Indicator description	**Newborn lives saved**
Version	Quest 4264865 version 1.1
Changes since last version	This is a new methodological note
Type of indicator	Cumulative
Methodological summary	This indicator measures DFID's contribution to the number of newborn lives saved. It considers the impact of programmes on reproductive, maternal and newborn health (RMNH); human immunodeficiency virus (HIV); malaria; other health; water, sanitation and hygiene (WASH); nutrition; humanitarian assistance; and general and health sector budget support. Because mortality data are reported infrequently, results on this indicator are obtained by modelling. Country offices complete a data collection template with information on each of their relevant programmes obtained from logframes and annual reviews. John Hopkins University has been contracted to run the estimation of lives saved from the information provided in the data collection template, using the Lives Saved Tool (LiST)[1]. For bilateral general or health sector budget support, the model estimates DFID's contribution to the results based on DFID's funding share. For support to specific programmes, the model estimates DFID's contribution to the results as 100% where DFID is solely responsible for delivery; or as the appropriate funding share where DFID works in partnership with other agencies.
Rationale	**Definition: newborn (neonatal) mortality is the death of a live-born baby within 28 days of birth.** Reducing child mortality is the fourth millennium development goal (MDG4). Its associated target is to reduce by two-thirds, between 1990 and 2015, the under-five mortality rate. More than 40% of deaths in children younger than 5 years occur during the neonatal period[2]. Therefore reducing these deaths is an important element of achieving the planned reduction in under-five mortality. Factors influencing the risk of neonatal death include maternal health, antenatal care, management of pregnancy/birth complications, hygiene during and after delivery, and care of the baby[3]. Many of these factors have strong cultural determinants, which need to be taken into account when planning interventions to reduce mortality. For example, women may have low status in society and inadequate nutritional status at conception. They may have their first child at a young age, and go on to have a high number of closely-spaced pregnancies. Practices such as inadequate cord care, leaving the baby wet and cold, discarding colostrum and inappropriate feeding may be widespread[3].

[1] John Hopkins Bloomberg School of Public Health, 2013. LiST: the lives saved tool. Available from http://www.jhsph.edu/departments/international-health/centers-and-institutes/institute-for-international-programs/list/.

[2] United Nations Inter-agency group for child mortality estimation, 2012. Levels and trends in child mortality. United Nations Children's Fund, New York. Available from http://www.unicef.org.uk/Latest/Publications/Child-Mortality-Child-Survival/

[3] World Health Organization, 2006. Neonatal and perinatal mortality. Geneva. Available from whqlibdoc.who.int/publications/2006/9241563206_eng.pdf

	DFID considered three options for measuring maternal and newborn lives saved through DFID funding. These were: 1. internal DFID monitoring, 2. selecting through competitive tender an external provider to undertake the monitoring, and 3. direct contract with John Hopkins University to model results using LiST.

Option 1 (internal DFID monitoring) was considered limited because data on newborn mortality are unavailable or not robust in many developing countries, particularly those which lack vital registration systems. Even where systems are in place, infrequent reporting renders it problematic to measure year-on-year progress towards the target.

Option 2 (selecting through competitive tender an external provider to undertake the monitoring) was considered limited because of the delay in generating the first set of results and the significantly greater time requirement from DFID staff compared with other options.

Option 3 (direct contract with John Hopkins University to model results using LiST) was considered the best option. Results are robust and credible within the global community, and could be generated within 1-2 months.

Therefore DFID's results on newborn lives saved are obtained by modelling undertaken by partners at John Hopkins University using LiST. LiST generates country-specific estimates of newborn lives saved from information on DFID's health-related programmes, their coverage, the best scientific evidence on the effectiveness of interventions, and publicly available demographic, family planning, HIV and cause of death data.

LiST was developed for the World Health Organization (WHO) and United Nations Children's Fund (UNICEF) over a period of 10 years by the child health epidemiology reference group (CHERG) and collaborators. Systematic reviews on the effectiveness of interventions that impact on newborn mortality informed the development of the tool[4]. Where robust epidemiological evidence was lacking, estimates were obtained from consultation with experts using a Delphi process (formalised consensus method). The model and parameters are updated regularly to reflect the most recent knowledge available. LiST is built into the Spectrum Policy Modelling Software, which is freely available. |
| Country office role | Country offices delivering programmes on RMNH, HIV, malaria, other health, nutrition, WASH, humanitarian assistance, or general or health sector budget support are asked to complete a data collection template. Information is requested on all relevant programmes of at least a year's duration during the period 2010 to 2015.

A formal update of the data collection template will be requested annually in October for return in November. Country offices will receive the preliminary results of the modelling in February for their validation or comments. Any adjustments required to the models will be made before submission of final estimates is required for the DFID results framework (DRF) return and annual report. Final lives saved estimates will be submitted centrally by human development department. Any updates to health-related programmes during the year will be |

[4] Darmstadt GL, Bhutta ZA, Cousens S, Adam T, Walker N, De Bernis L. *Evidence-based, cost-effective interventions: how many newborn babies can we save?* Lancet 2005; 365: 977-988.

	incorporated at the next round of data collection. As well as being required in the DRF, the results of the modelling are expected to be useful to country offices in the preparation of new business cases. The next training workshop on LiST will take place in November 2014. Discussion of estimates is welcomed by Johns Hopkins University. Support on completion of the template is given by Human Development Department.
Data sources	Data on country programmes are available from logframes and annual reviews. Information on the total government health budget comes from the ministry of health. Where possible, actual expenditure rather than planned expenditure should be used. Information on DFID's funding allocation is available from approved business cases.
Reporting organisation	DFID
Data included	1. For all programmes being delivered for at least one year between 2010 and 2015 which have an impact on health: • programme name • location • duration • population size • description • DFID spend, and • proportion of programme due to DFID. 2. Total government health expenditure. 3. For all sub-national programmes listed under 1 above, where information is known: • population • fertility • mortality, and • nutrition. 4. For all programmes noted under 1 above: • whether any of the listed periconceptual, antenatal, childbirth, malaria, vaccine, nutrition, case management of illness, food insecurity, and HIV indicators are being measured • any unlisted but similar indicators that are being measured, and • actual and forecast coverage or number of interventions delivered by year for each applicable indicator.
Data calculations	Country offices are not required to undertake any calculations
Good performance	In 2010, DFID committed to a target of saving 250,000 newborn lives. Results will be delivered over a period of five calendar years from 2011 to 2015
Return format	The data collection template should be returned by email
Data dis-aggregation	Country offices provide only input data to the model; no disaggregations are required

Data availability	Country offices are asked to populate the data collection template with information already available from programme logframes and annual reviews. Where the information required for the template is not readily available, country offices are not expected to seek it out.
Quality assurance measures	The completed data collection template should be checked by a second adviser before being submitted. Results from the modelling will be shared with the country office for validation before being finalised.
Data issues	Problems with data or completion of the template should be documented within the template. Support is available from human development department.