



# Saving Newborn Lives (SNL)

*Progress in Newborn Health in Mali*

---

**EnCompass LLC**

December 2016



## Progress in Newborn Health in Mali

*This report is part of a special study that consists of two country case studies conducted in Indonesia and Mali, and a synthesis study that draws lessons across the two. All studies were completed with support from Save the Children's Saving Newborn Lives (SNL) Program.*

### **EnCompass Study Team:**

Lynne Franco, Haoua Diallo,

Aissé Diarra, Kelsey Simmons

# Table of contents

**01**

Context

**02**

Methodology

**03**

Summary of Findings

**04**

Factors Explaining Progress

**05**

Looking Forward

**06**

Annexes



# Context

## **Section 01**

- Global context for newborn health
- History of newborn health in Mali
- SNL activities in Mali

## Context

# Global context for newborn health

*Before 2000, newborn health was not a top priority on global or national agendas.*

In their efforts to reduce infant and child mortality, many health policymakers were either unaware of the magnitude and severity of neonatal mortality and its contribution to infant mortality rates and under-5 mortality rates, or did not believe that it could be effectively addressed in low-resource settings. Even after the infant mortality rate declined and the neonatal mortality increasingly came into focus, many were unaware of effective interventions that could be implemented through lower level health services and in communities.

The increased attention to infant and child mortality from the Millennium Development Goals (MDGs) highlighted the need to reduce neonatal mortality in order to attain MDG 4. Evidence and guidance for lifesaving interventions for newborns were strengthened and disseminated. Countries began to incorporate specific plans and programs specifically targeting newborns.

**From 1990 to 2010, progress in reducing newborn deaths was 40 percent slower than for post-neonatal deaths, improving only 1.7 percent per year from 1990 to 2000, and 2.1 percent per year from 2000 to 2010.**

**-- Lawn 2012**

## Context

# History of newborn health in Mali from 2000

**Cultural beliefs do not consider the death of a newborn as a tragedy: “the jug is chipped, but it is not broken.”**

*Mali, with a high neonatal mortality rate and supportive environment for integrating newborn health activities, created a favorable situation for a concentrated effort on newborns.*

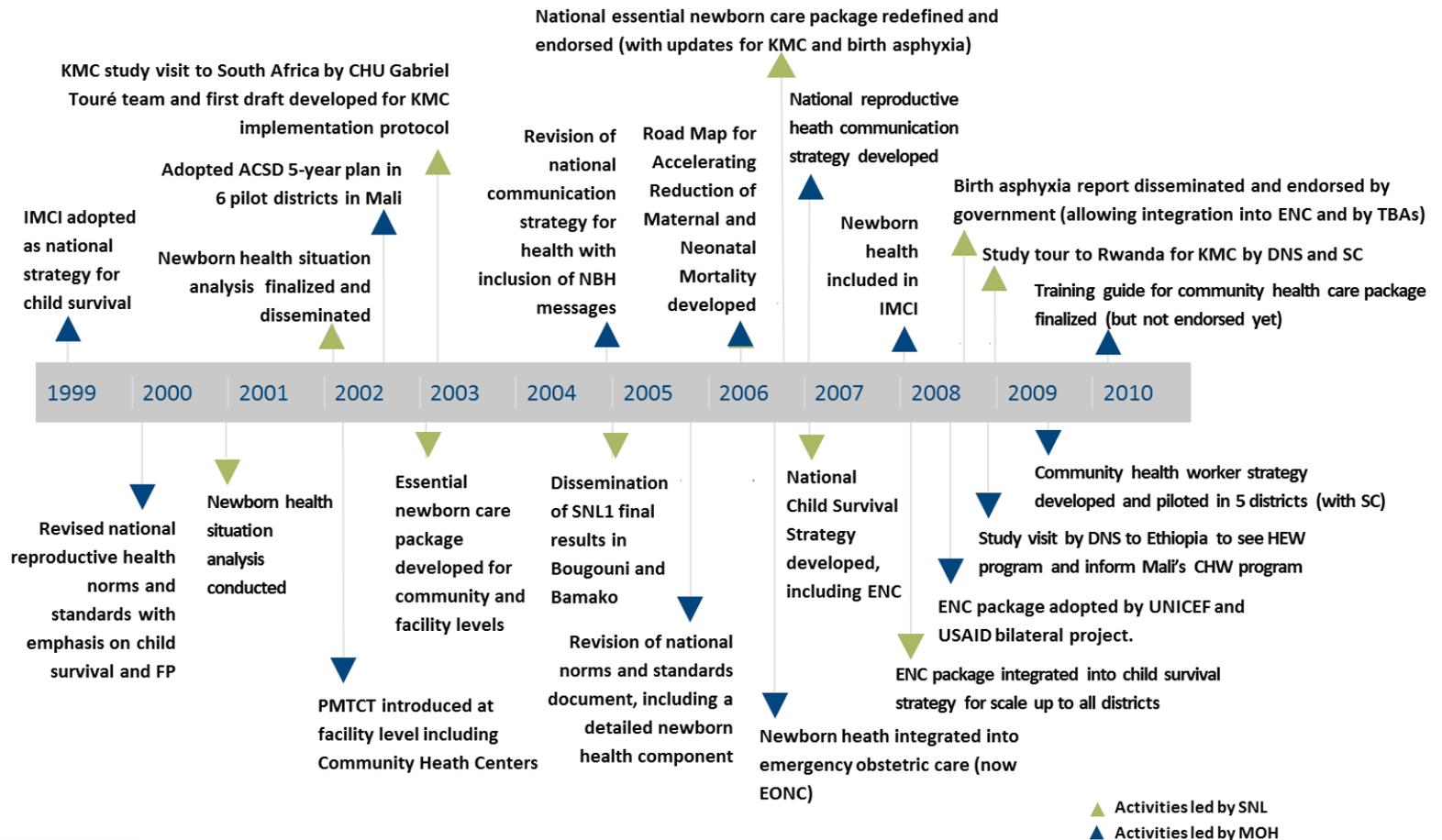
In Mali, neonatal mortality was 71/1,000 births in rural areas (EDSM 2001). This was exacerbated by the high rate of illiteracy, home births, and harmful practices in the communities.

As part of the country’s focus on safe motherhood, policies and resources developed contributed to the creation of a favorable environment for improving the health of newborns, including strengthening the referral and emergency transportation systems.

## Context

# SNL activities in Mali (2001-2010)

*SNL has supported bringing attention to newborn health by providing evidence of problems and possible solutions, and supporting the Ministry to design policies and strategies.*



## Section 01

## Context

# Purpose of the study

*To learn from the experience of Mali's efforts to integrate neonatal care into the national health system and study its progress along the Pathway to Effective Coverage.*

This study represents a unique opportunity for two reasons. First, SNL worked for more than 10 years in Mali, a long enough period for changes to take root. Second, although Mali does not benefit from direct funding anymore, SNL has funding for special studies that allow going back to countries where programs are no longer active in order to understand how their effects were sustained.

### Specific Objectives of the Study:

1. Identify progress
2. Discuss challenges faced in integrating newborn health in Mali
3. Make recommendations for further improvements
4. Identify the contributions of SNL and other actors to ensure continued progress in Mali

# Methodology

## **Section 02**

- Study questions
- Methodology

## Methods

# Key study questions

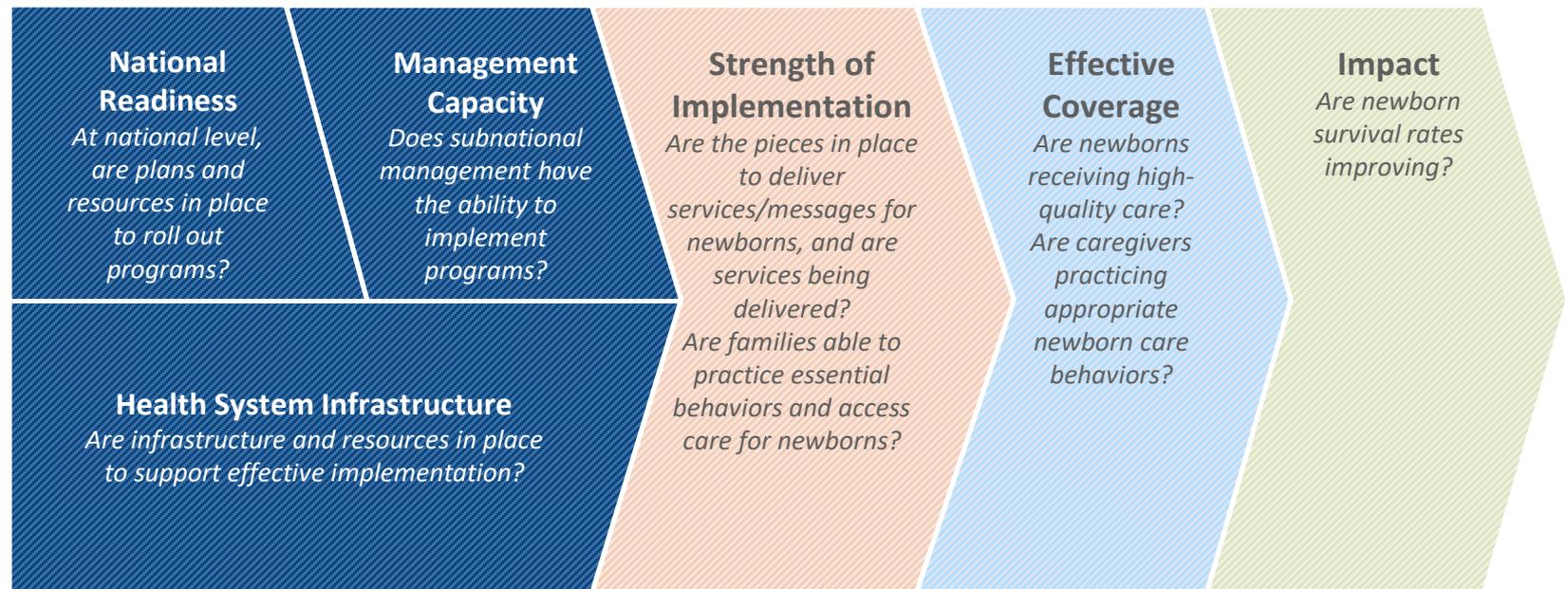
1. In what ways have countries previously supported by SNL maintained, increased, or decreased progress for newborn health?
  - a. Which aspects of progress do stakeholders perceive and value the most?
2. What factors have contributed to or inhibited progress in these countries?
3. How have SNL's activities at country or global level contributed to momentum in the case study countries?
4. Where do newborn stakeholders in these countries envision the need for greater progress and what is required (at both country and global levels) to make that progress happen?



## Methodology

# Pathway to Effective Coverage at Scale

*The Pathway to Effective Coverage at Scale, developed by SNL, was used as a framework for this study. The Pathway allows stakeholders to identify the key ingredients of success and assess the capacity for and degree of implementation of newborn programs. It contains six categories and 42 elements, all of which will be detailed in this report.*



### Section 02

## Methodology

# Jeremy Shiffman framework

*Shiffman's framework provides the means for understanding factors that facilitate or hinder elevation of newborn health issues in a specific context. It complements the Pathway by clarifying why progress in national and subnational readiness and implementation was or was not attained.*



***Transnational Influence:*** International agencies' efforts to establish a global norm for the unacceptability of newborn death, and the offer of financial and technical resources to address newborn mortality



***Domestic Advocacy:*** Political community cohesion among key stakeholders, presence of champions, credible evidence to demonstrate the problem, focusing events, and clear policy alternatives to reduce newborn mortality



***National Political Environment:*** Political transitions and changes, and competing health priorities

---

### Section 02

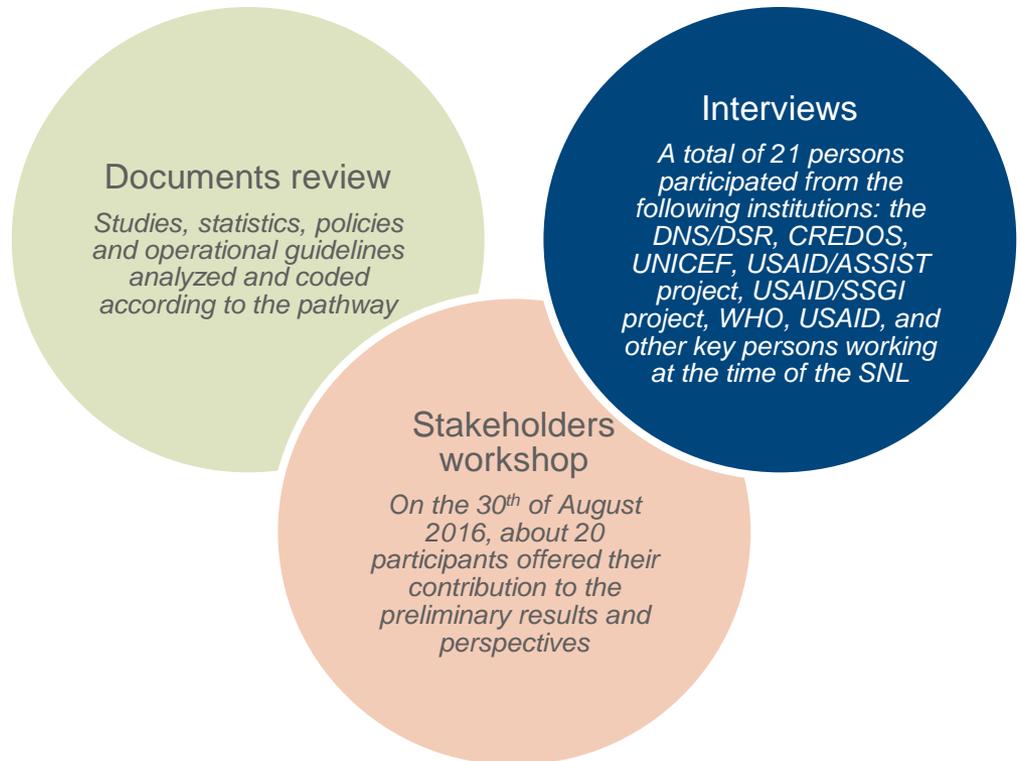
## Methodology

# Data collection and analysis

*This study is based on extensive document review, in-depth interviews, and a workshop with key stakeholders.*

To assess progress on the Pathway to Effective Coverage, the primary method of data collection was a review of the literature on newborn health in Mali, supplemented by interviews with people active in newborn health currently and/or during the implementation of SNL 1 and 2.

The literature review and interviews were iterative, followed by a workshop to validate the results, completing information and enriching data on different perspectives. Documents and interviews were coded according to the 42 elements of the pathway to effective coverage at scale and the Shiffman framework.



## Methodology

# Documents reviewed

### *Coded documents*

Analyse de la Situation des Interventions sur la Survie de l'Enfant (2013)

Annuaire Système Local d'Information Sanitaire (2015)

Countdown Mali Country Profile (2015)

Countdown Mali Equity Profile (2015)

Enquête Démographique et de Santé au Mali 2012-2013

Enquête d'évaluation du Projet MCHIP (2014)

Enquête par Grappes à Indicateurs Multiples (MICS) 2009-2010 et 2015

Étude de base de niveau de prestation SMNI SSGI (2015)

Étude de base sur les facteurs de idéation et les comportements KJK (2015)

Etude de Cas SMK à Tinkaré (2015)

Etude sur les perceptions des communautés sur les soins du cordon (2015)

Every Newborn Country Implementation Tracking Tool (2015)

Mali Niger Case Study Quality Improvement BJOG (2014)

Mali SRMNI Présentation 2015

Plan Décennal de Développement Sanitaire et Social 2014-2023

Plan Stratégique Santé de la Reproduction 2014-2018 (2014)

Politiques et Normes des Services de Santé de la Reproduction (2013)

Project USAID/ASSIST Mali Country Report 2015 et 2016

Recherche Qualitative sur les Facteurs qui Influencent l'Utilisation des Services SMI KJK 2016

Soins Essentiels dans la Communauté - Présentation SSGI (2015)

### *Consulted documents*

Carte de Score et de Performance de la SRMNI (2015)

SNL 2 Country Brief 2013

SNL Mali Scale-up Benchmarks Reporting Tool (2012)

SNL Mali Newborn Policy Activity Change SNL Contributions (2012)

SNL 1 Program Brief (2006)

## Methodology

# Main data sources

### Baseline study on MNCH service delivery (SSGI – 2015)

- Bamako, Kayes, Koulikoro, Sikasso
- Health facilities: Referral Health Center (Ref HC (35), Community Health Center (Com HC) (208), Maternity (177), Others (91)
- Service providers: Ref HC (106), Com HC (408), Maternity (194), Others (187), ASC (175)

### Baseline study on factors influencing attitudes and behaviors (KJK – 2015)

- Bamako, Kayes, Koulikoro, Mopti, Sikasso
- Households (4409), women who gave birth in the last 5 years (3087)

### Maternal and Child Health Integrated Program (MCHIP) Final Evaluation (2014)

- Districts of Diéma and Kita (Kayes region)
- Mothers of children under 2 (882), community health worker (CHW) (30), service providers (48 in 22 health facilities)

### Multiple Indicator Cluster Survey (MICS 2015)

- Bamako, Gao, Kayes, Koulikoro, Mopti, , Ségou, Sikasso, Tombouctou
- 2015: Households (11 830), Women with a live birth in the last 2 years (6756)
- 2010 (includes Gao): Households(13 852), women with a live birth in the last 2 years (10 795)

### Mali Demographic and Health Survey (EDSM 2012-2013)

- Bamako, Kayes, Koulikoro, Mopti, Ségou, Sikasso
- Households (10 105), women who gave birth in the last 5 years (6773)

### Annual Report of Local Health Information System (SLIS 2015)

- Over the whole territory: Bamako, Gao, Kayes, Koulikoro, Mopti, Ségou, Sikasso, Tombouctou, Kidal regions and the district of Bamako

## Section 02

## Methodology

# Study Limitations

*Despite some significant limitations, the consistency of the findings among secondary quantitative data sources, review of recent documents, and interviews and the group discussion is reassuring regarding the overall accuracy of the main findings.*

### *Information on the Pathway to Effective Coverage is limited*

Household surveys, such as the EDSM (Mali Demographic and Health Survey) and the Multiple Indicator Cluster Surveys (MICS), include a limited number of indicators on newborn services, while baseline studies on services and attitudes and behaviors from 2015 do not have baseline studies for comparison.

### *There was a high turnover among actors*

Institutional memory for actions that took place before 2012 is limited in the Ministry, as well as among partner organizations. Many actors working at the time of the SNL have moved to other structures/projects outside the country or have retired.

### *Availability of documents was an issue*

The ability to access the Ministry's and partners' documents was a challenge.

# Summary of Findings

## **Section 03**

- National readiness
- Management capacity
- System structures
- Program elements in place
- Program functioning
- Effective coverage/impact

---

# 1. National readiness

---



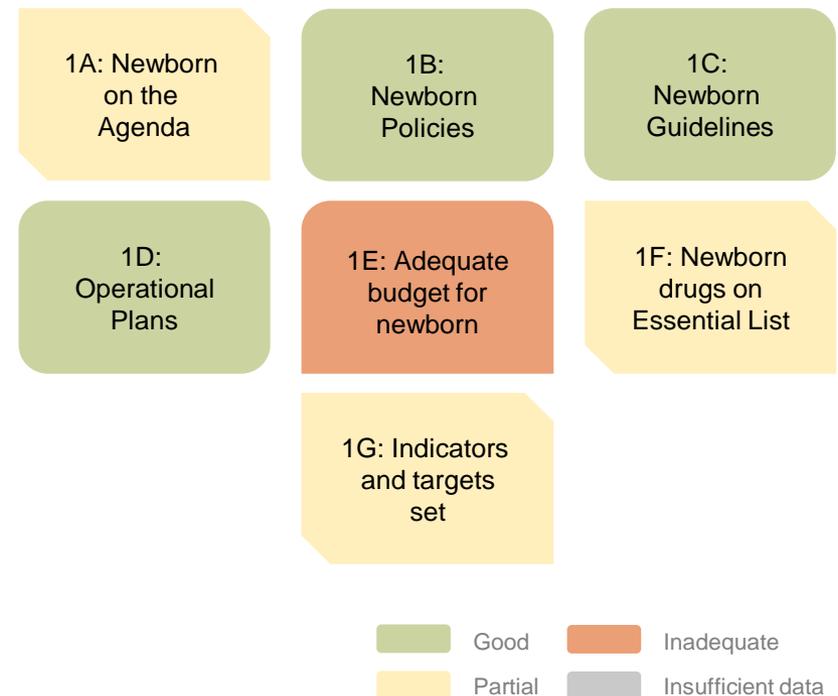
## Summary of Findings

# National readiness

*At the national level, have interventions been integrated into national systems and reflected in policies, plans, and resources?*

National readiness assesses the degree to which health systems are prepared to deliver interventions for newborn survival. National readiness includes measures of agenda setting, policy formation, and policy implementation.

### Status of national readiness



## Summary of Findings

1A: Newborn is on national agenda with a convening mechanism and a focal person at the Ministry of Health (MOH) is in place

*The newborn has a place on the national agenda, but it remains slightly hidden.*

There is an essential newborn care (ENC) focal point at the level of the Reproductive Health Division (within the National Health Directorate). There is no official newborn working group (it is included in the thematic maternal, newborn and child health [MNCH] group), but there is a technical working group on Chlorhexidine. Stakeholders reported that the newborn is not sufficiently taken into account in Mali, and there is no communication or advocacy plan in place for the newborn.

There is a plan to undertake research on newborn issues within the Center for Research and Documentation for Survival (CREDOS).

**There is no formal forum to discuss newborn issues.**

## Summary of Findings

# 1B: Policies are revised or formulated based on the latest evidence

**Policies include all new interventions for newborn recommended by the World Health Organization (WHO).**

*Mali's 2006 Reproductive Health Policies, Norms and Procedures incorporated key newborn interventions. The 2013 revisions fully integrated these interventions with those for the mother. Mali has now added Chlorhexidine for prevention of septicemia.*

Based on pilot project experiences and research, high-impact interventions, such as kangaroo mother care (KMC), Helping Babies Breathe (HBB), and umbilical cord care were integrated in the National PNP for Reproductive Health (PNP/SR) in 2006 as part of the Essential Newborn Care package. The PNP was revised in 2013 to integrate immediate mother and newborn care, and to increase the number of postnatal visits through essential community-based care. However, the newborn care package remains weak in its implementation.

In 2009, the integrated management of child illness (IMCI) included the first 7 days of life. Neonatal death audit is now required in health structures. Introduction of Chlorhexidine in the PNP is underway.

### Section 03

## Summary of Findings

### 1C: Implementation guidelines, training materials, and standards of care are developed

*The curriculum for newborn health, based on the PNP, was updated in 2013, and emergency obstetric and newborn care (EONC) training modules were updated in 2016. Training modules exist for ENC, HBB, KMC, SEC, IMCI, neonatal death audits, and Chlorhexidine.*

### 1D: National operational plans include newborn services

*Mali has a costed strategic plan for Reproductive Health (2014-2018). However, there is no specific plan for the newborn (ENAP). The conceptual framework for providing free referral/emergency transportation for mothers also includes newborns.*

## Summary of Findings

### 1E: National budgets updated sufficient allocation for newborn-related services

*Since 2016, there has been a budget line for reproductive health that includes a modest allocation for meetings and campaigns. However, all other health activities are included together in the overall budget for health. Budget estimates show that the portion allocated to reproductive health decreased from 2.1 percent in 2010 to 1.9 percent in 2012 (Plan Stat 2014). According to a funding analysis of reproductive, maternal, neonatal, and child health programs (2015), there is a 63 percent gap between funding needs and funds allocated to maternal and neonatal health.*

### 1F: Drugs are on the essential list and production plans are in place

*The four essential medicines for newborns (injectable antibiotics, Chlorhexidine, antenatal corticosteroids, newborn resuscitation devices) are on the essential medicine list in Mali.*

## Summary of Findings

# 1G: Appropriate targets and indicators are set for newborn-related interventions

*The reproductive health (RH) strategic plan and survey reports (EDSM and MICS) do not include all indicators for the newborn.*

The RH strategic plan only has one indicator, which is the neonatal death rate. The current local health information system (SLIS) does not take into account many newborn indicators: it includes the number of newborn resuscitations, but no data on neonatal septicemia, KMC, nor on the outcome for resuscitated babies etc. Indicators for newborns followed in the first 48 hours, KMC, and Chlorhexidine are included in the revisions of the SLIS, which are currently underway, but not yet disseminated in the field.

The last demographic health survey in Mali in 2012-2013, included an immediate postnatal visit in the first 2 days after birth, as well as neonatal death rate, maternal breastfeeding coverage, and vaccination.

Mali uses the RMNCH scorecard, which includes two indicators for newborns: 1) the number of Ref HC offering KMC and 2) the percentage of children born from HIV-positive mothers who test HIV negative.

**It is currently difficult to monitor progress with neonatal care services because the national health information system and surveys do not have precise enough indicators**

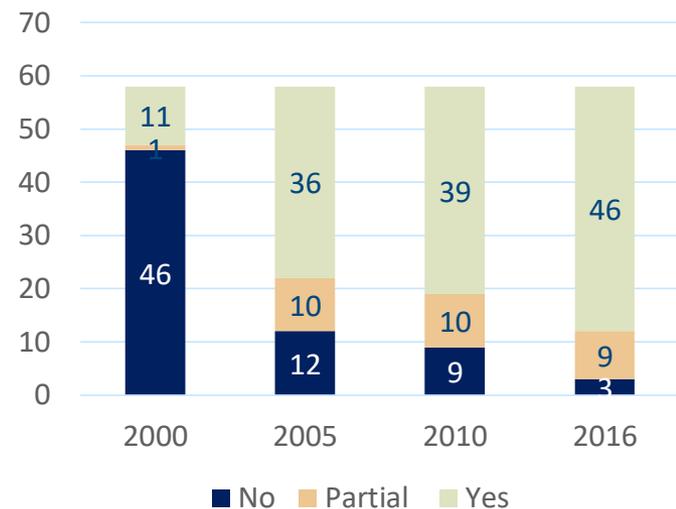
## Summary of Findings

# Milestones for scale-up readiness benchmarks in Mali 2000-2016

*Mali has made progress toward achieving benchmarks for scaling up newborn health interventions. Formalization of newborn activities in the community-based essential care program and the introduction of Chlorhexidine have also made progress towards scale-up.*

The Scale up Readiness benchmarks, developed by SNL between 2007 and 2011, provide a detailed examination of 58 elements in the Pathway to Effective Coverage at Scale's national readiness category. SNL previously evaluated these benchmarks for 2000, 2005, and 2010; this special study assessed the status in 2016. See Annex C for more detail.

Benchmark Achievements  
Mali

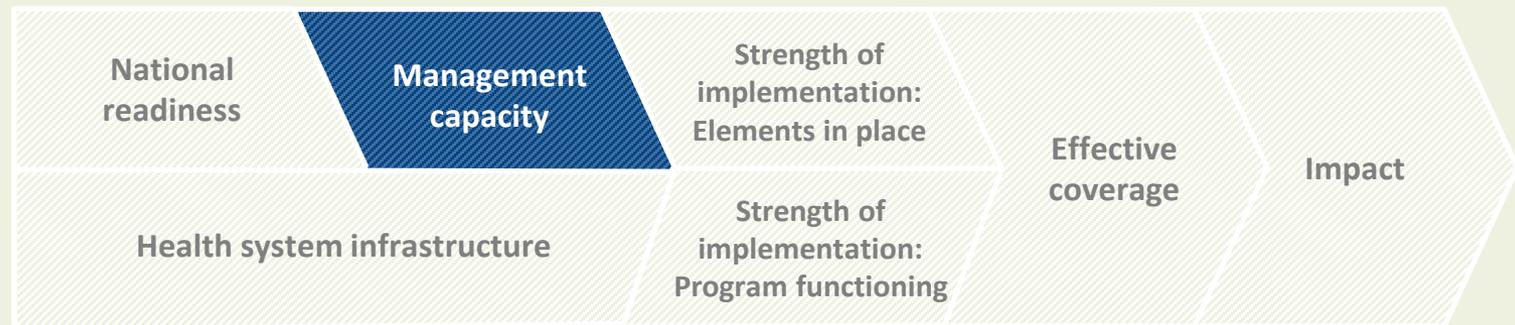


### Section 03

---

# 2. Management capacity

---



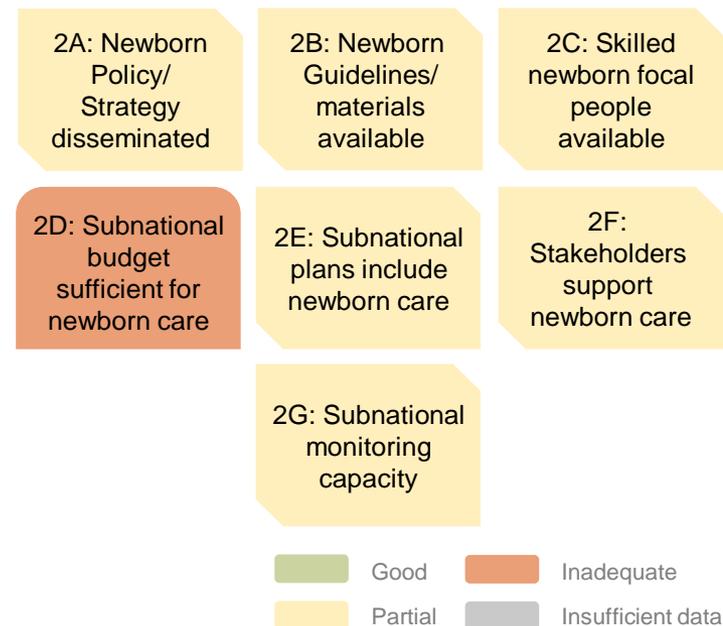
## Summary of Findings

# Management capacity at subnational level

*At the subnational level of the health system, is there sufficient management capacity to implement the newborn health program?*

Decentralized management capacity assesses whether personnel is able to manage implementation of interventions for the newborn, and implement and follow the policies, strategies, and guidelines developed at the national level.

## Status of subnational management capacity



## Summary of Findings

### 2A: Policy or strategy disseminated to intermediate management

*National dissemination of the PNP/RH (2013) is completed and regional dissemination is ongoing.*

### 2B: Guidelines and materials available at subnational level

*All training done at the national level focuses on building regional capacity, and the regions in turn provide training and capacity building at the district level.*

*EONC guidelines are available at 60 percent of Ref HCs and 22 percent of Com HCs, but availability is only approximately 3 percent at rural maternity wards and private and faith-based structures (SSGI 2015).*

## Summary of Findings

### 2C: Skilled focal management people in place at subnational level

*Each region has a focal person for emergency obstetric and newborn care and a Child Survival Officer, and there is a doctor in charge of the health district's maternity. However, there is no one specifically dedicated to newborn care at the regional or district level.*

### 2D: Subnational budget has sufficient allocation for newborn services

*All operational plans are budgeted for and consolidated at national level in order to allocate resources. However, there is no specific allocation for expanding newborn interventions.*

## Summary of Findings

### 2E: Decentralized work plans include newborn services

*All activities to reduce maternal and neonatal mortality are integrated in decentralized and coordinated plans in districts and regions.*

### 2F: Stakeholders ready to support newborn services because they have been informed and sensitized

*Each year there are multiple campaigns and conferences organized to raise awareness about newborn health; for example there is a Safe Motherhood Day, the Every One Campaign, the International Day of the Midwife as well as professional associations' conferences (i.e., gynecology, pediatrics). Results from the KMC research in the Tinkaré health area were shared at the Dièma Health District (Kayes region) and at national level in 2014. The conceptual framework for referral/emergency transportation for newborns is not applied in the majority of health districts.*

## Summary of Findings

# 2G: Monitoring capacity and accountability exist at subnational level

*There is a person in charge of the information system in each health district and each region. Quarterly activity reports cover all interventions, and some districts organize monitoring activities, but available data of newborn health are limited.*

---

# 3. System structures

---



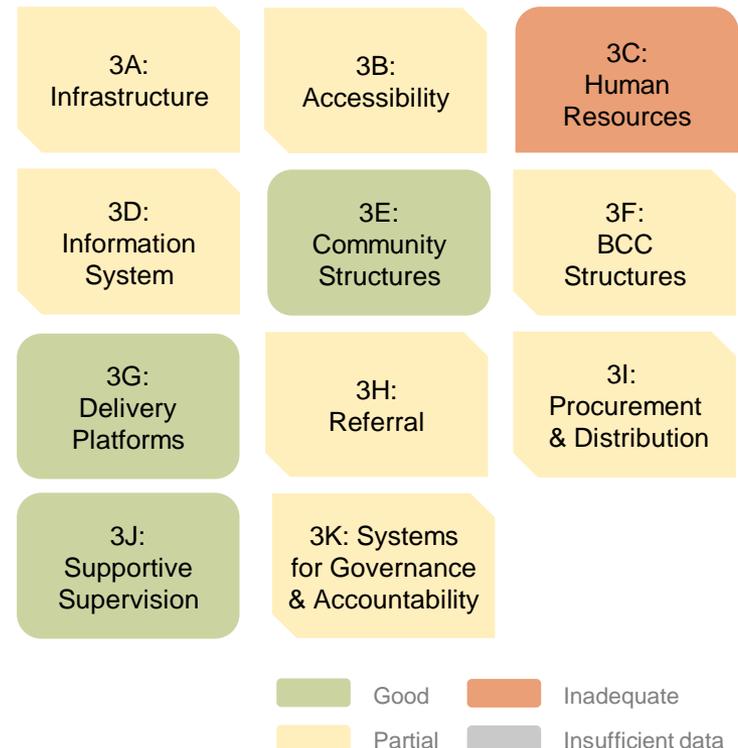
## Summary of Findings

# Health system infrastructure

*The platforms through which the intervention (service provision or demand generation) will be delivered are in place and sufficiently capacitated to deliver the intervention.*

Structures of the health system or implementing partners include important contextual elements that can have a direct effect on the strength of implementation. Many are not under the control of the program (e.g., geographic reach), while others may be more easily modified (e.g., linkages between health facilities and communities).

### Status of systems structures



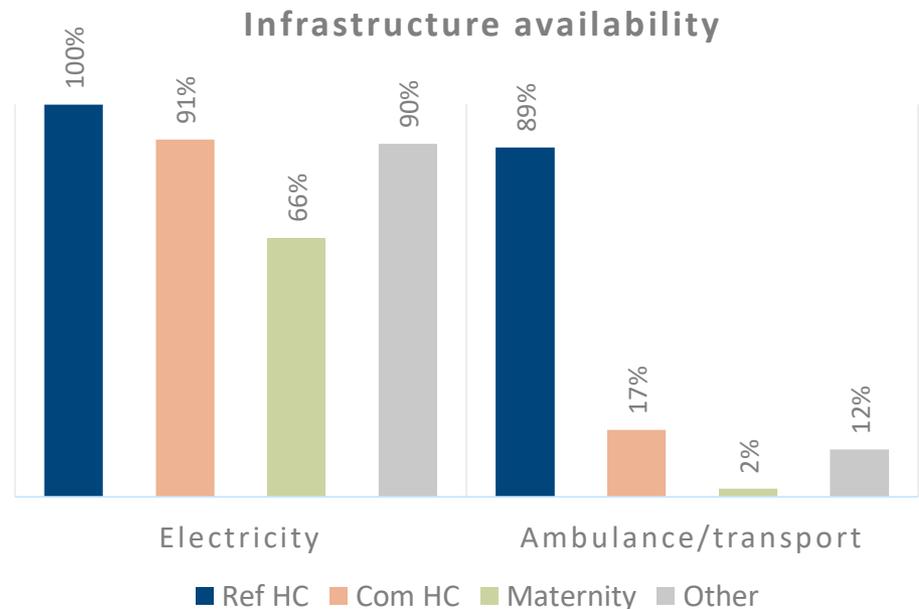
## Summary of Findings

### 3A: Physical infrastructures for service delivery exist

*The amount of health infrastructure in Mali has improved, but more progress is needed.*

Throughout the country, 99 percent of the targeted number of Community Health Centers (Com HC) exist, for a total of 1,241. There are also 63 Referral Health Centers (Ref HC), eight public hospitals at regional level, and five teaching hospitals in Bamako (SLIS 2015).

In 2016, there were 60 comprehensive emergency obstetric and newborn care (CEmONC) sites, and 183 basic emergency obstetric and newborn care (BEmONC) sites. This is in comparison to 61 CEmONC and 81 BEmONC sites in 2012.



*Available electricity during the whole service duration is of 69% (ref HC), 59% (Com HC), 37% (Maternity Clinics) and 75% in other health structures*

USAID/SSGI 2015. *L'étude de base du niveau de prestation des services de santé*. Projet USAID SSGI

## Summary of Findings

### 3B: The health system is accessible

***Geographic accessibility:** 58 percent of the population has access to the Minimum Package of Services (within 5 kilometers) and 87 percent live within 15 kilometers of a Com HC (SLIS 2015). Human resources are mostly concentrated in Bamako (SSGI 2015). **Financial accessibility** is facilitated by: free cesarean section, antiretroviral drugs, prevention and treatment of malaria in pregnant women, solidarity fund for referral/emergency transportation, health insurance, compulsory health insurance, and the medical assistance scheme.*

### 3C: Human resources/cadres exist for service delivery

*Human resources for health services, in terms of quantity, are insufficient and poorly distributed. There is a high turnover of qualified staff. However, the government is currently increasing the presence of medical personnel in the Com HC, and has achieved this at 33 percent of Com HC by 2015 (SLIS 2015). In terms of technical preparedness, basic pre-service training is offered to staff in institutes and schools on skills for delivery and emergency obstetric, neonatal care, and other specific newborn interventions (ENAP 2015).*

## Summary of Findings

### 3D: Information systems exist

*Mali has systems in place for managing information on service delivery: the national health information system [SNIS], the local health information system [SLIS], a system for logistics [SDADME], and another for human resources [SIGRH]).*

*Planning processes take place without the most current HIS information results, as nationally, the average rate for on-time submission in 2015 was only 26 percent. However, the country is transitioning to the DHIS2, which should improve timeliness. There are periodic surveys (DHS and MICS) which provide a platform to integrate additional information on neonatal health.*

### 3E: Community structures exist

*At community level, there are several structures that can be used to transmit behavior change messages for mothers and other newborn caretakers, including the community focal points (“relais communautaire”), community health workers (CHW), traditional birth attendants (TBA), breastfeeding and nutrition support groups, community action groups, groups of service users, and women’s groups.*

## Summary of Findings

### 3F: Behavior change communication structures exist

*Communication channels for messages exist: the National Health Information, Education and Communication Center (CNIECS), local radios, as well as local theater groups are used to pass on messages on maternal and neonatal health. The Reproductive Health Unit has a communication plan (2007-2011), but it does not specifically include activities related to newborn health.*

### 3G: Delivery platforms into which newborn services can be integrated are present

*Several platforms exist into which newborn care services can be integrated: prenatal visits where newborn care is already included (birth preparation, tetanus toxoid, advice on healthy habits) and postnatal visits (breastfeeding, danger signs, newborn examination, vaccinations, etc.). At the community level, essential community-based care is provided by community health workers, community volunteers, and there is an active outreach strategy for villages further than 5 kilometers from a health facility.*

## Summary of Findings

### 3H: Links exist between levels of the health system and community for referral and counter referral

*The referral and emergency transportation system for the management of obstetric and neonatal emergencies is organized in 100 percent of health districts (SLIS 2015) – starting at the village level up to the hospital, through Com HC and Ref HC. The village–Com HC link is the weakest because it depends on available resources at village level for transport. The conceptual framework for referral/emergency transportation covers the newborn, but it is not operational.*

### 3I: A system for procuring and distributing commodities exists

*Mali possesses an overall procurement and distribution system for essential medicines, which includes essential newborn medicines. While there is a birth kit for free cesarean sections, it does not include newborn medicines. A process evaluation of the Malian health logistics system is currently in progress.*

## Summary of Findings

### 3J: Supportive supervision system exists

*A support supervision system exists that can be implemented in an integrated manner – with guidelines for the health facility level and the essential community health level. However, supervision visits are not regular.*

### 3K: Systems for governance and accountability exist

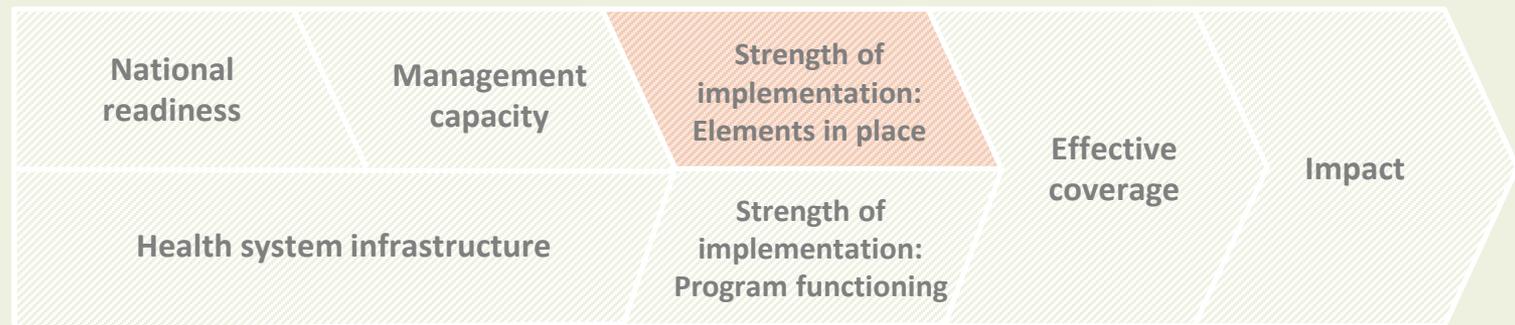
*The PDDSS (10-year health and social development plan) 2014-2023 describes governance structures for the delivery of decentralized services at the level of structures such as the ASACO (community health association) and others, in order to ensure adequate planning and local resources utilization for health. Data on the functioning of those structures are not available.*

*In order to improve commitment to the quality of care offered to the population, an accreditation system has been put in place and the Ministry has integrated the concept of results-based funding in the national strategy on quality, which is being elaborated to foster the effective implementation of quality improvement (QI).*

---

# 4. Program elements in place

---



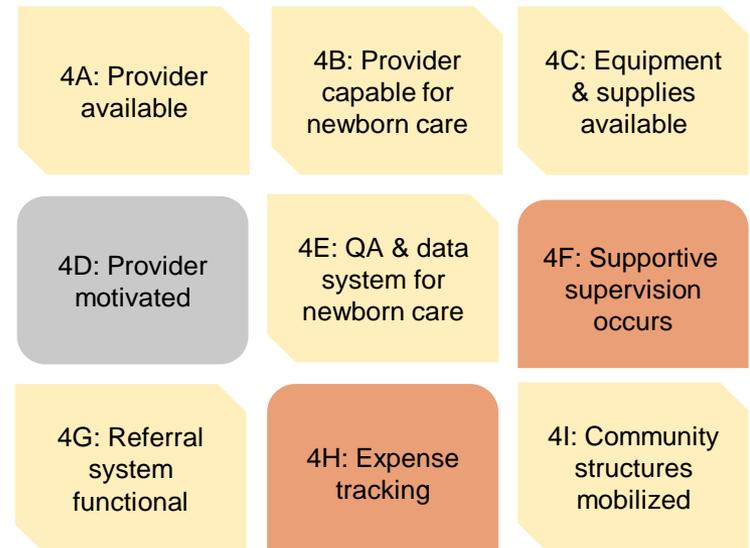
## Summary of Findings

# Program elements in place

*Are the elements in place to deliver newborn services?*

At the point of service delivery, resources are in place and adequate in terms of quality and quantity, and systems are functional.

### Status of program elements in place

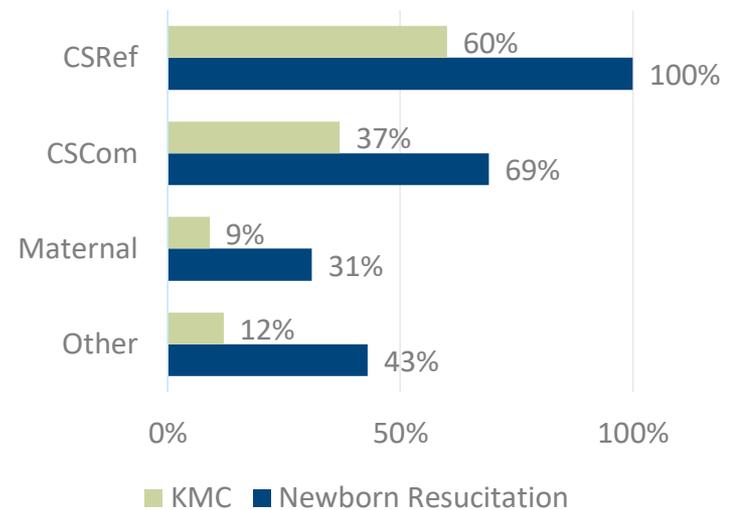


## Summary of Findings

# 4 Program elements in place

*The SSGI (2015) baseline study demonstrates that available services at Ref HC and Com HC include: prenatal visits, delivery, postnatal visit, newborn care (including the KCM offered in 60 percent of Ref HC). Moreover, ENC practices such as skin-to-skin contact, keeping the child warm, immediate breastfeeding, and the complete examination of the newborn are available in nearly all the Ref HC, Com HC, and maternity clinics, and at about 70 percent of private/faith-based structures.*

Practices reported by service providers



USAID/SSGI 2015. L'étude de base du niveau de prestation des services de santé.

## Summary of Findings

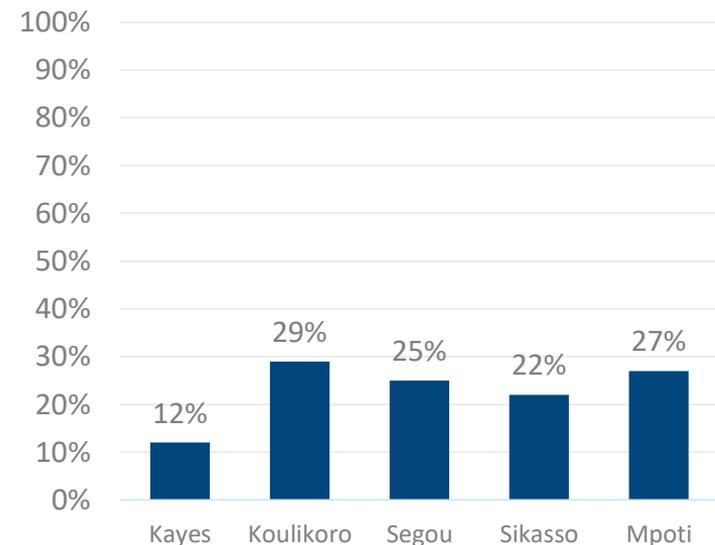
### 4A: Service provider is routinely available at service delivery point

*There are not enough service providers in all health structures.*

The baseline study of MNCH service delivery level (SSGI 2015) highlighted that each Ref HC has an average of 6.4 doctors, 9.3 midwives, 6.4 obstetric nurses, and 9.6 state nurses or medical assistants, with a high variation between health structures. There is on average only one gynecologist in each of these structures. Pediatrics specialists are even fewer; eight were identified in 2015 in the 35 surveyed Ref HC (1.7 per structure), as well as assistant nurses (1.4 per structure). At Com HC level, the most numerous service providers are midwives (1.7 per structure) and assistant nurses (1.4 per structure).

The 2015 SLIS shows a ratio of 4.3 health professionals (doctors, midwives, and nurses) for 10,000 inhabitants.

Percentage of the population covered by CHW

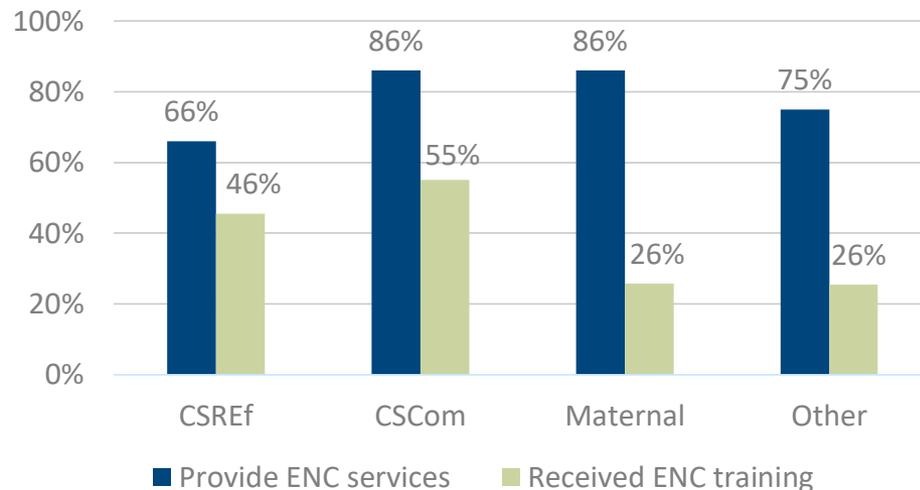


USAID/SSGI 2015. Présentation SEC

## Summary of Findings

# 4B: Service provider is capable (skills/knowledge)

Service providers that received continuous training or a refresher training



USAID/SSGI 2015. L'étude de base du niveau de prestation des services de santé.

*The ENC training is inadequate, and CHW knowledge is average.*

The baseline study on service delivery level (SSGI 2015) reveals that the training level of service providers varies between health structures, and there is no comprehensive and continuous evaluation of acquired knowledge. Fifty-seven (57) percent of CHW know at least three danger signs in the newborn and 2 percent at least seven signs, 82 percent have heard about KMC and 43 percent know at least two advantages of KMC, while only 15 percent can identify at least three advantages.

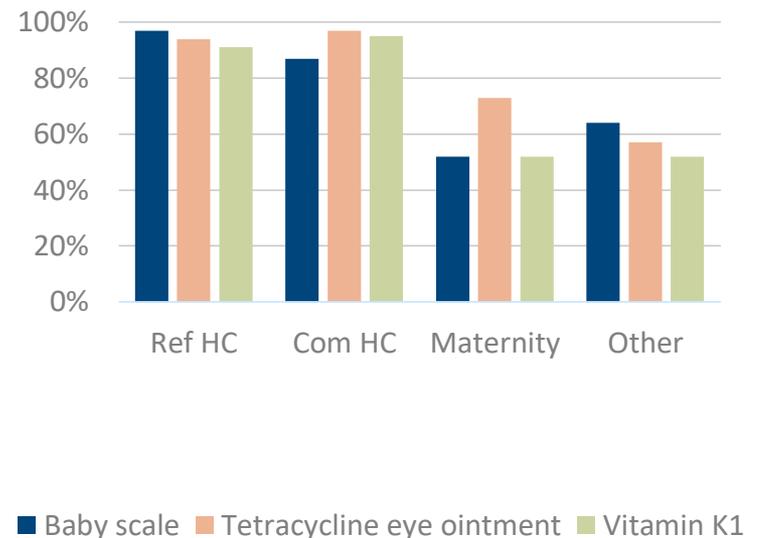
## Summary of Findings

# 4C: Service provider has equipment and supplies for newborn care

*Equipment and supplies for postnatal visit for the newborn are partly available, but insufficient.*

The baseline study on service delivery level (SSGI 2015) indicates that baby scales, tetracycline cream, and K1 vitamin are available at most health facilities. Data on resuscitation equipment are only available in the MCHIP project area in two districts (MCHIP 2014). In the 22 surveyed facilities, 77 percent of delivery rooms had an area for the newborn; 9 percent had a heating table; 54 percent had an electric or low pressure foot-operated secretion aspirator; 41 percent had secretion aspiration catheters (Ch. 8 – CH 10); 91 percent had self inflating bag and masks (20/22 ); 100 percent had facial masks (size 1 for normal sized newborns and size 0 for low birth weight babies); 72 percent had a resuscitation table; and 77 percent had an HBB mannequin.

Availability at the point of service delivery



USAID/SSGI 2015. L'étude de base du niveau de prestation des services de santé.

## Summary of Findings

### 4D: Service provider is motivated

**Quality of care at the level of our facilities (Com HC and Ref HC) has improved greatly: there is competition for quality and pride in the results. They are not comfortable when something is missing.**

**-- Implementation partner**

*There are no data specifically measuring service provider motivation for newborn care. However, according to the interviews, service providers who work in the areas where quality improvement is implemented are motivated to achieve results.*

## Summary of Findings

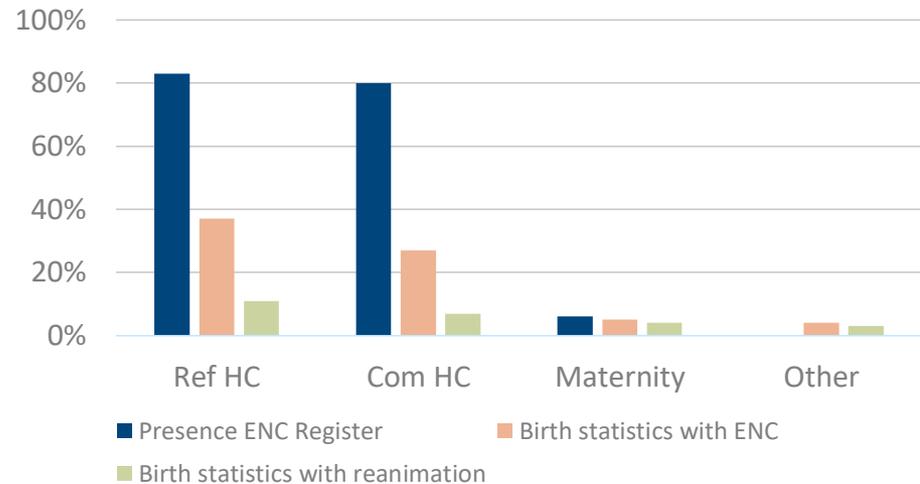
# 4E: Functional QI/QA systems with regular review and use of data

*QI is in place in limited areas, but most of the health facilities do not have statistics on ENC.*

### Quality Improvement:

In the Kayes and Sikasso regions, the USAID/Applying Science to Strengthen and Improve Systems (ASSIST) project has supported the creation of 338 quality improvement teams (QIT) in health structures, and coaching by coaches from the health district. This coaching serves to motivate the QIT and helps them solve challenges related to the adherence to HBB and active management of the third stage of labor (AMTSL)/ENC guidelines.

Proportion of health facilities with information available



USAID/SSGI 2015. L'étude de base du niveau de prestation des services de santé.

### Section 03

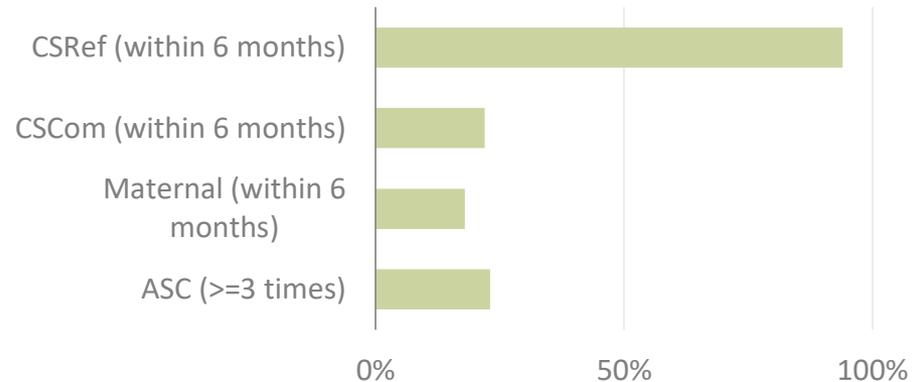
## Summary of Findings

# 4F: Supportive supervision occurring regularly

*Ref HCs are the most supervised, with gaps at other levels. Few service providers receive supervision on EONC or AMTSL/ENC.*

*The most recent MCHIP survey (2014) demonstrated that among surveyed providers, only 8 percent received supervision on EONC and 4 percent on AMTSL/ENC.*

Supervision received by the line supervisor



USAID/SSGI 2015. Baseline study of service provision level at health facilities

## Summary of Findings

# 4G: Referral system functional

**Mali has an obstetric and neonatal referral system that covers transport costs between the different levels of the health system. However, it is seldom used for newborns.**

*According to the statistical yearbook of 2015, 100 percent of health districts in the country have a referral/emergency transportation system in place.*

*According to the SSGI survey (2015), only 36 percent of CHW have a referral/emergency transportation system (for mother or child), and transport for the village to the Com HC is by motorbike in 90 percent of cases. While the system is designed to include the newborn, implementation is ineffective.*

## Summary of Findings

### 4H: Expense tracking used

*Community Health Associations (ASACO) are responsible for the management of resources generated by community funding. According to the 2014-2023 PDDSS, there are “difficulties to maximize benefits from the decentralization spinoffs... misunderstandings on respective roles of actors and ASACOs with low management capacity.”*

### 4I: Community structures mobilized to increase demand for high-quality services

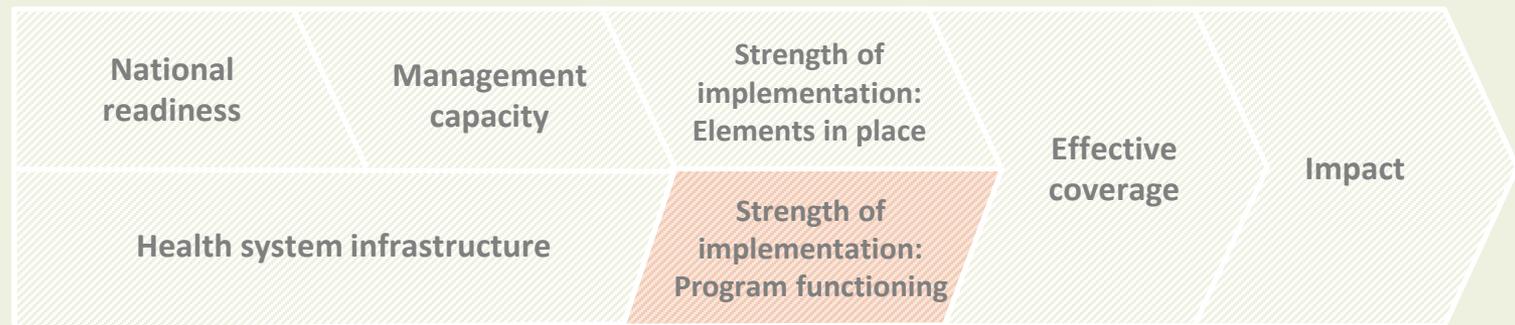
*Data on mobilization of community structures in the country are not available in general, although there are examples of success (see box on the right).*

**The USAID/ASSIST project, working in the pilot district of Bougouni, targeted and mobilized decision makers at the community level, such as grandmothers and mothers-in-law, for the follow-up of women during pregnancy and delivery. These activities have succeeded in improving the number of pregnant women identified that have undertaken early antenatal care (ANC) (from 35 in March 2015 to 229 in March 2016).**

---

# 5. Program functioning

---



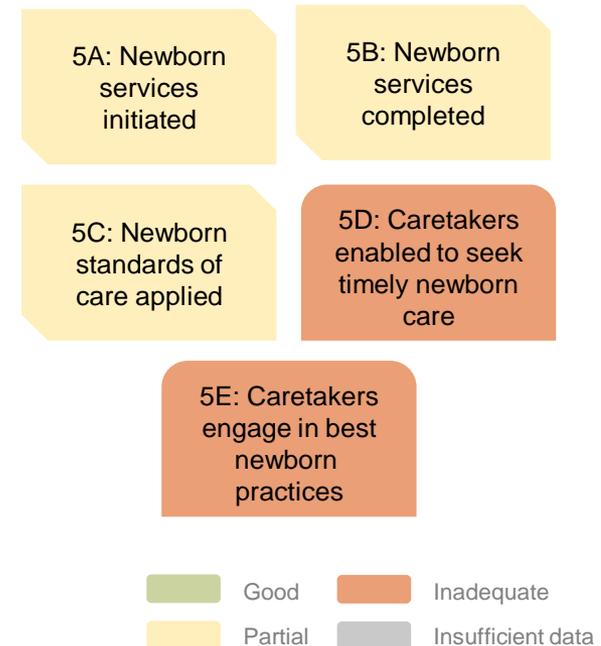
## Summary of Findings

# Program functioning

*Are services or messages being provided with adequate quality and do they reach those who need them, resulting in a decline in mortality in the target population?*

Demand and community mobilization efforts are particularly relevant to newborn programs, which require decision making around care-seeking and use of newborn care practices by families.

### Status of program functioning



## Summary of Findings

### 5A: Services initiated

*ANC and postnatal care (PNC) are platforms to offer advice and care for the newborn. Data from the Statistical Yearbook 2015 show a 75 percent utilization rate of ANC, with ANC3 at 39 percent, coverage of assisted delivery at 57 percent, a 38 percent PNC rate, 518,025 live births, 10,695 stillbirths, and 1,521 death before 7 days. In the most recent MCHIP survey (2014) in two districts, 49 percent of mothers seen in PNC benefitted from advice on exclusive maternal breastfeeding and 41 percent on early breastfeeding. The KJK survey (2015) reveals that 58 percent of newborns benefitted from PNC in Mali.*

### 5B: Services completed

*Regarding ANC, the Statistical Yearbook 2015 shows a 33 percent rate of effective ANC (defined as three ANC visits, two VAT, and two SP). The baseline survey on attitudes and practices of Kénèja jemu Kan (KJK) (2015) noted that about 85 percent of women received at least one dose of SP, only 28 percent received the three recommended doses, and 51 percent of women received four ANC visits. Now, the number of recommended SP doses can exceed three, as it can be given monthly starting in the second trimester.*

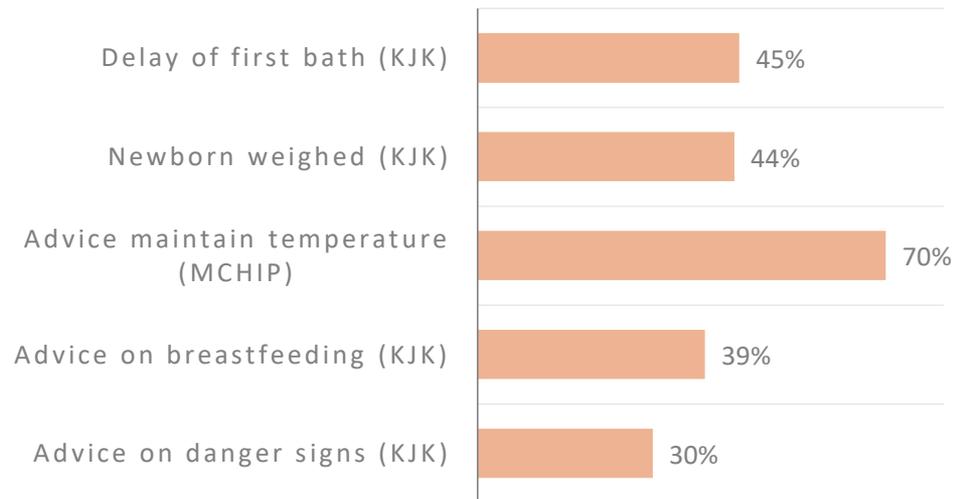
## Summary of Findings

# 5C: Newborn standards of care applied

**Advice regarding important parts of essential newborn care are not always given to mothers and the delay of the first bath remains an issue.**

The baseline study of KJK (2015) shows that delaying the first bath for at least 6 hours after birth is only done for 57 percent of newborns from mothers giving birth in a health facility. For babies born at home, the rate is 22 percent.

### Care provided according to the guidelines



Gueye M et al 2015. Étude de base sur les facteurs d'idéation et les comportements (USAID/KJK; MCHIP 2014. Enquête d'évaluation.

### Section 03

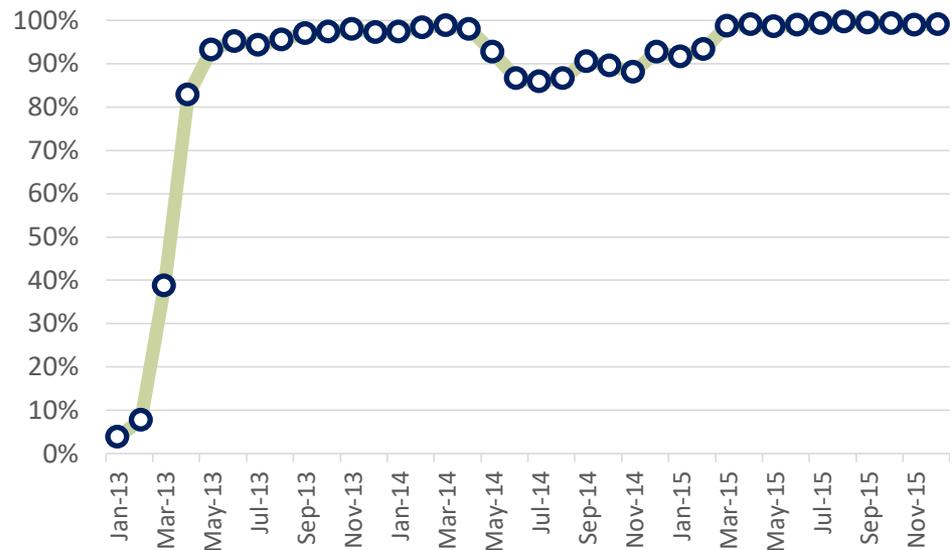
## Summary of Findings

# 5C: Newborn standards of care applied

*Quality of care data are limited to implementation areas of the ASSIST Project. The QI strategy seems to have a positive impact on quality of care provided and adherence to guidelines.*

In the Kayes region (extended to Sikasso), the ASSIST project and the district leaders have put in place a QI system in combination with the introduction of EONC and adherence to guidelines, with results showing clear progress.

Rate of adherence to guidelines of Essential Newborn Care at birth in 111 extension sites in four districts of the Kayes region



Data from the USAID/ASSIST project (2016) – denominator equals the number of guidelines to be followed

### Section 03

## Summary of Findings

# 5A: Newborn standards of care applied – specific interventions

*Available data on quality improvement are limited to intervention areas of the ASSIST and MCHIP projects.*

***HBB for neonatal resuscitation – it is possible to change services providers' practices to follow guidelines***

The USAID/ASSIST project measured guidelines adherence rate for resuscitation following the HBB approach in 179 health facilities (eight districts in Kayes) and in 56 health facilities in five districts in Sikasso in 2015. They found that in Kayes, service providers adhered to 98 percent of guidelines and in Sikasso to 90 percent of guidelines. In the MCHIP project areas, the final evaluation found that 88 percent of service providers interviewed say they use a self-inflating bag to help newborns cry or breathe, and 73 percent say they use an aspirator.

***Kangaroo mother care for low birth weight***

No specific information **was** available on adherence to kangaroo mother care guidelines.

***Neonatal septicemia treatment***

No specific information **was** available on adherence to neonatal septicemia treatment guidelines.

***Chlorhexidine to prevent septicemia is yet to be implemented. Current practices prove challenging.***

The study on perceptions of umbilical chord care (MCSP 2015) in two health districts indicates that providers give little information on umbilical chord care. The baseline study of KJK (2015) demonstrates that the examination of the umbilical chord during PNC visits is not systematic: 3 percent overall, 43 percent in urban areas, and 30 percent in rural areas.

### Section 03

## Summary of Findings

# 5D: Parents or caregivers enabled to seek timely care

**Community mechanisms for newborn care are only focused on accessing traditional medicine. That is because mothers-in-law find modern medicine too limited for newborn issues compared to traditional medicines.**

-- Qualitative Research (KJK 2016)

*Sociocultural factors (community perceptions toward the newborn, customs that include staying inside for some time even if the baby is ill, and nutritional practices) influence care-seeking behaviors.*

*The KJK baseline study on attitudes and practices (2015) found that 48 percent of mothers could identify at least two danger signs in the newborn, but only 15 percent could mention at least three signs. The most recent MCHIP survey (2014) indicates that 48 percent of mothers recognize a high fever as a sign that the child needs care. However, mothers do not always have the decision power in seeking care in health facilities, which can delay access to health care.*

### Section 03

## Summary of Findings

# 5E: Parents or caregivers enabled to engage in best practices for newborns

**Husbands and grandmothers play an important role in relation to mothers and the practices they undertake on their newborn.**

*The weight of traditions and customs often prevent the implementation of good practices.*

Good newborn health requires good practices at home, such as immediate breastfeeding, the use of colostrum, the care of the umbilical chord, and the delay of the first bath. Mothers', grandmothers', and other family members' knowledge is not always up-to-date, and mothers receive lots of harmful advice for newborn health. The study on perceptions of umbilical chord care showed that most mothers were advised by grandmothers (Musokoroba), TBA, and health workers to use cocoa butter. The study also showed that Chlorhexidine would be accepted by the population and could replace other substances currently used on the umbilical chord.

---

# 6. Effective coverage and impact

---



## Summary of Findings

# Effective coverage and impact

*Are newborns receiving high-quality services and care from health providers and caretakers, and are newborn survival rates improving as a result?*

The services or messages are being provided with adequate quality and are reaching those who need them.

As a result of the delivery of intervention(s) and/or changes in behaviors and care seeking, mortality in the target population is decreasing.

### Status of effective coverage and impact

6A: Effective coverage of newborn services

6B: Effective coverage of caretaker practices

6C: Neonatal mortality & stillbirth rates

Good Inadequate  
Partial Insufficient data

## Summary of Findings

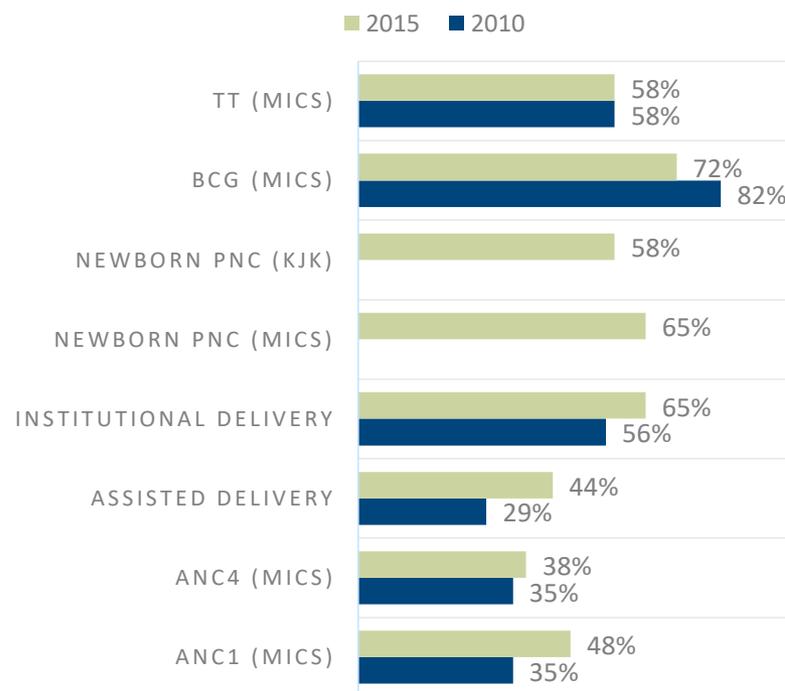
# 6A: High-impact, high-quality services received

*Data on effective coverage do not exist because data on service quality are limited. There is evidence of a slight improvement of ANC coverage, although rates remain low.*

There are no comparative data available for the PNC/newborn (2010/2015), but the rates correspond to the institutional delivery level.

Although the PNC/newborn rate is approximately 60 percent nationally, the KJK survey (2015) found important differences according to delivery location. The PNC rate is 81 percent for those born at a Ref HC and 60 percent for those born at a Com HC or maternity; however, it is only 23 percent for babies born at home. Additionally, for those born at home, the PNC visits are generally not carried out in the first 24 hours.

### COVERAGE

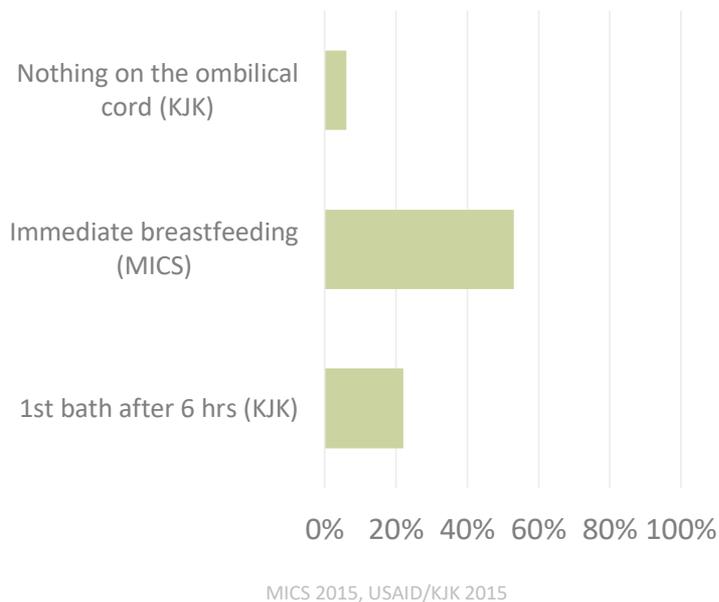


INFO-STAT MICS 2010, INS MICS 2015, USAID/KJK 2015 Étude de base sur les facteurs et comportements;.

## Summary of Findings

# 6B: High-impact, high-quality practices are implemented by family caretakers

Actions of mothers toward their newborn



*Mothers' and caregiver practices still have to improve.*

Generally the delay of the first bath is still an issue, for institutional deliveries as well as at home (KJK 2015). The results of the MCHIP project in a limited area show that progress is possible; delay of first bath increased from 52 percent (2011) to 61 percent (2014). However, the situation in terms of immediate breastfeeding in those areas remains nearly at a standstill.

Like the baseline rate for Chlorhexidine intervention, practices linked to the umbilical chord still have to improve: mothers and caregivers have applied cocoa butter in 80 percent of cases, including 50 percent of those having given birth in a Ref HC or a regional hospital.

### Section 03

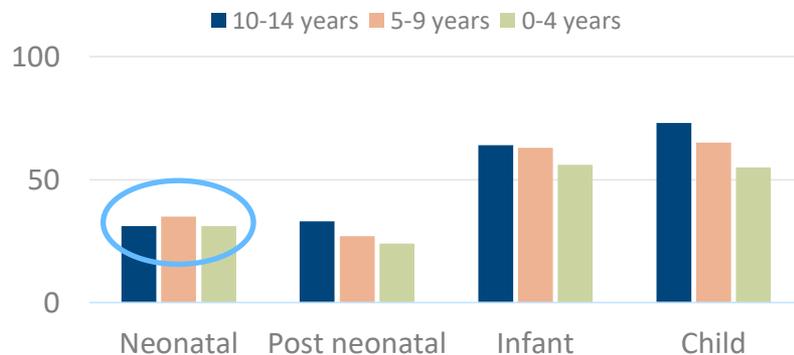
## Summary of Findings

# 6C: Improved survival of newborns and incidence of stillbirths

*Neonatal mortality rate (NMR) has not had the same improvements as post-neonatal, infant, or child mortality rates, and remains an important factor in child mortality.*

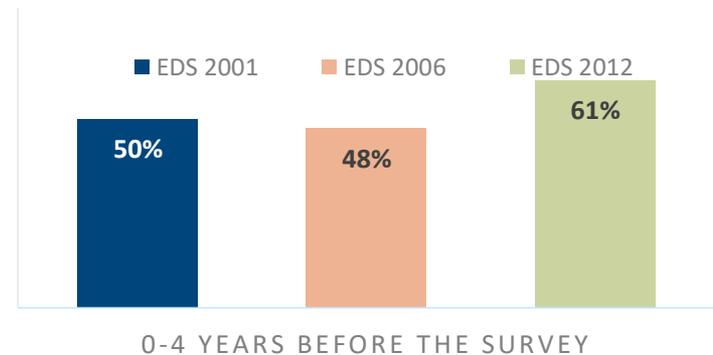
Data on stillborn and death before the 7<sup>th</sup> day exist in the Statistical Yearbooks without showing a clear trend.

### Evolution of neonatal mortality rate



Institut National de la Statistique. 2016. *Enquête par Grappes à Indicateurs Multiples au Mali (MICS-Mali), 2015, Résultats clés*. Bamako, Mali, INSTAT.

### NMR as portion of IMR



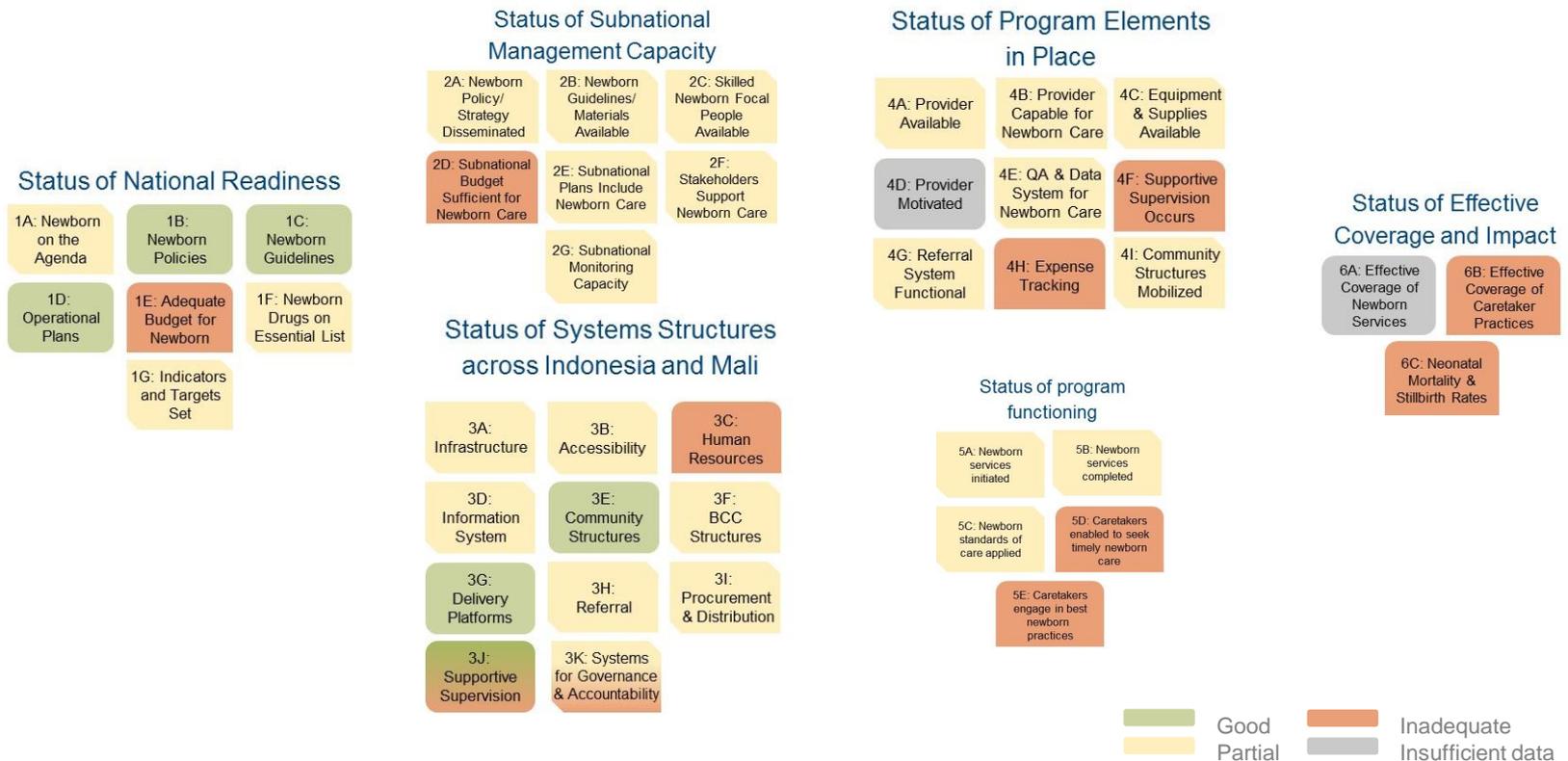
Institut National de la Statistique, INFO-STAT et ICF. 2014. *Enquête Démographique et de Santé au Mali 201-2013*.

## Section 03

## Summary of Findings

# Pathway to effective coverage

*Despite some elements being in place (in green), many elements must be strengthened if Mali is to reach effective coverage at scale.*

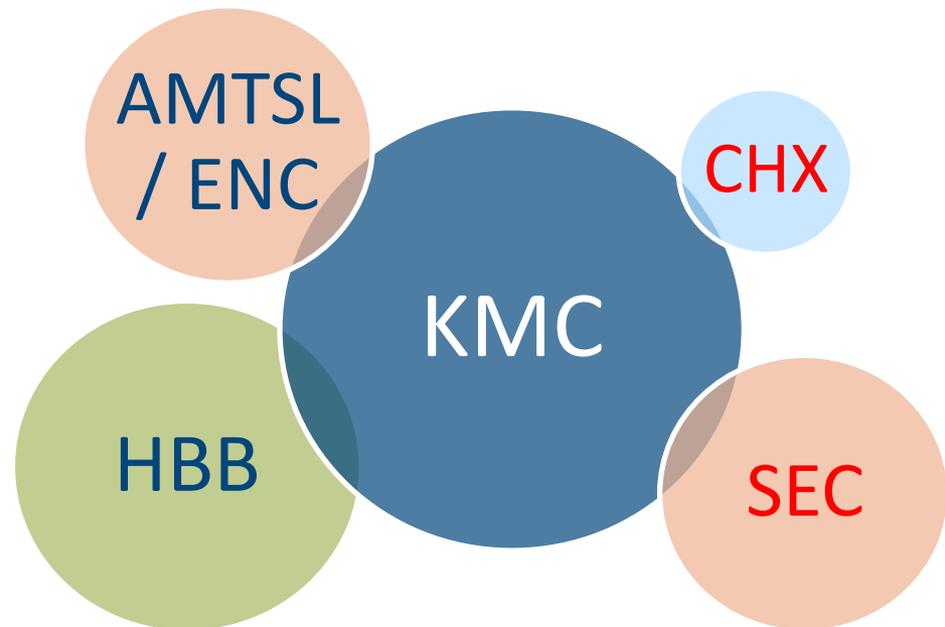


## Summary of Findings

# Interventions that progressed the most according to key actors

*Stakeholders reported newborn interventions that progressed the most.*

The size of the circles shows at what frequency each intervention was mentioned, KMC was reported most frequently.



# Factors Explaining Progress

Section 04

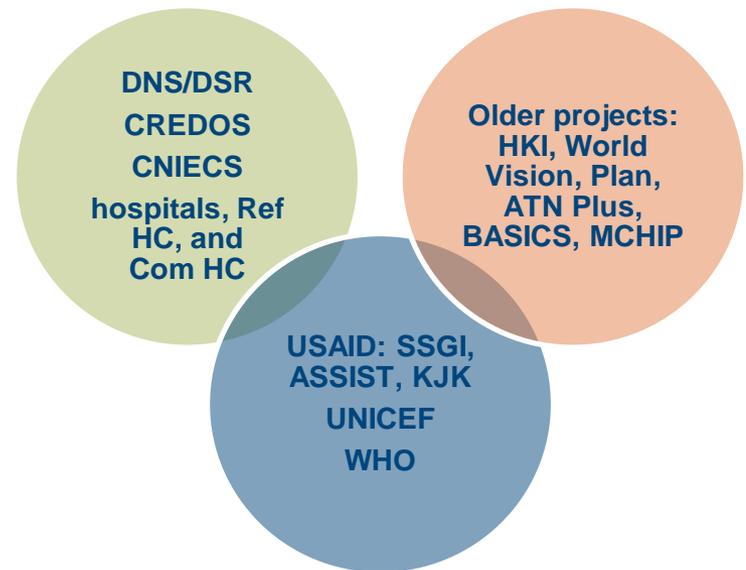
## Factors Explaining Progress

# Actors' contributions to current progress in newborn health

*Activities and support from the SNL facilitated the development of policies and programs for the newborn. Partners supported financially and technically the implementation of newborn interventions.*

### SNL 2001-2012:

- Sensitization of all stakeholders (national, regional, and local)
- Sourcing of financial and material resources for effective interventions
- Supervision actions to follow progress
- Capacity building of service providers at different levels



## Factors Explaining Progress

# SNL 2001-2012 contributions

*SNL's technical, financial and advocacy support helped Mali improve effective care for the newborn. Selected highlights from the program include:*

- Analysis and dissemination of newborn health situation in Mali
- Implementation of a pilot project in 2002 in Bougouni with activities at community level
- Development and validation of the “Essential Newborn Care” package
- ENOC integration in the PNP in RH
- Research and evidence on newborn care
- Capacity building of health workers on newborn care
- Scaling up learning from the Bougouni pilot project
- Development of a KMC approach for Mali
- Creation of the KMC Unit in Bougouni and of pediatrics in the University Hospital Gabriel Touré

## Factors Explaining Progress

# Factors facilitating and impeding progress



*Transnational Influence:* International agencies' efforts to establish a global norm for the unacceptability of newborn death and the offer of financial and technical resources to address newborn mortality



*Domestic Advocacy:* Political community cohesion among key stakeholders, presence of champions, credible evidence to demonstrate the problem, focusing events, and clear policy alternatives to reduce newborn mortality



*National Political Environment:* Political transitions and changes, and competing health priorities

## Factors Explaining Progress

# Transnational influence

### “ Global actions: MDGs, Call to Action, ENAP

MDGs mobilized political energies – the program was welcome at the time, it was well aligned with the PRODESS [Health and Social Development Plan] in order to reach the MDGs. – *Technical Partner*

With “Acting on the Call,” Mali saw itself as less performing: using the LiST and then the SCORECARD, we engaged with the MPH [Ministry of Public Health] and prioritized high-impact interventions. – *Financial Partner*

### “ WHO guidelines dissemination

When WHO introduced Chlorhexidine, we had meetings and people asked questions. When we did the study on current practices... it facilitated the review of Chlorhexidine in Mali’s PNP (Policies, Norms and Procedures). – *Technical Partner*

### “ International resources provision

Also a priority for partners supporting the government was to implement neonatal care services. – *MPH*

**The role of actors at international level is key to understanding the inclusion of the newborn in national policies and actions:**

- **The motivation to improve results**
- **Access to guidelines and evidence on priority interventions**
- **Resources for implementation**

## Factors Explaining Progress

# Domestic advocacy

### “ Evidence of the scale of the issue

The results of the 2012-2013 EDSM were a shock – the evaluation of infant death, the majority of which were newborn. – *Technical Partner*

### “ There are effective actions to be taken

It is the partners that have the know-how and know about the new recommendations – we gather documentation, organize a meeting with the ministry, and we discuss the next steps – studies, pilot projects, or adaptations. – *Technical Partner*

### “ The champions movement

The veterans of the [SNL] that remained in the system at the end of the project continue to promote neonatal health. – *Financial Partner*

The champions leaving – some have left their position or even the country – we lack the energy to push on. – *Technical Partner*

During the year 2000, there was a confluence of:

- Information on the importance and extent of the newborn issue
- A catalyst project that could bring evidence on effective strategies to solve the newborns situation – WHO guidelines, implementation strategies, research
- Champions within the project, the Ministry, research institutions, higher education institutions, and at service providers level

## Factors Explaining Progress

# National political environment

“ *A lack of prioritization of the newborn*

A clear vision of what is to be achieved is needed in order to capitalize on funding and mobilize more to reach our goal.

A clear definition of priorities is needed – every time there is a new intervention, we tend to neglect others that were initiated previously.

”

“ *A lack of leadership within the Ministry to boost the newborn care agenda*

We lack a counterpart... who has the leadership, vision and can direct us...

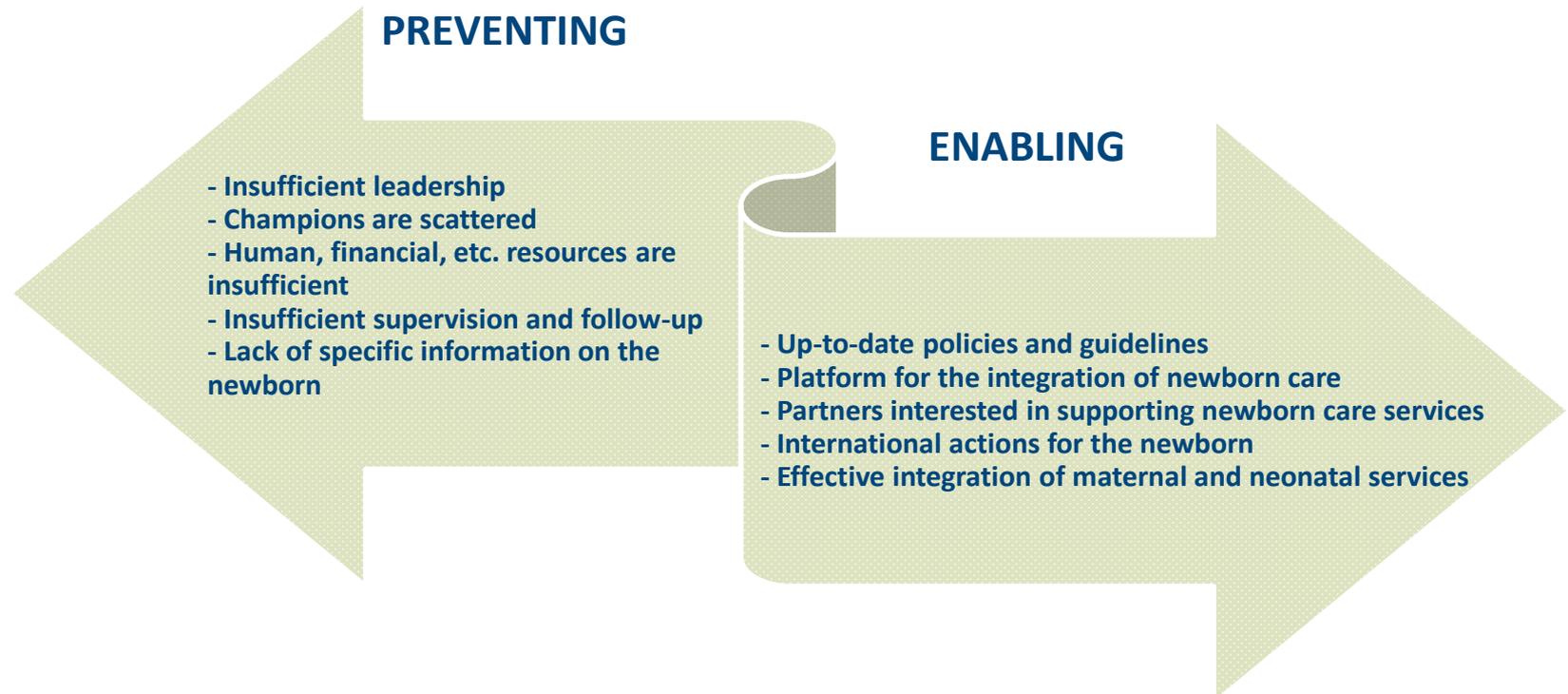
”

**Some people interviewed noted institutional weaknesses that bought a lack of prioritization and, as a consequence, of a continuous vision**

## Factors Explaining Progress

# Summary of current factors that enable or prevent progress

*These results came out of interviews and discussions during the stakeholder feedback workshop*



### Section 04

# Looking Forward

**Section 05**

## Looking Forward

# What remains to be done at national level in order to progress further?

*These results came out of interviews and discussions during the feedback workshop on results.*

### **Sensitization and policies**

- Creation of a thematic subgroup on the newborn
- Strengthening of achievements through newborn advocacy
- Development of a national decentralized strategic communication plan for the newborn
- Revision of plans and programs on mother and child health (MCH) to improve visibility of the newborn
- Scale-up of KMC at all levels of the health pyramid.

### **Strengthening of the structures**

- Design and implementation of a specific newborn program within the DNS (Finances and Procurement Directorate)
- Strengthening of the authority of the DNS to increase visibility of actions for the newborn
- Creating neonatology units in all regions
- Strengthening the referral/emergency transportation system with cost sharing for effective attention on the newborn
- Strengthening collaboration between public research institutions and newborn care services to improve evidence utilization.

### **Strengthening of human resources**

- Recruitment and equal distribution of staff that are qualified to attend neonatal health issues
- Strengthening of skills of nurses and midwives in neonatology
- Taking the newborn into account within the curriculum of health training schools
- Implementation of an orientation mechanism, and continuous training of managers and health workers in neonatology
- Implementation of monitoring processes to track and encourage effective support supervision.

## Looking Forward

# What remains to be done at global level in order to progress further?

*These results came out of interviews and discussions during the feedback workshop on results.*

### ***Ensuring exchange mechanisms***

- Creating a conference or a forum to share good practices and experiences on neonatology
- Supporting countries to design a plan for the newborn with interventions that have an impact on neonatal mortality (following countries' requests)
- Setting up a network with two focal points in each country that can share experiences on the newborn.

### ***Creating accountability***

- Setting up indicators and independent mechanisms to measure progress on newborn health in all countries, and publishing them.

### ***Financial support***

- Mobilizing the necessary financial resources with relevant key indicators to measure progress
- Financial and technical partners' support of all good practices regarding neonatal health, especially in countries where the neonatal death rate is high.

## Looking Forward

# Conclusions on the progress of newborn health in Mali

### *Progress*

Mali made important progress between 2000 and 2012 in relation to national preparation to scale-up, which has been consolidated between 2012 and 2016. Many interventions have taken place with the support of partners. However, these are not yet scaled up.

### *Key Actors*

SNL played a key role in building the momentum, in line with international and bilateral organizations' efforts (WHO, UNICEF, USAID etc.). It provided an orientation framework and key information that motivated decision makers to take action for the newborn. However, ownership of newborn issues has lost some momentum despite its integration into policies and programs.

### *Looking Forward*

More emphasis needs to be put on interventions for the newborn, and on strengthening the health system and decentralized management.

# Annexes

## **Section 06**

- A. Acronyms
- B. People Interviewed and workshop participants
- C. Milestones for scale-up preparation
- D. References
- E. Interview guide

## Annex A

# Acronyms

**ACSD** : Accelerated child survival and development

**AMO**: Assurance maladie obligatoire (compulsory health insurance)

**AMTSL**: Active management of the third stage of labor

**ANC**: Antenatal care

**ASACO**: Association de santé communautaire (community health association)

**ASSIST**: Applying Science to Strengthen and Improve Systems

**BEmONC**: Basic emergency obstetric and newborn care

**CEmONC** : Comprehensive emergency obstetric and newborn care

**CHU**: Centre hospitalier universitaire (Teaching Hospital)

**CHW**: Community health worker

**CNIECS**: Centre national d'information, d'éducation et de communication en santé (National center for health information, education, and communication)

**CREDOS**: Centre de recherche et de documentation pour la survie (Research and documentation center for survival)

**Com HC**: Community health center

**DNS**: Direction nationale de la santé (National Health Directorate)

**DSR**: Division santé de la reproduction (Reproductive Health Unit)

**EDSM**: Enquête démographique et de santé du Mali (Mali Demographic Health Survey)

**ENC**: Essential newborn care

**ENAP**: Every Newborn Action Plan

**EONC**: Emergency obstetric and newborn care

**EPH**: Etablissement Public Hospitalier (Public Hospital)

**HBB**: Helping Babies Breathe

**IMCI**: Integrated management of child illness

**IMR**: Infant mortality rate

**INFSS**: Institut National de Formation en Sciences de la Santé (National Health Sciences Training Institute)

**KJK**: Kénèya jemu Kan

**KMC**: Kangaroo Mother Care

**MCH**: Mother and child health

**MCHIP**: Maternal and Child Health Integrated Program

## Annex A

# Acronyms

**MICS:** Multiple indicator cluster survey

**MPH:** Ministry of Public Health

**NMR :** Neonatal mortality rate

**PDDSS:** Plan décennal de développement sanitaire et social (10-year health and social development plan)

**PNC:** Postnatal Care

**PNP:** Policies, Norms, and Processes

**PRODESS:** Programme de développement sanitaire et social (Health and Social Development Plan)

**QI:** Quality improvement

**QIT:** Quality improvement team

**RAMED:** Régime d'assistance médicale (medical assistance scheme)

**Ref HC:** Referral health center

**RH:** Reproductive health

**SDADME:** Schéma directeur d'approvisionnement et de distribution en médicaments essentiels (Master plan for Procurement and Distribution of essential medicines)

**SEC:** Soins essentiels dans la communauté (Essential Community-based Care)

**SLIS:** Système local d'information sanitaire (Local health information system)

**SNL:** Saving Newborn Lives

**SSGI:** Services de santé à grand Impact (High-impact health services)

**TBA:** Traditional birth attendant

**UNICEF:** United Nations Children's Fund

**USAID:** United States Agency for International Development

**WHO:** World Health Organization

## Annex B

# People Interviewed

Person	Current Organization	Link to SNL
Ami BA	DSR/DNS	
Dr. Mariama BAH	Bureau Santé, USAID	
Dr. Marguerite DEMBELE	Division de la Santé de la Reproduction, DNS	
Dr. Nialen DIABY	USAID/ASSIST	SNL1
Fatoumata DIAKITE	USAID/ASSIST	
Haoua DIALLO	Retraîtée	DSR/DNS au temps de SNL
Dr. Houleyemata DIARRA	USAID/ASSIST	SNL1 et 2
Dr. Modibo KANTE	USAID/SSGI	SNL 2, MCHIP
Dr. Assa KEITA	CREDOS	
Awa KEITA	CREDOS	
Dr. Sylvain KEITA	USAID/ASSIST	MCHIP (Kayes)
Dr. Sidiki KOKAINA	Cellule de Planification et Statistique	À la DRS de Sikasso avec SNL (Bougouni)

## Annex B

# People Interviewed

Person	Current Organization	Link to SNL
Bijou MUHURA	Bureau Santé, USAID	
Dr. Daniel NACOULMA	Section Santé, UNICEF	
Dr. Drissa OUATTARA	USAID/SSGI	À Bougouni au temps de SNL, MCHIP
Prof. Amadou SANGHO	CREDOS	
Mariam SIDIBE	Section Santé, UNICEF	SNL 2002-2004, HKI 2004-2009
Prof. Toumani SIDIBE	Retraité	Pédiatre, DNS, recherche avec SNL
Dr. Fatoumata TESSOUGUE	Organisation Mondiale de la Santé	

## Annex B

# Participants of the Feedback Workshop on August 30, 2016

**Coumba BA:** INFSS

**Dr. Dougoufana BAGAYOKO:** UNICEF

**Dr. Mariama BAH:** USAID

**Mamadou CAMARA:** DHPS/DNS

**Dr. Haoua DEMBELE:** CREDOS

**Dr. Marguerite DEMBELE:** DSR/DNS

**Awa GUINDO:** DNS/Unité

**Dr. Oumar GUINDO:** DNAS/DNS

**Oumar GUINDO:** DNS/SIS

**Seydou KOUYATE:** SI/DNS (PEV)

**Dr. Drissa OUATTARA:** USAID/SSGI

**Dr. Fatoumata OUOLEGUEM:** DNS/Nutrition

**Dr. Fatoumata TESSOUGUE:** OMS

**Dr. Aminata TRAORE:** DSR/DNS

**Dr. Fatoumata TRAORE:** USAID/SSGI

**Dr. Aoua TROARE:** USAID/KJK

**Sirantou WAGUE:** DSR/DNS

**Dr. Abdrahamane ZERBO:** DNS (Santé communautaire)

## Annex D

# Scale-up readiness benchmarks

Generating Evidence Base	
1	National level NB health needs assessment/Situational Analysis conducted
2	NB health services/packages tested and documented in local settings
Process of Consensus Building	
3	Evidence of NB health interventions/packages disseminated at provincial/district and national levels
4	Technical working/advocacy group established and advocating for NB health OR existing working/advocacy groups integrated newborn health into terms of reference
Going to Scale	
Policy	
5	National NB policy/strategy strengthened and adopted by MOH
5a	a. National NB policy/strategy includes early postnatal checkups at home
5b	b. National NB policy/strategy includes essential newborn care
5c	c. National NB policy/strategy includes facility-based KMC
5d	d. National NB policy/strategy includes management of newborn sepsis at the primary health center level
5e	e. National NB policy/strategy includes resuscitation of newborns who have trouble breathing at birth in basic essential obstetric care (EOC) package
6	National NB policy/strategy integrated into existing programs
6a	a. National NB policy/strategy integrated in maternal health program and endorsed by MOH
6b	b. National NB policy/strategy integrated in reproductive health program and endorsed by MOH
6c	c. National NB policy/strategy integrated in child health program and endorsed by MOH
6d	d. National NB policy/strategy integrated in other health program(s) and endorsed by MOH
7	IMCI adapted to cover newborns 0-1 week of age

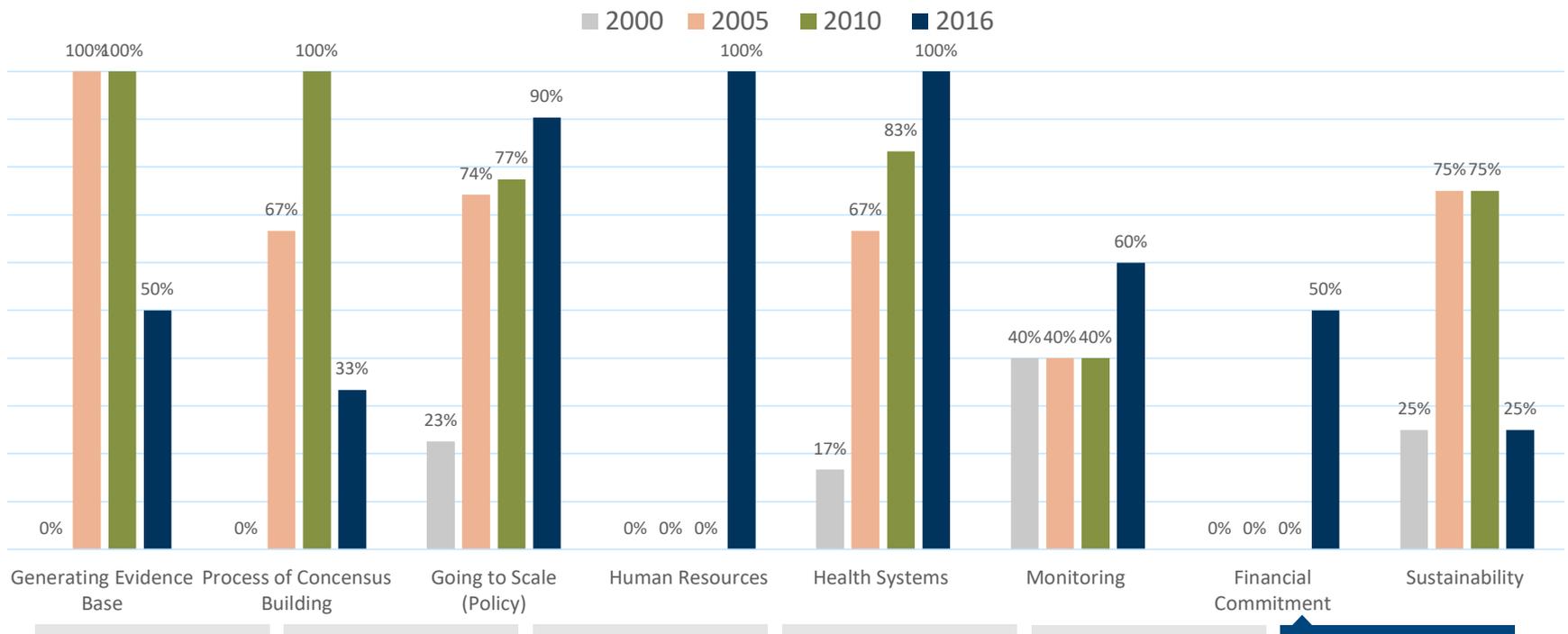
8	National policy/strategy includes community-based treatment guidelines for newborns with pneumonia/infection (with oral antibiotics) and endorsed by MOH
9	National essential drugs and supply list for newborn care developed and endorsed by MOH
9a	a. National essential drugs and supply list for newborn care includes gentimycin for treatment of NB sepsis at first level facilities
9b	b. National essential drugs and supply list for newborn care includes weighing scale (e.g. pan-style)
9c	c. National essential drugs and supply list for newborn care includes NB resuscitation equipment
9d	d. National essential drugs and supply list for newborn care includes thermometers for newborns (e.g. low grade or digital)
10	Implementation plan for maternal newborn and child health costed
11	National behavior change communication strategy for NB health established and endorsed by MOH
12	Maternal death audit/verbal autopsy policy established and endorsed by MOH
13	Neonatal death audit/verbal autopsy policy established and endorsed by MOH
14	National policy established to authorize midwives* to conduct newborn resuscitation and endorsed by MOH
15	Midwives authorized to administer core set of life-saving interventions
16a	Community-based cadre(s) authorized to provide injections for newborns
16b	Primary health center cadre(s) authorized to provide injectable antibiotics for newborns
17a	Community-based cadre(s) authorized to provide newborn resuscitation
17b	Primary health center cadre(s) authorized to provide newborn resuscitation
Human Resources	
18	Cadre(s) to deliver home-based NB care services identified and core competencies established
19a	In-service NB training curricula and materials developed for community-based cadres and integrated into existing curricula

19b	In-service NB training curricula and materials developed for facility-based cadres and integrated into existing curricula
20a	Pre-service NB education curricula and materials developed for community-based cadres and integrated into existing curricula
20b	Pre-service NB education curricula and materials developed for facility-based cadres and integrated into existing curricula
Health system	
21a	NB integrated into job descriptions for community-based cadres
21b	NB integrated into job descriptions for facility-based cadres
22	Supervision system for maternal/NB/child health established for relevant health cadres
23	Guidelines for referral of NB with complications established
24	Referral sites NB care strengthened
25	Perinatal death audits established and endorsed by MOH
Monitoring	
26	Key maternal and NB indicators included in national HMIS
27	Key maternal and NB indicators included in national surveys
28	National targets to track newborn health established
29	Specific notification of maternal deaths established and implemented
30	Specific notification of newborn deaths established and implemented
Financial Commitment	
31	Government expenditure on health as % of total government expenditure
32	Per capita Official Development Assistance (ODA) to maternal and neonatal health per live birth (US\$)
Sustainability	
33	Technical working/advocacy group meeting on regular basis
34	Functional national guiding institution for maternal/NB/child health established
35	Focal person for NB health established in MOH on NB health
36	Statements of public support (public and private) for NB health officially released
37	Resources leveraged for NB health

## Annex C

# Scale-up readiness benchmarks for Mali 2000-2016

The decrease between 2010 and 2016 is due to the adding of Chlorhexidine that still requires additional evidence, and the technical group for the newborn.



### Section 06

## Annex D

# References

Boucar M., K. Hill, A. Coly, S. Djibrina, Z. Saley, E. Kamgang et S. Hildebeitel. 2014. *Improving postpartum care for mothers and newborns in Niger and Mali: a case study of an integrated maternal and newborn improvement programme*. BJOG: DOI: 10.1111/1471-0528.12818

Cellule de Planification et de Statistique (CPS/SSDSPF), Institut National de la Statistique (INSTAT/MPATP), INFO-STAT et ICF International, 2011. *Enquête par Grappes à Indicateurs Multiples 2009-2010*. Bamako Mali.

Cellule de Planification et de Statistique (CPS/SSDSPF), Institut National de la Statistique (INSTAT/MPATP), INFO-STAT et ICF International, 2014. *Enquête Démographique et de Santé au Mali 2012-2013*. Rockville, Maryland, USA: CPS, INSTAT, INFO-STAT et ICF International.

Coulibaly A. Traoré FN, Mwebesa W, Lo A. 2015. *Promouvoir la Prise en Charge des Petits Poids de Naissance au Niveau Communautaire au Mali: Les Soins Mère Kangourou Pratiqués dans l'Aire de Santé de Tinkaré (District de Diéma, Région de Kayes)*. Projet MCHIP, USAID

Countdown to 2015. 2015. *Mali Country Profile*. [www.countdown2015mnch.org](http://www.countdown2015mnch.org).

Countdown to 2015. 2015. *Mali Equity Profile*. [www.countdown2015mnch.org](http://www.countdown2015mnch.org)

Djenefo F. 2016. *Recherche Qualitative sur les Facteurs qui Influencent l'Utilisation des Service de Santé Maternelle et Infantile au Mali*. KJK.

Gueye M., B. Fane, S. Fofana. 2015. *Étude de base sur les facteurs d'idéation et les comportements liés à la santé maternelle et infantile, la planification familiale, l'eau/hygiène/assainissement et le VIH/sida au Mali*. CERIPS et Projet USAID de Communication et Promotion de la Santé (KJK)

INFO-STAT(Centre d'Études et Information Statistiques). 2014. *Enquête d'évaluation du Projet Intégré de Santé Maternelle et Infantile (MCHIP) au Mali: Rapport d'analyse (version révisée du 12/06/2014)*. MCHIP/Mali

Institut National de la Statistique. 2016. *Enquête par Grappes à Indicateurs Multiples au Mali (MICS-Mali), 2015, Résultats clés*. Bamako, Mali, INSTAT.

Ministère de la Santé. 2013. *Plan stratégique de la santé de la reproduction 2014-2018*.

Ministère de la Santé, Direction Nationale de la Santé. 2014. *Annuaire Système Local d'Information Sanitaire 2015*. Bamako, Mali.

## Annex D

# References

Ministère de la Santé, Direction Nationale de la Santé, Division Santé de la Reproduction. 2013. *Politiques et Normes des Services de Santé de la Reproduction 2014-2018*.

Moran, A., K. Kerber, et al. 2012. *Benchmarks to measure readiness to integrate and scale up newborn survival interventions*. Health Policy and Planning 27:iii29-iii39.

Organisation Mondiale pour la Santé. 2015. *Les résultats de l'analyse des gaps de financements de programmes de SMNI au Mali*. Présentation ppt.

Projet MCHIP. 2013. *Rapport d'Analyse de Situation des Interventions en Matière de Survie de l'Enfant au Mali*. USAID et MCHIP.

Projet Service de Santé à Grand Impact. 2016. *Soins Essentiels dans la Communauté: Rôle des ASC*. Présentation (ppt)

Sans Auteur. 2015. *Carte de Score et de Performance de la SRMNI Décembre 2015*. Présentation (ppt)

Saving Newborn Lives. September 2016. *Conceptualizing and Measuring the Pathway to High Effective Coverage of Newborn Health Interventions, Save the Children: Washington DC*

Secrétariat Permanent de PRODESS, Cellule de Planification et de Statistique Secteur Santé, Développement Social et Promotion de la Famille. *Plan Décennal de Développement Sanitaire et Social 2014-2023*.

Shiffman, J. and S. Smith. 2007. *Generation of political priority for global health initiatives: a framework and case study of maternal mortality*. Lancet. 370: 1370–137

Sidibé T., H. Sangho, B. Keita, M. McKay, M. Berthé, D.B. Ouattara, B. Boureyma, H. Touré, L. Wilson-Williams, W. Mwebesa. 2015. *Etude sur les perceptions des communautés sur les soins du cordon des nouveau-nés en vue de l'introduction de la Chlorhexidine Digluconate 7,1% au Mali*. USAID: MCSP.

USAID/ASSIST. 2015. *Mali Country Report FY 2015*.

USAID/ASSIST. 2016. *AOR Quarterly Review Meeting (April 27-28, 2016)*.

USAID/SSGI. 2015. *Etude de base du niveau de prestation des services de santé maternelle, néonatale et infantile dans les sites d'intervention des régions cibles du Projet SSGI: Rapport d'analyse*. Bamako, Mali: Projet SSGI

UNICEF. 2015. *Every Newborn Country Implementation Tracking Tool – Mali*. Draft.

## Annex E

# Interview Guide

### Introduction

1. Please tell me/us briefly how you have been engaged with newborn health in [COUNTRY].
2. How long have you been working with [ORGANIZATION] in this area and in what capacity?

### Progress in Newborn Health

3. In your opinion, what progress has been made in newborn health over the past 4 years? Which interventions have seen the greatest progress?
  - a) Among these newer interventions, which ones have made the most progress?
4. In your opinion, what are the factors that have facilitated the integration of newborn interventions into the package of essential health services in Indonesia?
5. What would you say are the key factors that have enabled this progress?
6. What factors do you think have inhibited making further progress for newborn health and newborn interventions in Indonesia?
7. Thinking back over the last 5-10 years, which key people or organizations contributed to this progress?

### SNL's Contributions to Newborn Health

8. SNL worked in Indonesia from 2005-2014 to create attention and momentum around newborn health. Were you working in Indonesia during this period? (If No, skip to Q9)
  - a) In your opinion, did SNL contribute to the integration of newborn care into the minimum package of interventions?
  - b) What contributions did SNL make in newborn health?
  - c) How or in what ways did SNL make these contributions?
9. What other major contributions did other stakeholders make to help achieve progress towards newborn health?

### Looking Forward

10. If we want to strongly increase coverage with high impact newborn interventions in order to decrease neonatal deaths, what does Indonesia need to do in the next few years to achieve that result?
11. What kinds of global level actions over the next few years, if anything, would support achievement of these results?
12. If you had three wishes which would help sustain the gains achieved and achieve even more progress for newborns in (Country), what would they be?

### Conclusion

13. Is there anything else that you would like to share or discuss related to newborn health?
14. What questions do you have for me/us?

# Contact

**Lynne Franco**

*Vice President for Technical  
Assistance and Evaluation*

[lfranco@encompassworld.com](mailto:lfranco@encompassworld.com)

EnCompass LLC

1451 Rockville Pike, Suite 600

Rockville MD 20852

301-287-8717