EVERY WOMAN
EVERY CHILD

EVERY NEWBORN ACTION PLAN

Country Progress Tracking Report

World Health Organization

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Country Progress Tracking Report

DECEMBER 2015

About *Every Newborn*

The Every Newborn action plan is based on the latest epidemiology, evidence and global and country learning, and supports the United Nations Secretary-General's Every Woman Every Child movement. The preparation was guided by the advice of experts and partners, led by WHO and UNICEF, and by the outcome of several multi-stakeholder consultations and a web-based consultation with more than 300 comments. Discussed at the 67th World Health Assembly, Member States endorsed the document and made firm commitments to put in practice recommended actions. The Director General has been requested to monitor progress towards the achievement of the global goal and targets and report periodically to the Health Assembly until 2030.

This report takes forward the Every Newborn: an action plan to end preventable deaths, which was developed by the following organizations:

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

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Canada

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Advancing community health worldwide.

COINN
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Introduction

The global Every Newborn Action Plan (ENAP), launched in 2014, includes clear targets and strategies for reducing neonatal deaths and stillbirths and supports the United Nations Secretary-General's Every Woman Every Child initiative (EWEC). The explicit focus of new Global Strategy for Women Children and Adolescents is a great opportunity to integrate and adapt ENAP progress tracking in line with the monitoring framework for Global Strategy in 2016. The ENAP management team will review the need of process tracking from time to time to meet the needs of countries. A global ENAP partnership with three streams of work – country implementation, advocacy and metrics – was established to provide support for the achievement of the targets and milestones specified in the plan. The Country Implementation Group (CIG) for ENAP, co-chaired by the World Health Organization (WHO) and UNICEF, has focused its attention on tracking progress and providing technical assistance to countries for effective implementation of the plan. Establishing a functioning tracking and monitoring system for ENAP implementation was a priority for CIG, in line with the World Health Assembly resolution (WHA67.10) to submit periodic reports of progress. The new Global Strategy for Women's, Children's and Adolescents' Health incorporates the newborn mortality goal aligned with ENAP and calls on all stakeholders to use existing country-level multi-stakeholder engagement platforms, such as ENAP, in a coordinated and coherent way and ensure coordination among the various supportive initiatives under the Every Woman Every Child initiative.

All countries are being supported in their ENAP implementation through the country, regional and HQ offices of partner agencies. Twenty-eight countries were chosen by CIG as 'focus countries' on the basis of their high burden of neonatal and maternal mortality (Annex I) and pro-active engagement during the ENAP development process.[1] These focus countries have been targeted for data collection through the use of a progress tracking tool jointly developed by CIG partners. This systematic tracking of progress enables the assessment of the status of implementation of ENAP strategies, maps technical assistance needs and identifies barriers to implementation in line with the ENAP milestones and recommendations. The tool also aims to provide information to country, regional and global partners in order to facilitate and harmonize country technical support.

A tracking tool was first developed in 2014, and data were collected from 10 countries in the last quarter of the year. The report is attached as Annex II. The tool was later revised by June 2015 and shared with all 28 focus countries for their input. Sixteen focus countries had completed the tool by the end of November 2015 as well as two additional countries Cameroon and Namibia. This report provides an analysis of the information for the individual countries and trends seen across countries.

Establishing a functioning tracking and monitoring system for ENAP implementation aims to support the reporting requirements of WHA67.10. The new Global Strategy for Women's, Children's and Adolescents' Health (Global Strategy) incorporates the newborn mortality goal aligned with ENAP and calls on all stakeholders to use existing country-level multi-stakeholder engagement platforms, such as ENAP, in a coordinated and coherent way and ensure coordination among the various supportive initiatives under the Every Woman Every Child initiative. Once the Global Strategy is reviewed and endorsed at WHA69, it will be a great opportunity to integrate and adapt ENAP progress tracking in line with the monitoring framework for Global Strategy in late 2016. ENAP management team will review the need of process tracking from time to time to meet the needs of countries.

[1] Afghanistan, Angola, Bangladesh, Central African Republic, Chad, China, Democratic Republic of Congo, Ethiopia, Ghana, Guinea Bissau, India, Indonesia, Kenya, Lesotho, Malawi, Mali, Myanmar, Nepal, Nigeria, Pakistan, the Philippines, Sierra Leone, Somalia, United Republic of Tanzania, Uganda, Viet Nam, Zambia, Zimbabwe.

Background to the ENAP Progress Tracking Tool

Purpose

The purpose of the tool is to track ENAP implementation in line with national priorities and progress made in achieving national milestones (Table 1). Special emphasis is placed on tracking processes that are in place to ensure ENAP is implemented. The tool is a way to facilitate government and key stakeholders to come together to review country progress and collate information systematically.

Table 1 ENAP national milestones

National plans	Strengthen national strategies, policies and guidelines for reproductive, maternal, newborn, child and adolescent health (RMNCAH) for implementation at scale.
Data	Count every newborn by using and improving programmatic coverage data including equity and quality gap assessments.
Quality	Adopt Every Mother Every Newborn/Quality Improvement Initiatives on maternal and child health (MNH) and ensure commodity availability.
Investment	Develop or integrate costed human resources for health strategy into RMNCAH plans and ensure sufficient financial resources are allocated.
Health workers	Ensure the training, deployment and support of health workers, in particular midwifery personnel, nurses and community health workers.
Innovation and research	Develop, adapt and promote access to devices and commodities and agree on disseminating and investing in prioritized research.
Engagement	Involve communities, civil society and other stakeholders to increase demand and ensure access and coverage of essential maternal and new born care.

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Objectives

The objectives of the tool are:

- To support countries in assessing the status of progress and identifying barriers to implementation in line with ENAP recommendations.
- To support countries in using information they have gathered to define potential solutions and identify the type of technical assistance available or needed on a continuous basis.
- To provide information to country, regional and global partners to facilitate country technical support as needed.

Structure

The ENAP progress tracking tool consists of the following five sections:

SECTION 1 Country context for maternal and newborn health
This section provides background on key partners in maternal and child health (MNH); existing reproductive, maternal, newborn, child and adolescent health (RMNCAH) initiatives; Ministry of Health (MoH) focal point for newborn health and a newborn-related national coordination technical working group (TWG). The section is helpful for understanding the context and monitoring the evolution of partnerships and convening mechanisms.

SECTION 2 National/sub-national events on MNH
In this section, countries are requested to list national and sub-national events, past or upcoming (within six months), to inform partners of upcoming activities and facilitate support from the wider ENAP advocacy group, if required.

SECTION 3 Country MNH fact sheets
The country MNH factsheets are compiled from pre-existing global databases and do not require additional data collection or inputs from countries. The factsheets include the core ENAP indicators for which data is available and compiled by UNICEF HQ with data from global data sources: Commission on Information and Accountability (COIA), Countdown, Demographic and Health Surveys (DHS), Multiple Indicator Cluster Survey (MICS), State of the World Children (SOWC), and United Nations Inter-agency Group for Child Mortality Estimation (UN-IGME).

SECTION 4 Progress of Every Newborn country implementation for 2020
This section tracks progress in eight focus areas aligned with ENAP milestones, with tracer indicators to report status of progress and actions.

SECTION 5 Technical Assistance needs
Countries are requested to list their Technical Assistance (TA) needs, desired outcomes and a tentative timeline to help regional and global partners map country needs and respond according to the available capacities. A list of international consultants in newborn-related programming has also been developed by the ENAP Country Implementation Group.

Process of data collection

The information for these sections is led by the Ministry of Health (MoH) and gathered by a facilitating partner (Save the Children, WHO or UNICEF) in each country. The facilitating partner facilitates information collection through pre-existing coordination mechanisms for maternal and newborn health such as a TWG or a national steering committee under the leadership of the MoH. The information received from the countries is submitted to UNICEF for compilation at the global level. The proposed frequency of data collection is every six months.

Overview of progress

Eighteen countries had completed the tool at the end of November 2015; this included the 16 focus countries (Afghanistan, Angola, Bangladesh, China, Ghana, India, Indonesia, Kenya, Myanmar, Nepal, Pakistan, the Philippines, United Republic of Tanzania, Uganda, Viet Nam, Zimbabwe), and two additional countries Cameroon and Namibia.

SUMMARY BY SECTION

Section 1 Country context

All countries provided a list of the main RMNCAH initiatives they were currently engaged with. These included global initiatives such as A Promise Renewed, Helping Babies Breathe, Global Action Plan on Prevention of Pneumonia and Diarrhoea (GAPPD) and Scaling Up Nutrition (SUN). The regional initiatives Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA) and Early Essential Newborn Care (EENC) in the WPRO region were also highlighted.

The key partners supporting newborn programming are UN agencies (UNICEF, WHO and UNFPA), Save the Children, USAID programmes (JSI, MCHIP, Jhpiego, ASSIST) and professional associations of midwives, obstetricians, paediatricians and neonatologists, as well as international NGOs such as Mercy Corps and World Vision.

The names and designations of newborn focal points in MoHs are indicated by most countries that completed the tool. About half of the countries have a dedicated full-time position for newborn care at the national level. Only two countries, India and Ghana, indicated that they have a dedicated full-time position for newborn care at sub-national (state/regional) levels. The details of the TWGs on newborn care were provided by 16 out of 18 countries. Pakistan is in the process of notifying the TWG members and Nepal has not submitted details on the TWG.

Section 2 National/Sub-national events on maternal and newborn health

Countries provided the information on national MNH events (technical meetings, workshops, conferences, advocacy activities, etc.) organized during the last six months, specifying the date, key issues discussed and outcomes. Most of the events were related to advocacy on a specific issue such as care for pre-term babies or use of chlorhexidine for cord care, planning or strategy development, and trainings. Information was also provided on events planned for the next six months.

Section 3 Country MNH fact sheets

The ENAP-specific indicators were compiled by UNICEF HQ in individual country fact sheets in June 2015 and were updated in September 2015 after the release of new UN Interagency Global Mortality Estimates for child mortality and again in December 2015 for new maternal mortality estimates.

Section 4 Country progress of Every Newborn Country Implementation

This information was provided by each country according to the seven health system building blocks – leadership and governance, health information system, health service delivery, health financing, health workforce, essential medical products and technologies, and community ownership and partnership – and in relation to the ENAP milestones.

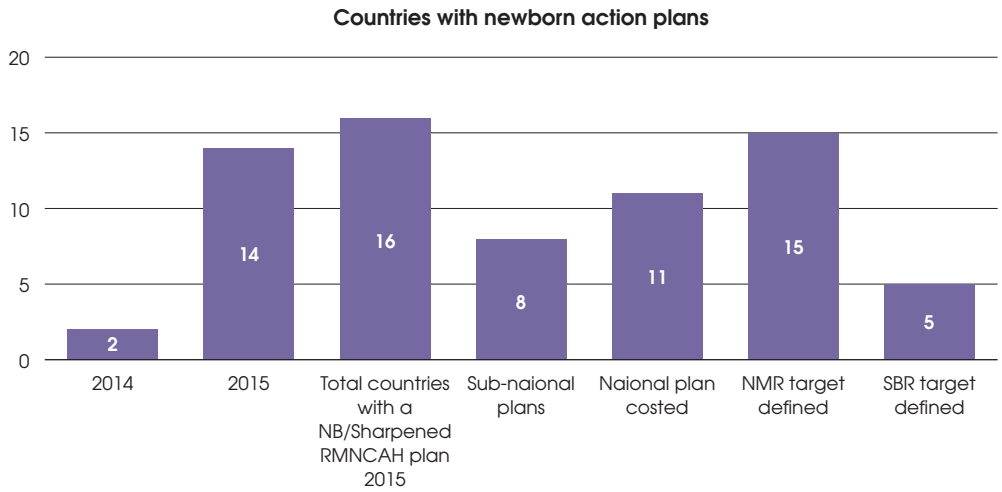
The information compiled from 18 countries from June to December 2015 presented in this section highlights the key areas of progress and challenges in ENAP implementation and is compared with the data received from the 10 countries in 2014.[2]

KEY AREAS OF PROGRESS AND CHALLENGES

I **Health system building block:** Leadership and governance
ENAP milestone: National plans and policies

Figure 1 and Table 2 below provide the number and names of countries that had developed and costed newborn action plans in 2014 and 2015.

Figure 1 Countries with action plans (n=18)



Note Countries developing a plan in 2015 include 12 with a standalone newborn action plan and four with sharpened RMNCAH plans. Eight countries have both newborn action plan and strengthened RMNCAH plans.

Table 2 Status of national plans

Indicator	2014 (n=10)			2015 (n=18)		
	Yes	In process	No	Yes	In process	No
National newborn action plan developed	Indonesia, Viet Nam (2)	Bangladesh, Kenya, Myanmar, the Philippines, Tanzania (5)	–	Afghanistan, Bangladesh, Cameroon, Ghana, India, Indonesia, Kenya, Myanmar, Nepal, the Philippines, Tanzania, Viet Nam (12)	–	Angola, China, Namibia, Pakistan, Uganda, Zimbabwe (6)

[2] Afghanistan, Bangladesh, Indonesia, Kenya, Myanmar, Nepal, Pakistan, the Philippines, Tanzania, Viet Nam.

Table 2 Status of national plans (continued)

Indicator	2014 (n=10)			2015 (n=18)		
	Yes	In process	No	Yes	In process	No
Newborn component strengthened in RMNCAH plan	–	Tanzania (1)	–	Afghanistan, Angola, Cameroon, China, India, Kenya, Myanmar, the Philippines, Tanzania, Uganda, Viet Nam, Zimbabwe (12)	–	Namibia, Pakistan (2)
Newborn Mortality Rate target defined In newborn or RMNCAH plan	–	–	–	Angola, Bangladesh, Cameroon, China, Ghana, India, Indonesia, Kenya, Myanmar, Nepal, the Philippines, Tanzania, Uganda, Viet Nam, Zimbabwe (15)	–	Afghanistan (1)
Stillbirth rate target defined in newborn or RMNCAH plan	–	–	–	Bangladesh, India, Indonesia, Nepal, Tanzania (5)	–	Afghanistan, Angola, Cameroon, China, Ghana, Kenya, Myanmar, the Philippines, Uganda, Viet Nam, Zimbabwe (11)
Specific activities for all ENAP milestones added, including scale-up of newborn-specific interventions in RMNCAH plan	–	–	–	Angola, Cameroon, India, Myanmar, the Philippines, Tanzania, Viet Nam (7)	–	Afghanistan, China, Uganda, Zimbabwe (4)
Newborn action plan costed*	–	–	–	Afghanistan, Bangladesh, Cameroon, China, Ghana, India, Kenya, Myanmar, Nepal, the Philippines, Tanzania, Uganda, Viet Nam (13)	Indonesia, Zimbabwe (2)	Angola, Namibia, Pakistan (3)
A dedicated full- time position for newborn care at national level available	–	–	–	Afghanistan, Bangladesh, Ghana, India, Myanmar, the Philippines, Tanzania, Uganda, Viet Nam (9)	–	Angola, Cameroon, China, Indonesia, Namibia, Pakistan (6)

Note The information in this report is based on progress tracking tools submitted by countries in 2014 and 2015. The timing of submission in 2014 may not have allowed capturing some of the completed newborn action plans and strengthened RMNCAH plans and there might be discrepancies with data presented in the 2014 ENAP progress report.

Of the 28 focus countries, only Viet Nam and Indonesia had finalized their plans in 2014. An additional 14 countries developed plans during 2015 indicating that the launch of the Global ENAP provided the guidance and impetus for the development of these national action plans or strengthening the newborn component in existing RMNCAH plans. It is also important to highlight that the five countries reporting plan development 'in process' in 2014 were able to finalize them in 2015. Afghanistan, Ghana and India had national newborn action plans dated 2014 though these were reported in the 2015 progress tracking tool. Similarly, Cameroon and China had revised RMNCAH plans before 2015.[3]

It is interesting to note that most countries that had developed a newborn action plan in 2014 and 2015 had conducted a bottleneck analysis workshop to identify the gaps in newborn care programming and build consensus around the proposed strategies and priority actions.

While some countries opted for developing a standalone newborn action plan, others reported sharpening their existing RMNCAH plans to include focused newborn activities and specified Neonatal Mortality Rate (NMR) and Stillbirth Rates (SBR) targets and activities in line with ENAP milestones.

Fifteen out of 16 countries with a newborn action plan or a sharpened RMNCAH plan had defined a target for NMR and only five out of 16 countries had an SBR target. Twelve countries have sharpened existing RMNCAH plans and seven of these have activities aligned with ENAP milestones. Eleven out of the reporting 18 countries have so far been able to cost their national plans and others are in process. Nine countries have a dedicated national full-time position for newborn care.

Eleven countries have a national Quality Improvement (QI) programme or initiative for healthcare (Table 3) and six of these have QI initiatives specific to maternal and newborn care (Afghanistan, Angola, Namibia, and Nepal). Fourteen countries have health workers at appropriate levels of care authorized to administer life-saving interventions and commodities. Afghanistan, Angola and Zimbabwe need focused attention on their health worker authorization issues. Eleven countries have adopted legislation or policies on the notification of maternal death within 24 hours (in line with recommendations from the Commission on Information and Accountability), and all countries have a policy on postnatal care home visits except Afghanistan, Angola, Nepal and the Philippines.

Table 3 Status of national policies

Indicator	2015 (n=18)		
	Yes	In process	No
National Quality Improvement initiative included in policies	Afghanistan, Angola, Bangladesh, China, Ghana, India, Kenya, the Philippines, Tanzania, Uganda, Zimbabwe (11)	–	Cameroon, Indonesia, Myanmar, Namibia, Pakistan, Viet Nam (6)
National QI Programme has specific focus on MNH	Angola, India, Kenya, the Philippines, Uganda, Zimbabwe (6)	–	Afghanistan, Cameroon, Ghana, Namibia, Tanzania (5)
Health workers authorized to administer life-saving MNH interventions	Bangladesh, Cameroon, China, Ghana, India, Indonesia, Kenya, Myanmar, Pakistan, the Philippines, Tanzania, Uganda, Viet Nam, Zimbabwe (14)	–	Afghanistan, Angola, Namibia, Nepal (4)

[3] Dickson, Kim E., et al., 'Every Newborn: Health-systems bottlenecks and strategies to accelerate scale-up in countries,' The Lancet, vol. 384, no. 9941, 2014, pp. 438-454.

Table 3 Status of national policies (continued)

Indicator	2015 (n=18)		
	Yes	In process	No
Policy adopted for maternal death notification	Angola, Bangladesh, China, India, Indonesia, Kenya, Myanmar, Tanzania, Uganda, Viet Nam, Zimbabwe (11)	–	Afghanistan, Cameroon, Namibia, Nepal, Pakistan, the Philippines (6)
Policy exists on home-based postnatal care	Bangladesh, Cameroon, China, India, Indonesia, Kenya, Myanmar, Namibia, Pakistan, Tanzania, Uganda, Viet Nam, Zimbabwe (13)	–	Afghanistan, Angola, Nepal, the Philippines (4)

II Health system building block: Health Information System
ENAP milestone: Data

ENAP progress monitoring includes mapping the coverage of four specific newborn care interventions i.e., use of antenatal corticosteroids, resuscitation, Kangaroo Mother Care (KMC) and management of neonatal sepsis (Table 4). Most countries have not included these indicators in their national Health Management Information Systems (HMIS). It is hoped that ongoing work by the Metrics group will be helpful to countries in adopting and tracking these indicators in a consistent fashion.[4] It is worth noting that the country responses have been varied for 2014 and 2015 in Table 4. For example, some countries (e.g., Myanmar and Kenya) reporting 'in process' status in 2014 ticked the 'No' column in 2015. India is the only country with all four newborn-specific indicators included in the national HMIS in 2015, although current functionality is limited to reporting by Special Newborn Care units (SNCU). The SNCU online monitoring developed by UNICEF in the state of Madhya Pradesh has been adopted by the Government of India for national scale-up.[5] Tanzania reported three indicators included in the HMIS: measuring resuscitation, KMC and management of sepsis. This has understandably been an area of limited progress due to lack of clear guidance.

Table 4 Status of data availability

Status of indicator inclusion in National HMIS	2014 (n=10)			2015 (n=18)		
	Yes	In process	No	Yes	In process	No
Eligible mothers given antenatal corticosteroids for foetal lung maturation[6]	–	Bangladesh, Kenya, Myanmar, Tanzania (4)	Indonesia, the Philippines, Viet Nam (3)	India (1)	Bangladesh (1)	Afghanistan, Angola, Cameroon, China, Ghana, Indonesia, Kenya, Myanmar, Nepal, Pakistan, the Philippines, Tanzania, Uganda, Viet Nam, Zimbabwe (15)

[4] See http://www.everynewborn.org/Documents/ENAP-metrics-webinar-11-march-2015-final.pdf.

[5] See http://www.unicef.in/Whatwedo/2/Neonatal-Health-#sthash.K5zmuoKM.dpuf.

[6] Suggestion is to remove this question from next survey till it is documented that ACS can be given practically, feasibly and without harm by following WHO's new guidelines.

Table 4 Status of data availability (continued)

Status of indicator inclusion in National HMIS	2014 (n=10)			2015 (n=18)		
	Yes	In process	No	Yes	In process	No
Eligible newborns receiving resuscitation	–	Bangladesh, Kenya, Myanmar, Tanzania (4)	Indonesia, the Philippines, Viet Nam (3)	Afghanistan, Bangladesh, India, Tanzania, Uganda (5)	–	Angola, Cameroon, China, Ghana, Indonesia, Kenya, Myanmar, Namibia ,Nepal, Pakistan, the Philippines, Viet Nam, Zimbabwe (13)
Eligible newborns that benefited from KMC	–	Bangladesh, Kenya, Myanmar, Tanzania (4)	Indonesia, the Philippines, Viet Nam (3)	India, Tanzania (2)	Kenya (1)	Afghanistan, Angola, Bangladesh, Cameroon, China, Ghana, Indonesia, Myanmar, Namibia, Nepal, Pakistan, the Philippines, Uganda, Viet Nam, Zimbabwe (15)
Eligible newborns treated for neonatal sepsis	–	Bangladesh, Kenya, Myanmar, Tanzania (4)	Indonesia, the Philippines, Viet Nam (3)	Afghanistan, Bangladesh, Cameroon, India, Indonesia, Nepal, Pakistan, Tanzania (8)	Kenya (1)	Angola, China, Ghana, Myanmar, the Philippines, Uganda, Viet Nam, Zimbabwe (8)

III Health system building block: Health service delivery
ENAP milestone: Quality

It is encouraging to note that although none of the countries reported having MNH QI guidelines and implementation plans in 2014, half of the countries reporting in 2015 responded in the affirmative.

Viet Nam and Myanmar reported national QI improvement guidelines to be in development and responded in the negative in 2015. This difference in reporting may be due to a subjective understanding of the different people reporting or filling in the tool. It also highlights the importance of the need for the tool information to be discussed in a stakeholder meeting and validated by the MoH.

All reporting countries, with the exception of Indonesia, reported having a Maternal Death Surveillance and Response (MDSR) mechanism in place in 2015 and more than half had a perinatal death review system in place. It is difficult to gauge the exact scope and functionality of MDSR systems in place with the limited information provided by the reporting countries. Uganda reported that 41 out of 155 health facilities (both public and private) were participating in MDSR and perinatal death reviews. China has 334 hospitals across the country enrolled in this process.

Table 5 Status of quality improvement guidelines and mechanisms

Indicator	2014 (n=10)			2015 (n=18)		
	Yes	In process	No	Yes	In process	No
National QI guidelines for MNH are available	–	Bangladesh, Kenya, Myanmar, Tanzania, Viet Nam (5)	Indonesia, the Philippines (2)	Afghanistan, Angola, Bangladesh, China, India, Kenya, Tanzania, Uganda (8)	the Philippines (1)	Camroon, Indonesia, Zimbabwe, Myanmar, Viet Nam, Nepal, Pakistan (7)
Plan available to implement the MNH QI guidelines	–	–	the Philippines (1)	Afghanistan, Angola, Bangladesh, Ghana, India, Kenya, Tanzania, Uganda (8)	the Philippines (1)	Cameroon, Zimbabwe (2)
MDSR mechanism in place	Bangladesh, Indonesia, Kenya, Viet Nam (4)	the Philippines, Tanzania (2)	–	Afghanistan, Angola, Bangladesh, Cameroon, China, Ghana, India, Kenya, Myanmar, Namibia, Nepal, Pakistan, the Philippines, Tanzania, Uganda, Viet Nam, Zimbabwe (17)	–	Indonesia (1)
Perinatal Death Review system in place	Indonesia (1)	Bangladesh, Myanmar, the Philippines, Tanzania (4)	Kenya, Viet Nam (2)	Afghanistan, Angola, Bangladesh, Cameroon, China, Indonesia, Kenya, Namibia, Tanzania, Uganda, Zimbabwe (11)	India, Ghana, the Philippines (3)	Myanmar, Viet Nam, Nepal, Pakistan (4)

IV Health system building block: Health financing
ENAP milestone: Investment

Sixteen countries reported having a free maternal health care policy, though implementation varies. Indonesia indicated that they are currently working on a broader universal health care agenda and progress is expected. Notably all the focus countries in South Asia, except for India, do not have insurance policies in place to cover care for sick newborns. In Africa, only Cameroon reported the lack of such a policy. The Philippines has developed a 'Prematurity Package' to provide health insurance coverage for premature newborns and is a good example for countries with an existing social health insurance system.

Table 6 **Status of investment in free maternal and newborn care services**

Indicator	2015 (n=18)		
	Yes	In process	No
Free maternal care policy/ national health insurance/ incentive schemes in place	Afghanistan, Angola, Bangladesh, China, Ghana, India, Kenya, Myanmar, Namibia, Nepal, Pakistan, the Philippines, Tanzania, Uganda, Viet Nam, Zimbabwe (16)	–	Cameroon, Indonesia (2)
Free newborn care policy/ national health insurance in place	Afghanistan, Angola, China, Ghana, India, Indonesia, Kenya, Namibia, the Philippines, Tanzania, Uganda, Viet Nam, Zimbabwe (13)	Nepal (1)	Bangladesh, Cameroon, Pakistan (3)
National health insurance scheme/free policy in place covering maternal and newborn care including sick newborns	Angola, China, Ghana, India, Indonesia, Kenya, Myanmar, Namibia, the Philippines, Tanzania, Uganda, Viet Nam, Zimbabwe (13)	–	Afghanistan, Bangladesh, Cameroon, Nepal, Pakistan (5)

Note Data only available for 2015.

V **Health system building block:** Health workforce
ENAP milestone: Health workers

In 2015, 13 countries indicated that they have developed a human resource plan or strategy for Skilled Birth Attendants (SBAs). With the exception of Bangladesh, China and Nepal, the same set of countries also reported availability of competency and a skill-based training curriculum for MNH. Many countries have indicated that they are aiming to increase the number of trained midwives to meet the current demands in the country, especially in remote and underserved areas where there is a general shortage of skilled health care providers in public health facilities. However, only five countries (Cameroon, India, Uganda, Viet Nam and Zimbabwe) reported in 2015 that they had a retention policy or strategy for SBAs. Their example will be a useful resource for other countries aspiring to develop human resource retention strategies for SBAs.

Table 7 **Status of health workforce strategies and competency development**

Indicator	2014 (n=10)			2015 (n=18)		
	Yes	In process	No	Yes	In process	No
A human resource plan/strategy for SBAs in place	Tanzania, Viet Nam (2)	Bangladesh, Kenya, Myanmar (3)	Indonesia (1)	Afghanistan, Angola, Bangladesh, Cameroon, India, Indonesia, Kenya, Myanmar, Pakistan, the Philippines, Tanzania, Viet Nam, Zimbabwe (13)	–	China, Namibia (2)
A retention policy/strategies for SBAs or relevant cadres in place	–	–	–	Cameroon, India, Uganda, Viet Nam (5)	Afghanistan (1)	Angola, Bangladesh, China, Indonesia, Kenya, Namibia, Nepal, Pakistan, the Philippines (9)
Competency and skill-based service/training/ education for MNH available	Indonesia, Myanmar, the Philippines, Tanzania, Viet Nam (5)	Bangladesh, Kenya (2)	–	Afghanistan, Angola, Cameroon, India, Indonesia, Kenya, Myanmar, Pakistan, the Philippines, Tanzania, Uganda, Viet Nam, Zimbabwe (13)	–	Bangladesh, China, Nepal (3)

Note There are fewer than 10 country reports for 2014 and fewer than 18 for 2015 due to missing responses.

VI Health system building block: Essential medical products and technologies

ENAP milestone: Innovation and research

All 18 reporting countries have included oxytocin and magnesium sulfate in their National Essential Medicines List (NEML). Although the others essential drugs are included in fewer country NEMLs (Table 8). The addition of recommended essential medicines and commodities for high-impact interventions in the NEML is one of the greatest areas of progress since 2014.

Table 8 Status of essential medical products and technologies

Indicator	2014 (n=10)			2015 (n=18)		
	Yes	In process	No	Yes	In process	No
Oxytocin included in the NEML	The Philippines, Viet Nam (2)	Bangladesh, Kenya, Myanmar, Tanzania (4)	Indonesia (1)	Afghanistan, Angola, Bangladesh, Cameroon, China, Ghana, India, Indonesia, Kenya, Myanmar, Namibia, Nepal, Pakistan, the Philippines, Tanzania, Uganda, Viet Nam, Zimbabwe (18)	–	–
Misoprostol included in the NEML	Viet Nam (1)	Bangladesh, Kenya, Myanmar, Tanzania (4)	Indonesia, the Philippines (2)	Angola, Bangladesh, China, India, Myanmar, Namibia, Nepal, Pakistan, Tanzania, Uganda, Viet Nam, Zimbabwe (12)	Afghanistan, Kenya (2)	Cameroon, Indonesia, the Philippines (3)
Magnesium sulfate included in the NEML	The Philippines, Viet Nam (2)	Bangladesh, Kenya, Myanmar, Tanzania (4)	Indonesia (1)	Afghanistan, Angola, Bangladesh, Cameroon, China, Ghana, India, Indonesia, Kenya, Myanmar, Namibia, Nepal, Pakistan, the Philippines, Tanzania, Uganda, Viet Nam, Zimbabwe (18)	–	–
Injectable antibiotics included in the NEML	The Philippines, Viet Nam (2)	Bangladesh, Kenya, Myanmar, Tanzania (4)	Indonesia (1)	Afghanistan, Angola, Bangladesh, Cameroon, China, India, Indonesia, Kenya, Myanmar, Namibia, Nepal, Pakistan, the Philippines, Tanzania, Uganda, Viet Nam, Zimbabwe (17)	–	–

Table 8 **Status of essential medical products and technologies** (continued)

Indicator	2014 (n=10)			2015 (n=18)		
	Yes	In process	No	Yes	In process	No
Antenatal corticosteroids included in the NEML	The Philippines, Viet Nam (2)	Bangladesh, Kenya, Myanmar, Tanzania (4)	Indonesia (1)	Afghanistan, Angola, China, India, Indonesia, Kenya, Myanmar, Nepal, Pakistan, the Philippines, Uganda, Viet Nam, Zimbabwe (13)	Tanzania (1)	Bangladesh, Cameroon (2)
Chlorhexidine included in the NEML	Viet Nam (1)	Bangladesh, Kenya, Myanmar, Tanzania (4)	Indonesia, the Philippines (2)	Afghanistan, Myanmar, Nepal, Pakistan, Uganda, Zimbabwe (6)	Kenya (1)	Angola, Bangladesh, Cameroon, China, Ghana, India, Indonesia, Namibia, the Philippines, Tanzania, Viet Nam (11)
Newborn resuscitation devices (Ambu bag and mask) included in the NEML	Viet Nam (1)	Bangladesh, Kenya, Myanmar, Tanzania (4)	Indonesia, the Philippines (2)	Afghanistan, Angola, China, Ghana, India, Indonesia, Kenya, Namibia, Pakistan, Uganda, Viet Nam, Zimbabwe (12)	Tanzania (1)	Bangladesh, Cameroon, Myanmar, Nepal, the Philippines (5)

Status of inclusion in Logistic Management and Information Systems

The inclusion of essential MNH commodities in Logistic Management and Information Systems (LMIS) is important to ensure the regular supply of these medicines and avoid stock-outs. Eight out of the 18 countries have included oxytocin, magnesium sulfate, injectable antibiotics and newborn resuscitation devices in their LMIS, seven have included misoprostol. Only four have included antenatal corticosteroids and two have included chlorhexidine. More effort is required to have antenatal corticosteroids and chlorhexidine included in the LMIS of countries which have included these in their NEML. Responses for these indicators are missing from many countries.

Table 9 **Status of inclusion of essential maternal and newborn commodities in LMIS**

Indicator	2014 (n=10)			2015 (n=18)		
	Yes	In process	No	Yes	In process	No
Oxytocin included in LMIS	The Philippines (1)	Bangladesh, Kenya, Myanmar, Tanzania (4)	_	Afghanistan, Indonesia, Myanmar, Pakistan, Tanzania, Uganda, Viet Nam, Zimbabwe (8)	Cameroon, India, Kenya (3)	Angola, Bangladesh, the Philippines (3)
Misoprostol included in LMIS	_	Bangladesh, Kenya, Myanmar, Tanzania (4)	The Philippines (1)	Bangladesh, Myanmar, Pakistan, Tanzania, Uganda, Viet Nam, Zimbabwe (7)	Cameroon, India (2)	Afghanistan, Angola, Indonesia, the Philippines (4)

Table 9 Status of inclusion of essential maternal and newborn commodities in LMIS (continued)

Indicator	2014 (n=10)			2015 (n=18)		
	Yes	In process	No	Yes	In process	No
Magnesium sulfate included in LMIS	The Philippines (1)	Bangladesh, Kenya, Myanmar, Tanzania (4)	_	Afghanistan, Indonesia, Myanmar, Pakistan, Tanzania, Uganda, Viet Nam, Zimbabwe (8)	Cameroon, India, Kenya (3)	Angola, Bangladesh, the Philippines (3)
Injectable antibiotics included in LMIS	The Philippines (1)	Bangladesh, Kenya, Myanmar, Tanzania (4)	_	Afghanistan, Indonesia, Myanmar, Pakistan, Tanzania, Uganda, Viet Nam, Zimbabwe (8)	Cameroon, India (2)	Angola, Bangladesh, the Philippines (3)
Antenatal corticosteroids included in LMIS	The Philippines (1)	Bangladesh, Kenya, Myanmar, Tanzania (4)	_	Afghanistan, Uganda, Viet Nam, Zimbabwe (4)	Cameroon, India, Kenya, Pakistan (4)	Angola, Bangladesh, Indonesia, the Philippines, Tanzania (5)
Chlorhexidine included in LMIS	_	Bangladesh, Kenya, Myanmar, Tanzania (4)	The Philippines (1)	Myanmar, Zimbabwe (2)	Afghanistan, Cameroon, Pakistan (3)	Angola, Bangladesh, Indonesia, the Philippines, Tanzania, Uganda, Viet Nam (7)
Newborn resuscitation devices (Ambu bag and mask) included in LMIS	_	Bangladesh, Kenya, Myanmar, Tanzania (4)	The Philippines (1)	Afghanistan, Indonesia, Myanmar, Namibia, Tanzania, Uganda, Viet Nam, Zimbabwe (8)	Cameroon, India (2)	Angola, Bangladesh, Kenya, Pakistan, the Philippines (5)

Note There are missing responses from countries; thus the number of reporting countries on each commodity is less than 18.

Prioritization of a research agenda

The prioritization of a research agenda for MNH has begun in 10 out of 18 countries planning in 2015. However, the issue of stillbirths needs to gain greater traction as only two countries, India and Viet Nam, indicated that they have planned research on this issue. All countries are required to develop an implementation research agenda relevant to their national newborn plans to understand how to bring life-saving interventions to scale in their context.

Table 10 **Status of prioritization of a research agenda**

Indicator	2014 (n=10)			2015 (n=18)		
	Yes	In process	No	Yes	In process	No
The country has prioritized a research agenda in MNH (as referenced in ENAP)	–	Bangladesh, the Philippines, Tanzania (3)	Indonesia, Viet Nam (2)	Afghanistan, Angola, Bangladesh, Cameroon, India, Indonesia, Nepal, the Philippines, Tanzania, Zimbabwe (10)	–	China, Pakistan, Uganda, Viet Nam (4)
The country has planned research focusing on stillbirths	–	–	The Philippines, Viet Nam (2)	India, Indonesia (2)	–	Afghanistan, Angola, Bangladesh, Cameroon, China, Kenya, Myanmar, Pakistan, the Philippines, Tanzania, Viet Nam, Zimbabwe (12)

VII Health system building block: Community, ownership and partnership

ENAP milestone: Parent voices and champions and community engagement

In 2015, five countries have developed communication plans while another four are in process. Ten countries reported having a community MNH engagement strategy. Countries have reported using existing networks and mechanisms of community mobilization including local community health workers and village health teams.

Table 11 **Status of community ownership and partnership activities**

Indicator	2014 (n=10)			2015 (n=18)		
	Yes	In process	No	Yes	In process	No
A national communication (advocacy, BCC/C4D) strategy on newborn developed	Viet Nam (1)	Bangladesh, Kenya, Myanmar, the Philippines, Tanzania (5)	Indonesia (1)	Ghana, Kenya, Tanzania, Uganda, Viet Nam (5)	Afghanistan, Bangladesh, India, the Philippines (4)	Angola, Cameroon, China, Indonesia, Myanmar, Namibia, Nepal, Pakistan, Zimbabwe (9)
A community MNH engagement/ mobilization strategy in place	Bangladesh, Indonesia, Tanzania (3)	Kenya, the Philippines (2)	Viet Nam (1)	Bangladesh, Cameroon, India, Indonesia, Kenya, Myanmar, Namibia, Pakistan, Tanzania, Uganda (10)	The Philippines (1)	Afghanistan, Angola, China, Nepal, Viet Nam, Zimbabwe (6)

Challenges and limitations

Only 16 out of the 28 focus countries submitted information on ENAP progress tracking, and in a number of them the tracking tool was not completely filled out. West and Central African countries had the lowest response rate, acknowledging that some of the countries in these regions faced considerable challenges due to the Ebola epidemic (Sierra Leone) and ongoing conflicts or crises (Chad, Central African Republic, Congo, Democratic Republic of the Congo, Guinea Bissau, Mali and Somalia).

Feedback indicates that in a number of countries the process of completing the tool has not been very inclusive of a variety of stakeholders, although specific guidance provided to the facilitating partner emphasized the importance of involving key partners in data collation under the MoH leadership. The tool guidance even suggests specifically using existing mechanisms or platforms such as the maternal or newborn TWGs to discuss the tool and jointly fill in responses during Working Group or Steering Committee meetings or even broader stakeholder meetings. This process requires strengthening to ensure more partners are engaged.

The 2015 revisions to the tracking tool do not allow complete comparability of certain responses. There were also inconsistencies in responses. Additionally there were also inconsistencies between 2014 and 2015 input by the same countries.

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Conclusion

In spite of the limitations and challenges there has been marked improvement in the process of tracking progress, and in 2015, the number of countries responding with the information on the ENAP progress tracking tool increased to 18 as opposed to 10 in 2014. These 18 countries included two countries, Cameroon and Namibia that were not focus countries but were interested in the process and voluntarily completed the Progress Tracking Tool and submitted the information. This is a positive development and partners should consider encouraging all countries with NMR greater than 10 to use the tool to map their progress at national and sub-national levels.

The main areas of progress in 2015 have been the development of national newborn action plans and the inclusion of life-saving maternal and newborn commodities in the essential medicines list. Areas requiring more attention in most countries are the inclusion of an SBR target in country newborn action plans, specific indicators in the HMIS, prioritizing newborn research agendas, the development or scale-up of communication strategies and community engagement.

In the coming year, efforts to initiate the process of progress tracking in the 12 focus countries that did not complete the tool need to be intensified as these countries have some of the worst newborn indicators. Technical assistance through consultants, joint partner missions to support progress tracking discussions and special regional events to advocate with country teams are some of the possibilities for intensifying support. All countries will also need to be encouraged to ensure that the completion of the tool is used for multi-stakeholder country review of progress. Greater sensitization of MoHs could increase the ownership of the ENAP progress tracking and facilitate more use of the data. Individual newborn country case studies such as those developed for Ghana, Myanmar, Pakistan and the Philippines could also highlight country progress and complement information gained from the tool.

Table 12 Estimates of NMR, SBR and MMR in ENAP focus countries

Country	NMR	SBR	NMR	Country	NMR	SBR	MMR
Afghanistan	36	29	396	Malawi	22	24	634
Angola	49	25	477	Mali	38	23	587
Bangladesh	23	36	176	Myanmar	26	20	178
Central African Republic	43	24	882	Nepal	22	23	258
Chad	39	29	856	Nigeria	34	42	814
China	6	10	27	Pakistan	46	47	178
Democratic Republic of the Congo	30	29	693	The Philippines	13	16	114
Ethiopia	28	26	353	Sierra Leone	35	30	1,360
Ghana	28	22	319	Somalia	40	30	732
Guinea-Bissau	40	30	549	Tanzania	19	26	398
India	28	22	174	Uganda	19	25	343
Indonesia	14	15	126	Viet Nam	11	13	54
Kenya	22	22	510	Zambia	21	26	224
Lesotho	33	25	487	Zimbabwe	24	20	443

Source NMR figures from UNICEF, 'Levels & Trends in Child Mortality: Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation', 2015, at http://www.childmortality.org/files_v20/download/IGME%20report%202015%20child%20mortality%20final.pdf. SBR figures from Cousens, S., H. Blencowe, C. Stanton et al., 'National, regional, and worldwide estimates of stillbirth rates in 2009 with trends since 1995: a systematic analysis', The Lancet, vol. 377, 2011, pp. 1319-1330, at http://www.who.int/entity/reproductivehealth/topics/maternal-perinatal/stillbirth/stillbirthspreadsheet.xls?ua=1. MMR figures from WHO, 'Trends in Maternal Mortality: 1990 to 2015 – Estimates by WHO, UNICEF, World Bank Group and the United Nations Population Division', 2015, at http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf?ua=1.

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Annex I: Every Newborn: Country implementation progress tracking tool report 2014

BACKGROUND

Every Newborn is a road map to save 3 million lives of newborns, women and stillbirths each year by improving quality care at the time of birth, and support for small and sick babies. Launched on 30 June 2014, and supported by a World Health Assembly Resolution (WHA67.10), the Every Newborn Action Plan (ENAP) is based on evidence published in The Lancet Every Newborn Series and also wider consultation with member states and multiple organizations and individuals. ENAP presents maternal and newborn mortality and stillbirth targets for 2030 and 2035 respectively, and specific milestones at the global and country level for 2020.

Every Newborn is action with a plan. WHA67.10 urges Member States to put ENAP into practice and requests periodic monitoring on progress to the Health Assembly. In addition, since 2010, at least 27 countries have made commitments relating to newborn health as part of the Every Woman Every Child initiative, with five countries committing specifically to the implementation of ENAP. Since the launch of the plan, many countries have taken action in response, and development partners have worked together to support government leadership, policymakers and programme managers in implementing the actions laid out in the plan. To better support implementation, three streams of work have been prioritized: (1) Country implementation, (2) Advocacy and (3) Data and Metrics.

As one of their activities, the ENAP Country Implementation Group (CIG)[7] monitors progress of ENAP implementation. As a first step, this group designed a tool to support countries in tracking ENAP implementation and progress towards achieving the national ENAP milestones. This report provides an overview of this tracking tool, the results and lessons learned.

DETAILS ABOUT THE TOOL

The ENAP CIG led the design and data collection of the tool, with UNICEF playing a lead role in this as well as in analysis, with support and review by all members of the CIG.

Objectives

The specific objectives of the tool are:

- To support countries in assessing the status of progress and identifying barriers to implementation in line with the ENAP recommendations;
- To support countries in using collected information to define potential solutions and identify the type of technical assistance available or needed on a continuous basis;
- To provide information to country, regional and global partners in order to facilitate country technical support as needed.

[7] CIG co- leads: WHO and UNICEF with core partners Save the Children, CIFF, BMGF, USAID.

Tool design

The tool design took place between August and October 2014. With the intention of being updated on a quarterly basis, the tool was designed to facilitate the provision of country technical support needed to scale up maternal and newborn health (MNH) programmes. The aim of the tool was not to measure intervention coverage (this is done through other mechanisms including the Commission on Accountability and Information, Countdown, etc.) or to provide a comprehensive assessment of progress made in the field of reproductive, maternal, newborn, child and adolescent health (RMNCAH), which is already done in countries through existing review mechanisms. It was also not the ENAP monitoring and evaluation (M&E) framework, which will be developed at a later stage to monitor ENAP outputs, outcomes and impact.

Content

The tool contains three sections:

1. Country context for MNH: This provides background on the list of key partners in MNH, existing RMNCAH initiatives, Ministry of Health (MoH) focal point for newborn health and a newborn-related national coordination technical working group (TWG). The section is helpful for understanding the context and monitoring the evolution of partnership and convening mechanisms.

2. National and sub-national events: This lists events past or upcoming (within three months), to inform global partners of upcoming activities and enable support from wider ENAP advocacy groups, if helpful.

3. Progress of ENAP national milestones for 2020: This information supports country tracking, and includes eight focus areas (aligned to ENAP milestones) with 15 tracer indicators to report the status of progress and actions.

The full tool is available in Annex II.

Data collection

We know that it is not feasible to systematically track detailed progress from all countries globally; thus the tracking tool was shared with 20 focus countries identified by the CIG in October 2014.[8] These countries were selected based on the basis of burden and the involvement of CIG members in country activities. The data collection process was supported by an 'Every Newborn facilitating partner'[9] who populated or completed the tool with input from the newborn focal point at the MoH, if available. The relevant MOH officials and key partners in the Technical Working Group (TWG) reviewed and discussed responses. Once completed, the facilitating partner shared the information with the ENAP global team.

Data sources included national RMNCAH strategies/plans/policies, national guidelines and standards, periodic program reports, country reviews, and existing project survey data. Information on progress made may also have been provided by relevant program managers at the Ministry of health or any other relevant ministries.

[8] Africa: Cameroon, DRC, Ethiopia, Ghana, Kenya, Malawi, Nigeria, Sierra Leone, Tanzania, Uganda, Zambia. Asia: Afghanistan, Bangladesh, India, Indonesia, Myanmar, Nepal, Pakistan, Philippines, Viet Nam.

[9] The facilitating partner is identified by the ENAP CIG. These partners are selected because they are already an active member of the Country Maternal and Newborn Health TWG. At the global level, the ENAP facilitating partner's organization is part of the broader Every Newborn Group (www.everynewborn.org).

Since it is a new tool, country teams were asked to also review the tool itself and provide feedback to the global level on the feasibility and usefulness of this tool for regular monitoring of progress. Information collected was asked to be shared with all relevant government representatives at the MoH to enhance evidence –based decision-making and implementation of effective strategies to address identified barriers in a coordinated manner.

Timeframe of development and data collection

The tool design took place between August and October 2014. The CIG members shared the tool with country teams in October 2014 and with facilitating partners. Data collection in countries took place from October to December 2014 and the information gathered was analysed in January 2015.

Results

Seven out of 20 countries returned a completed tool to the ENAP CIG – Bangladesh, Ethiopia, Kenya, Malawi, Myanmar, Nigeria and Tanzania. Reporting was inconsistent across countries and between indicators especially under the column 'Type of assistance needed'. Some countries did a good job in identifying specific needs, while others were vague or did not respond.

In order to assess the information across countries, we reviewed and categorized each tracer indicator response as 'yes', 'in process' or 'no'. Table 1 shows the categorization by country by indicator and includes reference to more details on the responses. Recognizing the subjectivity of the exercise and lack of validation by country teams of this categorization process (though validation is the next step), the categorization process helped to identify some issues with the tracer indicators. For example, the wording of Indicator 8 (Number of skilled birth attendants in health facilities trained in basic emergency obstetric and newborn care) did not include a time frame or benchmark for comparison which prevents tracking of progress and incomparability between different countries. Of the four countries who responded on Indicator 4 (Coverage of newborn specific indicators),[10] most indicated support was needed, a fair response given these same indicators have not yet been agreed and defined by the ENAP Metrics group. Only three countries responded on Indicator 11 (local adaption and development of key devices and commodities), indicating the tracer indicator may need to be revisited to clarify the question or that perhaps this is a gap in country activities. Very few countries had strong activities relating to the innovation and research milestone, with most responses categorized as 'in process' or incomplete. Community engagement and parent voices mostly had responses 'in process'. For these milestones, we should consider if the tracer indicators were not asked well or activities were actually not being done.

Only one country, Ethiopia, provided feedback on the tool itself suggesting the MoH found it useful. Other comments received from partners on the tool include the following:

- The need to spell out 'urban and rural' to ensure equity focus must be addressed.
- Consider rewording the MoH focal point for newborns under the country context section, given this may differ by country.
- Tracer indicators for health workers could include counselling skills.

[10] All four indicators to assess coverage for management of complications and extra care for newborns defined, tested, validated and integrated into routine HMIS (antenatal corticosteroid use, newborn resuscitation performed, newborns that beneficiated from KMC, treatment of neonatal sepsis).

- Reporting on deaths and coverage of management of complications is important but the lack of reporting on coverage of routine care (e.g., early initiation of breastfeeding, postnatal checkup etc.) is not clear.
- There is a possible need for a guiding document to assist countries in populating the tool.

INTERPRETING WHAT WE HAVE LEARNED

The tool needs to be revised

- The use of this tracking tool is low. We want a tool that is useful for countries to track progress without creating a huge level of effort for completion by the TWG. There are other tracer indicators to consider for each milestone that have already been collected as part of WHO policy monitoring and data collection (e.g., COIA and Countdown).
- Some of the tracer indicators need to be revised to be relevant (for e.g., indicators 4 and 8 as noted previously) and we should consider tracer indicators that are already monitored.
- For an ENAP tracking tool to be effective, countries need to update the tracking tool on a regular basis; however, this is difficult to do given the demands placed on TWGs.

Recommendation: Revise and simplify tool to fewer tracer indicators (no more than one per milestone) and try to use indicators that are already monitored by other mechanisms.

Recommendation: For tracer indicators requiring unique responses from countries, seek guidance on responses from ENAP advocacy and metrics teams, particularly those who sit across groups.

Recommendation: ENAP CIG to prepare responses based on knowledge they already have, and send them to ENAP facilitating partners in countries to validate responses.

Focusing on priority countries

- While the CIG country tracking process has not been comprehensive – primarily focusing on the 20 focus countries – regular updates from countries has helped to continue momentum, link the streams of ENAP work and build partnerships. Focus on the focus countries has been helpful in highlighting successes and identifying gaps.
- The 20 focus countries identified do not include some of the highest burden countries (by numbers or rates).

Recommendation: Revise priority list to include the top 10 countries with the highest neonatal mortality rates; top 10 countries with the highest newborn deaths, and additional countries that were tracked by the ENAP CIG.

Tracking progress for all countries

- To support countries in monitoring progress as per WHA67.10, a tracking tool should be available to all countries. Given a detailed tool that is focused on only one element of the RMNCH continuum may not be useful or practical for completion by many countries. A simplified tool that builds on indicators already monitored should be considered and tested before distributing widely.
- It is a massive undertaking to track progress on ENAP for all countries. For wider tracking beyond the ENAP CIG focus countries, a subset of countries that have not yet reached the ENAP neonatal mortality rate (NMR) and stillbirth rate (SBR) targets should be considered.

Recommendation: WHO should add one policy question specific to ENAP to their annual policy survey to track one ENAP indicator for all countries.

ENAP CIG should track one tracer indicator for all countries that have an NMR above 12 per 1,000 live births and an SBR above 12 per 1,000 births (105 countries). This tracer indicator should be the same one that WHO monitors in its annual policy survey.

The proposed list of countries to track both overall (105) and focus countries (28) can be viewed in this Excel document with tracer indicators included.

Table A ENAP tracking tool output from 2014

Focus Areas	Tracer Indicators	Africa					Asia				
		Ethiopia	Kenya	Malawi	Nigeria	Tanzania	Bangladesh	Indonesia	Myanmar	Philippines	Viet Nam
National plans: Sharpened national strategies, policies and guidelines for RMNCAH	1 National and/or sub-national maternal and newborn health (MNH) situation analysis conducted and validated	Yes (1)	In-process (1)	In-process (1)	Yes (1-2)	In-process (1)	In-process (1)	Yes (1)	In-process (1)	In-process (1)	Yes (1)
	2 Costed national plan	Yes (1-2)	In-process (2)	–	In-process (3)	In-process (2)	In-process (2)	No (2)	In-process (2)	In-process (2)	Yes (2)
Data: Count every newborn by improving and using programmatic coverage data including equity, quality gap assessments	3 Policies and guidelines on maternal deaths surveillance and response developed/endorsed	In-process (2)	Yes (3)	In-process (2)	In-process (4)	In-process (3)	Yes (3)	Yes (3)	–	In-process (3)	Yes (3)
	Policies and guidelines on perinatal deaths audits developed/endorsed	No	–	In-process (3)	In-process (4)	In-process (3)	In-process (3)	Yes (3)	No (3)	In-process (4)	–
	4 All four indicators to assess coverage for management of complications and extra care for newborns defined, tested, validated	In-process (3)	In-process (4)	–	–	In-process (4)	In-process (4)	No (4)	In-process (4)	No (5)	No (4)

Legend

Yes | In-process | – No information available | (Number) Refer below for detailed answers

Table A ENAP tracking tool output from 2014 (continued)

Focus Areas	Tracer Indicators	Africa					Asia				
		Ethiopia	Kenya	Malawi	Nigeria	Tanzania	Bangladesh	Indonesia	Myanmar	Philippines	Viet Nam
Quality: Adopt Every Mother Every Newborn Quality initiative standards and ensure commodity availability	5 National Every Mother Every Newborn Quality Improvement guidelines, standards and mechanism for MNH at all levels of the health system defined/ developed/endorsed	In-process (4)	In-process (5)	In-process (4)	In-process (5)	In-process (5)	In-process (5)	No (5)	In-process (5)	No (6)	In-process (5)
	6 All the 7 life-saving MNH commodities * included in the national Essential Medical List (NEML) and incorporated in LMIS	Yes (5)	In-process (6)	–	In-process (6)	Yes (6)	In-process (6)	No (6)	In-process (6)	In-process (7)	Yes (6)
Investment: Develop or integrate costed human resources for health strategy into RMNCAH plans and ensure sufficient financial resources allocated	7 Comprehensive costed human resource development plan	In-process (2)	In-process (7)	–	In-process (7)	Yes (7)	In-process (7)	No (7)	In-process (7)	In-process (8)	Yes (7)
Health workers: Ensure the training, deployment and support of health workers in particular midwifery personnel, nurses and community health workers	8 Number of skilled birth attendants in health facilities trained in basic emergency obstetric and newborn care	* (6)	* (8)	* (5)	–	* (8)	* (8)	Yes (8)	* (8)	In-process (9)	Yes (8)
	9 Competency and skilled based pre-service training reviewed/updated	Yes (7)	In-process (8)	Yes (6)	In-process (8)	Yes (9)	In-process (9)	Yes (9)	Yes (9)	Yes (10)	Yes (9)
Innovation and Research: Develop, adapt ad promote access to devices and commodities and agree on disseminate and invest in prioritized research	10 Prioritized research agenda for maternal and newborn health developed/reviewed, completed, funded and disseminated	In-process (8)	–	No	In-process (9)	In-process (10)	In-process (10)	No (10)	–	In-process (11)	No (10)
	11 Support for local development/adaptation of key devices and key MNH live saving commodities * to improve care for mothers and newborn babies	In-process (9)	No (10)	–	–	No (11)	In-process (11)	Yes (11)	–	Yes (12)	Yes (11)

Legend

Yes | In-process | – No information available

* Refer below for specific numbers of skilled birth attendants

(Number) Refer below for detailed answers

Table A ENAP tracking tool output from 2014 (continued)

Focus Areas	Tracer Indicators	Africa					Asia				
		Ethiopia	Kenya	Malawi	Nigeria	Tanzania	Bangladesh	Indonesia	Myanmar	Philippines	Viet Nam
Engagement: Involve communities, civil society and other stakeholders to increase demand and ensure access and coverage of essential maternal and newborn care	12 National community-based MNH strategies to improve demand for services, birth preparedness and essential newborn care practices	Yes (10)	In-process (11)	Yes (7)	In-process (10)	In-process (12)	In-process (12)	Yes (12)	In-process (10)	In-process (13)	Yes (12)
	13 Engaged and active in-country civil society organizations (CSOs) demand transparency and oversight and improve access	No (11)	In-process (12)	Yes (8)	–	Yes (13)	Yes (13)	Yes (13)	–	No (14)	In-process (13)
Parent voices and champions: Shift social norms so that it is no longer acceptable for babies die needlessly just as it has become unacceptable for women to die giving birth	14 Active use of Champions, media and/or local influential to advocate and promote change specific to social norms	Yes (12)	In-process (13)	In-process (9)	In-process (11)	Yes (14)	In-process (14)	Yes (14)	In-process (11)	Yes (15)	Yes (14)
	15 Community groups including women's groups and men engaged at district/regional level in MNCH advocacy and educational activities.	Yes (12)	No	Yes (10)	–	No (15)	Yes (15)	Yes (15)	In-process (12)	Yes (16)	Yes (15)

Legend

Yes | In-process | – No information available | (Number) Refer below for detailed answers

Detailed information per country:

AFRICA

Ethiopia

1 Both national maternal and newborn health situational analyses were conducted within the past five years based on strategies devised and sets of interventions developed.

2 Plans and strategies are in place but there is a need for funding support in order scale up.

3 Newborn resuscitation and treatment of neonatal sepsis are part of the routine HMIS. The HMIS was revised very recently and there is no current plan to revise it in the near future.

4 There is the national continuous quality improvement tool mainly focusing on HIV care and Prevention of Mother to Child Transmission (PMTCT) and another initiative on hospital paediatric care in selected hospitals. Need clarification on whether there is a QI tool for antenatal, childbirth and postnatal care. Country has requested support in improving the QI tools, material development and training of the health professionals.

5 All life-saving commodities are included in the essential drug list of the country except chlorhexidine and amoxicillin DT that are under process to be incorporated in the drug list. Coordination with MoH for chlorhexidine and amoxicillin DT to be incorporated in the drug list.

6 In the past three years a total of 4,000 health professionals were trained on basic emergency obstetric and newborn care.

7 USAID-funded HRH project is being implemented by Jhpiego that focuses on building capacity of health training institutions to deliver better, competency-based training. No national level plan at present.

8 Research agendas are being prioritized but not yet disseminated to research organizations. Support needed to undertake more research.

9 Chlorhexidine for cord care was adopted and production by a local manufacturer is underway but financial and technical (technology transfer) support needed for adaptation and local development of commodities like CPAP, amoxicillin DT and others.

10 More than 38,000 salaried government health extension workers deployed in health posts all over the country. The 16 packages are grouped into four, one major group being family health.

11 The in-country civil society organizations (CSOs) are not strongly engaged in the area of newborn health currently. It is one area which needs improvement in the future. No concrete plans in place to engage CSOs.

12 Religious leaders, celebrities and health ambassadors are being used to advocate and promote change regarding maternal and newborn health issues. (e.g., using celebrities for TV and radio spots) and the country is continuing with current activities.

13 A 'health development army' has been formed, which consists of a 1-to-5 network of women led by those who have adopted better health behaviour by completing the 16 packages of the health extension programme designed to influence each other to practice a healthy life style. Five such 1-to-5 networks of women form a women (health) development team and the country is continuing with current activities.

Kenya

1 A situation analysis has been conducted of progress on MDG 5, together with target setting for the post-2015 agenda, and an analysis of county -specific maternal and newborn mortality, The DHS is currently underway; preliminary results expected in January. However, the MNH situation has not been analysed as a whole though various assessments and studies have been conducted. There is also the issue of poor quality of DHIS reporting and the need for technical assistance.

2 An MNH Implementation Plan has been finalized for sign-off by the DMS and then adapted by counties for implementation. Technical support and funding resources are needed for scale-up.

3 Guidelines will be revised based on the findings of an MPDSR assessment that has been conducted and the recent WHO MPDSR guidelines. Technical assistance is needed for the revision of guidelines and financial resources to facilitate the process.

4 Technical assistance is needed to define and test coverage indicators.

5 Guidelines and standards have been defined, developed, endorsed and piloted. Resources are needed for scale–up.

6 CHX is not yet included in the EML but a request has been made to the secretariat together with requests for antenatal corticosteroids and misoprostol. Partner mapping and resource mobilization for the procurement of the three life-saving commodities for counties to initiate use while awaiting registration. Other local sources for these products need to be identified and national coordination of commodities is required at the national and county level.

7 There is no specific HRH strategy for MNH but a broader national HRH strategy exists. Resources are needed to help counties adapt and contextualize the national strategy, and for monitoring implementation. There is a need to align pre-service training curricula with current evidence based guidelines and updates.

8 Since 2012, when the national EmONC training programme commenced, 3,899 health professionals have been trained. In the Sept–Oct 2014 period (baseline period), 571 professionals were trained nationally: 49 doctors, 444 midwives/nurses, 78 clinical officers. There is a need to establish a database that includes change in practice.

9 Skills-based pre-service training has been updated for medical students. This includes maternal and newborn care during the antenatal, delivery and post-natal period at Kenya medical training College. The curriculum is under review.

10 Pilots are ongoing but not yet turned into policy. Advocacy is needed for the local adaptation of policy development and finances.

11 Technical assistance and financial resources are needed.

12 The First Lady is engaged in the Beyond Zero Campaign; media personalities are engaged as well. The counties need to be encouraged to identify and engage local champions.

Malawi

1 Recommendations are not being fully implemented due to inadequate funding, limited skilled health workers in most of the facilities, and quality RMNCAH care being improvised.

2 MDSR policies and guidelines have been developed and endorsed, and implementation is slowly being scaled out in five of the 28 districts.

3 Policies and guidelines are being discussed. Some districts and partners are implementing this strategy.

4 In progress. A facility assessment on care of the newborn has been planned.

5 A MICS survey has indicated that skilled institutional delivery is at 88.9 per cent, data is weak to respond and requires a computer package to calculate number.

6 Pre-service training is available in all nursing training institutions.

7 A national programme has been rolled out in all districts. However, the level of equity varies widely within each district and the quality of community-based MNH programme needs to be improved.

8 The country through RMNCAH grant has engaged a number of CSOs to improve demand and create awareness among communities. The Malawi Health Equity Network has received RMNCAH funding through UNICEF to increase demand for RMNCAH services. Activities conducted include briefing meetings with the District Health Management Team (DHMT), network members and other stakeholders, and training through radio listening clubs at meetings with local and community leaders.

9 Few media teams have been trained in newborn health issues for positive reporting, but there has been an improvement in media reporting on newborn health.

10 Women's groups are being championed by the NGO Maikhanda in selected districts.

Nigeria

1 A newborn situation analysis was done in 2011 and a newborn bottleneck analysis conducted in 2013/2014. Technical assistance and funds are needed.

2 Development of Nigerian ENAP is in process. Technical and financial resources are needed.

3 The Integrated Maternal Newborn and Child Health (IMNCH) strategy was revised in 2012/2013 without finalizing the costing section. An eventual costing revision was done to the 2007 edition. The Nigerian ENAP is yet to be developed or costed.

4 An MDR was developed and ratified by the National Council on Health in 2014 but not yet implemented. A perinatal death audit needs to be developed and integrated into the MDR and the MDR implemented.

5 Quality of Care (QoC) guidelines for MNCH services at secondary health referral centres are being pretested for national scale-up. The QoC protocol needs to be finalized and institutionalized. Quality Improvement (QI) systems, institutionalize ISS quarterly and TA and needs

6 Provisional approval has been received for chlorhexidine and ACS at secondary facilities only. Gentamicin and benzyl penicillin have been approved for all facilities while ceftriaxone is approved for referral only. A stakeholders meeting to build consensus on the appropriate levels for the remaining drugs including levels of care for ceftriaxone and amoxicillin

7 A profile of human resources for health was updated in 2012 but there is no profile specific for MNH. Strategic costing for IMNCH should include HR trainings, and a monitoring mechanism for HR is yet to be developed. A midwives service scheme and SURE-P (subsidy reinvestment and empowerment programme) MNCH are targeted at improving equity and distribution

8 Evidence-based curricula review is underway of the three cadres of Community Health Practitioners (JCHEW/CHEW/CHO) in a broad based continuum of MNCH involving all major thematics in health e.g., HIV, RH and FP. Stakeholders' involvement is also along these thematic areas and a needs assessment to gather critical data is ongoing among 69 schools of the Health Technology and CHO Training programme.

9 WHO commissioned researchers to work on priority MNH research questions in 2012 and the results are being awaited.

10 A National BCC strategy for newborn health was articulated in 2009 and is not currently under review to articulate a clear policy direction. Activities to generate demand are being organized in different corners of the country. The BCC strategy for maternal and newborn health needs to be finalized and disseminated.

11 More champions need to be engaged and their roles defined.

Tanzania

1. A mid-term review of the Road Map Strategic Plan 2008–2015 was conducted in 2013, and the rollout of the Sharpened Plan in all regions is ongoing including the RMNCH score card. Areas needing action are the following: strengthening LMIS to prevent stock-outs of essential commodities, improving case management of newborn sepsis and pre-term births and care during delivery and postnatal care, building capacity of health care providers on MNH including family planning. Building community awareness on the importance of the uptake of routine RMNCAH and emergency services and male involvement, and improving the quality of MNH services and resources to follow-up on the implementation of the Sharpened Plan and score card.

2 For RMNCAH Plan I (2008–2015) and Sharpened Plan (2014–2015), community awareness needs to be improved on the importance of the period between birth and the first week of life and tracking of every newborn birth and death needs to be improved as well.

3 Combined guidelines on maternal and perinatal death review surveillance and response were updated in 2013/2014. Currently it is awaiting approval, followed by printing and dissemination. Remaining actions include rollout training countrywide, conducting facility reviews at all hospitals and conducting technical reviews at national, regional and district levels.

4 Guidelines on the use of antenatal corticosteroids need to be finalized and disseminated.

5 A National Standard-based management for improving the quality of maternal and newborn care is available. Actions needed: review guidelines and rollout countrywide and support a nationwide rollout.

6 One of the seven life-saving MNH commodities (chlorhexidine) is not included in the national Essential Medical List. Advocacy and capacity for use of Life-Saving Commodities is required.

7 A comprehensive costed human resource development plan has been created that covers education and training for all cadres in the 2014–2019 period. Action needed: distribution of skilled HRH (urban/rural) and the implementation of motivation and retention packages. These are national priorities and resources must be leveraged for their implementation.

8 The number of SBAs is not available for the period under consideration. Challenges currently faced include insufficient number of simulators and inadequate visual teaching aids. The training of health workers on life-saving/EmONC needs to be scaled up, and additional simulators and visual teaching aid are required.

9 An Assessment of Competencies in Midwifery Training was conducted in 2010. Among the key findings was the poor performance in newborn competencies. A competency-based curriculum for midwifery training was developed in 2013, and is operational in selected training schools.

10 Research was identified as a priority. The national research agenda coordinated by the National Institute for Medical Research (NIMR) does not include research on stillbirths. There is a need for strengthening collaboration with research institutes to identify a newborn research agenda.

11 The present environment is not favourable for local manufacturers.

12 National community-based MNH strategies to improve demand for services, birth preparedness and essential newborn care practices, including home visits by designated community cadres have been defined, validated, and implemented in few regions (Morogoro, Mwanza, Shinyanga and Iringa). Operational research is underway. National rollout is planned and the recognition of CHWs within scheme of service is being developed.

13 Evidence for Action and White Ribbon Alliance were named as active CSOs. Actions needed: working with CSOs to advocate for ENAP and the Every Woman Every Child Initiative, and providing financial and technical support for advocacy and packaging of information for next year.

14 Many champions have been identified, including parliamentarians and celebrities. Increased engagement with parliamentarians, media and celebrities is needed and resources for engaging them is critical.

15 Community groups exist but no specific action has been reported over the requested time period (three months). Actions needed: community mobilization to form women's groups that will be engaged at the community level in advocating for MNCH, and resources for increasing the number and capacity of women's groups to advocate on MNCH.

ASIA

Bangladesh

1 The dissemination of the National Newborn Situation Analysis is expected in January 2015.

2 The country has two operation plans under the Health Population Nutrition Sector Development Program 2011-2016 have to costed Operation Plan (OP) – MNC&AH of DGHS and RMC-AH of DGFP for 2011-2016; that included newborn components. National Plan: *shared in WHO Regional ENAP and PNC Workshop

3 A primary draft of the Maternal Perinatal Death Review (MPDR) guideline has been developed and is being implemented in 10 districts but needs to be finalized.

4 Different initiatives have been taken to incorporate CHX, NR and sepsis-related indicators in DGHS and DGFP HMIS; piloting of the new indicators is needed.

5 SOP for newborn care in facilities was developed and endorsed in 2012; National Guideline for Kangaroo Mother Care, ACS, sepsis and CHX are in process. It is intended to finalize and operationalize the national QA/QI and accountability framework by December 15.

6 Five life-saving MNH commodities are already incorporated in the Essential Drug List (EDL); corticosteroid (dexamethasone) is also in the list but not with indication; CHX (7.1 per cent) is also not yet included. Initiatives have been taken to incorporate these two in the EDL; all are incorporated in the procurement list. Quality assurance of 7.1 per cent CHX product is in line with GMP procurement by MoH and WF (1 million doses)

7 There is no national costed human resource development plan that covers education and training for MNH, the distribution in urban and rural areas, motivation and retention of skilled personnel developed. A Human Resource for Health (HRH) strategy is in the process of development under MoH FW. There is a plan to develop a detailed scale-up plan of BENAP by October 15; advocacy is needed to synchronize it with developing a Human Resource for Health (HRH) strategy

8 The number of SBAs in health facilities trained in basic emergency obstetric and newborn care is not systematically recorded except for some data provided by cadre for different time periods.

9 Competency and skills-based pre-service training needs to be reviewed and updated with latest WHO guidelines and include maternal and newborn antenatal and delivery care.

10 Some initiatives taken to identify priority research agenda for key areas of maternal and newborn health including funding and planning for implementation research with local research organization, the MoH and international NGOs. Actions needed include agenda setting, planning and funding for research on stillbirth and prematurity issues.

11 Policy support for 7.1 per cent misoprostol production has been provided; oxytocin, antibiotics, MgSO4 and dexamethasone production are available in the market through local production. Initiatives are needed for local production of Resuscitation Devices (B&M and succor), ARI timer and baby-weighing machine.

12 No specific national, community-based MNH strategies exist but some initiatives have been taken, including the formation of CG and CSG, home visitation by CHWs of GO and NGO, and a plan to develop a national newborn campaign. New opportunities and challenges need to be assessed. Community groups, support groups (there are nearly 40,000 groups with 15 to17 members each); and the establishment of community clinics, one for every 6,000 of the population, and workload of HA and FWA.

13 Professional societies (Bangladesh Neonatal Forum, Bangladesh Perinatal Society, Bangladesh Pediatric Association and OGSB) played a partial role as CSO. Bangladesh Health Watch, Bangladesh Urban Health Network, Center for Policy Development also has ongoing activities.

The professional societies provide a platform for sharing programme, policy issues, new evidence and learning, and conduct formal and informal policy advocacy. The Bangladesh Breastfeeding Society works as a CSO for breastfeeding issues including updating and enforcement of the BMS code and facilitating the BFHI. SUN also has done work in the field of nutrition.

14 Some very influential and devoted professionals played a role as Champions to advocate and promote change in those social norms that pose challenges for improving maternal and newborn health.

15 Different community groups have been formed by the MoH and FW under the community clinic project. Coordinated initiatives need to be taken to use these huge networks to promote healthy MNH behaviour and improve care-seeking as well as ensuring the accountability of services.

Indonesia

1 National situational analysis on newborn is completed, the maternal health analysis is still on going.

Ensuring implementation of standard care is the main challenge to improve quality of maternal and newborn health.

2 National action plan for newborn is developed and endorsed by MoH on Oct 6th, 2014. Goal in national action plan is in line with targets and strategic objectives of the ENAP. No costed plan is being developed in all RMNCAH strategies.

3 Guideline on maternal death surveillance is developed and tested in 2 districts. It is endorsed by MoH but need to synchronize with CVRS from MOHA. Guideline and policy on perinatal death audit are in place and endorsed by all stakeholders. Implementation is mandatory but the real practice is vary in the districts

4 All of the four indicators has not yet integrated into routine HMIS

5 National Quality improvement guideline has not develop

6 Misoprostol, antenatal corticosteroid and chlorhexidine is not part of the 7 life-saving MNH commodities but it is available on the pharmacist department

7 No human resources development plan available

8 Only 18.6% health centre have capacity in providing BEmONC. It is team training and each team consist of medical doctor, 2midwives and 1 nurse. Only 11% midwives are competent in providing basic emergency and obstetric care

9 Competency and skilled based pre-service training has been reviewed and updated

10 No research agenda for maternal and newborn care developed

11 Policy and financial support for the local development or adaptation of key devices and commodities is in place

12 Birth preparedness and complication readiness strategy is in place as complimentary program to improve demand for maternal and newborn care and services. Three post-natal care visits is one indicator to be collected into regular HMIS system but it is emphasize on facility visit

13 MCH movement (GKIA) established in 2011. A qualitative study on civil society perspectives on policy and implementation of Indonesian maternal and child health programmes conducted in 2013. Result has been presented in Cape Town on October 2014

14 Issued related to maternal and child health issues are regularly published in national newspaper (Kompas daily) and there is a launched of serial promotion activities related to maternal and child health issues from August to November 2014 through different media including twitter, Facebook, path etc.

15 Parent's group is established and regularly engage on sub national MNCH advocacy

Myanmar

1 The National Newborn Situation Analysis was conducted and the draft is ready but not yet finalized for dissemination.

2 A Five-year Strategic Plan on Reproductive Health (2014–2018) has been launched; a four-year National Strategic Plan for Newborn-Child Health Development NSP-NCHD (2015–2018) is being drafted. The Myanmar Newborn Action Plan has been integrated into it. Technical assistance for the costing of NSP-NCHD or RMNCAH as a whole is required.

3 A perinatal-neonatal mortality database has been established in seven neonatal units in tertiary level hospitals. The establishment of neonatal-child death surveillance and response (CDSR) in Myanmar along with guideline development is under planning and discussion. Technical support to draft and roll out the CDSR guidelines is needed.

4 A MoH focal point is in discussions with the MoH HMIS focal point to incorporate these indicators into the HMIS.

5 Multiple quality improvement efforts are underway at the facility level including IMCNI and community level. Some modules need to be incorporated into curricula.

6 With the exception of chlorhexidine, antenatal corticosteroids and newborn resuscitation device have been incorporated into the NEML. Incorporating chlorhexidine into NEML is under discussion between the MoH newborn focal point and the NEML focal point. A national essential commodity list does not exist.

7 An HR Strategic Plan developed by the MoH with support from WHO and GAVI HSS exists but it is not costed, no implementation plan is available and no mechanism is in place to monitor its implementation.

8 SBAs received pre-service training on basic emergency obstetric and newborn care. The appointed numbers in the public sector are: 4,355 doctors, 8,927 nurses and 8,828 midwives (HMIS 2011).

9 A FMNCI module has been incorporated into the pre-service curriculum for medical students. An IMNCI module has been integrated into the midwifery pre-service curriculum.

10 A Community-based Newborn Care (CBNBC) module has been developed and rolled out in 26 townships with the support of UNICEF (including seven townships planned for 2015). It is one of the national level strategies. A Maternal Voucher Scheme supported by GAVI HSS has been piloted in one township.

11 A local NGO, MMCWA with its nationwide network, has been involved in MNCH service provision and the creation of demand. The 'Seven Things This Year' (STTY) initiative rolled out in 25 townships. Evaluation and documentation of STTY to observe behavioural change at the family level is yet to be implemented (resource mobilization to be done).

12 A faith-based organization, Rattna Myitta, has been reaching mothers and caregivers through Buddhist Monks with messages on newborn and child health care, education and child protection.

Philippines

1 Draft available

2 Draft available

3 Pilot with support of WHO in 2 regions. Guidelines to be developed. For technical assistance request by DOH to development partners

4 Three-year data 2010-2012 collected in DOH hospitals all over the country concerning preterm deaths, e.g. RDS

5 Formative research done by LRO in select DOH and LGU hospitals on ACS use 2014 (USAID-JHPIEGO)

6 EINC advance implementation in 11 hospitals to date. Scale-up implementation and planning workshops provided to select DOH hospitals – quality measures discussed and data management

7 National Formulary reflects antenatal corticosteroid, oxytocin, magnesium sulfate, parenteral antibiotics.

8 Draft Philippines Newborn Action Plan contains costed plan for HRH but only at Central level, LGU level not included

9 73% as per 2013 NDHS

10 Yes

11 Research agenda for newborn health submitted with funding support to Philippine Council for Health Research and Development (status needed follow-up)

12 MNCHN grant

13 There is national strategy deploying Community Health Teams but support is waning.

14 Yes – Alternative Budget Initiative of Social Watch

15 Advocacy partners assembled, two batches

16 Arugaan, Breastfeeding Pinay groups involved in breastfeeding and ENC Unang Yakap advocacies

Viet Nam

1 National and/or sub-national maternal and neonatal health (MNH) situation analysis was completed. Key challenges is financial resources for implementation.

2 Costed national plan that includes neonatal health within the continuum of RM-NCAH and nutrition is developed as part of national targeting programme on reproductive healthcare. Key challenge is financial resources for implementation.

3 Maternal Mortality Audit is developed and being implemented national wide. Key challenge: capacity of provincial staff in making remedial actions need to be improved; death report should be updated and shared regularly.

4 Not yet integrated in the national HMIS but in the reproductive health system. Key challenges are to ensure timely reporting and quality of data.

5 National Quality Improvement guidelines, standards and mechanism for MNH is partly being included in the Annual Hospital Quality Assurance.

6 All the 7 life-saving MNH commodities are included in the National Essential Medical List.

7 A comprehensive costed human resource development plan that covers education and training for MNH is being implemented with a loan from World Bank.

8 0.36 OBGYN specialists (basic level specialist and above) per 10,000 population, 0.25 paediatricians (basic level specialist and above) per 10,000 population, 1.16 general doctors are providing OBGYN/ and paediatric services per 10,000 population, 3.55 OB/Paed associate doctors and secondary midwives per 10,000 population.

9 Competency and skilled based pre-service training is reviewed and updated.

10 A prioritized research agenda for maternal and neonatal health is not yet developed. Research on stillbirth is not included. Research and surveys are quite ad-hoc manner based. Key challenge: budget support.

11 Policy and financial support for the local development or adaptation of key devices and commodities is in place.

12 National community-based MNH strategies to improve demand for services, birth preparedness and essential neonatal care practices, including home visits by designated community cadres is part of the national targeting programme on reproductive healthcare. Key challenges: budget support and innovation in communication.

13 In-country civil society organizations (CSOs) are engaged. A number of NGOs such as Save the Children, Pathfinder are supporting maternal, child and neonatal care activities. They are member of the Reproductive Health Affinity Group (RHAF). Bi-annual working groups are organized.

14 Media is being used through implementation of campaign on world breastfeeding week (media activities include press meeting, video launch, photo exhibition, talk show on BF, etc.).

15 Community groups including women's groups and men are engaged at district/regional level in MNCH advocacy and educational activities through implementation of national action plan on reproductive healthcare, and the national targeting programme on reproductive healthcare. These are partly reported. Key challenges are use of information and technologies and innovations for communication and social mobilization.

Annex II: Tracking tool 2014

EVERY NEWBORN
Country implementation tracking tool

GUIDANCE NOTE

The Every Newborn Action Plan (ENAP) has been developed with the support of countries and partners. The action plan sets out a vision of a world in which there are no preventable deaths of newborns or stillbirths, where every pregnancy is wanted, and babies and children survive, thrive and reach their full potential. The ENAP established national milestones to support reproductive, maternal, newborn, child and adolescent health (www.everynewborn.org).

Purpose and scope

- The purpose of the tool is to track ENAP implementation and progress made by countries towards achieving the national milestones. Special emphasis is placed on tracking processes that are in place to ensure ENAP is implemented.
- The tool is a pathway to inform countries and partners on progress made on a quarterly basis and to facilitate the provision of country technical support needed to scale up MNH programmes.
- It is a standard tracking sheet that can be used in all countries, whether the country has a separate newborn plan/strategy, or the newborn plan/strategy is integrated into the national RMNCAH plan.
- The tool is not designed to measure intervention coverage (done through other mechanisms including COIA, Countdown, etc.) or provide a comprehensive assessment or progress made in the field of RMNCAH, which is already done in countries through existing review mechanisms.
- The tool is not the ENAP M&E framework, which will be developed at a later stage to monitor ENAP outputs, outcomes and impact.

Objective

The tool is used to respond to the specific objectives:

- To support countries in assessing the status of progress and identifying barriers to implementation in line with the ENAP recommendations;
- To support countries in using collected information to define potential solutions and identify the type of technical assistance available or needed on a continuous basis;
- To provide information to country, regional and global partners in order to facilitate country technical support as needed.

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Data collection

- Data will be collected every six months.
- The 'Every Newborn facilitating partner', who is an active member of the Country Maternal and Newborn Health (MNH) Technical Working Group (TWG) will support the data collection process. At the global level, the ENAP facilitating partner's organization is part of the broader Every Newborn Group (www.everynewborn.org).
- The tool will be populated or completed by the newborn focal point at the MoH. The facilitating partner will support the MoH in this process. Findings should be discussed with key partners during the TWG meetings. Progress update should be clearly communicated to all members of the TWG. Once the form is completed, it should be sent back to the ENAP team at the global level.
- Possible data sources include national RMNCAH strategies, plans and policies, national guidelines and standards, periodic programme reports, country reviews and existing project survey data. Information on progress made will also be provided by relevant programme managers at the MoH or any other relevant ministries.
- Information collected should be shared with all relevant government representatives at the MoH to enhance evidence-based decision making and implementation of effective strategies to address identified barriers in a coordinated manner.

EVERY NEWBORN
Country implementation tracking tool

Country name: ..... Facilitating partner: .....
(Name, Agency)

Note Information collected from September through November 2014 will be considered most recent and used as baseline to populate the global database. Some questions, such as country context information, will not be collected on a regular basis once the baseline data is available. Please note that indicators are standardized for all countries to facilitate comparison and reporting. However, constructive feedback from countries to improve the formulation of indicator would be appreciated.

COUNTRY CONTEXT

List key partners in MNH	
Existing RMNCH initiatives	e.g.: CARMMA
Ministry of Health focal point for newborn	
National TWG (members, focal points and affiliation/agency)	

NATIONAL/SUB-NATIONAL EVENTS ON MATERNAL AND NEWBORN HEALTH

1 Please, provide information on national MNH events (technical meetings, workshops, conferences, advocacy activities, etc.) organized during the last three months; Specify date, key issues, outcomes.

Events and dates	Key issues discussed	Outcomes of event or meeting	Key coordinating partners (Please, attach events report)
1			
2			
3			

2 Please, provide information on **up-coming** national MNH events for the **next three months**; Specify date and objectives

Events and dates	Objectives of the meeting	Key coordinating partners
1		
2		
3		

TRACKING PROGRESS TOWARDS EVERY NEWBORN ACTION PLAN NATIONAL MILESTONES FOR 2020

Focus areas	Tracer indicators	Status of progress Where are you now? Why? Describe the challenges, barriers that you are currently facing?	Actions Describe solutions and type (local, external) of assistance needed
National plans: Sharpened national strategies, policies and guidelines for RMNCAH	1 National and/or sub-national maternal and newborn health (MNH) situation analysis conducted and validated within the last 5 years with an agreement on a core set of interventions and packages for the local context.		
	2 Costed national plan that includes newborn health within the continuum for RMNCAH and nutrition is developed/ sharpened, endorsed/validated by all key stakeholders and funded. National action plans should be in line with goals, targets and strategic objectives of the ENAP.		
Data: Count every newborn by improving and using programmatic coverage data including equity, quality gap assessments	3a Policies and guidelines on maternal deaths surveillance and response developed, endorsed by all stakeholders, and implemented in health facilities/hospitals.		
	3b Policies and guidelines on perinatal deaths audits developed, endorsed by all stakeholders, and implemented in health facilities/hospitals. Please specify the scale of implementation (regional, district)		
	4 All four indicators to assess coverage for management of complications and extra care for newborns defined, tested, validated and integrated into routine HMIS (Antenatal corticosteroid use, newborn resuscitation performed, newborns that beneficiated from KMC, treatment of neonatal sepsis)		
Quality: Adopt Every Mother Every Newborn Quality Initiative standards and ensure commodity availability	5 National Quality Improvement guidelines, standards and mechanism for MNH (e.g.: Every Mother Every Newborn) defined/developed, endorsed by key stakeholders, and implemented. Implementation could be at small/pilot (region, districts) or large scale (nationally) but should be specify in the comments		
	6 All the 7 life-saving MNH commodities* are included in the national Essential Medical List (NEML) and incorporated in LMIS to detect commodity stock outs at the facility level. *Please note that there is an exception for Chlorhexidine in countries with NMR<30 per 1,000 live births as per WHO guidelines*		

* Commodities as includes in the UNCoLSC

TRACKING PROGRESS TOWARDS EVERY NEWBORN ACTION PLAN NATIONAL MILESTONES FOR 2020 (continued)

Focus areas	Tracer indicators	Status of progress Where are you now? Why? Describe the challenges, barriers that you are currently facing?	Actions Describe solutions and type (local, external) of assistance needed
Investment: Develop or integrate costed human resources for health strategy into RMNCAH plans and ensure sufficient financial resources are allocated	7 Comprehensive costed human resource development plan that covers education and training for MNH, the distribution in urban and rural areas, motivation and retention of skilled personnel developed, funded, and implemented. A monitoring mechanism is in place to track implementation of the HR plan		
	8 Number of skilled birth attendants in health facilities trained in basic emergency obstetric and newborn care. *Provide separate numbers for doctors, nurses, and midwifes. Note that national estimates are preferable. Please specify if data are collected from project/program in selected regions in the country.*		
	9 Competency and skilled based pre-service training reviewed/updated with latest WHO guidelines and includes maternal and newborn care during antenatal care, delivery, and post-natal care		
Innovation and Research: Develop, adapt and promote access to devices and commodities and agree on disseminate and invest in prioritized research	10 A prioritized research agenda for maternal and newborn health developed/reviewed, completed, funded and disseminated to local research organizations and development partners. Please, specify whether or not the research agenda includes research on stillbirth.		
	11 Policy and financial support for the local development or adaptation of key devices and commodities* to improve care for mothers and newborn babies		

* Commodities as includes in the UNCoLSC

TRACKING PROGRESS TOWARDS EVERY NEWBORN ACTION PLAN NATIONAL MILESTONES FOR 2020 (continued)

Focus areas	Tracer indicators	**Status of progress** Where are you now? Why? Describe the challenges, barriers that you are currently facing?	**Actions** Describe solutions and type (local, external) of assistance needed
Engagement: Involve communities, civil society and other stakeholders to increase demand and ensure access and coverage of essential maternal and new born care	12 National community-based MNH strategies to improve demand for services, birth preparedness and essential newborn care practices, including home visits by designated community cadres defined, validated, and implemented. Strategies should be in line and part of national health plan. Specify if Implementation is at small/pilot (region, districts) or large scale (nationally) but should be specify in the comments		
	13 In-country civil society organizations (CSOs) are engaged and active to demand transparency and oversight and improve access to, and quality of, maternal and newborn care (social accountability). CSOs activities could be at small / pilot (region, districts) or large scale (nationally) but should be specify in the comments. *Please provide specific examples of activities conducted during the data collection period and attached short document if space is not sufficient*		
Parent voices and champions: Shift social norms so that it is no longer acceptable for babies to die needlessly just as it has become unacceptable for women to die giving birth	14 Champions, media and/or local influential are being used actively at the sub-national level (region, district) to advocate and promote change specific to social norms that pose challenges for improving maternal and newborn health (e.g. stigma related to pre-term or small babies, preference for bottle feeding over breastfeeding, etc.). *Please provide specific examples of activities conducted during the data collection period and attached short document if space is not sufficient*		
	15 Community groups including women's groups and men are engaged at district/regional level in MNCH advocacy and educational activities. *Please provide specific examples of activities conducted during the data collection period and attached short document if space is not sufficient*		

Every Newborn management team