Saving Newborn Lives (SNL)

Progress in newborn health in two countries benefiting from SNL support

EnCompass LLC

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Synthesis Report

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Table of contents

Context

Section 01

- Global Context for Newborn Health
- The Cases of Mali and Indonesia
- History of Newborn Health
- SNL Activities

Saving Newborn Lives

Since 2000, the Saving Newborn Lives (SNL) program, funded by the Bill & Melinda Gates Foundation, has worked to put the neglected issue of newborn care and survival on the global map and on the agenda of ministries of health.

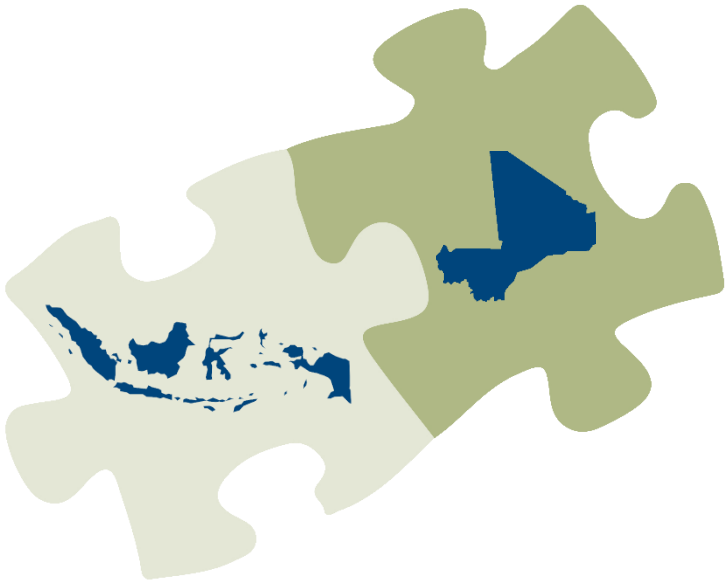
SNL1 (2000-2005)	SNL 2 (2006-2012)	SNL 3 (2013-2017)
First major international program to focus on newborn survival. Supported key research on newborn interventions in developing country settings. Raised global and national awareness. Pilot programs in **12 countries**. *"It is possible to save newborn lives."*	Implemented large-scale research activities and focused on global advocacy and partnerships. Established communication platforms, including the Healthy Newborn Network (HNN). Worked with countries preparing for scale-up (policy and implementation modalities). Worked with programs in **18 countries**. *"We can implement interventions and get results."*	Focus on maintaining momentum for newborn care and survival at the global level, institutionalizing newborn health interventions at high effective coverage in four countries, and targeting specific issues to enhance progress where SNL has a comparative advantage in three countries. Worked with programs in **7 countries**. *"We can scale these interventions and achieve effective coverage."*

Context

Special Study Synthesis Report

This special study provides an opportunity to return to two countries, Indonesia and Mali, 4 years after SNL ended its in-country activities. The study investigates what has happened to the momentum for and institutionalization of newborn care supported during SNL1 and SNL2.

This report presents a synthesis of two case study reports from **Indonesia** and **Mali**. The report begins with a background of each country's status in newborn health prior to the start of SNL1 and summarizes progress made between 2000 and 2010. Using SNL's Pathway to Effective Coverage as a frame, the report compares the current status of newborn care in each country, factors affecting progress, and what role SNL played in contributing to this progress. The report concludes with key stakeholders' suggestions for actions needed at the country and global levels to ensure continued progress in newborn health, and the study team's assessment of what country stakeholders, SNL3, and other global actors need to prioritize moving forward.



Global Context for Newborn Health: 2000 and Beyond

Before 2000, newborn health was not a top priority on global or national agendas. SNL was a key player in efforts to integrate newborn health into the global agenda.

In their efforts to reduce infant and child mortality, health policymakers were, for many years, either not aware of the magnitude or despondent about the severity of neonatal mortality and its contribution to infant mortality rate (IMR) and under-5 mortality rate (U5MR). Even after the IMR declined and the increasing proportion of neonatal mortality came into focus, many were either unaware or unpersuaded that there were 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 (reduce child mortality). With the advent of SNL and other efforts, evidence and guidance for lifesaving interventions for newborns were strengthened and disseminated at the country level. SNL began programmatic work in selected countries, incorporating plans and programs specifically targeting newborns.

In 2015, there were 2.7 million neonatal deaths, which represent 45 percent of deaths among children under 5 years of age.[1]

1 Healthy Newborn Network, 2015

Context

The Cases of Indonesia and Mali

Indonesia and Mali represent two very different contexts for studying what happens after a project has ended. Each country has unique economic, political, cultural, and security issues that affected how effectively and efficiently progress occurred in newborn health.

Mali

- 2016 population: 18 million
- Low-income country
- Relatively centralized health system
- NMR: 31/1,000 live births
- Several regions with significant security issues since 2012

Indonesia

- 2016 population: 258 million
- Lower middle-income country
- Decentralized health system: 500+ districts
- NMR: 19/1,000 live births
- Some security issues in specific pockets

Mali NMR Rate: MCS 2015; Indonesia NMR Rate: INAP (Recent government figures show a drop in NMR rate but have not been confirmed yet.

History of Newborn Health in Indonesia through the Early 2000s

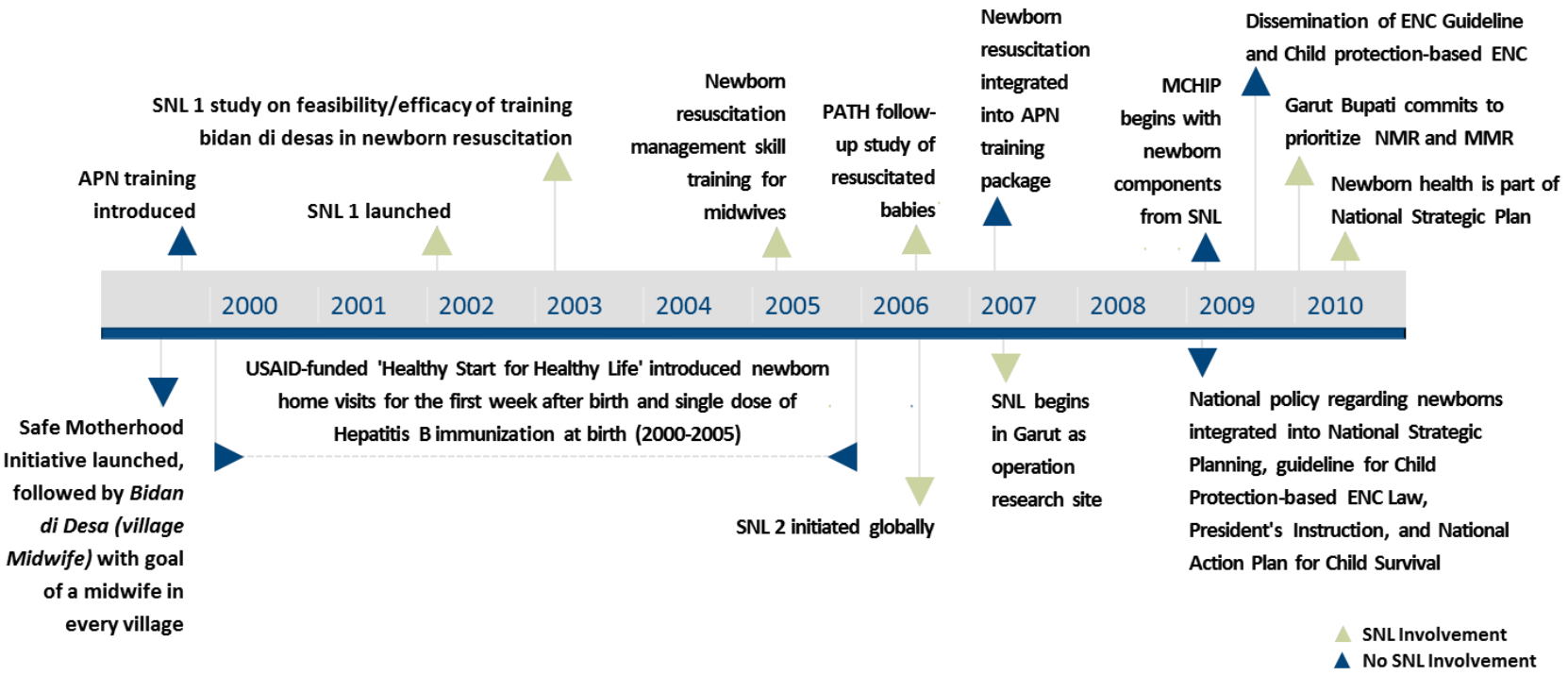
Newborn health became a program priority in Indonesia with the launch of the MDGs, in order to achieve MDG 4.

Newborn health was not a program focus in Indonesia until the late 1990s when IMR saw a steep decline while neonatal mortality rate (NMR) showed only a small decrease.

With the launch of the MDGs, there was global and national interest in decreasing neonatal mortality to achieve MDG 4. In 2000, Indonesia set its target to decrease the NMR from the 1991 rate of 32 deaths per 1,000 live births to 19 per 1,000 by 2015.

While a project funded by the Australian Aid (AusAID) included activities related to the first neonatal visit in the late 1990s, Healthy Start for Healthy Life, funded by the United States Agency for International Development (USAID) in 2000, was the first project to include a significant focus on newborn health. The project worked in four districts and focused on strengthening the first-week neonatal visit at the community level. In 2002, SNL was launched with a specific focus on newborn health. The research and demonstration projects undertaken by SNL 1 and 2 resulted in a number of policy revisions pertaining to newborns.

Activities Related to Newborn Health in Indonesia (2000–2010)



Activities of SNL in Indonesia (2000–2012)

SNL's support to Indonesia's efforts to improve newborn health focused mainly on presenting evidence of the extent and causes of the problem, demonstrating feasible solutions, and assisting the Ministry of Health (MOH) in policy and strategy development.

Highlight from SNL1

Managing birth asphyxia in home deliveries, Cirebon, 2000–2005

This SNL project demonstrated that most birth asphyxia cases can be managed by trained village midwives. The neonatal mortality rate was decreased from 13/1,000 live births to 9/1,000 live births. As a result of the study, the MOH declared managing birth asphyxia by village midwives as a national program in 2005. Supportive supervision for newborn care was also developed in this project.

Highlight from SNL2

Operations research in Garut district, 2007–2011

This SNL project developed and tested a model of comprehensive essential newborn care (ENC), with Kangaroo Mother Care (KMC) implemented in primary health care centers. By the end of the project, the MOH had adapted the ENC module for national implementation.

History of Newborn Health in Mali through the Early 2000s

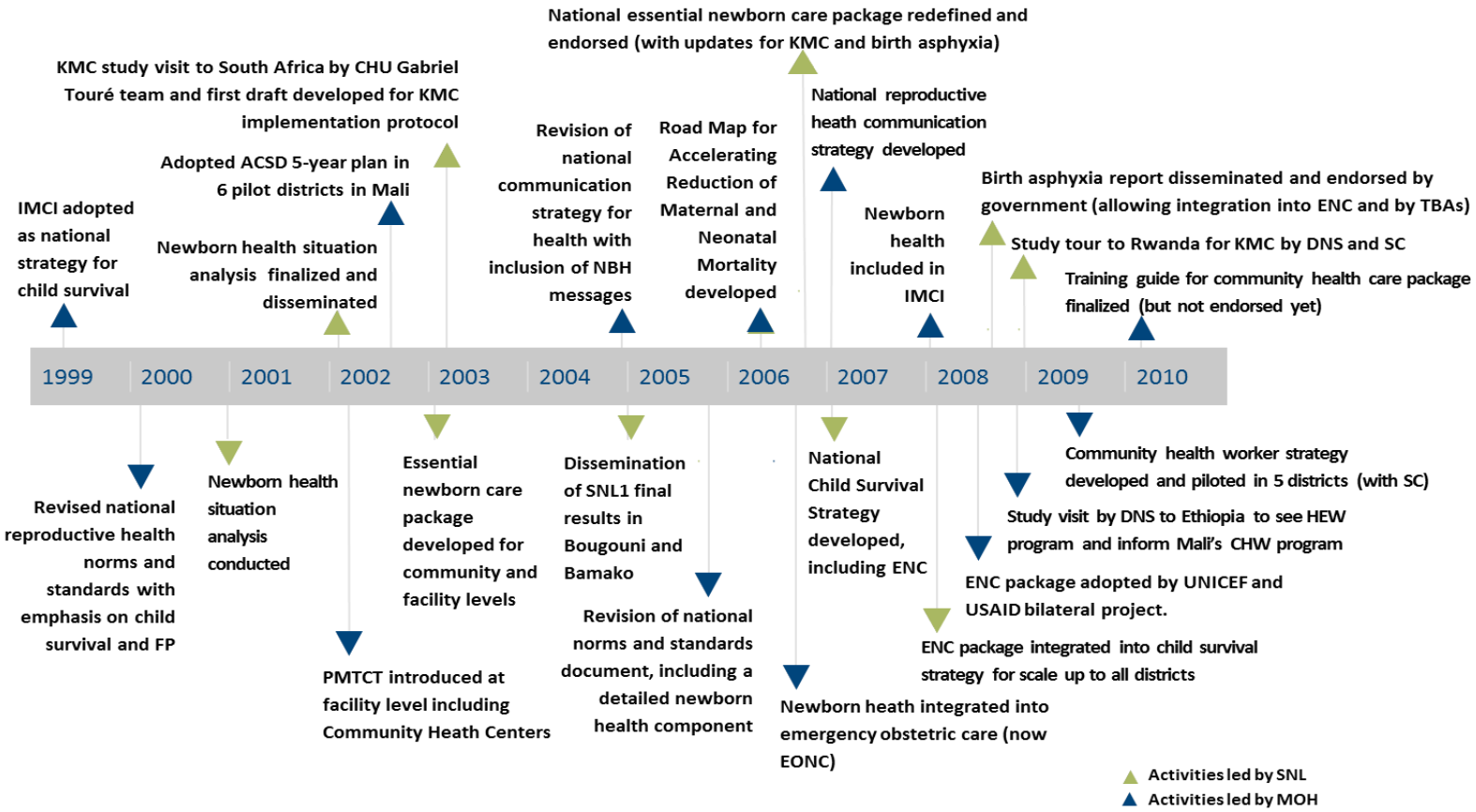
Traditional beliefs in Mali do not consider the death of a newborn as tragic: "*The jar may have holes, but it is not broken*."

With its high neonatal mortality and a favorable context for integration, Mali's context was ripe for a concentrated effort to improve the health of newborns.

Mali's neonatal mortality rate was 71 per 1,000 live births in the rural areas (Demographic Health Survey [DHS] 2001), exacerbated by high levels of illiteracy, home births, and harmful community practices related to newborns.

The Bamako Initiative envisioned primary health care services decentralized to community level. This, in conjunction with the resources, focused policies on safe motherhood, and strengthening of the referral systems contributed to a favorable situation to change the lives of newborns.

Activities Related to Newborn Health in Mali (2000–2010)



Activities of SNL in Mali (2000–2012)

SNL's technical, financial, and advocacy support increased momentum for newborn care by bringing forth evidence of the problem of newborn mortality and possible solutions, and then helping the MOH develop appropriate policies and strategies.

Highlight from SNL1

Implementation of a pilot project in 2002 in Bougouni

SNL, with the MOH, piloted a newborn care package in Bougouni district, which included home-based newborn care practices and health facility interventions. SNL's strategy included community mobilization, behavior change communication (BCC), strengthening community-facility linkages, and a focus on quality of care. The Bougouni pilot demonstrated that it is possible to improve newborn care knowledge and practices in the community and at health facilities, and furnished training materials and curricula, BCC materials, and supervision and community mobilization approaches that the MOH integrated into the national policies and guidelines.

Highlight from SNL2

Expansion of newborn care initiatives, including community-based care and establishment of KMC in hospitals

- SNL supported the scale-up of essential newborn care in Mali through training of 2,042 health workers in 49 administrative districts in seven of eight regions, plus Bamako city, representing 89 percent of all districts.
- SNL in collaboration with the Gabriel Touré Teaching Hospital in Bamako established a KMC unit and training center, which serves as a training site and has facilitated scale-up of KMC throughout the country.

Methodology

Section 02

- Study Questions
- Methodology

Special Study: Purpose and Objectives

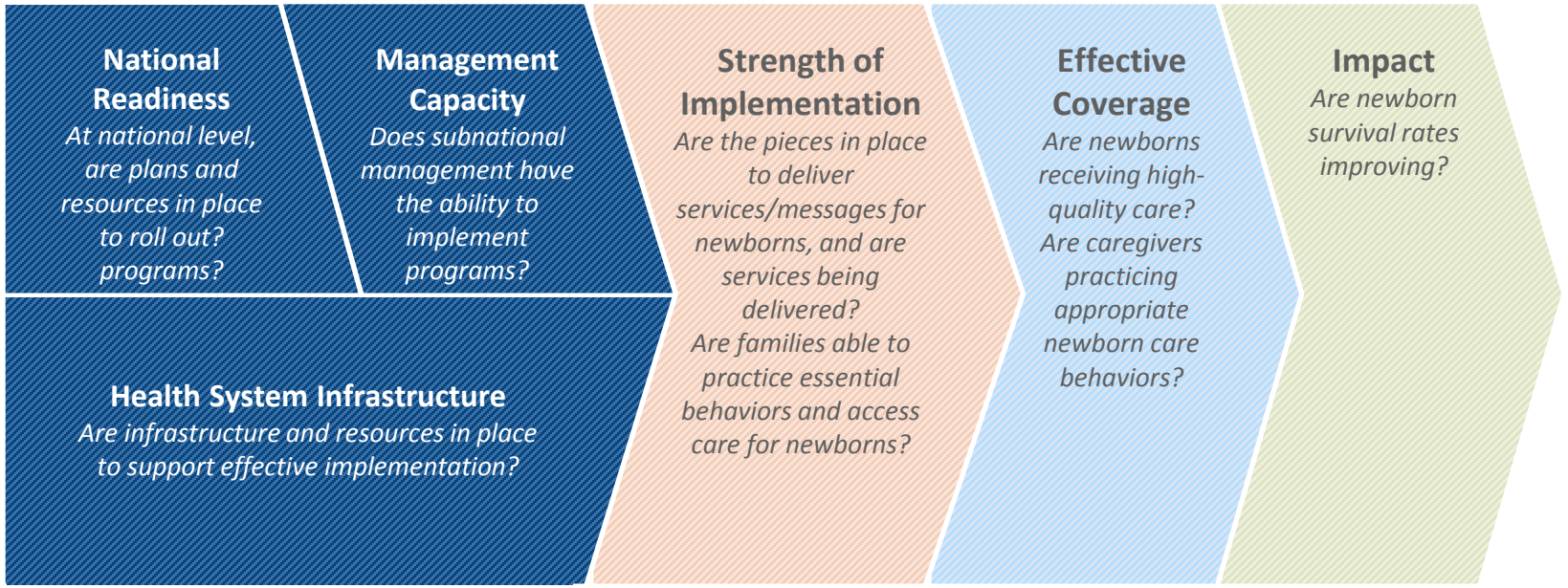
SNL has supported increased momentum for newborn care by bringing forth evidence of the problem of newborn mortality and the possible solutions, and then helping ministries of health develop appropriate policies and strategies.

Special Study Questions:

- In what ways have countries previously supported by SNL maintained, increased, or decreased progress for newborn health?
    - Which aspects of progress do stakeholders perceive and value the most?
- What factors have contributed to or inhibited progress in these countries?
- How have SNL's activities at country or global level contributed to momentum in the case study countries?
- 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?

Pathway to Effective Coverage at Scale

The Pathway to Effective Coverage is a conceptual framework to measure progress, identify key ingredients for success, and assess newborn programs' "capacity to implement" and "strength of implementation." The framework includes national readiness and subnational readiness as important steps between policy and system inputs to implementation on the ground. The Pathway includes six categories and 42 specific elements, which are detailed in this report.



Methodology

Jeremy Shiffman's Framework

Shiffman's framework provides a frame for understanding factors that facilitate or hinder ascendance of newborn health issues at global and country levels. It complements the Pathway to Effective Coverage by elucidating why progress in national and subnational readiness and implementation was or was not attained. The framework contains three key categories:

Transnational Influence: international agencies' efforts to establish a global norm for the unacceptability of neonatal 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

2-Shiffman, Jeremy et al., Generation of political priority for global health initiatives: a framework and case study of maternal mortality. Lancet . 2007; 370: 1370 - 1379

A Synthesis of Two Case Studies

This report synthesizes two case studies, which involved extensive document reviews, in-depth interviews, and group discussions with key stakeholders at the end of each field visit.

The study teams coded content from documents and interviews according to the elements of the Pathway to Effective Coverage and Jeremy Shiffman's framework. The team paid particular attention to SNL's role as mentioned both directly and indirectly.

Document Review

More than 60 policies, guidelines, research studies, statistics, program documents, and situation analyses were reviewed and coded in Excel according to the categories in the Pathway and Shiffman's Framework.

Interviews

Across the two studies, 46 people were interviewed from the Ministry of Health, donors, nongovernmental organizations (NGOs), and other key stakeholders in newborn health and SNL. Interviews were coded according to the categories in the Pathway and Shiffman's Framework.

Group discussion with Stakeholders

Both country study teams presented initial findings to more than 33 key stakeholders, soliciting additional input, corrections, and supplementary documentation.

Study Limitations

Although findings are based on triangulation of data from secondary quantitative data sources, recent documents, and qualitative data from interviews and the group discussion, a few key limitations should be taken into consideration when interpreting the data:

Data limitations

Data on some elements of the Pathway, particularly around strength of implementation and effective coverage, were not readily available or only represented a partial sample of the country. For others, there were no baseline data to compare progress. In addition, some perspectives are less well represented in our analysis, including service providers, clients, and private sector providers.

Informant (and interviewer) bias

Given the limitations of hard data, limited information of some informants, and that in some cases both the interview subjects and the interviewers were affiliated with the current or past newborn projects, there was potential for bias in responses.

Personnel turnover in government and NGOs

Many informants had been in their current positions for a limited time and did not have a historical perspective about the trajectory of newborn health in their country or knew little of the potential influence of SNL or both.

Summary of Findings

Section 03

- National Readiness
- Management Capacity
- System Structures
- Program Elements in Place
- Program Functioning
- Effective Coverage/Impact

National Readiness: Indonesia

Indonesia has many of the key elements of national readiness for newborn intervention necessary for scale-up.

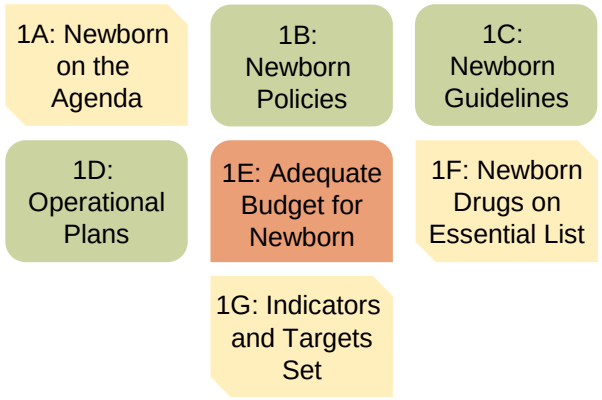
Status: Newborn policies, guidelines and plans, including the Indonesia Newborn Action Plan (INAP), cover all of the key newborn interventions at national level, and reflect current global evidence. While there is a maternal, newborn, and child health (MNCH) coordination group, including both Indonesian and international NGOs, there is no working group focused exclusively on newborns. The overall health budget does not meet the Indonesian government's minimum requirements, there is no specific budget line for newborn health, and MCH budgets have been subject to cuts.

Indonesia has set overall newborn mortality reduction targets, and collects data on newborn deaths and stillbirths. However, there are effective coverage targets at the national level only for postnatal visits and exclusive breastfeeding.

Factors Affecting Progress: The results of SNL 1- and 2-funded research were instrumental in the formulation and adoption of Indonesia's first newborn policies and standards, particularly the authorization of midwives to manage birth asphyxia, ENC standards, and ensuring newborn commodities were on the essential medicines list.*

The Every Newborn Action Plan and the accompanying global attention were important motivators for developing the INAP. USAID's Expanding Maternal and Neonatal Survival (EMAS) project, now in its final year, has worked with the MOH to pilot new approaches to referral and draft national referral guidelines, which are expected to be adopted in the future.

Status of National Readiness



*Chlorhexidine is not on the Essential Medicines List, because Indonesia's national neonatal mortality rate falls on the cusp of WHO's recently issued criteria for use of chlorhexidine. The country is still deciding on its guidance, which may recommend chlorhexidine for certain areas only.

Summary of Findings

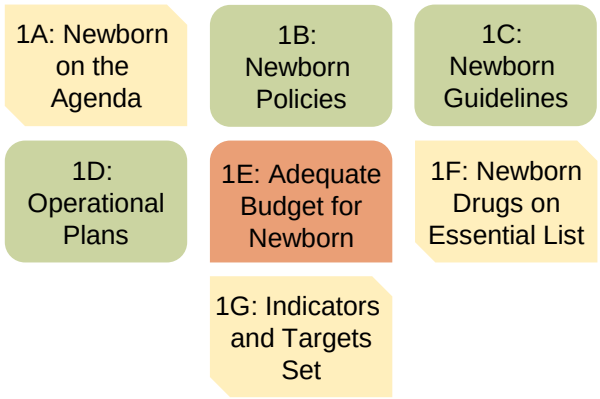
National Readiness: Mali

Indonesia has many of the key elements of national preparedness in place.

Status: Newborn health is well integrated into the national agenda and fully included in policies, guidelines, training materials, and operational plans, as part of the Reproductive Health agenda. The MOH has recently integrated Chlorhexidine into the newborn care guidelines, and it has been added to the essential drug list. Additional newborn indicators were added to the most recent Multiple Indicator Cluster Survey (MICS) (2015), but not all newborn interventions are covered in the Health Management Information Systems (HMIS). No specific budget line exists for newborns and funding for MNCH services is only 37 percent of what is needed. While newborn care is well integrated, it also gets somewhat lost in the shuffle.

Factors Affecting Progress: Most of the efforts to fully develop and integrate newborn interventions took place in the 2000s, with key support from SNL. SNL assisted by conducting a situational analysis, implementing a pilot project, funding essential intervention research, and providing technical support to develop the newborn care package and training materials. The MOH took the lead in integration, with continued support from USAID and the United Nations Children's Fund (UNICEF) for expansion of scale of implementation.

Status of National Readiness



Summary of Findings

National Readiness: Lessons across Indonesia and Mali

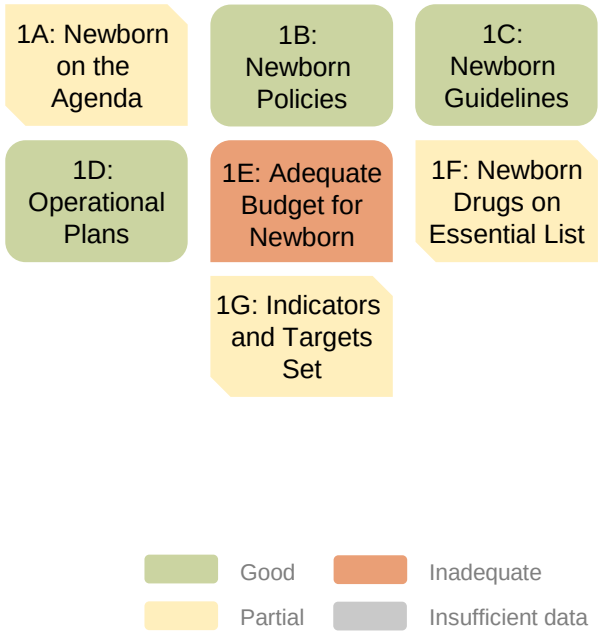
Similarities

Status: Indonesia and Mali are ranked as same status in every category of national preparedness. Both countries have integrated newborn health into the national agenda in policies, guidelines, and operational plans. However, both countries also have yet to succeed in translating these policies into implementable actions. This gap can be seen in the absence of a budget line for newborn health, a working group specifically for newborns, and comprehensive indicators that include the full spectrum of newborn health interventions.

Differences

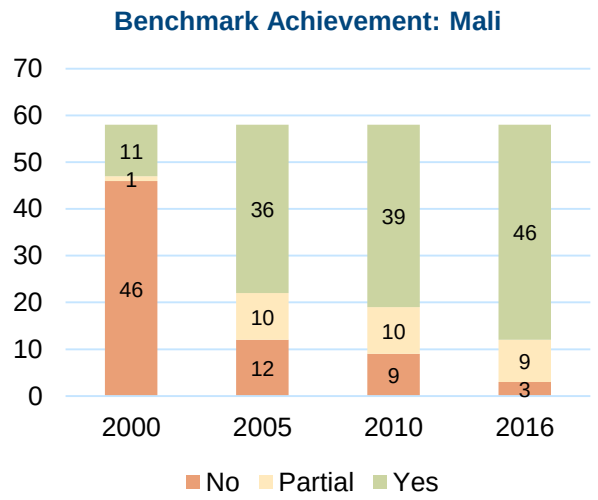
Factors Affecting Progress: : In both countries, SNL's research helped spur policy change. However, the way in which each country used this research differed. In Mali, change was seen during SNL implementation. SNL's pilot projects influenced the integration of high-impact newborn interventions into the National Policies, Norms and Procedures for Reproductive Health in 2006. In Indonesia, although some newborn policies and strategies were implemented during SNL's implementation, most were developed in response to the global initiatives, such as ENAP in 2014. In addition, Mali did not create an ENAP because they had already updated their reproductive health strategy to include newborn health in 2013 and finalized it in early 2014, prior to ENAP's launch.

Status of National Readiness across Indonesia and Mali



Comparison of Scale-up Readiness Benchmark Achievement

The Scale-up Readiness Benchmarks measure readiness in policy, health systems, and programs to deliver newborn interventions at scale. These benchmarks, developed by SNL between 2007 and 2011, provide a detailed examination of more than 50 elements in the "National Readiness" category of the Pathway to Effective Coverage. SNL previously evaluated these benchmarks for 2000, 2005, and 2010; this special study assessed status in 2016. Indonesia assessed 52 benchmarks. Mali assessed 58.



Summary of Findings

Management Capacity at Subnational Level: Indonesia

The shortcomings in the operationalization from national to subnational level, and particularly at district level, impede Indonesia's progress on several elements of the Pathway for newborn interventions.

Status: Dissemination of policies and guidelines is generally successful from the central to the provincial level, but inconsistent at the district level.

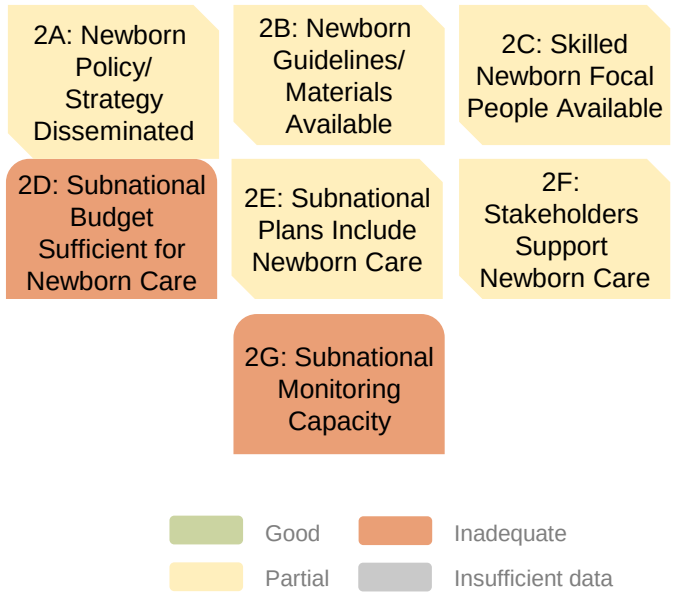
Human and financial resources for effective monitoring of standards are insufficient, and the system and chain of authority remain unclear in the context of decentralization.

Budgets for health are decided at the district level, but few district health offices and political leaders are sensitized to the needs of newborns. Therefore, funding likely remains insufficient in most districts, although hard data are not available.

Similarly, potentially important stakeholders, such as professional associations and women's groups, while generally supportive, are not knowledgeable about specific aspects of newborn health.

Factors Affecting Progress: The MOH has been quick to develop and disseminate new policies and guidelines, including some that arose out of the work of SNL 1 and 2, and SNL global-level activities. However, neither the MOH nor external projects or advisors have successfully developed a model to operationalize policies and plans throughout the system.

Status of Subnational Management Capacity



INAP, AIP Bikor and Midwives 2015. National Health Act 36, Indonesia Health Profile 2014, EMAS Year 4 Annual Report, interviews

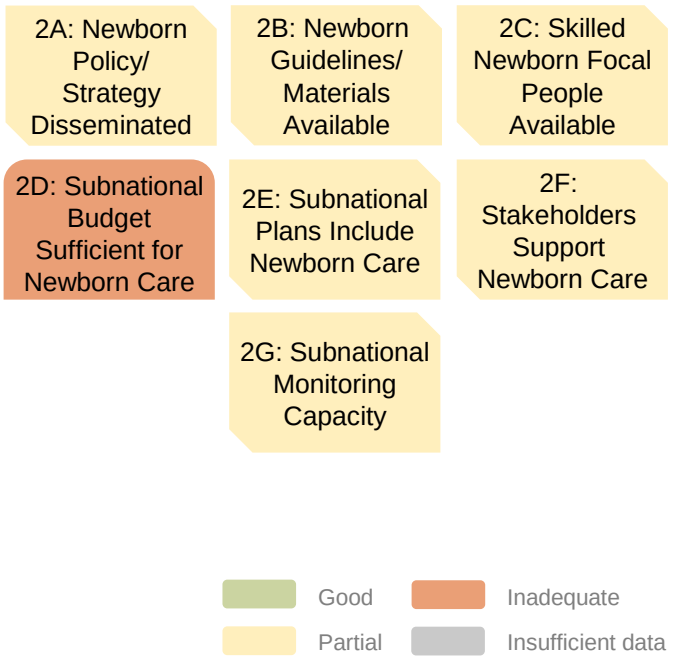
Management Capacity at Subnational Level: Mali

Management capacity for newborn programs at the subnational level is still a work in progress because the focus on newborn care is somewhat diluted by its integration.

Status: Mechanisms for dissemination of newborn care policies, strategies, guidelines, and training materials exist, but outside of the referral-level facilities, they are rarely available. There are no focal points specifically for newborn care, and newborn care gets lost among the myriad of health issues, as it moves to decentralized-level operational plans and generation of local stakeholder engagement. Budget allocations are insufficient (as they are insufficient already at central level). There are systems for monitoring at the decentralized level, but data collected on newborn care are limited.

Factors Affecting Progress: SNL laid the groundwork by creating training manuals and curricula on ENC for health staff at the facility and community level, and provided technical assistance and training. Since then, the MOH systems for decentralized training of trainers has implemented the trainings. Additionally, USAID and UNICEF have provided financial and technical support at the regional and district level for implementation of newborn interventions.

Status of Subnational Management Capacity



INAP, AIP Bikor and Midwives 2015. National Health Act 36, Indonesia Health Profile 2014, EMAS Year 4 Annual Report, interviews

Management Capacity: Lessons across Indonesia and Mali

Similarities

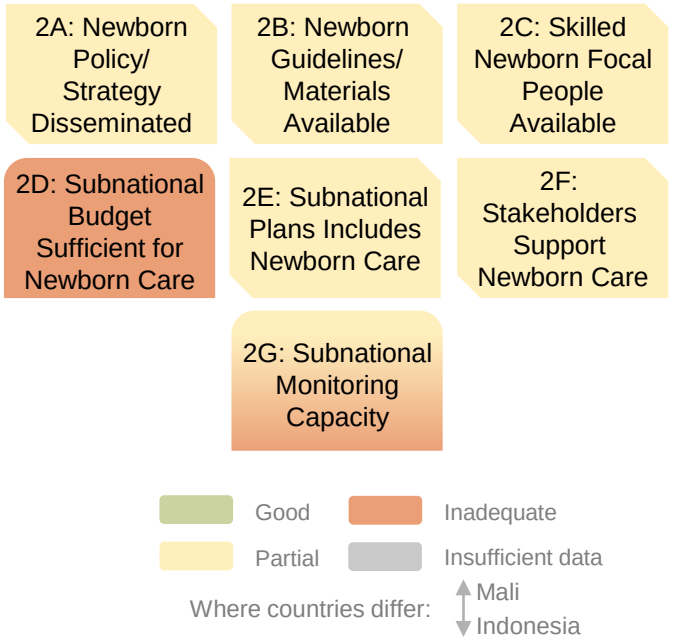
Status: Management capacity at lower levels of the system is challenging for any intervention, and both Indonesia and Mali face these challenges in implementing the set of interventions needed to improve newborn care and survival. These challenges lie mainly in the broader health systems context—how effectively are capacity, authority, and resources decentralized, the degree to which skilled staff are available, and how effectively priorities developed at national level are diffused and implemented throughout the system.

Differences

Status: The differences in management capacity reflect the degree to which each country has decentralized its health system. Indonesia has devolved most authority for monitoring capacity, including budgeting, management, supervision, and quality assurance to the district level where management skills are less often in place. The provincial level has more skilled human resources, but limited authority. In Mali, the health system is more centralized and the regional level plays a larger technical role in monitoring capacity. This difference can be seen in the different ranking of Subnational Monitoring Capacity in the Pathway to Effective Coverage.

Factors Affecting Progress: While Mali has used a cascade system of training of regional trainers for newborn (and other) interventions, Indonesia's government and donors have not found a model to successfully support the implementation of newborn policies at all levels throughout the country.

Status of Subnational Management Capacity across Indonesia and Mali



Health Systems Structures: Indonesia

Most basic system structures for newborn care exist, and government and development partners are working to strengthen them, but some elements are not consistently functional.

Status: The fundamental systems and platforms for service delivery are in place in many regions, and newborn health has been explicitly incorporated into MNCH platforms. There are great discrepancies across facilities, however, and in many places quality and functionality are poor.

The new universal insurance scheme has significantly reduced economic barriers to access, but equity is still a significant problem, with remote areas often left out of improvements.

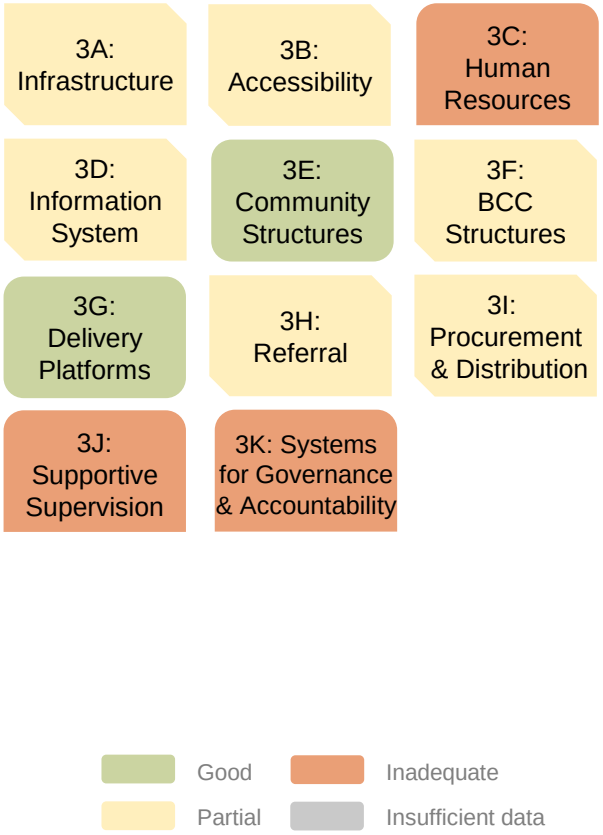
According to a 2010 national-level World Bank study, 63 percent of Indonesia's 2,100 obstetricians and 55 percent of its 2,700 pediatricians practice in Java. The overall numbers may have increased since then, but distribution problems remain.

Supportive supervision, and governance and accountability structures are very weak due to unclear lines of management and accountability throughout the levels of the system. The efficiency of procurement and distribution systems is hampered by a limited number of authorized producers.

Civil society and local governance structures that could be sensitized to the needs of newborns exist.

Factors Affecting Progress: Indonesia has long prioritized a basic health care system accessible throughout the country. SNL and other external projects have focused on improving MNCH-relevant elements in selected provinces and districts as pilots for expansion, often quite successfully. However, replication of these improved structures has proven challenging. In any case, the projects often do not address the needs of high-mortality areas.

Status of Systems Structures



IDAI news, EMAS Year 4 Annual report, MOH Local Level Advocacy, World Bank Readiness 2014, World Bank And then she died 2010, INAP Annex 1, Indonesia Health Profile 2014, Indonesia Health Facility Survey 2011, MOH documents, Wibowo, Shankar, Makoweicka, Interviews

Summary of Findings

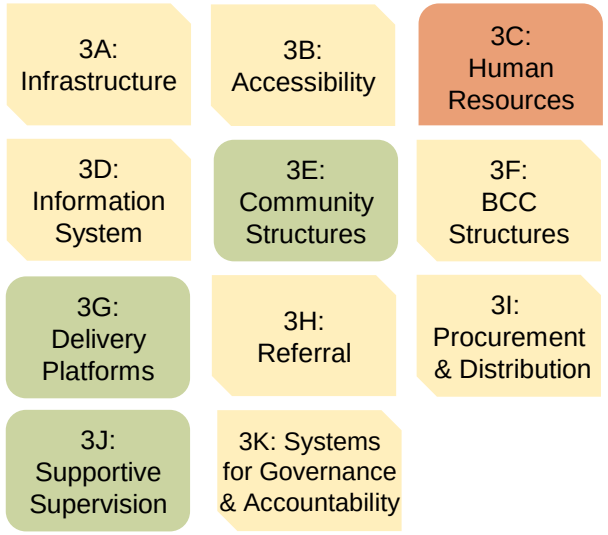
Health Systems Structures: Mali

Mali's heath system has several strengths, but also some key weaknesses that will inhibit strength of implementation.

Status: Through MOH's efforts and donor support, Mali has been able to upgrade its health infrastructure and improve accessibility, but more efforts are needed. Human resources, however, remain insufficient and inequitably distributed. Mali has created community platforms for engagement and service delivery, the information system includes both service statistics and regular population surveys, and there is framework for supportive supervision with guidelines. Guidelines and mechanisms exist for free referral for maternal and newborn emergencies from village to health center to hospital. Procurement and distribution systems for drugs exist. However, accountability systems are still nascent.

Factors Affecting Progress: Mali's health system has benefited over the years from government efforts and donor support for health systems strengthening, particularly from USAID and other donors. While SNL and other external projects have focused on improving MNCH-relevant elements, SNL's focus did not include health systems strengthening more broadly.

Status of Systems Structures



Health Systems Structures: Lessons across Indonesia and Mali

Similarities

Status: Both Mali and Indonesia have systems and infrastructure for health service delivery, although inequitably distributed across each country. Newborn care has been integrated into the existing service delivery and community structures, but quality remains an issue. There are insufficient numbers of skilled personnel in both countries and they too are inequitably distributed. Systems for information and accountability are not yet fully functioning in either country.

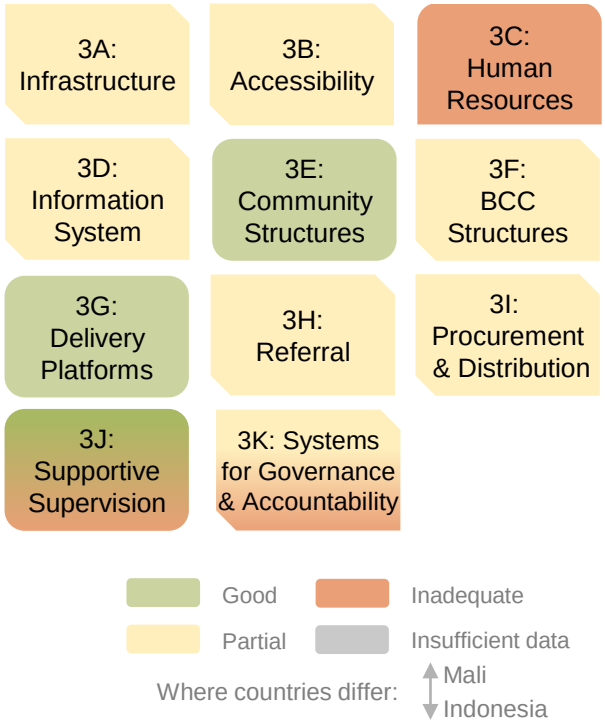
Factors Affecting Progress: Both countries continue to rely on external donor support for health systems strengthening projects to pilot new approaches, yet comprehensive scaling of systems improvements has not been achieved in either country.

Differences

Status: Mali has a framework for supportive supervision, while in Indonesia supportive supervisions structures at lower levels are unclear due to gaps in the chain of authority in its decentralized structure. Data are lacking on private sector services in Indonesia, but many people obtain health services from private providers who exist largely outside of government oversight.

Factors Affecting Progress: In Mali, USAID and other donors have focused on health systems strengthening across the country, whereas in Indonesia multiple projects have done smaller scale programs across the country to pilot various specific interventions in newborn health.

Status of Systems Structures across Indonesia and Mali



Program Elements in Place: Indonesia

Many newborn program elements remain weak, particularly in large parts of the country's remote areas.

Status: Most facilities have providers, but a full complement of staff is often not available 24/7. More remote locations may lack even a village midwife. Perinasia and MOH report that providers are motivated to improve their skills, but remote areas have difficulty attracting and retaining personnel. In a 2014 World Bank study, only 11 percent of Basic Emergency Obstetric Neonatal Care (BEONC or PONED) facilities had all of the essential supplies for neonatal care.

Links between health system levels are widely recognized as dysfunctional, affecting supervision, monitoring, and referral. Focused on monitoring and referral systems, Expanding Maternal and Newborn Survival (EMAS) project has piloted new approaches, and developed systems and guidelines in a limited geographic area.

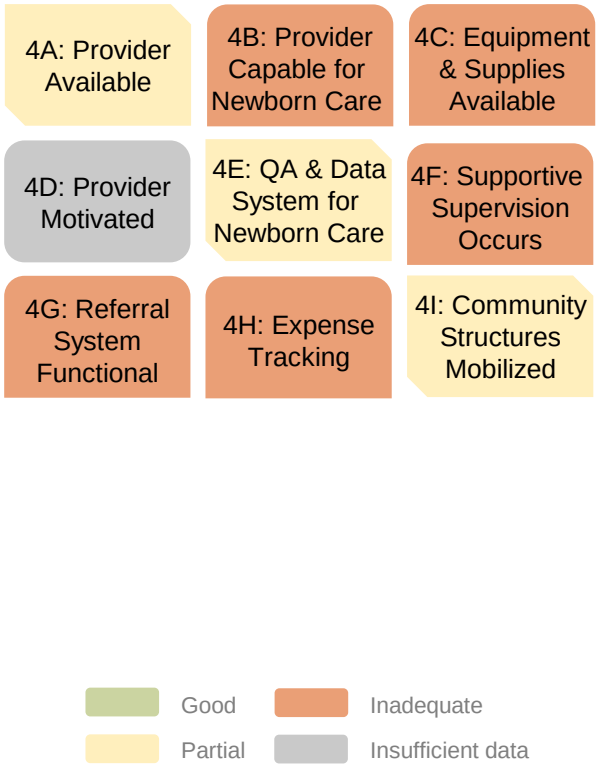
Hospital accreditation includes newborn indicators, but whether information is used for quality improvement is not known. At the primary level, there is supposed to be a weekly meeting that could be used for Quality Assurance (QA)/Quality Improvement (QI), but actual practice is unknown.

INAP recognizes the potential role of the existing community structures throughout Indonesia. Special projects, such as EMAS, have invested in sensitizing *pokjas* and civic forums to newborn health issues.

Newborn expenditures are not aggregated and reported from local to national level in order to obtain an overall figure.

Factors Affecting Progress: The Indonesian government and international donors have been addressing key elements of the health system, including MNCH programs, for many years. The lack of a comprehensive approach, however, makes it challenging to design successful programs in the decentralized context. Although SNL 1 provided early evidence of the shortcomings in provider skills, SNL has not operated at a scale that would influence this element of the Pathway.

Status of Program Elements in Place



EMAS Year 4 Annual Report, RUU KEBIDANAN 2016 (DRAFT), World Bank Readiness 2014, Health Facility Survey 2011, Wibowo 2016, INAP 2014, INAP Situation Analysis 2014,interviews

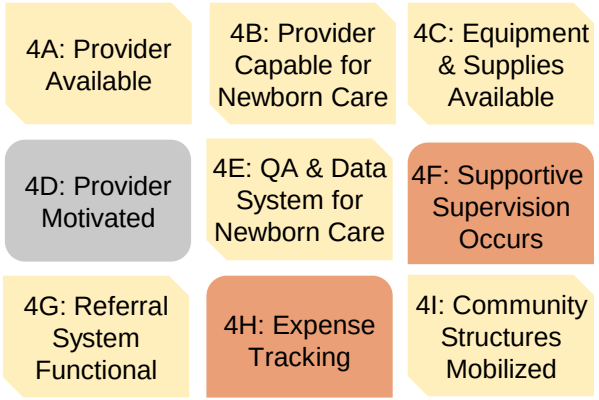
Program Elements in Place: Mali

Many of the key elements are not consistently available at the point of service delivery.

Status: Helping Babies Breathe (HBB) and KMC are not offered in all health facilities and the maldistribution of health personnel manifests itself at the point of service delivery. The community health worker cadre is expanding, but currently serves only 25 percent of the population. While ENC is offered in most health facilities and basic supplies are available, less than half of providers have received ENC training, and equipment for keeping the newborn warm and for HBB is frequently not available. In two regions, QI systems are now being implemented in most districts and are showing good results, but more work needs to be done to ensure data availability in many health facilities in other regions. Outside of the referral hospitals, supervision is inadequate and rarely focuses on newborn care. The free emergency transport for referral is rarely used for newborns. More efforts are now targeting grandmothers for BCC.

Factors Affecting Progress: With support mainly from USAID and UNICEF, improvements have been made in several regions and districts to strengthen provider capacity, equipment, QI, and community mobilization for an integrated maternal and newborn care package. Much of this builds on the pilot work done by SNL in the 2000s.

Status of Program Elements in Place



Program Elements in Place: Lessons across Indonesia and Mali

Similarities

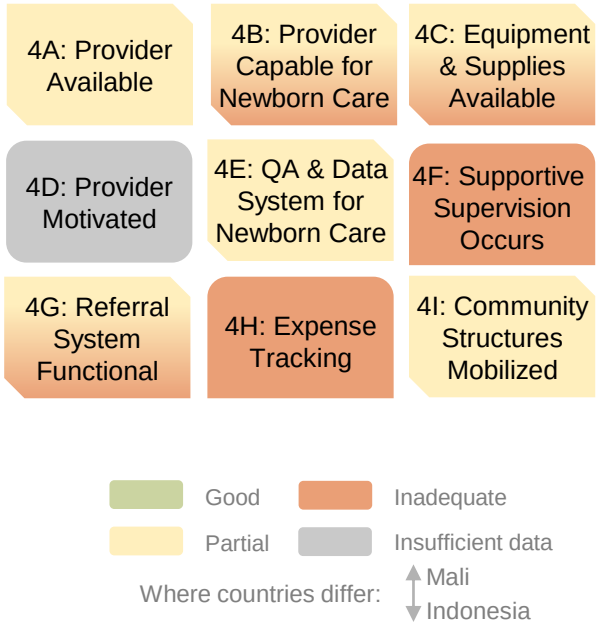
Status: Both countries ranked "partial" for the same three areas: QA in data systems, community structures, and provider availability. QA is improving, but there is still limited information on data quality and use. Community structure engagement continues to improve, including engaging grandmothers in Mali and investment in community health structures in Indonesia, but progress is limited to specific geographic pockets. Provider availability remains limited and inequitably distributed in both countries. A lack of adequate newborn equipment at the facilities, limited supportive supervision, and insufficient expense tracking were ranked as inadequate across both countries.

Factors Affecting Progress: Both countries have received substantial support from international donors in key elements of the health systems. Yet, there has been a lack of a comprehensive approach to addressing broader challenges inherent in the health system.

Differences

Status: In Mali, a referral system is in place, although it is limited to hospitals. In Indonesia, referral systems are very weak, as evidenced by the focus of the EMAS project on improving referrals. Provider capability was ranked "partial" for Mali. Due to the great inequality of providers in Indonesia both in skill and knowledge, provider capability ranked "inadequate." The MOH in Indonesia has recognized this gap and is working to improve the system.

Status of Program Elements in Place across Indonesia and Mali



Program Functioning: Indonesia

Data suggest shortcomings in standards, completeness of services, and caretaking for newborns.

Status: The MOH's Indonesia Health Profile 2015 states that only 60 percent of newborns with a complication received standard care.

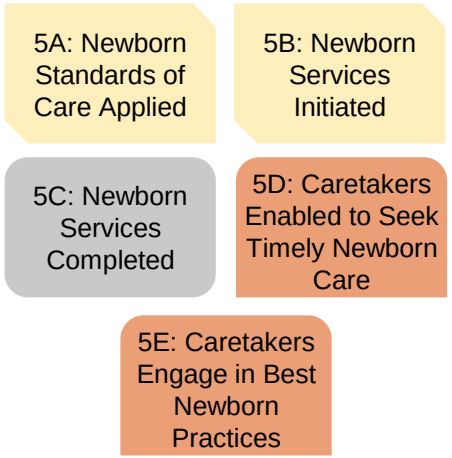
No national data more recent than the 2012 DHS are available, but these data suggest that understanding of the specific standards of care for newborns is lagging among providers. While coverage of the in-home postnatal visit for mothers within 2 days after birth was 80 percent, coverage for the neonatal visit was only 48 percent, suggesting providers are not paying attention to the needs of newborns.

The only national data for any kind of services completed are for antenatal visits in the 2012 DHS, which indicate that 73 percent of women received the full set of four antenatal visits.

Although expert consensus indicates shortcomings in caretaking by mothers and families, actual data are limited. A 2013 study found that only 35 percent of mothers practice immediate breastfeeding and only 24 percent refrain from applying anything to the cord stump. Similarly, the SNL-2 baseline survey in the district of Garut in 2011 found that 65 percent practiced immediate breastfeeding, 45 percent practiced skin-to-skin contact, 47 percent refrained from applying anything to the cord stump, and 20 percent delayed the first bath by 24 hours.

Factors Affecting Progress: Although the current status is somewhat bleak, special projects operating in limited geographic areas have demonstrated that significant improvements can be made at both service delivery and community level.

Status of Program Functioning



Interviews and INAP 2014, IMCI Evaluation Survey 2009, DHS 2012,MOH Indonesia Health Profile 2015, INAP 2014, interviews, Indonesia Basic Health Research 2013, Baseline Survey Report for SNL-2 Garut 2007

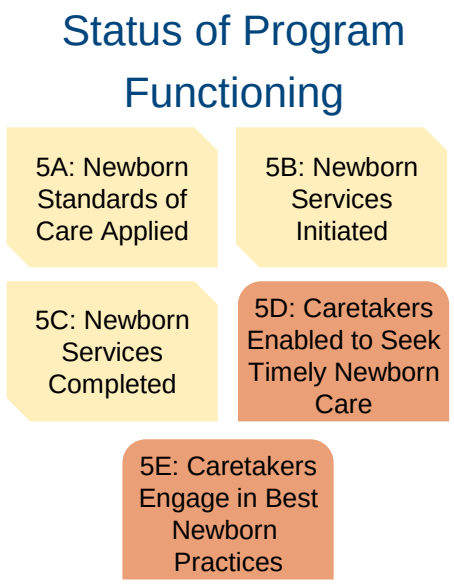
Summary of Findings

Program Functioning: Mali

Caretaker knowledge levels remain low and counseling is not offered consistently. While adherence to norms for ENC and HBB appear high where the QI strategy has been implemented, little to no information is available on implementation of KMC.

Status: The quality of newborn care services appears to depend on the kinds of projects that have been implemented. Where QI support is in place, adherence to standards appears high (HBB and ENC). More broadly, however, counseling of mothers related to newborn practices is not consistent, and mothers' knowledge related to appropriate care seeking behavior and home-based newborn care remains low. A 2015 Keneya Jemu Kan (KJK) project study reported that only 57 percent of mothers who delivered at a facility and 22 percent who delivered at home delayed bathing their newborns for at least 6 hours.

Factors Affecting Progress: While there remains significant work to be done in program functioning, there is evidence of effective strategies and approaches, and additional data are now available on the issues to be addressed through MOH's efforts and donor-supported projects operating in many regions of Mali.



Sources: SLIS 2015, MCHIP final evaluation 2014, USAID/KJK baseline study 2015, interviews

Program Functioning: Lessons across Indonesia and Mali

Similarities

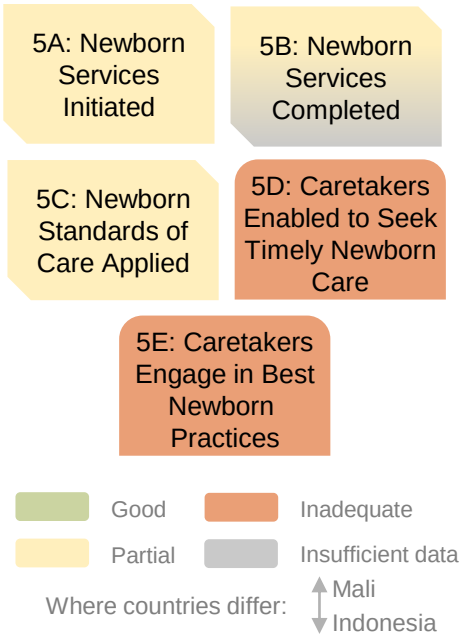
Status: Both countries are seeing improvements in standards and services applied. However, there remains a lot of work to be done at both the point of service delivery, and in caretakers' knowledge and practice of newborn best practices. In both countries data show that only in areas where donor-funded projects are occurring is there an improvement in caretaker practices. The majority of caretakers still lack the basic knowledge and skills to protect their newborns' health. At the facility level, data are limited on provider adherence to norms outside of where QI activities are taking place.

Factors Affecting Progress: Significant work remains to be done in both countries on program functioning, both in creating awareness of newborn danger signs among mothers and the ability to provide essential newborn practices at home. Most donors and governments are continuing to implement programs focused on ensuring that there is an adequate supply of well-trained and supervised providers; however, demand-side activities focused on increasing knowledge among families and caretakers need to be strengthened.

Differences

Status: In Mali, services completed is ranked "partial." Indonesia did not have recent data at the service provider level to know whether services were being completed or not.

Status of Program Functioning across Indonesia and Mali



Summary of Findings

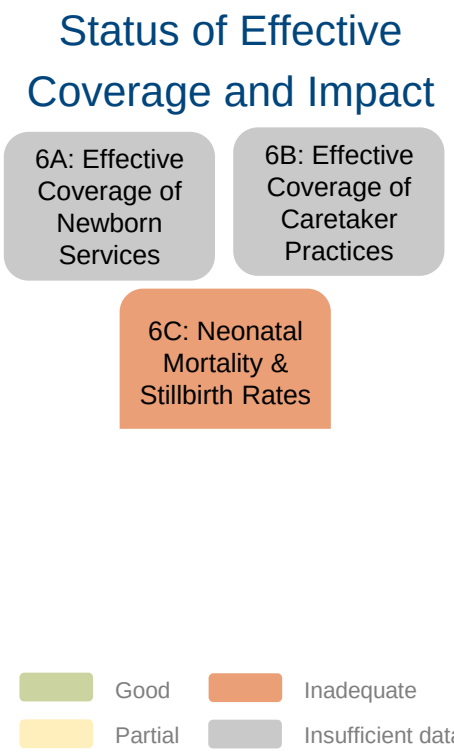
Effective Coverage and Impact: Indonesia

Following more than a decade of decline, neonatal mortality has been stagnant at 19 per 1,000 live births for the past decade.

Status: Little or no recent data are available on receipt of high-quality services. Older data, combined with the persistent NMR, suggest a continuing problem with quality. For example, Indonesia Basic Health Research 2010 showed that, although coverage of first neonatal visit was 73 percent, coverage of the first neonatal visit meeting quality standards was only 13 percent.

Data on caretaker practices are limited, although expert consensus is that they are suboptimal. Immediate initiation of breastfeeding is the one indicator that is tracked nationally, and it shows a modest improvement from 44 percent at the time of the 2007 DHS to 49 percent in the 2012 DHS.

Factors Effecting Progress: Although the current status is somewhat bleak, special projects operating in limited geographic areas have demonstrated that significant improvements can be made at service delivery and community levels.



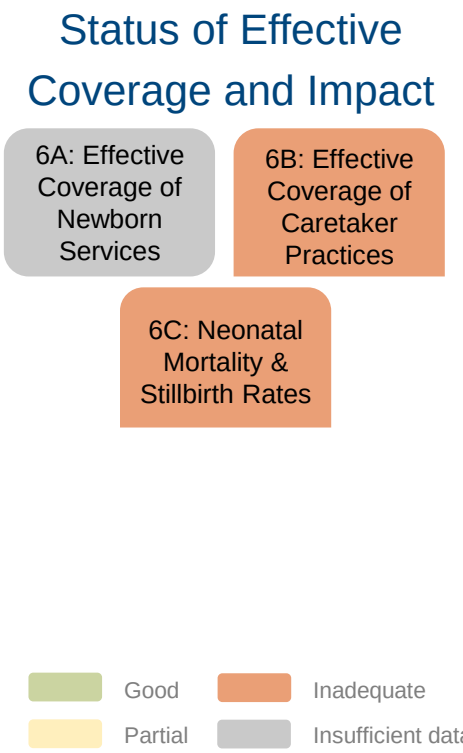
DHS 2007, DHS 20012, Ministry of Health, in INAP Situational Analysis 2014, Indonesia Basic Health Research 2010, interviews

Summary of Findings

Effective Coverage and Impact: Mali

Mali has made some progress in coverage for antenatal and delivery care, and although no comparison data exist for postnatal care, rates are similar to those of assisted deliveries. Caretaker practices remain problematic and neonatal mortality remains high.

Status: Data on effective coverage (including quality of care) are not available, but while there is some improvement in coverage for antenatal care and assisted deliveries, these rates, as well as postnatal care, remain around 60 percent nationwide. Postnatal care coverage varies widely, depending on the place of delivery. The KJK survey (2015) reported postnatal care at 23 percent for babies born at home, 60 percent for babies born at a maternity clinic, and 81 percent for those born at a Referral Health Clinic. Delayed bathing (after 6 hours) remains a problem in both home-based and institutional deliveries and 80 percent of mothers or caretakers put shea butter on the umbilical cord (50 percent for those who delivered at a hospital). Neonatal mortality remains high.



Source: MCHIP final evaluation 2014, USAID/KJK baseline study2015

Summary of Results

Effective Coverage and Impact: Lessons across Indonesia and Mali

Similarities

Status: Both countries have made greater improvements in newborn services in comparison to caretaker practices. In terms of caretaker practices, the data are limited across both countries, except for low rates of immediate initiation of breastfeeding (Indonesia) and delayed bathing (Mali). Although both remain low, but may not represent the status of ENC more broadly. In newborn services, delivery is varied across both countries with limited attention to the quality of services, particularly in more rural locations.

Neonatal mortality rates remain high in both countries, with 31 deaths per 1,000 live births in Mali and 19 deaths per 1,000 live births in Indonesia.

Differences

Status: Mali and Indonesia are at different stages of progress in newborn health, which can be seen in the differences in their NMR rates. However, these differences can be closely correlated to each country's level of socioeconomic development, rather than any project or initiative put in place by external donors.

Summary of Findings from Indonesia and Mali

Pathway to Effective Coverage

National Readiness

- 1A: Newborn on the Agenda
- 1B: Newborn Policies
- 1C: Newborn Guidelines
- 1D: Operational Plans
- 1E: Adequate Budget for Newborn
- 1F: Newborn Drugs on Essential List
- 1G: Indicators and Targets Set

Subnational Management Capacity

- 2A: Newborn Policy/ Strategy Disseminated
- 2B: Newborn Guidelines/ Materials Available
- 2C: Skilled Newborn Focal People Available
- 2D: Subnational Budget Sufficient for Newborn Care
- 2E: Subnational Plans Includes Newborn Care
- 2F: Stakeholders Support Newborn Care
- 2G: Subnational Monitoring Capacity

Health Systems Structures

- 3A: Infrastructure
- 3B: Accessibility
- 3C: Human Resources
- 3D: Information System
- 3E: Community Structures
- 3F: BCC Structures
- 3G: Delivery Platforms
- 3H: Referral
- 3I: Procurement & Distribution
- 3J: Supportive Supervision
- 3K: Systems for Governance & Accountability

Program Elements in Place

- 4A: Provider Available
- 4B: Provider Capable for Newborn Care
- 4C: Equipment & Supplies Available
- 4D: Provider Motivated
- 4E: QA & Data System for Newborn Care
- 4F: Supportive Supervision Occurs
- 4G: Referral System Functional
- 4H: Expense Tracking
- 4I: Community Structures Mobilized

Program Functioning

- 5A: Newborn Services Initiated
- 5B: Newborn Services Completed
- 5C: Newborn Standards of Care Applied
- 5D: Caretakers Enabled to Seek Timely Newborn Care
- 5E: Caretakers Engage in Best Newborn Practices

Effective Coverage and Impact

- 6A: Effective Coverage of Newborn Services
- 6B: Effective Coverage of Caretaker Practices
- 6C: Neonatal Mortality & Stillbirth Rates

Good | Partial | Inadequate | Insufficient data

Where countries differ: Mali / Indonesia

Factors Explaining Progress

Section 04

Factors Facilitating and Impeding Progress[1]

Transnational Influence: international agencies' efforts to establish a global norm for the unacceptability of maternal 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

1, Shiffman, Jeremy et al., Generation of political priority for global health initiatives: a framework and case study of maternal mortality. Lancet . 2007; 370: 1370 - 1379

Factors Explaining Progress

Transnational Influence

Global actions influence country priorities	*Global evidence encourages countries to adopt newborn interventions*	*International financial support assists countries in progressing along the Pathway*
• **Indonesia** follows global health priorities, so when ENAP was rolled out, health officials followed suit and created INAP. • **Mali:** The SDGs energized political priority for newborn health and aligned with the existing programs, such as Health Sector Development Program (PRODESS) happening at the time.	• **Indonesia:** MOH waits for international standards to be set on new evidence prior to establishing programs. The Lancet 2011 was repeatedly cited as influencing national priority setting. • **Mali:** MOH uses evidence to see where the country falls on global standards and then uses global tools to move forward in newborn health nationally.	• **Indonesia:** Resources have been important to convince policymakers to test key newborn interventions for feasibility and effectiveness in Indonesian context. • **Mali:** Resources have been key to helping the Government of Mali in implementing projects on newborn health.

Factors Explaining Progress

Domestic Advocacy

Continuity of leadership in newborn health	*Building a national evidence base*	*Global evidence builds national advocacy*
• **Indonesia:** Senior leaders in MOH focus attention on newborn health and have been supported by the President's Healthy Indonesia initiative, which includes a target for IMR. • **Mali:** Key newborn health champions in government and from SNL moved out of key roles, leaving a current gap in advocacy for newborn health.	• **Indonesia:** SNL pilot project and local trials to test global norms/interventions in the Indonesian context provided the necessary evidence to spur policy action. • **Mali:** SNL's catalytic efforts, including bringing international strategies and evidence to national level decision makers, facilitated moving the country forward in planning for newborn health projects.	• **Indonesia:** Importance of MDG4 and showing the increasing proportion of newborn mortality in IMR and U5MR led to a greater focus on newborn health in national programming. • **Mali:** Results from 2012 DHS shed light on the importance and scope of newborn deaths, while World Health Organization (WHO) guidelines and international research on newborn interventions provided a platform for action.

Factors Explaining Progress

National Political Environment

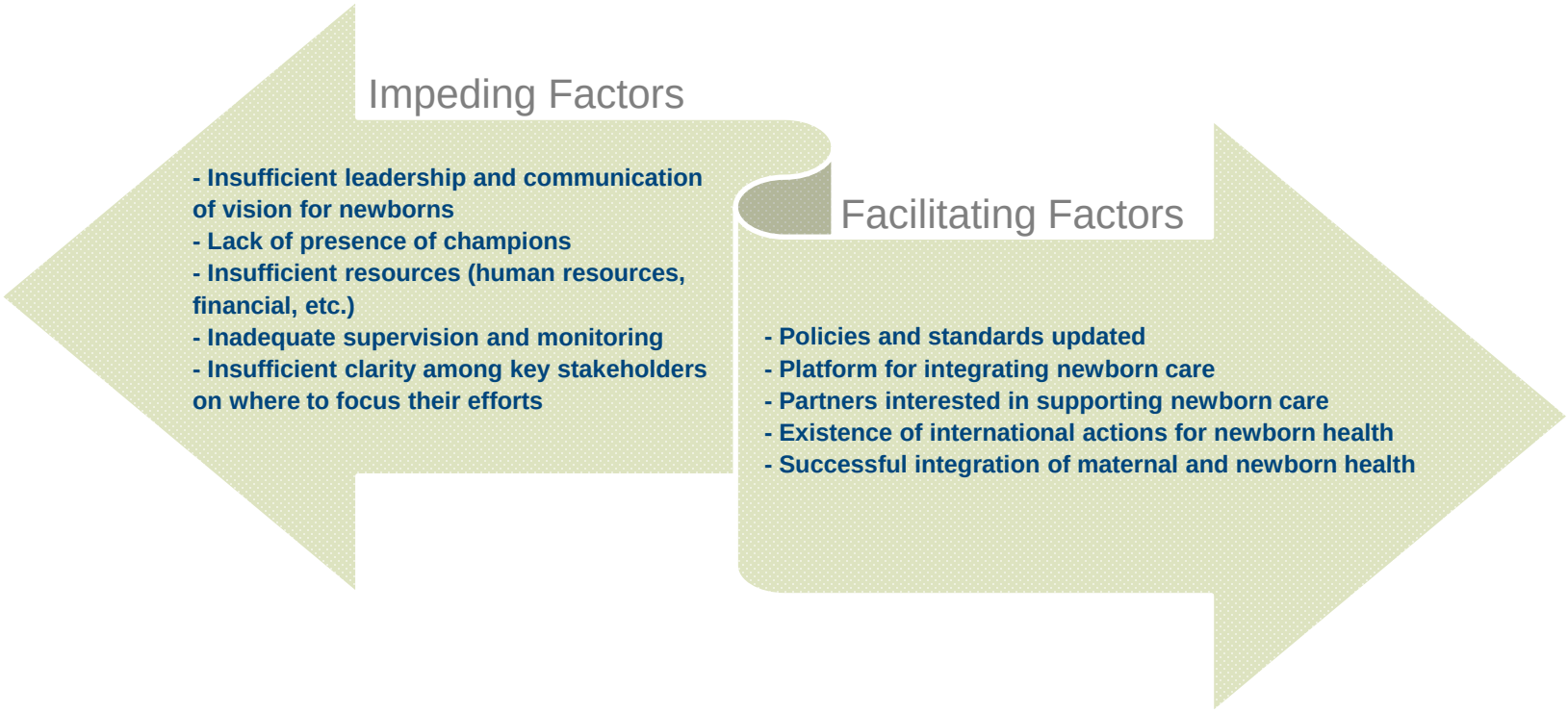
Changing political leadership influences attention on newborn health

- **Indonesia:** When new government officials were elected on national and subnational levels, the existing newborn projects and priorities were put at risk unless the new officials were quickly educated and convinced of the importance of supporting newborn health.
- **Mali:** Key newborn health champions in government and from SNL moved out of key roles, leaving a gap in advocacy for newborn health.

Competing health and political priorities influence attention given to newborn health

- **Indonesia:** The country's high maternal mortality rate creates competition for a focus on newborn health. Although these health priorities are interlinked, the focus on maternal mortality has commanded attention over newborn health.
- **Mali:** Competing priorities and fewer strong champions have led to less priority and vision communicated around newborn health.

Summary: Factors that Facilitate or Impede Progress



Looking Forward

Section 05

- Key Factors Identified by Respondents that Affect Progress
- Key Considerations to Foster Continued Momentum

Advice from Key Stakeholders

*During interviews and group discussions, key newborn health stakeholders were asked, "**What is needed for greater progress in newborn health at the national and global level?**" Their responses provided insights into where the newborn community should focus efforts moving forward.*

Looking Forward: Key Stakeholders Feedback

What is needed at the *national level* for greater progress?

Indonesia		Mali
Translate INAP and other national initiatives into action and policy at subnational level, with accountability mechanisms	Focus on quality	Create a strategic communications plan for newborn health to create better visibility
Implement mechanisms that engage stakeholders in identifying and defining local problems and priorities, and designing solutions	Strengthen advocacy and engagement by creating a working group and building on the existing community structures	Strengthen collaboration between state research facilities and support service providers to to strengthen the evidence base
	Strengthen human resources and distribution of qualified personnel	

Looking Forward: Key Stakeholders Feedback

What is needed at the *global level* for greater progress?

Indonesia		Mali
Timely, highly specialized expertise in how to scale and operationalize local responses to global initiatives, such as INAP	Accountability mechanisms	A forum to share experiences and successes in newborn health from countries at different stages of the Pathway
Accountability mechanisms to improve quality and keep spotlight on progress	Implementation plans	Focal person for sharing global experiences on implementing newborn health initiatives and providing technical expertise
		Continued resources for project implementation and newborn research

Key Considerations to Foster Continued Momentum

Triangulating data from document review, interviews across two countries, group discussion with key stakeholders, and discussions with global stakeholders and SNL staff, the study team summarized key consideration to foster continued momentum moving forward at country and global levels.

Key Considerations to Foster Continued Momentum in Newborn Health: *National Level*

Creating a critical mass of newborn advocates: Countries need a critical mass of individuals who can and will continue the momentum for newborns once projects end. The organizational affiliation of these individuals will differ based on country contexts, and will need to include individuals within and outside of the MOH leadership.

Integrating newborn and maternal care: Integration is key to successful implementation at the point of service delivery, but too much focus on integration can mean that newborn care gets lost in the process. In many countries, specific newborn technical working groups no longer exist, leading to subsequent decline in advocacy for the newborns. If no working group exists, a key focal person for newborn health or sub-group could be useful to sustain momentum in newborn progress.

Coordination: Having a continuous convening and coordinating agent for other newborn health key actors is important for maintaining momentum. SNL has played this role in many countries, and this role should be passed to others (within national structures or by other actors) at country level before project closeout (whether it was SNL or other projects that played this role).

Whole-systems approach: Focusing on the strengthening of overall health systems, specifically in increasing health personnel availability and capacity, is needed for future progress in newborn health.

Move from policy to implementation: Countries must begin to budget and plan for moving their progress from research to implementation on a national scale.

Key Considerations to Foster Continued Momentum in Newborn Health: *Global Level*

Global convening is key to country progress: Global actions, such as the creation of ENAP, evidence building on newborn health interventions, and the act of bringing a variety of actors together have proven to be of critical importance to county-level progress. Countries use global evidence and norms to push newborn health policies, interventions, and research forward in their own countries. Global convening on newborn health needs to bring in more country actors to give their perspective on how global actions are translating into country level progress.

Technical guidance and use of global tools: Countries continue to rely on global actors to provide technical expertise in newborn interventions, implementation science, and planning for newborn health. Global actors can play this role by continuing to produce evidence on a global and local level, but also by translating this evidence into clear implementation plans for countries. SNL's Pathway to Effective Coverage provides a framework for conducting a situational analysis, in a specific country, but also for comparing countries' progress to foster cross-learning about how to continue to progress along the Pathway.

Whole-systems approach: Global-level actors' investment in health systems strengthening, including designing programs that have a systems lens, is key to forward progress. To date, progress focuses on different key issues within the health systems that remain due to a lack of focus on strengthening the root of the problem – the health system itself. A systems approach will include projects that are longer term, with "softer" metrics, but that can improve progress on a broader level in the future.

Annexes

Section 06

- References
- Interview Guides

Annex A

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Annex B

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Annex C

Interview Guide: Indonesia

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 heath?

14. What questions do you have for me/us?

Annex D

Interview Guide: Mali

Introduction

1. **Combien de temps vous travaillez dans le domaine de la santé néonatale au Mali ?**
2. **Depuis combien de temps travaillez-vous dans cette structure dans ce domaine et à quel titre?**

Progrès réalisés dans la santé néonatale

Maintenant, nous aimerions explorer plus profondément les progrès réalisés ou pas réalisés dans votre pays et les aspects que vous appréciez le plus au Mali.

3. **Sur la base de notre première revue documentaire, nous avons constaté que le Mali a fait des progrès dans le domaine de la santé néonatale. Selon vous, quels sont les facteurs qui ont favorisé/facilité l'intégration des interventions néonatales dans le paquet minimum d'activités au Mali?**
4. **À votre avis, quelles sont les progrès réalisés (enregistrés) au Mali dans le domaine de la santé néonatale au cours des 4 dernières années? Pour quelles interventions y a-t-il le plus de progrès ?**
    a. **Parmi ces nouvelles interventions, le ou lesquels ont mis plus de progrès ?**
5. **Selon vous, quels sont les principaux facteurs qui ont permis ces progrès?**
6. **Selon vous, quels facteurs ont empêché d'autres progrès dans la santé néonatale et les interventions néonatales au Mali?**
7. **En réfléchissant sur les 5-10 dernières années, quelles personnes ou organisations clés qui ont contribué aux progrès réalisés?**

Contributions de SNL dans la santé néonatale

1. **SNL a travaillé au Mali à partir de 2000 à 2012 pour créer l'attention et le dynamisme autour de la santé néonatale. Avez-vous travaillé dans le domaine de la santé néonatale pendant cette période. (Si non, passer à Q9)**
    a. **Selon vous, est ce que SNL a contribué à la prise en compte (ou l'amélioration) de nouveau-né dans le paquet ?**
    b. **Quels ont été ces contributions de SNL dans le domaine de la santé néonatale au Mali?**
    c. **Comment ou de quelles manières SNL, a-t-il fait ces contributions ?**
2. **Quelles principales contributions des autres parties prenantes, ont-ils fait dans la réalisation des progrès dans la santé néonatale?**

Perspectives

3. **Si nous voulons fortement augmenter la couverture des interventions néonatales à haut impact en vue de diminuer le taux des décès néonatals, Qu'est-ce le Mali doit entreprendre dans les prochaines années pour atteindre ce résultat?**
4. **Quels types d'actions au niveau mondial dans les prochaines années, si possible, appuieraient l'atteinte de ces résultats?**
5. **Citer trois souhaits qui aideraient à maintenir les acquis obtenus et même d'autres progrès en faveur des nouveau-nés au Mali.**

Conclusion

6. **Y a-t-il d'autres choses que vous aimeriez partager ou aborder sur la santé néonatale ?**
7. **Quelles questions avez-vous pour moi/nous?**