen their capacity to analyse and use data to shape policy decisions, and more efficiently allocate financial resources.

As part of action plan development, it is therefore essential that countries adequately plan monitoring and evaluation activities. Most plans have a table of monitoring indicators with benchmarks but evaluation activities are seldom planned or budgeted. The means of verification for the monitoring and evaluation framework need to be planned, costed and budgeted as well e.g. if certain information will be obtained from a periodic facility assessment, lot quality assurance sampling (LQAs) or household surveys- these activities needs to be factored into the overall plans.

**Monitoring** can help determine whether policies and programmes accomplish the goals they set out to achieve, such as improving health outcomes. It involves repeatedly observing a situation to watch for changes over time. Monitoring health at the population level helps to show if the health situation is improving, worsening or staying the same. As shown in the figure below, health monitoring is a cyclical process that can be broken down into five steps: 1. identify relevant health indicators; 2. obtain data for these indicators; 3. analyze the data; 4. report the results; and 5. disseminate results to inform policy, programmes and practice. This can result in a changed health environment, which calls for a new monitoring cycle.
A comprehensive monitoring and evaluation framework further organizes health indicators into four categories: inputs and processes, outputs, outcomes and impact. Input indicators tend to be broader in scope, affecting many parts of the health system. Output and outcome indicators are more specific to a health topic (e.g. newborn health) and may respond more quickly to changes in the health sector. Impact indicators provide an overview of the health status of the population, and are slower to change in response to policies and programmes.

In the context of newborn health, relevant indicators may include:

- **Inputs**: Health workforce: midwives per 10 000 population; Information: births registered, deaths registered (with cause).
- **Outputs**: Service access and readiness: caesarean section rate in rural populations; postnatal care; Risk factors and behaviours: low birth weight among newborns; early initiation of breastfeeding.
- **Outcomes**: Coverage of interventions: births attended by skilled health personnel.
- **Impact**: Health status: maternal and newborn mortality ratios; Financial risk protection: out-of-pocket payments as a percentage of total health expenditure.

An iterative monitoring process enables tracking of policy outcomes over time and evaluating the need for changes in policy and practice to accelerate progress.
Figure 6
Components of a national health sector monitoring, evaluation and review framework


Evaluation in turn is defined as a systematic assessment of an activity, project, programme, strategy, policy, theme, sector, operational area or institutional performance. It focuses on both expected and unexpected results by examining the results chain, processes, contextual factors and causality in order to understand achievements or the lack thereof. It aims at determining the relevance, impact, effectiveness and sustainability of interventions, and can thus inform planning, programming, budgeting, implementation and reporting. Evaluation aims to improve or reorient the policies, strategies or programmes examined, as well as to contribute to learning beyond that specific case and to strengthen reporting for accountability.

In this context, the Every Newborn Tracking tool (2014) was designed to track country progress on newborn health activities. Increased uptake of this tool in 2016 has made it possible to assess progress in 51 countries and territories on various newborn health issues, such as: quality of care improvement programmes, human resources strategies, maternal death surveillance and reviews, stillbirth rate reductions, national health monitoring information systems, among others. The 2016 tracking tool report can be accessed at: https://www.dropbox.com/sh/cfm7o2si6aws32n/AACgHXnRJNJQN1OxF45ju6nta?dl=0


Yearly tracking of country action is crucial to accelerate progress, as it can help to identify existing barriers to plan implementation, as well as possible solutions and technical assistance requirements. This information can help understand quality gaps, and advance coverage. The figure below shows progress between 2014 and 2016 on policies supporting quality of care for mothers and newborns around the time of birth:

**Figure 7**  
Number of countries reporting having national policies supporting quality of care for mothers and newborns around time of birth

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>National quality improvement initiative included in policies</td>
<td>41</td>
<td>31</td>
<td>0</td>
</tr>
<tr>
<td>National QI Programme has specific focus on MNH</td>
<td>31</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Health workers authorised to administer life-saving MNH interventions</td>
<td>45</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>Policy adapted for maternal death notification</td>
<td>34</td>
<td>16</td>
<td>0</td>
</tr>
</tbody>
</table>

Further details on ENAP progress can be found at: Implementation of the Every Newborn Action Plan: Progress and lessons learned[^40]:  

Supporting these monitoring efforts, the Maternal and Newborn Information Tracking for Outcomes and Results (MoNITOR) mechanism was set up to develop and align a core set of indicators for maternal and newborn health. Led by WHO's maternal, child and adolescent monitoring and evaluation team in collaboration with global partners, it consists of an expert group that seeks to harmonize maternal and newborn measurement efforts and provide guidance for improving national data collection capacities, based on evidence\(^4\).

**Monitoring and evaluation resources:**

- UNICEF evaluation webpage: [https://www.unicef.org/evaluation/index_evaluation.html](https://www.unicef.org/evaluation/index_evaluation.html)
- WHO evaluation webpage: [http://www.who.int/about/evaluation/en/](http://www.who.int/about/evaluation/en/)
- Every Newborn Country implementation tracking tool. This tool helps to inform countries and partners on progress made, and highlight areas needing technical support to scale up maternal and newborn health programmes. It can also be used for programmatic purposes. Possible data sources for completion of the tool include: national RMNCAH strategies, plans and policies, national guidelines and standards, periodic programme reports, country reviews and existing project survey data. Link: [http://www.healthynewbornnetwork.org/hnn-content/uploads/160525-ENAP-country-progress-tracking-report-2015-v2.pdf](http://www.healthynewbornnetwork.org/hnn-content/uploads/160525-ENAP-country-progress-tracking-report-2015-v2.pdf)
- The WHO developed a framework to help assess quality of care for mothers and newborns around the time of childbirth. It presents eight domains of quality of care that should be assessed, improved and monitored within the context of the health system building blocks. Each domain includes standards that define what is required in order to achieve high-quality care, and help to set a benchmark against which improvements can be measured. They entail broad statements underpinned by more specific quality statements, each linked to input, output or process and outcome measures. They can therefore be used to set national standards and monitor service improvements for maternal and newborn care. The Standards for improving quality of maternal and newborn care in health facilities are available at: [http://www.who.int/maternal_child_adolescent/documents/improving-maternal-newborn-care-quality/en/](http://www.who.int/maternal_child_adolescent/documents/improving-maternal-newborn-care-quality/en/)
- The WHO Service Availability and Readiness Assessment (SARA) tool is designed to assess and monitor service availability and readiness of the health sector and to generate evidence to support the planning and managing of a health system. It consists of a survey to generate a set of tracer indicators of service availability and readiness, and includes a section on maternal and newborn health. Link: [http://www.who.int/healthinfo/systems/sara_indicators_questionnaire/en/](http://www.who.int/healthinfo/systems/sara_indicators_questionnaire/en/)
- The USAID-supported Service Provision Assessment (SPA) is a health facility assessment tool that provides a comprehensive overview of a country’s health service delivery. It includes a section on delivery and newborn care in

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the inventory questionnaire, as well as additional questions related to services for newborns. Link: http://dhsprogram.com/What-We-Do/Survey-Types/SPA.cfm

- The Emergency Obstetric and Neonatal Care Needs Assessment tool, developed by Columbia University, helps to evaluate how well and to what extent health systems are providing Emergency Obstetric Care. It provides data for planning and to address existing gaps in EmOC service provision. Link: https://www.mailman.columbia.edu/research/averting-maternal-death-and-disability-amdd/toolkit

- Network for Improving Quality of Care for Maternal, Newborn and Child Health (Quality of Care Network). Includes resources for monitoring quality of care for maternal and newborn health. Link: http://qualityofcarenetwork.org/


- Further resources for monitoring and evaluating progress on newborn health are available at: http://www.healthynewbornnetwork.org/issue/monitoring-evaluation/

Examples of monitoring and evaluation frameworks in national plans:


COUNTRY EXPERIENCES IN MONITORING AND EVALUATING NEWBORN HEALTH PLANS:

Example of a Monitoring and Evaluation Framework: Nepal

Nepal’s Every Newborn Action Plan includes a comprehensive monitoring framework for tracking progress up to 2035. As shown in the table below, it includes targets for impact and outcome indicators to measure progress at defined points in time. It also includes targets for reducing stillbirths rates, which is a model to be followed.


Table 7: Monitoring Indicators of the Nepal ENAP

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal mortality ratio</td>
<td>170</td>
<td>165</td>
<td>161</td>
<td>156</td>
<td>152</td>
<td>148</td>
<td>128</td>
<td>112</td>
<td>98</td>
</tr>
<tr>
<td>Newborn mortality rate</td>
<td>23</td>
<td>22</td>
<td>21</td>
<td>20</td>
<td>20</td>
<td>19</td>
<td>16</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td>Stillbirth rate</td>
<td>18</td>
<td>18</td>
<td>18</td>
<td>17</td>
<td>17</td>
<td>17</td>
<td>15</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>Under-5 mortality rate</td>
<td>38</td>
<td>37</td>
<td>36</td>
<td>35</td>
<td>34</td>
<td>33</td>
<td>28</td>
<td>25</td>
<td>21</td>
</tr>
<tr>
<td>Preterm birth rate</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>Outcome</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antenatal care (4 visits)</td>
<td>60</td>
<td>62</td>
<td>64</td>
<td>66</td>
<td>69</td>
<td>72</td>
<td>79</td>
<td>87</td>
<td>95</td>
</tr>
<tr>
<td>Skilled birth attendance</td>
<td>56</td>
<td>58</td>
<td>60</td>
<td>62</td>
<td>64</td>
<td>66</td>
<td>75</td>
<td>85</td>
<td>95</td>
</tr>
<tr>
<td>Institutional delivery</td>
<td>55</td>
<td>57</td>
<td>59</td>
<td>61</td>
<td>63</td>
<td>65</td>
<td>75</td>
<td>85</td>
<td>95</td>
</tr>
<tr>
<td>BEmONC</td>
<td>8</td>
<td>9</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>14</td>
<td>19</td>
<td>25</td>
<td>30</td>
</tr>
<tr>
<td>Chlorhexidine cord cleansing</td>
<td>45</td>
<td>48</td>
<td>50</td>
<td>53</td>
<td>55</td>
<td>58</td>
<td>70</td>
<td>83</td>
<td>95</td>
</tr>
<tr>
<td>Newborn resuscitation</td>
<td>25</td>
<td>28</td>
<td>31</td>
<td>34</td>
<td>37</td>
<td>40</td>
<td>55</td>
<td>70</td>
<td>85</td>
</tr>
<tr>
<td>Kangaroo mother care</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>9</td>
<td>18</td>
<td>26</td>
<td>35</td>
</tr>
<tr>
<td>Full supportive care for sepsis</td>
<td>7</td>
<td>10</td>
<td>12</td>
<td>14</td>
<td>17</td>
<td>19</td>
<td>31</td>
<td>43</td>
<td>55</td>
</tr>
</tbody>
</table>
Example of a Monitoring and Evaluation Framework: Malawi

The Malawi Newborn Action Plan has the ultimate goal of halving neonatal mortality by 2035. To achieve this goal, the country ENAP includes a clear monitoring and evaluation framework with measurable indicators in order to track progress. The plan also stresses the importance of building the capacity of health workers and other relevant stakeholders to monitor and evaluate programme implementation.

The action plan includes monitoring milestones, and selected indicators to measure progress, as reported in tables 8 and 9 below:

Table 8:

<table>
<thead>
<tr>
<th>Year</th>
<th>National Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2015</td>
<td>National launch of the Malawi Newborn Action Plan</td>
</tr>
<tr>
<td>December 2015</td>
<td>Production and dissemination of the newborn guidelines and protocols in all district hospitals / tertiary facilities</td>
</tr>
<tr>
<td>March 2016</td>
<td>Introduction of newborn registers in all the facilities.</td>
</tr>
<tr>
<td>November 2015-2017</td>
<td>Establishment of sick newborn care units in all the district hospitals.</td>
</tr>
<tr>
<td>November-December 2017</td>
<td>Midcourse review</td>
</tr>
<tr>
<td>2017-2018</td>
<td>Accountability framework developed and operationalized at all levels of health care</td>
</tr>
<tr>
<td>2020</td>
<td>Review and update action plan</td>
</tr>
</tbody>
</table>

Table 9:
List of indicators for interventions in the Malawi action plan

<table>
<thead>
<tr>
<th>Number</th>
<th>Indicator</th>
<th>Means of verification</th>
<th>Frequency of collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact</td>
<td>Neonatal mortality rate</td>
<td>Surveys</td>
<td>Every 5 years</td>
</tr>
<tr>
<td></td>
<td>Stillbirth rate</td>
<td>Surveys</td>
<td>Every 5 years</td>
</tr>
<tr>
<td></td>
<td>Mortality rate in low birth weight babies (disaggregated by birth weight groups)</td>
<td>Facility surveys</td>
<td>Every 2-3 years</td>
</tr>
<tr>
<td></td>
<td>Fresh stillbirth rate</td>
<td>Facility surveys</td>
<td>Every 2-3 years</td>
</tr>
<tr>
<td>Inputs</td>
<td>Percentage of district hospitals with neonatal guidelines and protocols available</td>
<td>Facility surveys</td>
<td>Every 2-3 years</td>
</tr>
<tr>
<td></td>
<td>Percentage of health workers in maternity units trained in Essential Newborn Care</td>
<td>Facility surveys</td>
<td>Every 2-3 years</td>
</tr>
</tbody>
</table>

Objective 1: Strengthen and invest in care during labour, delivery, first day and week of life
<table>
<thead>
<tr>
<th>Number</th>
<th>Indicator</th>
<th>Means of verification</th>
<th>Frequency of collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Proportion of newborns who received all five elements of Essential Newborn Care; Quality of Care (INDEX)</td>
<td>Facility surveys</td>
<td>Every 2-3 years</td>
</tr>
<tr>
<td>2</td>
<td>Proportion of newborns delivered at a health facility receiving chlorhexidine for cord care</td>
<td>Facility surveys</td>
<td>Every 2-3 years</td>
</tr>
<tr>
<td>3</td>
<td>Percentage of institutional deliveries</td>
<td>Facility Reports</td>
<td>Monthly</td>
</tr>
<tr>
<td>4</td>
<td>Percentage of deliveries by an SBA</td>
<td>Facility Reports</td>
<td>Monthly</td>
</tr>
<tr>
<td>5</td>
<td>Percentage of preterm births</td>
<td>Facility Reports</td>
<td>Monthly</td>
</tr>
<tr>
<td>6</td>
<td>Caesarean section rate</td>
<td>Facility Reports</td>
<td>Monthly</td>
</tr>
<tr>
<td>7</td>
<td>Percentage of women with preterm labour (&lt;34 weeks) receiving at least one dose of antenatal corticosteroid</td>
<td>Facility surveys</td>
<td>Every 2-3 years</td>
</tr>
<tr>
<td>8</td>
<td>Percentage of newborns at health facility receiving vitamin K at birth</td>
<td>Facility Reports</td>
<td>Monthly</td>
</tr>
<tr>
<td>9</td>
<td>Percentage of low birth weight babies</td>
<td>Facility Reports</td>
<td>Monthly</td>
</tr>
<tr>
<td>10</td>
<td>Percentage of district hospitals with functional special care newborn units</td>
<td>District Health Office reports</td>
<td>Yearly</td>
</tr>
<tr>
<td>11</td>
<td>Percentage of postnatal mothers who stayed for 48 hrs in the facility</td>
<td>Facility surveys</td>
<td>Every 2-3 years</td>
</tr>
<tr>
<td>12</td>
<td>Percentage of newborns with birth asphyxia resuscitated successfully</td>
<td>Facility Reports</td>
<td>Monthly</td>
</tr>
<tr>
<td>13</td>
<td>Percentage of babies less than 2,500g receiving KMC</td>
<td>Facility Reports</td>
<td>Monthly</td>
</tr>
<tr>
<td>14</td>
<td>Percentage of newborns weighed at birth</td>
<td>Facility surveys</td>
<td>Every 2-3 years</td>
</tr>
<tr>
<td>15</td>
<td>Cause specific neonatal mortality</td>
<td>Facility surveys</td>
<td>Every 2-3 years</td>
</tr>
</tbody>
</table>

**Objective 2: Count every newborn: measurement, programme tracking and accountability**

| 16     | Percentage of district hospitals conducting perinatal death audits          | DHO Reports                  | Yearly                 |

**Objective 3: Strengthening Advocacy, Communication and Social Mobilization and other Community-Based Interventions**

| 17     | Proportion of communities with community mobilization structures for promoting optimal MNH practices | Surveys                        | Every 2-3 years         |
| 18     | Proportion of media houses involved in MNCH                                     | Surveys                        | Every 2-3 years         |

**Objective 4: Reach every woman and every newborn to achieve equitable and quality universal coverage**

| 19     | Vacancy rate for SBAs                                                          | Surveys                        | Every 2-3 years         |
| 20     | Disaggregated data on newborn care indicators (economic, geographic, educational) | Surveys                        | Every 2-3 years         |
Other country experiences:

- Monitoring and evaluation of newborn plans at the national and especially at the subnational levels is important to track the progress. Many respondents have reported using health management information systems (HMIS), district health information systems, and household (HH) surveys as the main vehicle to monitor indicators for newborn health.

- For Indonesia, holding regular meetings to monitor progress on newborn health has been essential to ensure tracking is approached as a joint initiative among different stakeholders. Monitoring takes place on a yearly basis at the national level, and 2 or 3 times a year at the subnational level. This ensures that data collection is ongoing, and that data sources are regularly verified and kept up to date. This approach also encourages stakeholders to reflect on lessons learned and ways to accelerate progress as they embark on the next phase of work. Monitoring is followed by evaluation and planning meetings in districts and provinces.

- Other countries with highly decentralized health systems shared about operating monitoring systems at the subnational level. For example India is using sentinel surveillance for monitoring neonatal mortality rates at periodic intervals and is initiating surveillance of still birth rates. Individual states in India have invested in monitoring of inputs, processes and outputs for improved newborn health, and many have their own 6 monthly review for both RMNCAH and ENAP plans. While monitoring is managed by individual states, monitoring and evaluation activities for the country are costed in collaboration with the central administrative units.

- Uganda highlighted the use of a scorecard to monitor implementation of the RMNCAH plan, which includes 3 indicators on newborn health (out of a total of 21) on newborn mortality rates (NMR), infections and asphyxia, and management of preterm births. The scorecard is implemented as part of a district planning tool for performance monitoring and review. It is also linked to the district health information system (DHIS), so that districts are automatically scored on performance. The districts review scores on a quarterly basis, after which they perform a bottleneck analysis and propose actions to address these. Finally, the country is also developing an assessment tool for the plan, whereby each facility will assess their performance and develop a health facility improvement plan, based on selected indicators.

- Ghana’s newborn action plan lays out how the country plans to operationalize monitoring and evaluation activities. Steps include: development of an M&E framework; mid- and end- term evaluations; collaboration with national surveys to measure progress on indicators. Key target activities include: establishing a uniform system to document morbidity and causes of death, setting up data collection systems (registers, forms) at facility and community level, and conducting data validation meetings for improved quality at all levels. Finally, the ministry planned quarterly monitoring visits from national to sub-national and sub-national to local levels, in addition to annual national stakeholders meetings on newborn care.


- South Africa: striving towards continuous quality improvement, the ministry of health's monitoring efforts spanned over a decade, providing a comprehensive view of trends in newborn and maternal health. To this end, it established mechanisms to regularly gather data from provinces, districts and facilities (through site visits, clinical audits, and mortality review and data quality meetings). The feedback and reporting at all levels has been instrumental to gather up-to-date information and track progress. Such long term monitoring effectively informed policy decisions and recommended interventions to reduce newborn and maternal mortality in the country (e.g. establishment of Kangaroo Mother Care (KMC) wards).

India: gives another example of long term monitoring efforts. The country set up an online, real-time data monitoring system to record vital information on the performance of special newborn care units (SNCUs), as well as long term outcomes of discharged neonates. This system guides policy and actions to improve perinatal care. A web-based health management information system (HMIS) further collects data on a range of outputs and service delivery indicators at the facility level. India also uses sentinel surveillance centres to monitor neonatal mortality rates, conducting ongoing death reviews to identify gaps in services and target interventions accordingly. The death review findings are transmitted from facilities to districts and up to the state level for child death audit reporting. Stillbirths surveillance has also been initiated. Overall these strengthened monitoring, records and audit procedures have enabled states to submit monthly reports to the ministry of health and family welfare at central level, thus improving reporting, analysis and action planning. The figure below shows trends in newborn mortality rates in India for the 2000-2012 period.


Regional monitoring initiatives exist to track progress on newborn health such as in the Western Pacific Region. Under the Action Plan for Healthy Newborn Infants in the Western Pacific Region3 (2014-2020), UNICEF and WHO initiated benchmark monitoring to assess EENC scale-up readiness, as illustrated in the graph below:

### Figure 8
Regional Action Plan Benchmarks - 2013 and 2014

<table>
<thead>
<tr>
<th>Component</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>National quality improvement initiative included in policies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EENC Action Plan</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>EENC Action Plan costed</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>EENC technical working</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>EENC focal person</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>EENC stakeholder group</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Clinical protocol</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Consensus building workshop</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Professional association</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

Source: Benchmarks for preparing to scale-up early essential newborn care: progress report.

Benchmarks forPreparing to Scale-up Early Essential Newborn Care (2013-2014) for Western Pacific Region Priority countries. Available at: https://www.dropbox.com/sh/cfm7o2si6aws32n/AACgHxnrJNjQN1Oxf45ju6nta?dl=0

WHO Western Pacific Region, UNICEF.
Finally, the table below shows annual rates of reduction and monitoring progress on NMR reduction in selected countries. Regular monitoring thus bring to light progress made over time and existing gaps.

### Table 10

<table>
<thead>
<tr>
<th>Country</th>
<th>NMR 1990</th>
<th>NMR 2000</th>
<th>NMR 2010</th>
<th>NMR 2015</th>
<th>NMR milestone by 2020 based on achieving SDG target by 2030. For countries that already have achieved the target or will based on their current trends we assume current trends continue</th>
<th>NMR in 2030 if current trends continue</th>
<th>NMR target by 2030</th>
<th>ARR between 2000-2015 (per cent)</th>
<th>Required ARR to achieve SDG target 2015-2030</th>
<th>Year to achieve SDG target if current trends continue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>52.8</td>
<td>45.2</td>
<td>38.7</td>
<td>35.5</td>
<td>25</td>
<td>27.9</td>
<td>12</td>
<td>1.6</td>
<td>7.2</td>
<td>2050+</td>
</tr>
<tr>
<td>Angola</td>
<td>59.1</td>
<td>58.4</td>
<td>52.6</td>
<td>48.7</td>
<td>31</td>
<td>40.6</td>
<td>12</td>
<td>1.2</td>
<td>9.3</td>
<td>2050+</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>51.3</td>
<td>49</td>
<td>46.4</td>
<td>42.6</td>
<td>28</td>
<td>37.0</td>
<td>12</td>
<td>0.9</td>
<td>8.4</td>
<td>2050+</td>
</tr>
<tr>
<td>Pakistan</td>
<td>64.3</td>
<td>60.4</td>
<td>50</td>
<td>45.5</td>
<td>29</td>
<td>34.3</td>
<td>12</td>
<td>1.9</td>
<td>8.9</td>
<td>2050+</td>
</tr>
</tbody>
</table>

### Challenges:

- Monitoring activities require commitment to conduct research, verify existing data or collect new data, and find ways to address gaps. Many countries face challenges in conducting this exercise, but those who have overcome them have greatly benefited from a strengthened M&E system. It has helped them to collect the necessary evidence to draw attention to newborn health issues, influence new policy directions and attract financial resources.

- Newborn health indicators may not be included in countries’ health management information systems (HMIS). Nepal shared about its efforts to include the relevant indicators into the system, especially regarding service provision. As the indicators are currently missing, an opportunity to include them may present itself during the next planned revision of the HMIS. This country also shared about the transition from a manual data collection system to an electronic data-capture system, which is expected to expedite data availability.

- When key indicators are not included in national tracking systems such as HMIS, it also impacts on the availability of baselines from which to measure progress. One such example was shared by Myanmar, which included relevant newborn health indicators in the national child health strategic plan but faced challenges to track them due to a lack of baselines. The next revision of the HMIS (2018) will be an opportunity to advocate for inclusion of relevant indicators.

- In relation to such data gaps, an encouraging example was shared by Bangladesh, which is planning to introduce selected newborn and maternal indicators in the national data collection system (e.g. on quality of care). With support from the Bill and Melinda Gates Foundation, the government has agreed to collect this information as part of a pilot project with the potential for roll out at the national level. Such initiatives can pave the way for inclusion of new indicators and enable measurement of progress.

- The timeframe for measuring progress on national ENAPs may not coincide with the
data collection cycles available in countries. Myanmar shared that the DHS was started in 2015, but that the next DHS might only take place after 5 years, making it difficult to measure progress. Countries may work with existing timeframes for data collection, while also consider alternative sources (e.g. MICS or facility surveys) to complement the data. In another example, Bhutan aims at following up every mother and every newborn using a maternal and newborn car and through digitalization of patients’ record which will help to get up-to-date information of mothers, newborns and services uptake.

- Countries shared that reported data was not always accurate. To address this issue, teams are strongly encouraged to validate data sources to verify the information.

- Countries with a decentralized monitoring system such as India, shared that national reporting through the ENAP tracking tool raised challenges, in particular to decide how much of the subnational level data should be used for national reporting. Given that each state has an individual monitoring systems in place, there was a need to channel state level data for global reporting purposes. Such a transition could be managed through careful analysis of the data and of the tracking tool, to decide how best to transmit the information from each state.

- Private sector providers are not incorporated into routine government information systems, such as in Bangladesh where 40% of deliveries take place in the private sector. Although the country benefits from a strong DHIS, it does not capture private sector data.

**Recommendations:**

- When selecting indicators for a monitoring framework, countries should ensure the relevant data to measure progress can be collected. One country shared that it sought to be very ambitious when deciding on the indicators—however it later emerged that many required household survey data, whereas the available HMIS data only concerned facilities.

- For this reason, it is highly recommended that during initial discussions on monitoring and evaluating ENAPs, experts on data collection systems such as HMIS or other data sources are included. If the list of indicators to be considered for an ENAP is drafted jointly by technical experts from the ministry of health, professional bodies for newborn health, as well as data experts, the ensuing document will ultimately present indicators for which data is more readily available.

- When systems to collect data and to monitor progress are limited, tracking newborn health plans can be challenging. It is recommended in such cases to form working groups that can collaborate to collect the missing information. For example one country used information shared at multi-stakeholder forums for monitoring purposes. A positive outcome of such efforts is that they can highlight existing gaps and draw attention to the issue, potentially creating the momentum required for new data-focused initiatives.

- If a country faces difficulties reconciling nationally available data with global ENAP reporting requirements, a suggestion is to discuss the global ENAP indicators during national consultations on newborn health. One country shared that it based its monitoring report on national indicators, but included the ENAP indicators as an annex to be discussed during relevant stakeholder meetings. This could help initiate inclusion of ENAP indicators in the national data collection system.

- When developing a monitoring framework, it is helpful to break it down into milestones that can be reviewed periodically (e.g. a yearly basis).

- Innovative channels for data collection may be available in countries, such as through use of mobile technology, electronic patient records and other eHealth strategies.
Regarding evaluation:

- What countries evaluate is directly related to the objectives set out in their plans. A key question is to determine whether defined targets have been met over a period of time. For example, if a country set out to reduce inequalities within a particular region, key evaluation questions should help to understand whether this goal was achieved. An informed evaluation therefore also requires robust baselines to measure progress.

- The Global ENAP includes national milestones for 2020, and for every 5 years up to the year 2035. Countries can frame evaluation criteria in line with the global ENAP milestones they have included in country plans, or (if different) their individual country milestones.

- Evaluations are an opportunity for countries to take stock of progress made against national targets for newborn health, but also to gain sight of how this work aligns with national health and broader development goals.

- Countries can complete evaluations for all newborn health activities included in the plan, but can also focus on one aspect to conduct an in-depth analysis.

- Coverage evaluation surveys conducted by WHO and UNICEF include maternal and newborn care data and are a helpful resource to inform evaluations. Examples of coverage evaluation surveys:

Program evaluation surveys are currently missing, and this is an area needing attention going forward.

- In addition to conducting a final plan evaluation, it is helpful to organize a mid-term evaluation to assess progress on activities.

Finally, it is important to remember that monitoring and evaluation are not just ends in themselves, but serve the purpose to strengthen health systems for delivery of services for mothers and newborns.

Equity considerations

A key element to consider in monitoring and evaluation efforts is how they can support reduction of equity gaps. Health equity is the absence of unfair and avoidable or remediable differences in health interventions and outcomes among groups of people. Disparities in health may occur due to social, demographic, economic or geographical factors. Disaggregated data by these groups can help to identify vulnerable populations, and help to track progress on health targets using an equity-based approach.

Resources for health equity monitoring:


- Countries can identify the key equity gaps and formulate benchmarks for reduction of these gaps.

- Narrowing the Gaps to Meet the Goals, is a 2010 report by UNICEF highlighting the benefits of an equity-focused approach to address child survival and development. Available at: https://www.unicef.org/publications/files/Narrowing_the_Gaps_to_Meet_the_Goals_090310_2a.pdf

- WHO’s Health Equity Monitor database presents data for reproductive, maternal, newborn and child health indicators, disaggregated by education, economic status, place of residence (rural vs. urban) subnational region and child’s sex. It also presents country profiles and interactive visuals. The health equity monitor is available at: http://www.who.int/gho/health_equity/en/

- WHO’s Handbook on health inequality monitoring with a special focus on...
low- and middle-income countries provides an overview of the process for health inequality monitoring, data sources, measurement and reporting issues, as well as examples from low- and middle-income countries, with many examples from the field of reproductive, maternal and child health43. The handbook is available at: http://apps.who.int/iris/bitstream/10665/85345/1/9789241548632_eng.pdf

Country example: equity monitoring in Thailand
- Thailand developed strategies to reduce disparities in provinces as evidences through its monitoring data. The country was able to expand its health infrastructure and launch a universal health coverage scheme, including care during childbirth and other maternal and child health services. These efforts greatly benefited the population, for example significantly increasing coverage of skilled attendance at birth, and the rates of institutional deliveries:

<table>
<thead>
<tr>
<th>Demographic and Health Survey (DHS) 1987</th>
<th>Total</th>
<th>Urban</th>
<th>Rural</th>
<th>Among mothers with no education</th>
<th>Poorest</th>
<th>Richest</th>
<th>Bangkok</th>
<th>Central</th>
<th>Northern</th>
<th>North-east</th>
<th>Southern</th>
<th>Thai</th>
<th>Non-Thai</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>88</td>
<td>93.6</td>
<td>69.9</td>
<td>43.7</td>
<td>-</td>
<td>-</td>
<td>96.6</td>
<td>95.7</td>
<td>64.9</td>
<td>50.5</td>
<td>58.8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Multiple Indicator Cluster Survey (MICS) 2005–06
- 97.3 92.7 97.8 81.1 92.7 99.8 - 99.4 94.1 97.9 92 99.4 81.7

MICS 2012 (Preliminary Findings)
- 99.6 97.8 98.3 91.8 98.6 100 99.8 99.9 99.7 99.6 98.5 99.66 96.82

A consistent equity-based approach has enabled almost complete elimination of regional disparities, as shown in the figure below.

**Figure 9**
Thailand: Achieving success by close watch on regional disparities and addressing them

![Skilled Attendance at birth](image-url)

DHS1987, MICS2005-06, MICS2012

<table>
<thead>
<tr>
<th>Skilled Attendance at birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
</tr>
<tr>
<td>South</td>
</tr>
</tbody>
</table>

XI

Costing national newborn action plans
Once countries have completed newborn action plans, either as standalone documents or integrated as part of wider plans, the next step is to cost them. The OneHealth tool is now widely used to support this process, helping countries to assess health investment needs by offering a single framework for planning, costing, impact analysis, budgeting and financing of strategies or plans for all major diseases and health system components.

The tool presents a modular format, enabling adaptation to different country contexts and needs. It can be used to generate scenarios, set priorities and assess costs for maternal and newborn health – either at the programme level, or at the broader health systems level. The model takes a comprehensive approach that costs all the health systems building blocks: human resources, facilities, equipment and transportation, medicines and supply chains, health management information systems, monitoring and evaluation, governance activities such as policy and advocacy, and activities related to financing and administration. OneHealth contains pre-populated data for countries to work with, with default values for both quantities and prices updated annually based on UN statistical databases. The tool is further linked to the Lives Saved Tool discussed in Chapter IX.

OneHealth is available at: http://www.avenirhealth.org/software-onehealth

Examples of OneHealth applications in countries: http://www.avenirhealth.org/software-onehealthcountries.php

Additional Resources on OneHealth (FAQ): http://www.who.int/choice/publications/OneHealth_Tool_Detailed_FAQs_2012.pdf?ua=1

Support site for users to post questions and interact with OneHealth technical teams: https://spectrummodel.zendesk.com/hc/en-us

Examples of costed plans:

- **Reproductive maternal, newborn and child health sharpened plan for Uganda (2013).** Ministry of Health, Republic of Uganda. Includes total costs for the plan, and intervention and programme cost breakdown. Costing assumptions and approach are explained, for example costs exclude health systems investments (e.g. infrastructure, equipment and human resources).

- **Estimated cost of National Strategic Plan for Newborn and Child Health Development (2015-2018).** Ministry of Health, The Republic of the Union of Myanmar. Presents the costing process, and costs to deliver newborn health interventions over a 4 year period, including detailed unit costs.

  Link: https://static1.squarespace.com/static/57be2f5e893fc0b6f3592200/t/581d3ffe197aea75e7efcee7/147831936444/national-strategy-for-newborn-and-child-survival-in-ethiopia-201516-201920.pdf

To support the process of costing newborn health plans, countries have requested more guidance and examples of best practices in these efforts. This chapter presents lessons learned from countries, as well as examples of costed plans.

Country experiences

• Many countries reported having previously used the Marginal Budgeting for Bottlenecks (MBB) tool to cost plans. More recently many used the OneHealth tool as it brings together all the features of existing tools, offering an enhanced platform for planning and costing.

• Countries also shared that applying OneHealth requires preparation, in particular to gather the relevant unit cost data. However when adequately applied it helps to identify costs by health systems or program components, which significantly increase understanding of the outcomes that can be achieved with planned activities.

• Another benefit of the tool is that it provides a strong evidence-base for costs proposed in a plan, which is helpful for financial and political processes. Costing a newborn health plan has proven to be a powerful way to gain support from governments and international funding bodies, especially if it is underpinned by a robust methodology. Beyond helping to attract political attention, a costed plan can assist UN agencies and other donors to better program available funding.

• The planning and costing exercise using the OneHealth tool also helps to understand the health system requirements to strengthen newborn care services and planning them accordingly with estimates of the investment required over the years according to established scenarios.

• Bangladesh described key steps to successfully cost the newborn action plan. Following official endorsement of the plan in 2015, it was costed by two country representatives who attended a regional workshop on OneHealth (from the ministry of health and from a local research institute). The costing process lasted about one year, a delay caused by initial difficulties in locating the required data. It was particularly challenging to locate the subnational data on unit costs, and as a result the team enlisted the support of a local NGO to collect this information. With this dedicated support the team completed the costing process in 2016. The team aimed to complete it in time so that newborn health could be included in the next health sector programming cycle. The availability of an evidence-based newborn costing package was timely, and led to a planning week at the ministry to ensure all ENAP priorities would be included in the new health sector programme. In addition, newborn health was included in the ministry’s new essential service package (ESP). The costing methodology was well received by the government, and the unit costs identified for the newborn health plan were therefore used as a reference to cost the ESP. Moreover, the government decided to use the same method (using the OneHealth tool) to cost the next cycle of national health programs. As an outcome of this work, the ministry also created a separate program for newborn health within the maternal newborn child and adolescent health (MNCAH) program, with a dedicated budget.

Key success factors in Bangladesh’s achievements:

1. Extensive consultative processes held (2014) prior to costing, involving different technical committees, and consultation workshops at national level with diverse stakeholders (ministry of health, UN partners, research institutes, NGOs, professional associations, academia).

2. A costing expert from the ministry of health was involved in the training workshop on OneHealth. Building the capacity of the government to understand the costing methodology was essential to achieve the required buy-in of the plan in the long term.

In turn the team faced challenges related to:

1. The significant length/duration of the plan to be costed becomes a challenge due to changing costs and inflation factors. For this reason the technical group decided to develop a priority action plan for costing purposes, with a yearly scale-up plan for selected interventions. Based on the unit cost data collected during the initial phase, costs for newborn health interventions were discussed during a 3 day key stakeholder workshop. On this basis, the country developed a costed plan for scaling up newborn health interventions across 64 districts.

2. Identifying unit costs was initially challenging, however was facilitated by the fact that several special newborn care units had been established in districts and data was more readily available in these locations, in addition to the support provided by a dedicated data collection team. Finally, allowing ample time to complete the process was a key enabler for the country. Overall unit costs did not vary greatly within the country, except for minor variations in remote areas.

3. The ministry used different budgeting codes for newborn health than those used in the costing tools. However after careful analysis of the costing categories in the two budgeting formats (from the ministry, and the OneHealth tool) the team was able to work with the codes provided by the government.

- **Ethiopia** led a successful capacity building initiative to develop a costed plan for the country. The ministry of health and regional health bureaus initially drafted the neonatal and child survival strategy, and subsequently organized an extensive training on OneHealth (delivered by Avenir Health\(^\text{45}\)). The country took a unique approach with the roll out of a 10 day workshop: the first 2.5 days covered the principles and theories underlying the tool, and the remaining provided a hands-on training inviting participants to populate the OneHealth datasheets using country data. The outcome of the workshop was two-fold: the newborn and child health survival strategy was costed (using LiST); and health workers were adequately trained on OneHealth. Ethiopia also used OneHealth to cost the national health strategic plan.

A key benefit for the country of applying the tool was that the process generated relevant discussions within the ministry, by illustrating whether the current costing plan aligned to the government’s policy. In fact, OneHealth showed that most financial allocations were directed towards secondary and tertiary levels of care, whereas the country’s policy sought to focus on primary level care. This led to a revision of the plan to better align to the government’s position.

The main challenge faced by the team related to the data required to use the tool (costing of activities), which was not available through routine data collection systems and called for additional research. To overcome this challenge, the team consulted different data sources including reports, surveys and research by the government and NGOs. As a second option, when data was still missing, the team used the information pre-populated in the tool. However in cases where this default data was felt to be inadequate, as a final option the team relied on the opinion of experts.

Overall the tool provided a strong methodology that was well received at key stakeholder meetings, in particular when the plan’s costing was approved at the ministerial level. On this occasion the ministry’s leadership inquired about the rationale for the selection of NMR targets. The OneHealth methodology presented in response was perceived as a persuasive model to arrive at the results. Similarly, partners such as the Global Financing Facility (GFF) agreed to support the work based on the robust calculations performed through the tool.

- **Iraq** finalized the ENAP Iraq Budget for 2017-2020 through a collaborative effort between the health financing unit and the maternal and child health department of the ministry of health, with support from UNICEF, WHO and UNFPA. The process involved the following steps:

  - Ministry of health (MoH) and UNICEF convened a two day workshop to discuss ENAP activities, with participation from WHO and UNFPA.
  - Health financing and maternal and newborn health experts (MoH) estimated the budget using the approved ministerial standardized cost per item/unit in Iraqi Dinar (ID) (with exception of the maternal and newborn care (MNH) supplies, which

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\(^{45}\) Avenir Health: http://www.avenirhealth.org/software-onehealth
were costed using rates from the UNICEF supply division catalogue).

- Experts calculated costs to implement activities, and developed a tool for detailed yearly costing, which will be used for future program planning and budgeting in other areas.
- The team also prepared a costed list of MNH supplies to be procured to health facilities during ENAP implementation (to be funded separately).
- The budgeted ENAP was shared with key stakeholders in the ministry of health for endorsement, and with all relevant partners for validation.

The proposed budget includes costs for all key newborn health activities and sub-activities, broken down for each year in the 2017-2020 period. The budget overview also specifies the responsible stakeholder for each budget line/activity. Finally, the document illustrates total budget requirements, funds allocated by the ministry of health, and the resulting funding gap that needs to be filled.

- **India** proactively addressed costing of Kangaroo mother care (KMC) for the care of low-birth weight babies. The ministry of health and family welfare requested all states to propose a budget for KMC implementation and training of service providers in their annual programme implementation plan 2017-2018. To accelerate progress, the ministry further provided a reference to suggested budget heads for both state and district level implementation. In addition, the country also developed a toolkit for public health managers involved in the planning and costing of maternal and neonatal health services. It provides a standard for establishing sick newborn care units, with requirements for infection prevention, capacity development, reporting and recording systems, and referral transport and quality assurance.


**Challenges:**

**Locating data and unit costs**

- Many countries have faced obstacles in locating the detailed costing information required to complete OneHealth. They addressed this by exhausting all available data sources, and in some cases by relying on a professional assessment to arrive at acceptable estimates. Myanmar also recommended multi-stakeholder forums as a helpful vehicle to advance the work, where experts could guide on how to address data gaps. Such forums include for example: relevant divisions within the ministry of health in charge of maternal and newborn health program; academic institutions; civil society; and representatives from the subnational level, such as health workers with in-depth knowledge on the services delivered. Another avenue is to try filling data gaps with external support (e.g. consultancy firm).

- Having said this, when teams have to make assumptions in estimating unit costs, this may raise concerns about the reliability of results, and how these should be evaluated and assessed. The insights provided by experienced professionals can help to contextualize the figures, and support with interpretation of results.

**Building local capacity**

- The costing process can be lengthy. To ensure dedication to this work, countries recommend appointing a focal point and establish a national team (e.g. within the ministry or a research institution) to take ownership of the process. Countries have also engaged consultants to collaborate with the ministry of health to apply the tool. However caution should be applied when engaging external consultants, as country staff may miss the opportunity to develop the skills to apply the tool independently. For example, the tool allows users to create different costing scenarios, however country teams have faced difficulties to generate new costing information after the engaged consultant had left. As a lesson learned, experts should transfer this knowledge to the country team.
Costing in decentralized systems / at subnational level

- In countries with highly decentralized health systems, centrally determined unit cost may not apply homogeneously across the country. Costing challenges may arise due to variations in unit costs, and in these cases it may be helpful to break down costs at the subnational level. For example India identified facility based newborn care as one of the biggest pillars to tackle prematurity, however faced challenges in determining the cost for a national medical officer working in intensive care units (ICU) in light of the different pay scales for health workers across states. In response, health systems and finance experts worked together to identify the best solution.

- Countries working with costed plans at the subnational level can take the average of costed figures e.g. from districts in order to calculate national overall figures (e.g. as part of development of an investment case).

- Applying the tool at the district level can raise challenges related to technology requirements. One country addressed this by adapting the tool to an Excel sheet format to enable district staff to use it. Countries have also highlighted the need to build capacity at the district level to work with available costing instruments, including Excel sheets.

Challenge of high overall costs following application of the tool

- The overall cost for the newborn health plan was felt to be high in one country, following the application of the OneHealth tool, and this was perceived to be an obstacle in gaining government support for this work. High overall costs may be justified in some cases, however they could also result from the inclusion of common health system costs in the calculations (e.g. costs for non-newborn health related work performed by health workers, or aggregated costs for facility maintenance, human resources, information systems etc). To address the issue of ‘pooled’ or health systems costs, countries can consider these approaches:

  1. Using a marginal (or incremental) costing approach and exclude system costs that are not incremental – e.g. a doctor at a health facility who will be paid independently of the fact that the country has newborn health activities (or an ENAP), the cost of their salary can be left out as it is not incremental in nature.

  2. If systems costs have to be included, the team can try to estimate the best possible allocation of these costs e.g. try to estimate time spent by a doctor on ENAP activities (as a %), as opposed to other activities.

Structural / organizational challenges

- Structural factors might impact on costing exercises, for example Myanmar faced challenges in light of the ministry of health having separate divisions for maternal and child health, which resulted in separate plans for maternal reproductive health, and for newborn and child health. OneHealth was used to cost the latter, however the maternal and reproductive health plan was costed with an Excel spreadsheet. This made integration of costing efforts difficult, and resulted in a degree of overlap between costing scenarios. The team addressed this by including different options in the newborn and child health plan (one including and one excluding intrapartum care). On this subject, costing of newborn plans that are integrated in wider plans (e.g. in RMNCAH plans) should be carried out as a collaboration between the relevant RMNCAH departments.

Resistance to change in adopting new tool

- Take up of newly available costing tools by ministries’ technical units can be slow if they previously relied on traditional budgeting tools. Ministries may place greater attention on expenditures, and may not require additional information on costs. However costing information can support more strategic planning processes, with a view to long term outcomes. In addition, capacity to use costing tools is particularly helpful for countries relying on donor funding, as costed figures are often requested as a part of funding application processes.
Recommendations:

Approach and key stakeholders involved

- The OneHealth tool was designed to link technical public health information, such as interventions and targets, with costing and monitoring data. Its application therefore requires a wide skillset in these areas. A recommended approach is to bring together experts with different backgrounds in public health, statistics, planning, and costing. The costing team should be aware of this requirement when convening stakeholder meetings.

- Costing newborn action plans should be done in collaboration with the monitoring and evaluation and/or health information systems section of the ministry of health, to ensure that costed scale-up plans and targets can be tracked over time.

Documenting the costing process

- When costing a newborn action plan the key step is “knowing what you are costing” and what the ultimate aim of the costing exercise is. Countries are advised to determine and document how they obtain costing estimates, and to explain this in an accompanying note. Further, each unit of measurement should be clearly defined.

- Producing “costing notes” to accompany the plan, explaining why and how costing figures were selected, can also ensure key stakeholders involved have a common understanding of the proposed costed plan. Costs are not self-explanatory, so countries should define how they arrived at figures, and explain what assumptions were made in the process.

Costing steps

- Following data collection, costing experts have described data validation as one of the most important steps in the costing process. As a guideline, the steps should be:
  1. First, examine each data item to be collected, considering how it is defined, possible sources and alternatives;
  2. Second, collect the data;
  3. Third, conduct a quality assurance and data cleaning exercise;

  4. Fourth: validate the data, for example by comparing data from different sources. In cases of discrepancies, the team would determine the most reliable source (e.g. costing figures originating directly from districts, versus the same data provided by the national information system).

- Countries are further advised to proactively collect costing data on a regular basis, so that it is readily available when newborn health plans are costed.

Building local capacity

- It is recommended to strengthen the costing team’s capacity during the initial data-collection stage, for example by engaging additional team members to collect unit cost data (e.g. from facilities or ministry sources). Countries shared that even when teams learned to use the tools, additional guidance by costing experts (e.g. on data gathering methods) can help to ensure success, so that the final costing results fit the local context.

- Resources exist to support in the application of the OneHealth tool. These include country and regional capacity building workshops, online webinars, and a wealth of resources available on the Avenir Health website (www.avenirhealth.org). One country shared that following a training session run by Avenir Health, they greatly benefited from continuous discussions with the training team to address emerging issues.

- Concerning training, it is recommended that staff who complete the training is also in a position to contribute to costing and planning processes within the ministry. In one example 2 country representatives attended a regional training on OneHealth, however subsequently could not participate in the application of the tool at the ministry level due to lack of seniority. Training recipients should apply their knowledge to avoid losing the acquired skills.

Alignment with country processes: timing of government planning cycles, internal costing systems, and political economy

- Many countries have linked successfully costing their newborn health plan to the timing of this process. It is recommended to consider the broader government planning
cycles when costing newborn health plans, as countries shared this was one of the most important factors in successfully integrating the newborn health agenda into national budgets, and to ensure newborn health activities received dedicated funds. Costing newborn health plans at an opportune time was experienced by Myanmar, who costed the newborn health package when the country was developing an essential package of services (EPS) as part of a move towards universal health coverage (UHC). This facilitated inclusion of newborn health interventions in the country’s new EPS, which is expected to be rolled out in selected townships, and scaled-up for the whole country by 2020. Timing is therefore crucial: considering when the results of a costing exercise will be ready, and for what purpose they will be used, should be an integral part of costing the newborn health plan.

The table below show national health planning cycles for selected countries, which newborn health teams can consider:

<table>
<thead>
<tr>
<th>Country</th>
<th>National Health Policy Strategy and Plan Cycle Start</th>
<th>National Health Policy Strategy and Plan Cycle End</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cameroon</td>
<td>2014</td>
<td>2020</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>2015</td>
<td>2019</td>
</tr>
<tr>
<td>Kenya</td>
<td>2015</td>
<td>2020</td>
</tr>
<tr>
<td>Lesotho</td>
<td>2012</td>
<td>2017</td>
</tr>
<tr>
<td>Myanmar</td>
<td>2015</td>
<td>2018</td>
</tr>
<tr>
<td>Tanzania</td>
<td>2016</td>
<td>2020</td>
</tr>
</tbody>
</table>

• Costing teams are advised to take note of the ministry’s internal costing system. For example, a community mobilization campaign may be costed a certain amount with the OneHealth tool, however the ministry may recognizes that cost as salary, or as cost of printing communication materials. This can result in a mismatch in economic classifications between the government’s budgeting system and that used in the costing tool. A key lesson learned is to map costs produced by the tool against the classification system used by the government, and to take steps to harmonize the two formats.

• Costing teams also need to consider the political economy in the country and its effect on policy directions and funding allocations. While a team may develop a robust evidence base for investing in newborn health, the political climate will impact on budgetary decisions. Teams advancing newborn health agendas should consider these wider political trends, for example by aligning key messages to the wider political discourse, finding relevant entry points to raise newborn health issues, and seizing opportunities as they present themselves. This also means being agile in plan development, given that political climates can change over a short time. Advocating for evidence-based policy making may be helpful (e.g. showcasing successes, identifying champions from technical and planning departments). A helpful working paper on political economy analyses is: Analysis of the political economy of health, particularly reproductive, maternal, newborn and child health, in four countries of south and east Asia, UNICEF 2015. Link: https://www.unicef.org/videoaudio/PDFs/UNICEF_Working_Paper_on_political_economy_analysis_in_the_health_sector_-_27Aug15.pdf
Costing process and preparing for implementation of costed plan.

- Countries should ensure that tools such as OneHealth are used to plan and cost plans, and not to calculate current expenditures. Calculating the cost of interventions can highlight the gaps between current expenditures and projected costs for the scale-up of those interventions.
- Teams are advised to compare the costs estimated with the tools with the actual government expenditures, and to analyse the gaps.
- Costing teams should beware of the potential for duplication of costing activities, for example advocacy activities which might be championed by two different organizations. To avoid this, it is advisable that costing be conducted as a national level activity.
- To ensure that costing results are acted upon, relevant government stakeholders should be involved in the process from the beginning. This can ensure that the rationale for a proposed costed package for newborn health is better understood by decision-makers, therefore increasing buy-in. Effectively packaging costing results can also help influence key decision makers to place newborn health high on the agenda. Finally, developing multi-year annual implementation plans, spanning from districts up to the national level, can also foster plan implementation.
- Teams can learn from other countries who have costed newborn action plans in the past, and are encouraged to seek partners in similar country contexts to draw on examples. When consulting costed plans, caution should be applied as unit costs can vary greatly according to country-specific factors. For example, one study examining unit costs variations across countries noted particularly high unit costs in one location. It later emerged this was due to the presence of a mountainous region, and the cost for transporting the medicines to high altitudes had increased the overall unit costs. Having said this, countries can learn from examples of costing approaches, and refer to unit costs in country plans while considering contextual factors.
- As a starting point, countries can create a sample costing for newborn health activities for an individual district. Such a template can then be scaled up to subnational and national levels.
XII

Country Experience – developing an investment case
Many countries report that no designated funds are available for newborn health at the national level. Even if they have developed costed plans, a lack of funding can hamper implementation. In this context, developing an investment case can help to attract the required funds by making a compelling case for investing in newborn health activities. In fact, international donors increasingly request rigorous investment cases as part of their funding cycle application processes. The investment case can inform funding bodies how resources will be used, and can similarly benefit fund recipients by delineating a roadmap for plan implementation.

Examples of investment cases:

- **Uganda Investment case for Reproductive, Maternal, Newborn, Child and Adolescent Health Sharpened Plan for Uganda (2016), Ministry of Health, Uganda.** Available at: https://www.dropbox.com/sh/cfm7o2si6aws32n/AACgHXnRJNQJQN1OxF45ju6nta?dl=0


- Other example from countries at different stages of investment case development for RMNCAH can be found on the GFF website: www.globalfinancingfacility.org

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46 Information is available on the GFF website for Ethiopia, Senegal, Nigeria, Democratic Republic of Congo, Mozambique, Bangladesh. Links:

- https://www.globalfinancingfacility.org/ethiopia
- https://www.globalfinancingfacility.org/senegal
- https://www.globalfinancingfacility.org/bangladesh
- https://www.globalfinancingfacility.org/mozambique
- https://www.globalfinancingfacility.org/nigeria
- https://www.globalfinancingfacility.org/democratic-republic-congo
### Table 13

**Tanzania Resources costing of the One Plan II activities in US Dollars: Newborn and Child Health.**


<table>
<thead>
<tr>
<th>Key result area</th>
<th>TOTAL RESOURCES NEEDED IN US DOLLARS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essential newborn care services provided at all facilities conducting deliveries by 2020.</td>
<td>3,853,430</td>
</tr>
<tr>
<td>Management of preterm and low birth weight babies improved by 2020.</td>
<td>322,655</td>
</tr>
<tr>
<td>Management of sick newborn improved by 2020.</td>
<td>595,432</td>
</tr>
<tr>
<td>Management of common childhood illnesses improved by 2020.</td>
<td>32,196,210</td>
</tr>
<tr>
<td>Routine Under Five vaccination sustained with equitable coverage by 2020.</td>
<td>356,220,684</td>
</tr>
<tr>
<td>Improve breastfeeding rates and practices by 2020.</td>
<td>4,377,780</td>
</tr>
<tr>
<td>Infant and Young Child Feeding (IYCF) practices and nutrition status improved by 2020.</td>
<td>19,755,172</td>
</tr>
<tr>
<td>Coverage of Management of Severe Acute Malnutrition (SAM) through the national health system increased by 2020.</td>
<td>8,254,360</td>
</tr>
<tr>
<td>Improved community and household practices for child survival by 2020.</td>
<td>0</td>
</tr>
<tr>
<td>Improved accountability for U5 deaths by 2020.</td>
<td>8,376,480</td>
</tr>
<tr>
<td>TOTAL COSTS</td>
<td>433,952,203</td>
</tr>
</tbody>
</table>
Country experiences:

- **Uganda** found OneHealth very helpful to develop the sharpened RMNCAH plan (2016), including an investment case for newborn health. The country used the OneHealth tool and LIST to cost the interventions, with support from WHO, using cost estimates when this information was missing. The investment case was developed through an elaborate and stepwise approach and was subsequently approved by the ministry of health.

The Uganda Investment case for Reproductive, Maternal, Newborn, Child and Adolescent Health Sharpened Plan for Uganda (2016) was developed based on the existing sharpened RMNCAH plan 2013-2017. Key steps leading to the finalized investment case were:

- Situation and trends analysis (using the Rapid Assessment of Interventions and Commodities Tool (RAIC) tool, and through equity analyses using DHS data);
- Identification of barriers and bottlenecks (using the BNA tool, existing analyses (SARA, SDI) and strategies and plans);
- Development of strategic shifts including prioritisation of high impact interventions (through consultations and technical meetings, using LiST);
- Costing (using the OneHealth tool), and resource mapping for RMNCAH for an overview of the funding gap and to help strengthen coordination among partners at national and district level.

The investment case outlines estimated costs to implement the plan over a 5 year period, and maps available resources and current funding gaps. The document further describes how the sharpened plan was developed, Uganda’s progress towards RMNCAH targets, bottlenecks to effective implementation of interventions, and how the proposed strategic shifts can be operationalized through a roadmap to address RMNCAH gaps.

The Global Financing Facility is supporting the ministry of health to implement the plan, using results based financing and health systems strengthening approaches for RMNCAH services in selected facilities. Additional partners are funding selected elements of the investment case, for example UNICEF is supporting implementation of newborn health interventions and a quality of care improvement tool at facility level. Aligned to these activities, the country recently developed a score card for district level evidence based planning, implementation and monitoring of RMNCAH services, and is developing an automated community based health management information system (HMIS) to help fill the data gap.

- **Tanzania** in turn applied the Lives Saved Tool (LiST) to estimate interventions, and the OneHealth costing tool for financial projections to implement activities in the One Plan II, or the National roadmap strategic plan to improve reproductive, maternal, newborn, child and adolescent health in Tanzania (2016-2020). Costing was completed by an external consultancy firm (the Futures Group). The document presents a table of estimated costs for 10 key newborn health result areas, associated activities and resource requirements for each year in the 2016-2020 timeframe. Assumptions made during the costing exercise are also laid out, for example it excluded costs for distribution of commodities, human resources for health, or renovation of health facilities, among others.

The country received support from the Global Financing Facility to implement the One Plan II to strengthen RMNCAH service delivery. Aligning with GFF’s mission, proposed activities include for example expansion of emergency obstetric and neonatal care, antenatal and postnatal care, skilled deliveries, and introduction of results-based financing at the facility level. The plan also proposes key partnerships to scale-up services and strengthen the national RMNCAH referral system, including a voucher system to foster the coordinated public-private referral efforts.
The Global Financing Facility (GFF)

The Global Financing Facility in support of Every Woman Every Child (GFF) is a financing mechanism that aims to support country efforts to end preventable maternal, newborn, child and adolescent deaths and improve the health and quality of life of women, adolescents and children\(^47\).

GFF requests interested countries to develop investment cases that address the following concerns\(^48\):

- **Prioritization**: addressing the gap between costs of proposed interventions and resources available.

- **Returns on investment**: analysing and making a compelling case of the benefits for society and the economy of health investments.

- **Fragmentation**: addressing the lack of coherence across the RMNCAH spectrum by highlighting joint objectives.

- **Implementation focus**: addressing how the plan will be delivered.

- **Longer-term orientation**: illustrating how the investment case takes a long term perspective, and considers impacts from sectors other than health on the health status of women, adolescents, and children.

The investment case should be the end product of a rigorous process to identify priorities, make a case for investing in them, and help to attain complementary financing from both domestic and external financiers. In summary, it should present a compelling case for how a limited number of priorities will place the country on the path to improve the health of women, children, and adolescents over the long term.

The format of the investment case will vary by country contexts. It may entail a shorter document in countries where a strong RMNCAH strategy already exists; in others, preparation of a longer document may be required to cover key elements such as a situation analysis, and an assessment of the bottlenecks around RMNCAH service delivery.

As a general guideline, the four key elements to be covered in an investment case are:

- intended results (targets over a defined period)
- set of priority investments (costed)
- definition of available resources to implement the priorities (resource mapping)
- description of monitoring and evaluation of desired results

For more details on the GFF: [https://www.globalfinancingfacility.org/](https://www.globalfinancingfacility.org/)


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47 The Gobal Financing Facility: [https://www.globalfinancingfacility.org/our-approach](https://www.globalfinancingfacility.org/our-approach)
Challenges:

- Indonesia faced challenges in attracting funds for newborn health plan monitoring activities, with government funds rather being directed to implementation of interventions. As monitoring activities are key to assess progress, the team is advocating for their inclusion in the national budget.

- Following the costing exercise, Myanmar faced challenges to obtain funding for newborn health, mainly due to the fact that the government relies on project-based external funds for this work. However, the country recently developed an essential package of services as part of universal health coverage efforts, which include newborn health. This could potentially lead to more clarity on financial commitments from the government, with more systematic funding sources.

Recommendations:

- Developing and presenting an investment case to international donors can be a lengthy process and needs consistency, for example by having the same focal point involved in the process from the beginning to end.

- Costing for development of an investment case should be conducted at the beginning of the year rather than at the end, to ensure the proposed costing figures remain relevant.

- The government should lead the process. While it should be conducted as a consultative process involving all key stakeholders, the stewardship should lie with the government. Establishing close collaborations with policy makers helped to gain support for newborn health investments in several countries.

- Countries can engage with insurance providers and the private sector to improve newborn health service coverage, especially in areas where they are not available in the public sphere. For example:

  - The Philippines developed and implemented a benefit package for premature and small newborns through a national health insurance program (PhilHealth). The health insurance package, launched in 2016 by the Ministry of Health, PhilHealth, and UNICEF, offers families a comprehensive, evidence-based and equity-focused package of care for newborns suffering from preterm and low birth weight complications. It is estimated to reach 350,000 newborns every year. Partners engaged in the creation of this benefit package ensured the process was transparent, consultative, evidence-based and equity- and child-focused. For example it used explicit criteria on what services to include, drew on both global and local data on burden of disease and cost-effectiveness of interventions, and on clinical practice guidelines to establish standards of care.

  - The GFF similarly recognized the important role of the private sector in closing the funding gap for RMNCAH services, including for newborn health. It notes that private expenditures are a key component of domestic financing, however a bulk of this is from out-of-pocket payments, which are inequitable and fall disproportionately upon the poorest segments of the population. Since in many countries the private sector is already a significant provider of services, the GFF highlights its role in efforts to improve RMNCAH outcomes. It points to the significant potential for innovative financing mechanisms and is committed to facilitating partnerships with the global private sector. Importantly, it envisions leveraging the private sector in countries for investment case needs, and encourages inclusion of the private sector in GFF investment cases to help deliver on objectives.

49 UNICEF’s support to the national health insurance entity PhilHealth to develop a nationwide health insurance package for premature and small newborns in the Philippines. UNICEF 2017

Private sector engagement

The role of the private sector in providing childbirth care varies by region, as shown below.

It is therefore essential that countries include engagement with the private sector as a provider. The diversity in private sector providers is a strength that can be leveraged to reduce the burden placed on limited public resources for service provision. Private sector engagement can take place through social franchising models, or partnerships for specific needs such as training of midwives in private midwifery schools or blood bank facilities. Many countries have also raised contracts with private obstetricians or neonatologists to provide mentoring support to public facilities.

Another example is Indonesia’s Expanding Maternal and Neonatal Survival (EMAS) program, engaging government agencies, civil society organizations, public and private health facilities, health professional organizations, and the private sector. Set up as a cooperative agreement funded by the U.S. Agency for International Development (USAID), it aims to improve the quality of emergency maternal and newborn health services, and to increase the efficiency and effectiveness of referral systems for maternal and newborn health. With a focus on 150 hospitals and 300 community health centers in six provinces, it is expected to result in an overall 25 percent decline in national maternal and newborn mortality over a five year period.

Leveraging both public and private providers can thus expedite progress towards maternal and newborn health targets. Countries can support public-private partnerships by:

- Increasing private sector participation in policymaking processes;
- Regulating the engagement of private providers (e.g. through legislations);
- Standardizing quality of care, e.g. by establishing a minimal package of services;
- Supporting professional associations and regulatory bodies to ensure adherence to quality standards;
- Building networks of high quality providers.

Source: Benova, L. et al. 2015. Role of the private sector in childbirth care: cross-sectional survey from 57 low- and middle-income countries using Demographic and Health Surveys

However trends indicate that the private sector has gained prominence as a provider of maternal and newborn care, as evidenced by the high percentage of women in many Asian and African countries delivering in private facilities. For example, demographic health data in Indonesia indicates that 46% of births take place in a private health facility (private hospital, clinic, private doctor/midwife), compared to 17% in public facilities (government hospital or health center), as shown in the figure below.

Source: Indonesia Demographic and Health Survey 2012.
From an equity standpoint, countries have found ways to address health disparities (e.g. based on wealth-quintiles) and move towards Universal Health Coverage (UHC) through both public and private sector engagement. Strategies include for example: pooling of risk and resources, strategic purchasing of health services and innovative provider payment systems, demand-side incentives, and voucher programs. Country case studies on advancing UHC can be found in the World Bank publication: *Going universal: how 24 developing countries are implementing universal health coverage reforms from the bottom up* (2015). Two examples from this collection are:

1. **Argentina’s Plan Nacer program**, which was designed to reduce maternal and child mortality among the uninsured. Under the plan, the central government provides capitated payments to provinces, which are used to purchase services from providers. Resources are partly transferred based on results (e.g. when beneficiaries enrol in the program, when provinces reach targets for MCH indicators). The payment mechanism thus incentivizes both enrolment and service delivery. The plan has been found to increase birth weight, reduce the probability of very low birth weight, significantly improve newborn Apgar scores, and reduce newborn early mortality rates.

2. **Bangladesh set up a voucher program** that considerably cut the amount paid for maternal health services. It provides free access to selected maternal and child health care services as well as coverage for transport costs, a gift box, and a cash incentive after delivering with a qualified provider. Results show a positive impact of the program in health care-seeking behavior from qualified providers (for antenatal care, delivery, and postnatal care) and an increase in institutional delivery. The authors found that women in program intervention areas were less likely to incur out-of-pocket expenditures (OOPE), and that they paid less for maternal health care services.

The reference guide developed by WHO to assist countries developing national health financing strategies can support preparation of investment cases, as it highlights key health financing elements which need to be addressed to ensure delivery of all maternal and newborn health services. *Developing a national health financing strategy: a reference guide*. World Health Organization, 2017. Link: [http://www.who.int/health_financing/tools/developing-health-financing-strategy/en/](http://www.who.int/health_financing/tools/developing-health-financing-strategy/en/)

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Defining ‘N’ in RMNCAH - Every Newborn Action Plan Country Planning and Costing Toolkit and User Guide XIII. Annexes
1. Examples of comprehensive RMNCAH and standalone costed newborn national health plans- links to plans available in public domain.


2. Overview of ENAP plan development cycle and available tools.

### Overview of ENAP plan development cycle and available tools

<table>
<thead>
<tr>
<th>ENAP process &amp; corresponding chapter in ENAP user guide</th>
<th>Purpose of process</th>
<th>Available tools</th>
<th>Approach</th>
<th>Time commitment (average)</th>
<th>Resources required</th>
<th>Outputs / expected results</th>
<th>Sources of support / contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Situation Analysis / Desk Review (User Guide Chapter V, VIII)</td>
<td>To assess the degree to which countries’ health systems are prepared to deliver health services and interventions for newborn health.</td>
<td>• Benchmarks to measure readiness to integrate and scale up newborn survival interventions (Save the Children); • Situation Analysis Guide (Save the Children); • Rapid Assessment of Life-saving Interventions and Commodities (RAIC) tool; • District planning tool for maternal and newborn health strategy implementation (WHO); • EQUIST.</td>
<td>Application of tools complemented by desk review, interviews, health facility visits.</td>
<td>• 2-3 weeks desk review; • 3-4 weeks interviews and health facility visits; • 1-2 weeks application of tools.</td>
<td>One dedicated staff member / consultant with access to a computer to conduct desk research.</td>
<td>Transport, accommodation and time of staff conducting field visits.</td>
<td>Relevant country and regional offices in UN agencies (UNICEF, WHO, UNFPA), NGOs (Save the Children), and other research institutions.</td>
</tr>
<tr>
<td>Bottleneck analysis (User Guide Chapter VI, VIII)</td>
<td>To analyse health system bottlenecks and challenges preventing the scale-up of high-impact, cost-effective interventions for newborns.</td>
<td>• Tool to support countries to identify bottlenecks and solutions to scale-up newborn care (UNICEF); • EQUIST.</td>
<td>• 3-4 weeks workshop preparation • 4-5 day workshop roll out.</td>
<td>Space to convene relevant experts to conduct bottleneck analysis workshop; facilitators (nr depending on group size) to run the workshop; workshop materials (flipcharts etc).</td>
<td>Bottleneck analysis with summary of key barriers to scale-up of newborn health interventions.</td>
<td>Relevant country and regional offices in UN agencies (UNICEF, WHO, UNFPA), NGOs (Save the Children), and other research institutions.</td>
<td></td>
</tr>
<tr>
<td>Prioritization of activities at national and subnational levels (User Guide Chapter VII, VIII, IX)</td>
<td>To decide which activities should be given highest priority in efforts to improve newborn health in plans.</td>
<td>Outcomes of situation and bottleneck analysis tools can be used to inform decisions on which activities to prioritize. EQUIST and LiST can support with decision-making processes.</td>
<td>See Chapter VII of user guide for examples of approaches taken in countries.</td>
<td>Varies depending on approach taken, but as a minimum expect to take 4-6 weeks.</td>
<td>Scenarios based on different intervention coverage targets and fiscal space. Consensus reached on priority activities and included in the newborn health plan.</td>
<td>• EQUIST site: <a href="http://equist.info">http://equist.info</a> • User Guide: <a href="http://equist.info/files/general_files/User_Guide.pdf">http://equist.info/files/general_files/User_Guide.pdf</a> • Technical Notes: <a href="http://equist.info/files/general_files/Technical_Notes.pdf">http://equist.info/files/general_files/Technical_Notes.pdf</a></td>
<td>Training resources for LiST: <a href="http://livessavedtool.org/training">http://livessavedtool.org/training</a></td>
</tr>
<tr>
<td>ENAP process &amp; corresponding chapter in ENAP user guide</td>
<td>Purpose of process</td>
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<tr>
<td>Equity analysis (User Guide Chapter V, VIII)</td>
<td>To identify health disparities between the most marginalized population groups and the better-off in countries, and to target health plans that can reduce such disparities.</td>
<td>• EQUIST tool.</td>
<td>EQUIST complemented by other resources (e.g. maternal and newborn health disparity profiles outlined in Chapter V of user guide).</td>
<td>• 1-2 weeks to collect and review data; • 1 week (approx.) for policy discussions (including stakeholder orientation, prioritization of bottlenecks and strategies to address them). • 2-3 weeks to refine intervention strategies.</td>
<td>Computer to access the EQUIST online platform. Space to convene relevant experts to conduct policy discussions.</td>
<td>Understanding and summary of key health disparities affecting the country / region.</td>
<td>• EQUIST site: <a href="http://equist.info">http://equist.info</a> • User Guide: <a href="http://equist.info/files/general_files/User_Guide.pdf">http://equist.info/files/general_files/User_Guide.pdf</a> • Technical Notes: <a href="http://equist.info/files/general_files/Technical_Notes.pdf">http://equist.info/files/general_files/Technical_Notes.pdf</a></td>
</tr>
<tr>
<td>Development of a Monitoring and Evaluation Framework (User Guide Chapter X)</td>
<td>To track progress on newborn health in countries, take stock of and address existing gaps.</td>
<td>• Every newborn country implementation tracking tool. Please see user guide chapter X for more tool references.</td>
<td>See chapter X of user guide for examples of M&amp;E frameworks in country plans.</td>
<td>• 4-6 weeks to conduct preparatory research, meetings. • 4-6 weeks to develop the M&amp;E framework.</td>
<td>Time and space to meet and gain input on M&amp;E framework from all relevant stakeholders.</td>
<td>Robust M&amp;E framework, containing all key newborn health indicators and specific targets for the country.</td>
<td>Relevant country and regional offices in UN agencies (UNICEF, WHO, UNFPA), NGOs (Save the Children), and other research institutions.</td>
</tr>
<tr>
<td>Costing of the plan (User Guide Chapter XI)</td>
<td>To develop financing scenarios, assess health investment needs to support budgeting and financing of newborn health plans.</td>
<td>• OneHealth tool. See chapter XI of user guide for examples of costing of newborn health plans in countries.</td>
<td>• 2-4 months to collect costing data; • 2-4 weeks to conduct quality assurance and data cleaning; • 2-3 weeks for data validation with relevant experts.</td>
<td>Staff time and travel to collect costing data. Space to conduct data validation and analysis with relevant experts.</td>
<td>Unit cost data obtained for all newborn health activities, and costing completed for all portions of the plan.</td>
<td>Examples of existing investment cases and other resources (e.g. provided through Global Financing Facility).</td>
<td>OneHealth support site for users: <a href="https://spectrummodel.zendesk.com/hc/en-us">https://spectrummodel.zendesk.com/hc/en-us</a></td>
</tr>
<tr>
<td>Development of an investment case (User Guide Chapter XII)</td>
<td>To identify improvements in newborn health that a country envisions, and a prioritized set of investments required to achieve these results.</td>
<td>• Tools included for all of the above. Examples of investment cases can be found in chapter XII of the user guide.</td>
<td>• 4-8 weeks.</td>
<td>Staff time to conduct the necessary background research / application of tools, and convening of stakeholder meetings to develop the investment case.</td>
<td>Investment case document highlighting how investments would be channelled to improve newborn health in the country.</td>
<td>Examples of existing investment cases and other resources (e.g. provided through Global Financing Facility).</td>
<td></td>
</tr>
</tbody>
</table>
3. **Examples of: TORs for ENAP consultant to conduct situation analysis, action plan development, costing; and agenda for a bottleneck analysis workshop.**

**SAMPLE 1 TOR ENAP Consultant: Situation Analysis**

**TERMS OF REFERENCE FOR INSTITUTIONAL CONTRACTORS**

**Requesting Section:**

1. **Nature of Consultancy:** The contractor will support the regional office in undertaking a comprehensive needs assessment of newborn care in selected countries. The exercise will help to identify gaps at policy and implementation levels covering both supply and demand side issues together with identifying gaps in family and community practices at the same time taking into account the continuum of care approach with an equity lens. The findings will be used to develop country level strategies, work plans and partnerships for accelerating momentum towards reduction of neonatal mortality.

2. **List of Proposed Organizations & Consultants:**
   see attached list

3. **Purpose of Assignment:**
   East Asia Pacific Region has seen sharp reductions in under-five mortality in last three decades but as older children survive an increasing proportion of U5 deaths – now 50% – are among neonates (babies less than four weeks old) whereby mortality rates seem to highest among most deprived and disadvantaged populations. Asian countries are seeing reductions on mortality rates, but these reductions are not occurring in all populations. Maternal and Newborn deaths reflect the greatest health inequity among countries and within countries, yet they are largely preventable. Among the countries who have the slowest progress in the region towards MDG4, the burden of newborn deaths in numbers is highest in Philippines, Myanmar, Vietnam, Cambodia and PNG. Pacific Islands also face the issue of high neonatal mortality, though the numbers may be small given the island populations. The predominant causes of deaths among the newborns include, low birth weight, prematurity, birth asphyxia and severe infections including pneumonia. Well-documented and cost-effective solutions exist to prevent these deaths. Most interventions to save newborn lives are clustered at the time of pregnancy, child birth and post natal period and are very much linked to maternal health and nutrition along the continuum of care. This provides unique opportunity to tackle both maternal and child health concerns at the same time since to a considerable extent, the well-being of a newborn depends on the health of the mother. For example, management of hypertensive disorders of pregnancy can not only decrease maternal deaths due to eclampsia but will also decrease chances of prematurity. Maternal and Newborn health are intrinsically linked, programmatically and consequentially. Newborns whose mothers have died during childbirth are 3 – 10 times more likely to die within its first 2 years of life. The nutritional status of girls and women before and during pregnancy affects foetal development and newborn health. Mothers with severe anaemia are at increased risk of maternal death, stillbirth, and early neonatal death; and their infants are at increased risk of low birth weight, prematurity, and/or cognitive impairments. Similarly investing in post natal care is beneficial for both mother and the newborn as most of the PPH related deaths and newborn mortality is concentrated in the first seven days after birth. Preventive strategies to save newborn lives involve training of midwives and community workers on essential maternal and newborn care to be effective in settings with either institutional or home births. Midwives and community workers have been successfully trained in using ambu-bag to manage birth asphyxia or to initiate antibiotics for infection. In other complications, specialized neonatal care units are required to manage very sick babies.
In order to make newborn care operational at the health facilities, but also at family and community levels, equity focussed policies must be defined and objectives and targets set, taking into consideration the actual situation in the country. A critical step in the development of the national plans is the assessment of maternal/neonatal health status, geographic localisation of highest mortality rates, existing health policies, services, management, infrastructure, as well as family practices and behavioural patterns that influence maternal mortality and morbidity. Such an assessment, or situation analysis, would enable health managers and policy makers to identify gaps and constraints in neonatal health provision and to formulate evidence-based, equity focussed recommendations in this area. The overall purpose of the assignment is to conduct a comprehensive, equity focussed needs assessment for country specific newborn care programming. The assessment will contribute to the strengthening of neo-natal health programmes in countries by facilitating strategic planning and implementation, and documenting the lessons learned to refine programme direction, recommended actions which will contribute to Intermediate Results 1 and 2 in the EAPRO unit of Young Child Survival and Development.

4. **Programme Area and Specific Project Involved:** YCSD, MNCH

5. **Reasons Why the Assignment cannot be done by a UNICEF Staff Member:** The contract involves a multi-country exercise by a public health professional with knowledge of public health, neonatology, monitoring and evaluation and health systems. More dedicated time at each country level is required to do in-depth assessment. The Maternal and Child health Specialist will be devoting a significant amount of her time to coordinate with the country offices, contractors and partners for this study.

6. **Work Assignments:**
   The specific activities will include
   - Desk review of available literature, strategies, tools, evaluations and reports related to newborn and postnatal care in – and outside of countries concerned.
   - Consultations with UNICEF advisors and programme staff at RO and participating countries to identify sources of information, gaps in information, key informants potential partners collaborating agencies and possible sources of information for documentation of best practices.
   - Develop a conceptual framework for the needs assessment, draft the tools and assessment methodologies
   - Conduct consultations with representatives from key partner organisations (UN, bilaterals, multilaterals, NGOs/CSOs, private sector etc. and with relevant government authorities
   - Facilitate workshops, meetings and discussions as appropriate
   - The assessment should include
     - Situation analysis of neonatal mortality along the continuum of care and trend analysis over time (including relevant indicators as ANC, SBA, PNC, LBW, birth registration) and existing inequities in coverage on the basis of residence, socio-economic status, ethnicity etc. Situation assessment will include both facility and community levels. Some countries have already completed National needs assessments and identified corresponding interventions for Emergency Obstetric and Neonatal Care. This needs to be reviewed together with the progress made so far and finding areas where further progress is needed.
     - Policy and strategy environment (situation/management of newborn care at national and district level, situation of delegation of functions at community health workers levels and midwives; inclusion of essential commodities in the country’s essential drug list; provision for decentralized planning and budgeting; social protection offered for ANC, delivery and postnatal care)
     - Gaps in service delivery (at hospital, health centre and community levels)
- Situation as regards relevant human resources (community health workers, midwives, doctors, neonatologists, specialized neonatology nursing) for required numbers and placement, knowledge and skills and mechanisms of continued training/motivation.
- Availability of Medicines/Equipment/Commodities/ status of available technologies being used both for institutional and home deliveries.
- Availability of national and subnational guidelines and protocols related to the management of newborns include the well and sick baby at different levels of care.
- Barriers on demand side (addressing geographic, financial and cultural barriers to access); what is being done to address these and what more can be done. Understanding of prevalent family and care taker and cultural practices and how these impact newborn outcomes.
- Mechanisms to involve service providers, mothers and communities in designing of maternal and newborn health care services.
- Country readiness to support and implement community based newborn and post-natal care including home visits in geographic areas where numbers of home deliveries and post natal care coverage is low.
- What is being done by national governments, international agencies and civil society to systematically prevent and track neonatal deaths.
- Map the country readiness for scaling up newborn care on the following adapted benchmark model (Save the Children, 2012) and provide recommendations for the way forwards.
- Identify lessons learned and innovative approaches from respective countries which could then be adapted to the local context of other countries in the region, who feature similarly high newborn death rates.
- Identify drivers for inequities in newborn health and analysis of potential cross sectorial interventions along the continuum of care.

<table>
<thead>
<tr>
<th>Agenda Setting</th>
<th>Policy Formulation</th>
<th>Policy Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>National needs assessment for newborn health</td>
<td>National new born policy endorsed</td>
<td>Cadre identified for home-based new born care</td>
</tr>
<tr>
<td>Local evidence generated for newborn survival</td>
<td>New born policy integrated into other health policies or strategies</td>
<td>In-service new born care training materials for community-based cadres</td>
</tr>
<tr>
<td>Local evidence disseminated on newborn survival</td>
<td>National behaviour change communication strategy</td>
<td>In-service new born care training materials for facility-based cadres</td>
</tr>
<tr>
<td>Existence of a convening mechanism for newborn health issues</td>
<td>Essential drug list includes injectable antibiotics for primary level care</td>
<td>Pre-service new born care education for community-based cadres</td>
</tr>
<tr>
<td>Focal person for newborn health in Ministry of Health</td>
<td>Midwives authorized to perform neonatal resuscitation</td>
<td>Pre-service new born care education for facility-based cadres</td>
</tr>
<tr>
<td>Key maternal and newborn indicators included in national surveys e.g. NMR, % of newborns with low birth weight, % of newborns visited within first 3 days of birth etc.</td>
<td>Community-based cadres authorized to administer injectable antibiotics for newborn infections</td>
<td>Supervision system for maternal, newborn and child health established at primary health centre level</td>
</tr>
<tr>
<td></td>
<td>Primary level cadres authorized to administer injectable antibiotics for newborn infections</td>
<td>Protocol or standard for district hospital care of sick newborns in place</td>
</tr>
<tr>
<td></td>
<td>Community-based cadres authorized to perform neonatal resuscitation</td>
<td>Integrated Management of Childhood Illness algorithm adapted to include the first week of life</td>
</tr>
<tr>
<td>Agenda Setting</td>
<td>Policy Formulation</td>
<td>Policy Implementation</td>
</tr>
<tr>
<td>----------------</td>
<td>--------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Primary level cadres authorized to perform neonatal resuscitation</td>
<td>Resource requirement for scaling up home based newborn care available</td>
<td></td>
</tr>
<tr>
<td>Key maternal and newborn indicators included in national health information systems</td>
<td>Resource requirement for primary health care level available for newborns</td>
<td></td>
</tr>
<tr>
<td>National targets to track newborn health established</td>
<td>Resource requirement for secondary level health care available for newborns</td>
<td></td>
</tr>
<tr>
<td>Reproductive, maternal, newborn and child health expenditure per child under five and per woman aged 19–49</td>
<td>System for neonatal death audits exists</td>
<td></td>
</tr>
<tr>
<td>Costed implementation plan for maternal, newborn and child health</td>
<td>System for peri-natal death audits exists</td>
<td></td>
</tr>
</tbody>
</table>

- Prepare draft and final reports (soft and hard copies) for review and discussion. There should be an executive summary capturing the salient findings at the regional level with separate and comprehensive country reports. The final deliverables should include power point presentations on key findings by region and by country.

7. **Work Schedule:**
   To be determined after consultation with participating countries.

8. **End Product(s):**
   - A detailed work plan and methodology to conduct the exercise at country level
   - Individual Country Reports with recommendations as regards to (a) programme components aiming at improving newborn health and care practices (“the what”); (b) operational strategies for implementing newborn health activities such as advocacy, training, communications, infrastructure improvement, community based services etc. (“the How”); (c) key actors to be involved in implementation, monitoring and evaluation of newborn health programmes (“the Who”). Suggested recommendations will be evidence based (link to Lancet series on newborn health) and take into consideration relevance to and feasibility of implementation in particular country context (4) Lessons learned and innovative approaches which could be adapted to the local context of other countries in the region.
   - Final report with regional summary of key findings by country, highlighting overlapping issues and opportunities and detailed country chapters. The outline of country chapter’s information should consider sub-headings in section 6. The annexures should include the study tools and list of partners consulted (with full contact details).
   - This should include power points on key findings at regional level as well as separate country presentations for dissemination and advocacy.

9. **Estimated Duration of Contract:**
   Total expected working days is 80 days of work over the duration of the contract, from 1 October 2012 to 3 March, 2013.
   **Start Date:** 1 October 2012
   **Expected End Date:** 3 March 2013

10. **Official Travel Involved:** To participating countries
11. **Estimated Cost of Contract:** This should include the total cost of the consultant e.g. Travel expenses, DSA and miscellaneous and other (specify) and consultancy fee.

12. **Amount Budgeted for this Activity:**

13. **Chargeable Budget Code for this Activity:**

14. **Payment Schedule:** Indicate expected output/product at each payment period, if applicable.

Payment will be released upon satisfactory completion of written end-products as outlined in Point 8.

<table>
<thead>
<tr>
<th>Date</th>
<th>Output Expected</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>15/10/2012</td>
<td>Work plan with clear timeline and expectations of support after inception approved by the supervisor</td>
<td>30%</td>
</tr>
<tr>
<td>30/01/2013</td>
<td>Draft Report</td>
<td>50%</td>
</tr>
<tr>
<td>03/03/2013</td>
<td>Final report with soft and hard copies and a power point presentation on highlights of the report with a dissemination plan.</td>
<td>20%</td>
</tr>
</tbody>
</table>

15. **Qualifications or Specialized Knowledge/Experience Required:** Indicate qualifications requirement.

1. Team leader/consultant with degree in public health, neonatology or related field
2. At least ten years’ experience in public health and newborn care, and demonstrated experience in resource-limited environments
3. Familiarity with East Asia and Pacific region an advantage
4. Excellent analytical and interpersonal skills
5. Strong communication and writing skills, with ability to lead/train a group of individuals and impart knowledge

16. **Contract Supervisor:**

17. **Type of Supervision that will be Provided:** Overall oversight of quality of outputs supervised.

18. **Consultant’s Work Place:** Own arrangements; Working station can be provided during coordination visits to UNICEF offices (XX, XX, XX)

19. **Nature of ‘Penalty Clause’ to be stipulated in Contract:** Should the consultant fail to submit the end-products by the deadlines, or should the quality be unsatisfactory, this office will reserve the right to withhold the payment until the outputs meet the pre-established requirements.

**Certified and Approved:**
### SAMPLE 2 TOR ENAP Consultant: Planning for ENAP

**UNICEF REQUEST FOR A CONTRACT FOR SERVICES (INDIVIDUAL)**

**SHORT TITLE OF ASSIGNMENT**: Assist the country office and the MoH to adapt a country specific ENAP that can attract funding within the context of the 2016-2020 CPD

<table>
<thead>
<tr>
<th>Item</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>DUTY STATION</td>
<td>XXX</td>
</tr>
<tr>
<td>SUPERVISOR</td>
<td>XXX</td>
</tr>
<tr>
<td>OTHER CONTACTS IN OFFICE</td>
<td>XXX</td>
</tr>
<tr>
<td>PROPOSED DURATION (may not exceed 11 months)</td>
<td>10 weeks</td>
</tr>
<tr>
<td>CONTRACT PERIOD</td>
<td>July - September</td>
</tr>
<tr>
<td>NATIONAL / INTERNATIONAL</td>
<td>International</td>
</tr>
<tr>
<td>WBS</td>
<td>6850/A0/04/881/002/004</td>
</tr>
<tr>
<td>GRANT</td>
<td>SC 130294</td>
</tr>
<tr>
<td>DAYS OF REMOTE WORK</td>
<td>0</td>
</tr>
<tr>
<td>DAYS IN DUTY STATION</td>
<td>50 working days</td>
</tr>
<tr>
<td>DAYS ELSEWHERE</td>
<td>0</td>
</tr>
</tbody>
</table>

- Need for individual consultant is reflected in the AWP: **YES**
- The tasks cannot be completed by UNICEF staff or counterparts: **YES**
- ToR is clearly defined with tangible, measurable deliverables or an end-product and with payments (contract fee) clearly linked to these: **YES**
- ToR includes a description of the specific activities and timeframes for completion of the activities: **YES**
- The ToR includes performance indicators for evaluation of results (e.g. timeliness or quantitative measures): **YES**

**SIGNED FOR AGREEMENT**

**Prepared by**
Programme Officer/Sp
Date 01/07/2016

**Reviewed by**
HR Officer
Date

**Recommended by**
Section Head
Date

**Cleared by**
Dep Rep
Date
# TERMS OF REFERENCE

## SHORT TITLE OF ASSIGNMENT

Every New-born Action Plan (ENAP) Expert

## BACKGROUND

MICS reports have indicated improvements in under-five mortality rate per 1000 live births: 223 in 2006; 116 in 2010 and, 89 in 2014. The infant mortality rates dropped from 138 to 55.4 per 1000 live births over the same period. Malnutrition contributes significantly (50%) to child and maternal mortality: prevalence of all forms of under-nutrition in children under five years is still high, with 27.5% of under-five children stunted, 6% global acute malnutrition and 18% underweight in 2012 (SMART) and only 53% of children 0-6 months are exclusively breastfed (MICS, 2014). According to the 2015 inter agency monitoring groups reports, 40 to 44% of U5 mortality is due to neonatal causes and include: Asphyxia (13%), Preterm (11%), Sepsis (10%), Congenital (3%) Other (3%). Maternal mortality, estimated at 900/1000 live births, also remains one of the highest in the region. In spite of the registered progress in the reduction of U5 mortality rates, considerable disparities pertain across XX health regions of XX (MICS 2014). U5 mortality range from 42/1,000 in XX (lowest) to 159 /1,000 in XX (highest). Breaching equity and gender gaps in quality care coverage is a priority for health in the next CPD 2016 – 2020. **As a strategic shift, existing policies and protocols will be revised to include specific strategies focusing on improving the quality of care provided during delivery and post-partum including country specific Every New-born Action Plan (ENAP).**

While focusing on the life cycle from pre-pregnancy- pregnancy through delivery- child hood-adolescents and to productive adult hood, surviving and thriving pillars shall not be limited to reduction of preventable deaths, but also shall include integrated child development to full potential, promotion of healthy life styles among adolescents, healthy reproductive life with every pregnancy wanted and maternal complications significantly reduced, financial protection and universal access for the vulnerable and marginalised groups. Similarly, innovative approaches will be applied to improve availability of quality data to influence decision making and programming for action, as well as advocacy for high level commitment, partnerships and resources in favour of maternal and new born health. The Government has adhered to the Promise renewed and have also validated its investment case (actually in the process of doing so).

As per the 2016-2017 RWP, UNICEF shall continue support scaling up of high impact interventions through the dissemination of key family practices at communities including in emergencies. A renewed focus shall be on neonatal care beginning with support to government to adapt a country specific Every New-born Action plan (ENAP). In collaboration with WCARO, UNICEF XX is recruiting an ENAP expert to support in this direction.

## OBJECTIVE

Assist the country office and the MoH to adapt a country specific ENAP that can attract funding within the context of the 2016-2020 CPD.
ACTIVITIES, TASKS, DELIVERABLES AND TIMELINES

ACTIVITIES AND TASKS:
• Hold Meetings with UNICEF management and technical teams;
• Hold Meetings with DG/MOH and other relevant departments of the MoH;
• Review the available documentation on New born health;
• Hold Meetings with key partners (EU and H4+/other UN agencies like UNFPA, WHO and NGOs);
• Conduct field trips as necessary to project and non-project sites including selected communities (urban, rural);
• Discuss strategic choices with all relevant programme sections/components as well as with the relevant Government Departments;
• Explore avenues for fund raising to implement ENAP and strategies on fundraising approach;
• Discuss the opportunities for leveraging resources to strengthen ENAP development and implementation for the next proposed CPD cycle (2016-2020) in line with the Strategic Note/RWP/AMP and the SDGs;
• Organize a national workshop to present and validate the ENAP for XX;
• Provide inputs and accompany the budget expert in the costing of ENAP;
• Provide inputs towards the finalisation of the ENAP monitoring tool for XX;
• Debriefing with UNICEF management, MoH and relevant stakeholders;
• Present the final report of mission.

DELIVERABLES, TIMEFRAME AND PAYMENT:

<table>
<thead>
<tr>
<th>Time frame</th>
<th>Deliverable</th>
<th>Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 15th, 2016</td>
<td>Signature of Contract and start of consultancy</td>
<td>20%</td>
</tr>
<tr>
<td>August 1st, 2016</td>
<td>First draft of situation analysis (SA) submitted to supervisor</td>
<td>20% when approved by CoS</td>
</tr>
<tr>
<td>September 16th, 2016</td>
<td>The first draft proposal of Specific ENAP interventions shared with stakeholders for reviews,</td>
<td>30% when approved by CoS</td>
</tr>
<tr>
<td>September 21st – 23rd, 2016</td>
<td>Integration of stakeholders’ reviews and submission of final draft to supervisor</td>
<td></td>
</tr>
<tr>
<td>September 24th-26th, 2016</td>
<td>National validation workshop prepared (presentations, participants list, invitations)</td>
<td>30% when approved by CoS</td>
</tr>
<tr>
<td>September 27-28th, 2016</td>
<td>National ENAP validation workshop moderated</td>
<td></td>
</tr>
<tr>
<td>September 30th, 2016</td>
<td>Submission of final costed ENAP document.</td>
<td></td>
</tr>
</tbody>
</table>

NB/The consultant shall work in collaboration with the budget expert beginning the 12/09/2016 so as to ensure that the final ENAP is costed.
QUALIFICATIONS, SPECIALIZED EXPERIENCE AND ADDITIONAL COMPETENCIES

The selected consultant will have to possess:

- University degree or equivalent in medicine, public health or other relevant discipline, with master's degree in public health;
- Five to eight years of work experience in National Child Health programme and monitoring and evaluation of ENAP is an asset;
- Work experience in development of ENAP policies, strategies and training guidelines;
- Excellent communication skills, including written and oral presentations;
- Good team player with ability to work independently and under considerably tight deadlines;
- Creative thinking, drive for results and strong commitments;
- Good inter-personal relationship even in diverse work environment;
- Work experience in Africa is an added advantage

Language: Fluency in one UN language (English or French) and knowledge of Portuguese is a major asset.

CONDITIONS OF WORK

The organization will assume responsibility for the following:

- The consultant will work from UNICEF office with an effective collaboration with MoH staff.
- The consultant should have personal computer but will be provided with supplies related directly to the task for the duration of the consultancy;
- The consultant's fee will be negotiated but UN official DSA rates for XX shall be applicable;
- UNICEF will only cover the costs of economy class from place of residence to XX and back. All work related transport (land/plane) costs within XX will also be covered by UNICEF;
- Ethical Considerations & Property Rights
- All documents, including data and reports, developed in the course of this mission are the intellectual property of UNICEF. The technical assistance should not share these products without the express permission of, and acknowledgement by UNICEF. The mission process should support and respect children's and women rights.
### SAMPLE 3 TOR ENAP Consultant: Costing the ENAP

<table>
<thead>
<tr>
<th>Heading: Costing the National Strategic Plan for Newborn-Child Health Development (2015-2018)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section in Charge: Young Child Survival and Development</td>
</tr>
<tr>
<td>How does the consultancy relate to work plan: Increased equitable access and use of quality high impact maternal, newborn and child health (MNCH) services</td>
</tr>
<tr>
<td>Outcome reference:</td>
</tr>
<tr>
<td>Output reference:</td>
</tr>
</tbody>
</table>

#### Background:
To achieve the MDGs and to address the post MDG agenda, the Department of Health under the Ministry of Health has been implementing interventions to reduce under five and newborn mortality rates with the guidance of the national health plan, the five year strategic plan for newborn and child health development and the five year strategic plan for reproductive health. The five year strategic plan for child health development (2010-2014) has been implemented through an implementation plan which contains an indicative budget. Led by the Ministry of Health in technical collaboration with WHO and UNICEF, the National strategic Plan for Newborn and Child Health (2015-2018) was recently developed. The Short Programme Review as a structured process to review status of new born and child health program and identify current status, strengths and gaps to be addressed was first conducted. Then it was followed by several meetings and a participatory national workshop with a wide variety of stakeholders to build consensus on the strategy within HSS framework. The draft version of the National Strategic Plan (2015-2018) is now available but yet to be costed. The strategic plan is the national guide for all the stakeholders and implementing partners in prioritizing high impact strategies and interventions on newborn and child health development and support its implementation. It is very essential for MOH to have the costed plan and use it to mobilize resources and guide implementation.  

#### Objectives of the consultancy:
This consultancy will lead to the development of a costed strategic plan of newborn and child health development (2015-2018) which will later be disseminated to all stakeholders for effective implementation at national/subnational level.  

#### Geographic Area:
Consultant needs to travel to XX for meeting with key ministry, and also for the meeting with key stakeholders or the national workshop.  

#### Duration (including potential extension):
22 April - 22 June, 2015  

#### Supervisor:
XXX  

#### Type of Supervision/support required from UNICEF:
Consultant will work closely with UNICEF and focal person from Ministry of Health/ Department of Health as well as with WHO technical officers as required.  

#### Description of assignment:

<table>
<thead>
<tr>
<th>Tasks</th>
<th>End Product/deliverables</th>
<th>Duration/Deadline</th>
</tr>
</thead>
</table>


1. Prepare a tentative action plan and proposed timeline for the costing exercise. The action plan should include a minimum of the following:
   - Indicate clear activities
   - How each activity will be done
   - Stakeholders involved in each activity
   - Expected deliverables from each activity
   - Timeline for each activity

<table>
<thead>
<tr>
<th>Action plan with timeline</th>
<th>1st week (home-based: 1 week)</th>
</tr>
</thead>
</table>

2. Using the outputs of the Newborn and Child Health Strategic Plan and the short program review on newborn and child health, the incumbent would identify detailed activities for 2015-2018 through a consultative process with the Programme Manager (DOH-Child Health Development section and if required with Maternal Health section), WHO and UNICEF.

<table>
<thead>
<tr>
<th>A list of identified activities for the NSP</th>
<th>2nd-3rd week (on-site: 2 weeks)</th>
</tr>
</thead>
</table>

3. Liaise with relevant government departments and non-governmental organizations to obtain their inputs/contributions to arrive at a consensus on the identified list of activities and prioritize and/or expand to develop a comprehensive list of activities.

<table>
<thead>
<tr>
<th>A comprehensive list of activities for the NSP</th>
<th>4th week (on-site: 1 week)</th>
</tr>
</thead>
</table>

4. Assist the Programme Manager (CHD)-Department of Health, in conducting individual meetings/national workshop on development of the costing for the next four year strategic plan with additional inputs from national and international experts and partner organizations. This would involve:
   - developing the agenda
   - collecting required information from participants or preparing participants to come up with relevant information for the workshop like unit costs for interventions
   - facilitating the workshop if required
   - documenting the key outputs from the workshop (preparing minutes)
   - incorporating relevant inputs

<table>
<thead>
<tr>
<th>Input from key Stakeholders’s to cost NSP through National level workshop/individual meetings as required</th>
<th>5th week (on-site: 1 week)</th>
</tr>
</thead>
</table>

5. Submission of draft costing of the Four Year National Strategic Plan for Newborn and Child Health Development 2015-2018 based on MOH, WHO and UNICEF inputs.

<table>
<thead>
<tr>
<th>Draft Costed NSP on Newborn and Child Health Development</th>
<th>6th week (Home-based: 1 week)</th>
</tr>
</thead>
</table>

6. Support the finalization of the plan after incorporation of suggestions by the Ministry of Health and stakeholders.

<table>
<thead>
<tr>
<th>Finalized Costed NSP on Newborn and Child Health Development</th>
<th>8th week (Home-based: 1 week)</th>
</tr>
</thead>
</table>
7. Submit an assignment report at the end of the assignment. The report should consist of, as a minimum:
   - Executive summary
   - Background with a clear purpose
   - Process followed
   - Challenges and lessons learned
   - Outcome of the consultancy
   - Recommendations for next steps and similar future activities
   - Annexes containing all the outputs and other relevant documents for the consultancy

   **Assignment Report**
   **8th week (Home-based: 1 week)**

8. Advertisement / Invitation / Request for Expression of Interest
   The TOR will be circulated through HR and the UN international network.

9. Selection process (EOI to be attached to TOR)
   Interested candidates are required to complete the Expression of Interest Form circulated with the call for proposals, answering the technical questions included.
   The consultant will be identified by UNICEF based on a competitive selection process, taking into account the candidate's experience, the quality of the answers produced, and of the lump-sum requested.
   If deemed opportune, UNICEF will require a telephone interview with shortlisted candidates.

10. Qualification and specialized knowledge/experience required for the assignment:
    The Consultant must have following criteria to be eligible to apply for the assignment
    - A minimum of a Master Degree in Health Economics/ Master in Public Health
    - More than 5 years of experience in costing and financing preferably by applying OneHealth Costing tool
    - Good knowledge, understanding and enough experience of MNCH programmes in the region/country
    - Experience in working with governments, NGOs and UN agencies
    - Experience in conducting participatory and consensus building workshops/meetings.
    - Good computer skills including Word, Excel, PowerPoint, and Costing tool
    - Very good facilitation and communication (oral and written) skills in English.
    - Ability to work without supervision to meet TOR

11. Estimated costs to UNICEF:
    Please add in EOI submission

12. Funding Source:
13. Other conditions:

Desk space will be provided at the UNICEF office when required and where possible. The consultancy will require at least one trip to XX which will include overnight stays and UN DSA. The consultant is required to use his/her own laptop and submit all deliverable in paper and digital format. Internet will be provided at UNICEF offices.

**Life and health insurance**

UNICEF does not provide or arrange life or health insurance coverage for consultants and individual contractors, and consultants and individual contractors are not eligible to participate in the life or health insurance schemes available to United Nations staff members. Consultants and individual contractors are fully responsible for arranging, at their own expense, such life, health and other forms of insurance covering the period of their services as they consider appropriate. The responsibility of UNICEF is limited solely to the payment of compensation for service-incurred death, injury or illness as per the provisions detailed below.

**Insurance for service-incurred death, injury or illness**

Consultants and individual contractors who are authorized to travel at UNICEF expense or who are required under their contract to perform services in a UNICEF or United Nations office shall be provided with insurance coverage, through a UNICEF-retained third party insurance provider, covering death, injury and illness attributable to the performance of official UNICEF duties. Compensation in the event of service-incurred death, injury or illness shall be equivalent to amounts stipulated in the agreement between UNICEF and the insurance provider.

**Payment**

20% of payment upon receiving action plan and timeline
40% of payment upon receiving of Draft costed NSP
40% of payment upon receiving of Final Costed NSP and Assignment report

**Confidentiality:**

The documents produced during the period of this consultancy will be treated as strictly confidential, and the rights of distribution and/ or publication will reside solely with UNICEF. The contract signed with the consultant will include the other general terms defined by UNICEF.

14. Nature of Penalty Clause to be stipulated in the contract:
UNICEF reserves the right not to pay the Contractor or withhold part of the payable amount if one or more requirements established for this assignment is not met or deadline set for the accomplishment of the tasks is missed.

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Prepared by:                                                                                                 ____________________________

Name                                                                                     Signature
Date

Commitment of funds:                                                                        _________________________________  

Name                                                                                     Signature 
Date
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### SAMPLE 4: Agenda for Bottleneck Analysis Workshop

**Agenda**

**Bottleneck Analysis Workshop for Newborn Care Programming**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator</th>
</tr>
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<tbody>
<tr>
<td><strong>Day 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>08.00-08.30</td>
<td>Registration</td>
<td></td>
</tr>
<tr>
<td>08.30-08.45</td>
<td>Introduction of participants</td>
<td></td>
</tr>
<tr>
<td>08.45-08.55</td>
<td>Welcome Address</td>
<td></td>
</tr>
<tr>
<td>08.55-09.10</td>
<td>Opening of the workshop</td>
<td></td>
</tr>
<tr>
<td>09.10-09.20</td>
<td>Objectives of the workshop</td>
<td></td>
</tr>
<tr>
<td>09.20-10.00</td>
<td>Situation of Maternal and New-born care in XX: Progress and Challenges</td>
<td></td>
</tr>
<tr>
<td>10.00-10.15</td>
<td>Open discussion</td>
<td></td>
</tr>
<tr>
<td>10.15-10.30</td>
<td>Tea/Coffee break</td>
<td></td>
</tr>
<tr>
<td>10.30-10.45</td>
<td>Global Every New-born Action Plan and progress in countries</td>
<td></td>
</tr>
<tr>
<td>10.45-11.00</td>
<td>Presentation by Regional Advisor</td>
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<tr>
<td>11.00-11.15</td>
<td>Open discussion</td>
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<tr>
<td>11.15-11.30</td>
<td>Introduction to Group Works</td>
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<tr>
<td></td>
<td>Group Work 1: Identifying bottlenecks</td>
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<tr>
<td>11.30-13.00</td>
<td>Group Works</td>
<td></td>
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<tr>
<td>13.00-14.00</td>
<td>Lunch Break</td>
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<tr>
<td>14.00-15.15</td>
<td>Group Work</td>
<td></td>
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<tr>
<td>15.15-15.30</td>
<td>Tea/Coffee break</td>
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<tr>
<td>15.30-17.30</td>
<td>Group presentations (Each group 10 min presentation and 15 minute discussion)</td>
<td>Each group</td>
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<tr>
<td><strong>Day 2</strong></td>
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<tr>
<td>09.00-09.15</td>
<td>Introduction to Group Work</td>
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<tr>
<td></td>
<td>Group Work 2: Recommending strategies to address bottlenecks</td>
<td></td>
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<tr>
<td>09.15-12.30</td>
<td>Group work with running tea arrangement</td>
<td></td>
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<tr>
<td>12.30-13.30</td>
<td>Lunch break</td>
<td></td>
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<tr>
<td>13.30-15.15</td>
<td>Group presentations and discussion (Each group 10 min presentation and 15 minute discussion)</td>
<td>Each group</td>
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<tr>
<td>15.15-15.30</td>
<td>Tea/Coffee break</td>
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<tr>
<td>15.30-16.00</td>
<td>Wrap-up and next steps</td>
<td></td>
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<tr>
<td>16.30-17.00</td>
<td>Closing Remarks</td>
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</tr>
<tr>
<td>17.00</td>
<td>Closing of the workshop</td>
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Planning group works for the BNA consultation

Groups:
1. Management of pre-term birth focus on antenatal corticosteroids
2. Skilled care at birth focus on the use of the partograph
3. Basic Emergency Obstetric Care focus on assisted vaginal delivery
4. Comprehensive Emergency Obstetric Care focus on caesarean section
5. Basic Newborn Care focus on cleanliness/cord care, warmth, and feeding
6. Neonatal resuscitation
7. Kangaroo mother care focus on skin to skin, breastfeeding and feeding support for premature and small babies
8. Treatment of severe infections focus on using injectable antibiotics
9. Inpatient supportive care for focus on IV fluids/feeding support and safe oxygen for sick and small newborns

Proposed division for group work:

Group 1: 2, 3, 5 (Section 2) Participants from midwifery and obstetrics background with DoH representatives responsible for community and primary care and basic EmOC facilities

Group 2: 1, 4, 6 (Section 2) Participants from midwifery and obstetrics background with DoH representatives responsible for secondary care and Comprehensive EmOC facilities

Group 3: 7, 8, 9 (Section 3) Participants with neonatology/paediatrics background and DoH representative responsible for hospital services (secondary and tertiary levels)

Group 4: Discussing Section 1

1. Leadership and governance
2. Health finance
3. Health workforce
4. Health service delivery
5. Essential medical products and technologies
6. Health information systems
7. Community ownership and partnership

Please assign facilitators for each group (one who has worked on the draft), a chair person (MoH relevant person); note –taker (volunteer who can work well with the facilitator).

Logistics: It will be ideal to have space for 4 groups (split up rooms to allow freedom from noise) and a laptop and a projector so all can see what is being noted and can provide inputs. This will also save time later on for inputting information from flip charts.

4. WHO roster of consultants.
Available at: https://www.dropbox.com/sh/cfm7o2si6aws32n/AACgHxNRJNQn10xF45ju6nta?dl=0

5. WHO link for RMNCAH tools:
Implementation toolkit in support of the Global Strategy for Women's, Children's and Adolescents’ Health: http://www.everywomaneverychild.org/h6-toolkit/
6. Links to ENAP tools and resources.

Key ENAP tools:

- **Newborn Health Planning in the context of MNCH: Situation Analysis Guide.** Save the Children (2006). Available at: https://www.dropbox.com/sh/cfm7o2sil6aws32n/AACgHXnRNJQNN10xF45ju6nta?dl=0
- **EQUIST tool:** http://equist.info
- **Lives Saved Tool (LiST):** http://livessavedtool.org/
- **OneHealth tool:** http://www.avenirhealth.org/software-onehealth

Links to more resources available in the body of this user guide, and in the dropbox folder: https://www.dropbox.com/sh/cfm7o2sil6aws32n/AACgHXnRNJQNN10xF45ju6nta?dl=0

7. Interview questions used for development of user guide.

- Do you have a newborn health plan in your country, and is it costed? Who are the main stakeholders responsible for newborn health in your country? Could you give a brief overview of the roadmap you followed to get to where you are today, and share at what stage you used the tools available for creating plans for maternal and newborn health? Please describe the approach you took, what have been the main challenges, what stage of development you are at now, and whether you have financial support to advance this work.
- Was newborn health addressed through the development of a standalone plan, or as part of a wider RMNCAH plan? In the latter case, how was the experience? Were you able to include specific targets, e.g. NMR, Stillbirth Rate?
- Which tools did you use, when and for what purpose? Did you use any other tools not listed below? What were the pros and cons in using each tool?
- What did you find most helpful in applying these tools? Did they help you achieve the objectives they were designed for (e.g. did you obtain a costed newborn health plan as a result of applying costing tools, such as the OneHealth tool)?
- Could you share your experience of costing the newborn health plan? What were some key factors for completing this step, what were some barriers you faced, and how did you overcome them?
- Is there anything you would change in the tools, to make them more user friendly, or more relevant to your situation? Was anything missing, which you would recommend we include in the tools going forward?
- If you were to apply the tools again in the future, is there anything you would change in how you approached the process, any lessons learned that you will apply in the future?
- Can you describe a challenge you faced in applying the tools, for example in gaining attention (political, financial) to support its application? How did you overcome such challenges?
- What are your tops 3-5 recommendations to a country who is seeking to establish a newborn action plan? What advice would you give to someone who is just starting to engage with this process, how should they approach it?
- Were the tools applied only at national, or also at sub-national level?
- Do you have a process for monitoring and evaluating your newborn health plan (or newborn health in general if no plan is in place)? What indicators or tools have you used to this end? Is M&E and health information system capacity focused on the national or also sub-national level?
- How has your experience been in using the tools available for implementation of the ENAP?
- Is there anything else you would like to mention?
8. Example of newborn health interventions mapped against levels of the health system (Ghana).

**Table:**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Home</th>
<th>Community Health Planning and Services (CHPS) Compound/Centre</th>
<th>Maternity Clinics</th>
<th>Health Centre</th>
<th>Referral Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic essential newborn care</td>
<td>Yes, all components by all care providers (vitamin K and immunisations only by skilled attendants)</td>
<td>Yes, all components</td>
<td>Yes, all components</td>
<td>Yes, all components</td>
<td>Yes, all components</td>
</tr>
<tr>
<td>Prematurity</td>
<td></td>
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<tr>
<td>Antenatal corticosteroids. Although these may be administered at peripheral centres it would be ideal to refer the mother for delivery to a referral facility that can care for preterm babies.</td>
<td></td>
<td>Yes with midwife/ trained Community Health Nurse (CHN), but ideally send mother to referral facility that can care for preterm babies.</td>
<td>Yes, with midwife or trained CHN, but ideally send mother to referral facility that can care for preterm babies.</td>
<td>Yes; ideally send mother to referral facility that can care for preterm babies.</td>
<td>Yes, full management including the delivery and care of the preterm baby.</td>
</tr>
</tbody>
</table>
### Intervention | Home | Community Health Planning and Services (CHPS) Compound/Centre | Maternity Clinics | Health Centre | Referral Hospital
---|---|---|---|---|---
**Kangaroo Mother Care** | Yes, definitely after being discharged from KMC care at a facility, by all categories of trained health workers. More evidence may be required for routinely commencing KMC after a home birth. Even if it is started at home, a preterm/low-birthweight baby needs to be referred to a suitable facility for initial assessment, care and monitoring of problems. | May commence it if the baby is born in the clinic, but the baby is likely to need to be sent to a referral centre for further evaluation. All categories of health workers may do follow-up KMC care, if trained, after the baby is discharged from the hospital. | May commence it if the baby is born in the clinic, but the baby is likely to need to be sent to a referral centre for further evaluation. All categories of health workers may do follow-up KMC care, if trained, after the baby is discharged from the hospital. | Yes, but may need to be sent to a referral centre for further evaluation unless local health workers are well trained in KMC. All categories of health workers may do follow-up KMC care, if trained, after the baby is discharged from the hospital. | Yes, full care and follow-up.

**Basic neonatal resuscitation for adverse intrapartum events (birth asphyxia)** | Only drying and stimulation unless the delivery is conducted by a trained nurse/midwife/CHN who is a skilled birth attendant. | Only drying and stimulation unless the delivery is conducted by a trained nurse/midwife/CHN who is a skilled birth attendant. | Yes, with midwife or trained nurse/midwife/CHN. | Yes | Yes. In addition, advanced resuscitation with intubation and further management will also be required.

**Management of neonatal infections**

**Minor infections** | Yes, with a trained nurse/midwife/CHN. | Yes, with a trained nurse/midwife/CHN. | Yes, with a trained nurse/midwife/CHN. | Yes | Yes

**Neonatal sepsis treatable with intramuscular injections** | IMNCI strategy is to administer the first dose and send to the referral centre. Explore, through pilot interventions, providing full treatment to babies that are able to accept feeds at any centre with skilled trained health workers instead of further referral. This may be particularly applicable to facilities that are close by where the baby can be brought daily or the CHN can visit the home daily to administer the doses. | IMNCI strategy is to administer the first dose and send to the referral centre. Explore, through pilot interventions, providing full treatment to babies that are able to accept feeds at any centre with skilled trained health workers instead of further referral. This may be particularly applicable to facilities that are close by where the baby can be brought daily or the CHN can visit the home daily to administer the doses. | IMNCI strategy is to administer the first dose and send to the referral centre. Explore, through pilot interventions, providing full treatment to babies that are able to accept feeds at any centre with skilled trained health workers instead of further referral. This may be particularly applicable to facilities that are close by where the baby can be brought daily or the CHN can visit the home daily to administer the doses. | Yes, full care | Yes, full care
<table>
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<tr>
<th>Intervention</th>
<th>Home</th>
<th>Community Health Planning and Services (CHPS) Compound/Centre</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Sick newborn requiring additional care</td>
<td>No, except first dose of the antibiotic with a trained CHN.</td>
<td>No, except first dose of the antibiotic with a trained CHN.</td>
<td>No, except first dose of the antibiotic with a trained CHN or midwife.</td>
<td>Mostly no, except first dose of the antibiotic with a trained CHN or midwife.</td>
<td>Yes, full care</td>
</tr>
</tbody>
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