

USAID/ETHIOPIA REPORTING TEMPLATE

Maternal and Child Health Integrated Program

Submitted by Jhpiego

PROGRESS REPORT FOR

FY 2013

October 1, 2012 – September 30, 2013

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October, 2013

Addis Ababa

List of acronyms and abbreviations

ANC	Antenatal Care
ART	Anti-retro Viral Therapy
ARV	Anti-retro Viral
BEmONC	Basic Emergency Obstetric and Newborn Care
CKMC	Community based Kangaroo Mothers Care
EMA	Ethiopian Midwives Association
ENC	Essential Newborn Care
FP	Family Planning
FMOH	Federal Ministry of Health
HBB	Helping Babies Breathe
HC	Health Centre
HEW	Health Extension Workers
HIV	Human immune deficiency virus
iCCM	Integrated Community-based Case Management
IMNCI	Integrated Management of Newborn and Child illnesses
KMC	Kangaroo Mother Care
LQAS	Lots Quality Assurance Sampling
MCHIP	Maternal and Child Health Integrated Program
MNCH	Maternal Newborn and Child Health
MSD	Medical Services Directorate
NCSTWG	National Child Survival Technical Working Group
PHCU	Primary Health Care Unit
PMTCT	Prevention of Mother to Child Transmission of HIV
PP-FP	Post-Partum Family Planning
PP-IUCD	Post-Partum Intra Uterine Contraceptive Device
PQI	Performance Quality Improvement
PRCMM	Performance Review and Clinical Mentoring Meeting
RHB	Regional Health Bureau
SMS	Short Message Service
SNNPR	Southern Nations Nationalities and Peoples Region
TWG	Technical working Group

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General Information

Program/Project title	Maternal and Child Health Integrated Program (MCHIP)
Prime partner	Jhpiego
Cooperative agreement(contract) number	GHS-A-00-08-00002-000
Program/project start date	March 2011
Program/Project end date	September 30, 2014
Life of Project budget	Year Three Obligations: MCH: \$2,000,000 FP: \$1,000,000 PMTCT: \$1,200,000 Total Field Funds (PY3/PY4): \$4,200,000 Urban Health MCHIP Core funds: \$203,302 Year Two Carry over: \$3,412,000 Total Field and Core funds Budgeted for PY3 and PY4: \$7,815,302
Reporting period	October 1, 2012 – September 30, 2013

Background/Introduction

The goal of the MCHIP Ethiopia program is to reduce maternal and newborn morbidity and mortality in Ethiopia; the strategic objective is to increase use of and coverage of high impact maternal and newborn interventions including the reduction of maternal to child transmission of HIV. The program builds upon current and previous USAID supported efforts in four regions, namely Tigray, Amhara, Oromia and Southern Nations and Nationalities People (SNNP), which have been identified by USAID as priority regions. Within these regions there are a number of existing USG-funded programs, including the Integrated Family Health Program and the Community –based Prevention of Mother to Child Transmission Project (PMTCT). MCHIP’s physical presence in these regions is supporting a stronger focus on facility based Maternal Newborn and Child Health (MNCH) to work towards Government targets to increase facility utilization and provide a comprehensive approach to MNCH and PMTCT service delivery. In addition to its regional level support, MCHIP also provides national level technical assistance in a number of critical areas, such as roll out of the national essential newborn care program, strategic guidance to the national in-service training program for Basic Emergency Obstetric and Newborn care (BEmONC), and the national family planning (FP) program. This support is coordinated through the relevant technical working groups.

Summary of key accomplishments and successes

In FY 13, MCHIP continued to engage in national and regional level MNH activities by playing a leading role in the Safe Motherhood, PMTCT, FP and Child Survival Technical Working Groups (TWGs). After conducting and sharing a review of the literature on cultural barriers that affect utilization of health facilities, MCHIP has **integrated women friendly and respectful maternity care** into the MNH services in its supported facilities, through training, educating staff and raising awareness including through the development and distribution of job aids and mentoring during integrated supportive supervision. MCHIP has finalized the draft report documenting nine **promising MNH practices**, which includes MCHIP’s Performance Quality Improvement (PQI) approach. The Federal Ministry of Health (FMOH) is now in a position to use the report to identify practices they would like to scale-up.

To strengthen the government’s demand generation strategy for MNCH services, MCHIP provided technical assistance to facilities and woredas for the **monthly pregnant women meetings** to educate pregnant women on the importance of institutional delivery by skilled providers and to build the trust of the community on their respective health facilities. Similarly MCHIP technically supported **Primary Health Care Unit (PHCU) meetings** to ensure that MNCH issues are recurring topics in the agenda for these regular meetings and assist facilities to strengthen linkages with their surrounding health posts and community.

MCHIP supported the **Ethiopian Midwives Association (EMA)** to strengthen the professionalization of midwifery in Ethiopia. A Memorandum of Understanding has been signed with EMA and MCHIP supported the association to strengthen its regional chapter offices, network with midwifery teaching universities and strengthen ties with its members.

MCHIP activities to improve and standardize the quality of facility level MNCH services continued with the implementation of the PQI approach which is now present in **116 supported facilities** (104 health centers and 12 hospitals). Site expansion has been more notable in Oromia and Tigray regions where MCHIP has expended upon request of the RHBs. Based on gaps identified in the PQI process MCHIP has provided BEmONC training, donated materials and supplies to facilities and provided direct financial support to Woredas to lead the quality improvement process.

MCHIP contributed in the Government's roll out of Option B+ treatment approach and finalized revision of the PMTCT training packages by FMOH. Upon request from the government, MCHIP introduced PMTCT service to eight facilities in SNNP and Oromia. A total of **24,242** pregnant mothers were counseled and tested for HIV in ANC (Antenatal Care) clinics and outreach programs in 44 MCHIP facilities; among these **8,446** (34.8%) were tested with their partners.

In FY13, MCHIP had substantial engagement in national FP activities. Technical and financial support was given to FMOH in hosting national and international FP forums such as the National Family Planning Symposium. The Post-Partum Intra Uterine Contraceptive Device (PP-IUCD) training materials were successfully incorporated into the national comprehensive FP training package. MCHIP developed a pool of national PPIUCD trainers and increased the number of facilities providing PPIUCD insertion from **8 to 18**. A total of **9,541 mothers were counseled for PPIUCD** and **543 insertions** have been done by MCHIP trained providers in 26 facilities that are implementing the Post-Partum Family Planning (PP-FP) services as part of comprehensive MNCH.

As part of evaluating the feasibility of implementation of **Kangaroo Mother Care at community** level, five out of ten Primary Health Care Units (PHCUs) were supported to assess the coverage and quality of community MNCH services (including Community based Kangaroo Mothers Care, CKMC). The findings from the Lots Quality Assurance Sampling (LQAS) assessment guided PHCUs and woreda health offices to improve their support for Health Extension Workers (HEWs) and Health Development Army (HDA) to conduct home visits and improve postpartum care.

MCHIP continued implementation of the Integrated Community-Case Management (ICCM) in Oromia. Performance Review and Clinical Mentoring Meetings (PRCMM) were conducted in the region with the review indicating that ICCM services are of good quality with an average of 75% assessment and classification agreement and 58% classification and treatment agreement for all cases of malaria, pneumonia and diarrhea. Cognizant of the high rates of child and neonatal mortality rates in the region and upon request from Afar RHB, MCHIP initiated ICCM implementation in **five woredas of two zones in Afar region**.

In this reporting period MCHIP organized **regional annual review meetings** in Amhara, Oromia, SNNP and Tigray to share experience and lessons from program implementation with

stakeholders and partners. MCHIP also organized special information sharing forums called “**knowledge and experience sharing events**” to MCHIP supported and non-MCHIP facilities and woredas to build local ownership and sustainability and share success of implemented interventions.

Two rounds of **integrated supportive supervision** were conducted in **85 supported facilities**, and health workers were coached on-site. Major observations from the visit were that women friendly care has been integrated in routine MNCH services and the overall quality of MNCH services is continually improving using PQI.

Detailed description of achievements by results

Overarching Activities across all Intermediate Results

In FY13 MCHIP organized regional annual review meetings in the four regions it works in to update stakeholders and partners on MCHIP program implementation and share work plan highlights with government counterparts. The MCHIP team shared its experiences and lessons learnt from implementation across all program areas, in particular on the PQI approach to improve the quality of MNCH services. The review meetings included site visits to selected health facilities to showcase the tangible changes brought about in MCHIP supported sites by providers, health facility managers and woreda and zonal level officers.

In a new initiative MCHIP held special knowledge sharing events in the four supported regions with the objective of sharing implementation experiences and successes in improving quality of care by bringing health managers, providers and clients together at the facility level. Participants came from zones, woredas, health facilities and neighboring woreda and facilities that are not supported by MCHIP. These events demonstrated how the PQI process has empowered providers and managers to assess and address performance gaps in MNH service delivery. Furthermore it created an opportunity to present a sense of ownership and sustainability for quality improvement efforts and for woredas and health facilities where the PQI approach is not being implemented to learn how to take quality improvements efforts forward, thus expanding the reach of the PQI approach.

Intermediate Result 1 : MNCH and PMTCT services improved by enhancing and strengthening the enabling environment for MNH care

Communication and Advocacy

In FY13, MCHIP continued providing technical assistance to the National MNH, PMTCT and FP and Child Survival Technical Working Groups at the FMOH. Significant contributions are:

- Provided technical assistance to the FMOH in the development of national MNCH policies, strategies and training materials such as:

- Adaptation and endorsement of the USAID ACCESS Program FP Post-Partum Intra Uterine Contraceptive Device (PPIUCD) training materials, and their inclusion into the national comprehensive FP training package;
- Finalization of the National Basic Emergency Obstetric Newborn Care (BEmONC) training package. The revised training package was approved by the FMOH for printing.
- Revision of the national PMTCT training package and job aids. As result, the Option B+ treatment approach was incorporated into the revised PMTCT training package;
- Contributed in the Safe Motherhood TWG for the development of national MNH policies and actively participated in the:
 - Review of the national campaign for demand generation for PMTCT and inventory of PMTCT communication materials for printing and distribution during the 2013 Safe Motherhood Campaign;
 - Review and finalization of the FMOH's Maternity Waiting Homes Guidelines;
 - Review of the Monthly Pregnant Women Meetings Guide. MCHIP also provided technical assistance during meetings conducted in its selected sites. During the meetings the importance of key danger signs during pregnancy, the importance of institutional delivery, the role of male partners in preparing for birth, and complication readiness were discussed. For example, in Shelle Health Center in SNNP Region, pregnant mothers that completed the 4th antenatal visit and lactating mothers that delivered in the facility were recognized during a pregnant mothers' meeting in order to encourage others to use the service;
- Actively participated in the National Child Survival TWG through;
 - Providing support to the review process of the National Child Survival Strategy, including inclusion of community based newborn care into the existing strategy, and the development of a detailed implementation plan to strengthen MNH care in a selected 100 woredas;
 - Technically assisting to the African Leadership for Child Survival meeting held in Ethiopia in January 2013;
 - Representation and technical and financial support for the Ethiopia country team delegation that attended the Global Newborn Health Conference in Johannesburg in April 2013. Support extended to cover travel costs of the Director of the Health Promotion and Disease Prevention Directorate at the FMOH to attend this important conference, and development of posters on Newborn Health Care for Ethiopia which were presented during the global conference;
 - In response to the World Health Organization Africa Regional Office's request for proposals from countries on life saving commodities that address key challenges to provide basic MNH care for women and children, MCHIP contributed in the National



Recognition of pregnant and lactating mothers in Shelle HC during pregnant mothers' meeting

Child Survival TWG, on the proposal development which was then submitted to the UN Commission on Life-Saving Commodities for Women and Children.

- Developed and distributed posters and job aids on women friendly services for the 2013 Safe Motherhood Campaign.
- MCHIP provided regular technical support to the PHCU meetings by ensuring that MNCH is prioritized in the meeting agenda. The meetings emphasized the role of the HEWs to orient the HDAs and increase demand for institutional delivery and HIV testing and counseling (HTC). MCHIP's regional and zonal staff were instrumental in these meetings in providing facility staff with information and knowledge on key MNCH issues and guidance on integrating women friendly care into their routine services.
- Actively participated in annual health review meetings organized by RHB of the four regions, and provided targeted financial assistance to selected annual meetings. MCHIP used these meetings as opportunities to share good practices in its supported facilities. During the Tigray Regional Annual Health Review Meeting the MCHIP supported woreda, Degu Tembien, was recognized for its best performance in MNH.

MNH programs informed on cultural barriers to accessing MNH care

MCHIP has completed the literature review to identify cultural and behavioral barriers that inhibit women from seeking institutional MNCH care, and disseminated it to the FMOH, RHB and partners. During the integrated supportive supervision it was possible to observe that a number of facilities are already integrating women friendly care into their practice. This is described in more depth in IR2. MCHIP also advocated for women friendly care by developing posters and job aids on women friendly care and distributed them at various events including the 2013 Safe Motherhood Campaign.

Documenting promising practices in MNH

MCHIP has worked through the FMOH Safe Motherhood TWG to identify and document promising practices in MNH. Comments on the draft report of the shortlisted and verified promising practices were finalized during a two day meeting held with FMOH and other key stakeholders. The draft report was approved by the FMOH and is currently undergoing final editing and formatting before printing and dissemination. Based on suggestions by the FMOH the promising practices were extended beyond MNH to FP and reproductive health. PMTCT was excluded as promising practices in PMTCT have already being documented. MCHIP's PQI approach is among the nine selected practices and MCHIP is working with the Medical Services Directorate at the FMOH to endorse the approach. For other practices the FMOH will identify which of the identified practices it wants to scale up.

Strengthening the Professionalization of the Ethiopian Midwife Association

MCHIP continued its technical and financial support to the Ethiopian Midwives association (EMA) to lead the professionalization of midwifery in FY13. Major activities implemented during the year include:

- Provided financial and technical support for the annual EMA General Assembly meeting in November 2012. During the meeting MCHIP made a presentation on evidence based care in MNH to 150 member midwives attending the assembly from all over the country;
- MCHIP supported the Midwife of the Year award. The award, initiated by MCHIP in 2011 was designed to motivate midwives by recognizing their contributions. This is the second year the award has been made and the EMA was able to lead the award selection process with minimal support from MCHIP. In this assembly three best performing midwives received the award.
- MCHIP supported the International Day of the Midwife in May 2013. During this celebration, MCHIP provided technical and financial support for a one day knowledge update session on “Research in Midwifery” for 120 participants.
- A Memorandum of Understanding between MCHIP and EMA was signed. The MOU is aimed to clarifying responsibilities and expectations of both parties to facilitate the execution of planned activities as per the work plan. One of the key deliverables is building the capacity of the regional chapters. To date, two regional meetings for Amhara and Oromia chapter offices have been held in April and August, 2013 for a total of 298 midwives;
- MCHIP provided technical and financial support for a two day networking meeting for midwifery departments of universities and health science colleges. 32 instructors, department heads and midwives from 31 institutions attended the networking meeting. The purpose of the meeting was to improve the quality of midwifery education nationally and share experiences and best practices in the teaching and learning processes of midwifery, and discuss ways to improve the quality of midwifery education.



From left to right: Sr. Andinet Sisay, Sr. Fikirte Jemal and Ato Dereje Tassew awarded for the Best Performing Midwives of 2012

Intermediate Result 2: Availability, accessibility and quality of Key MNH and PMTCT services improved

Performance and Quality Improvement (PQI)

In an effort to obtain FMOH approval for the PQI approach, Standards-Based Management and Recognition (SBM-R) that MCHIP is using, MCHIP staff organized a re-orientation session on SBM-R for the FMOHs Medical Service Directorate (MSD) staff including the then acting director of the MSD. The MSD has selected a senior officer as a focal person to guide the approval process. The MSD is also placing quality of service delivery as a priority and has reformed the National Delivery Service Quality Improvement TWG, as well as a newly established working group focusing on quality of delivery services for MNH. MCHIP is actively participating

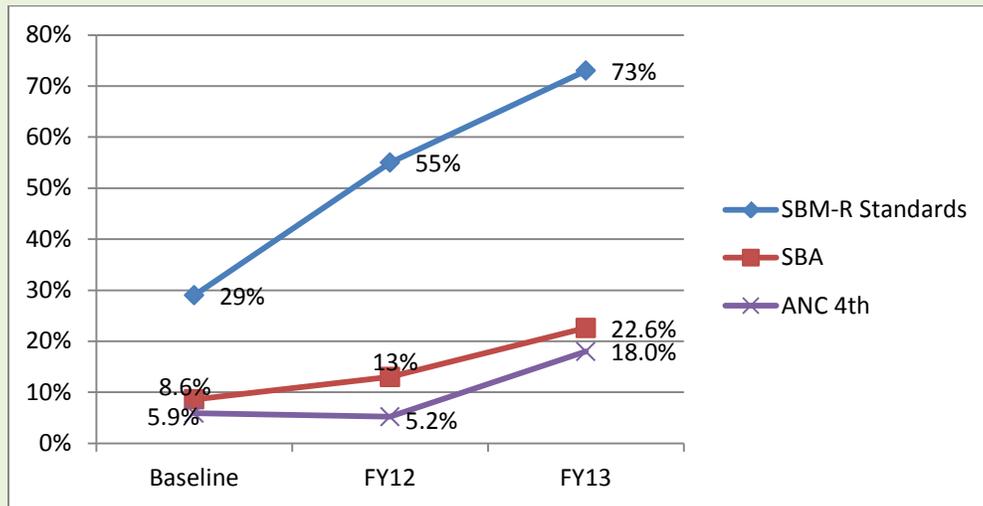
in the TWG and working group meetings. With the return of the director of MSD from his overseas study, and re-structuring of the MSD, MCHIP will continue engagement with the MSD as well as continue discussions with the newly formed MCH Directorate to obtain approval if not endorsement of SBM-R.

In response to a request from the MSD, MCHIP supported the directorate to conduct site visits to 6 “Lead Hospitals” in Oromia (2), Amhara (2) and Tigray (2) regions. The purpose of the site visits was to provide onsite technical support and coaching to providers on the 10 chapters of the Ethiopian Hospitals Reform Initiative Guidelines. MCHIP’s support was in the areas of infection prevention and nursing care; areas that MCHIP’s PQI process is in alignment with.

In October 2012 MCHIP supported the Annual Review Meeting of the Health Sector Development Plan which was held in Amhara Region. Two MCHIP supported HCs, Adet and Merawi HCs, were showcased for the annual meeting for their improved quality in MNCH services. This serves as recognition for the HC staff who were highly motivated following the visit.

At facility level MNCH services are being improved by MCHIP through SBM-R in **116** supported health facilities in the four regions (104 HC, 12 hospitals). To date three rounds of the modular, SBM-R workshops have been conducted, and SBM-R has been introduced and strengthened facilities resulting in a gradual and visible improvement of services. Through the results from the SBM-R assessment facilities have been able to mobilize resources, either within their facility using the facility income or by advocating with the woreda for additional resources such as staff. To date MCHIP has trained a total of **774** health workers, woreda, zonal and regional health officials and MNCH experts in SBM-R in the 116 facilities (*See Annex 3 for details*). An overall increase in the quality of MNH services has been noted in a number of these facilities since SBM-R was introduced. These improvements are reflected in the some key MNCH indicators such as increases in institutional delivery, first ante-natal care visits, 4th ante-natal care visit, post-natal care visits in the facility and newborn resuscitation. Figure 1 shows changes in selected key indicators vs. the percent of SBM-R standards achieved. While MCHIP accepts that there are a number of newly introduced initiatives such as the HDA that are likely to have increased facility utilization, MCHIP and the facility providers consider that SBM-R is contributing greatly to the improvements seen in MNCH service delivery.

Figure 1 MCHIP Supported Sites Average Performance in Key MNH Indicators and SBM-R Standards, 2011-2013



Throughout the year, MCHIP staff have provided site level technical assistance to support PQI activities in the facilities. Immediately following the SBM-R Module I workshop, baseline assessments were conducted for new PQI implementing sites to identify major gaps in MNCH services and set MNCH and PMTCT service targets. Through routine follow-up visits MCHIP staff have provided guidance to facility staff on how to identify performance gaps and solve problems using cause analysis techniques providers learned in Module II SBM-R workshop. In addition, facilities in Amhara, Oromia, SNNP and Tigray regions that have been implementing PQI efforts since 2011¹, are now ready for benchmarking, external verification and recognition.

MCHIP also provided financial support to 11 Woredas in Amhara, Oromia and in SNNP. The support is aimed at complimenting support to facility level quality improvement efforts and strengthens ownership of PQI to Zones and Woredas. The investment builds capacity of woreda health offices to independently lead the PQI even beyond the life of the project. MCHIP also organized a supervisory skills training for 42 regional, zonal and woreda health experts to improve their knowledge and skills on conducting effective supportive supervisions in their respective woredas.

During the year, MCHIP has donated and distributed essential medical supplies and equipment to **73** sites. These include items such as newborn weighing scales, autoclaves, examination beds, delivery beds, baby towels and hats, and infection prevention supplies. These items were identified gaps during the baseline assessment conducted at the start of the PQI process.



MCHIP donation of materials and equipment at Chitu Health Center, South West Shoa Zone, Oromia Region.

¹ The number of MCHIP sites has expanded during the life of the project. Some sites had PQI introduced in 2011, additional sites were added in 2012 and 2013 and are therefore at a later stage of PQI implementation.

In FY13 MCHIP conducted two rounds of integrated supportive supervision (ISS) to a total of 85 health facilities with the woreda and zonal level staff. Supervision was conducted using a comprehensive ISS tool that is a checklist designed to assess all MNCH, PMTCT and FP services in MCHIP supported sites. The tool has been finalized following field testing. Some key activities during supervision visits were:

- On-site coaching for health care providers. With the participation of the Zonal and Woreda's officials that were present during the ISS, service delivery gaps were identified and addressed, and an action plan with timelines was developed to respond to gaps. Some health facilities have addressed gaps by mobilizing resources from their health care financing (income generated by service fees) and other partners (local and international) working in the Woreda and region;
- In SNNP Gamo-Goffa Zonal health department and the Woreda health office have already began incorporating selected SBM-R standards into their routine Integrated Supportive Supervision checklist.

After actively participating in the PQI process and observing transformative changes made by facilities that have put in place quality improvements using the SBM-R tool, some zones have requested MCHIP to provide them with technical support so that they can scale-up PQI efforts themselves in non-MCHIP supported woredas and health facilities in their zones. As an example of this ownership Hadiya Zone in SNNPR region initiated a benchmarking visit for other HCs in their woredas that are not supported by MCHIP facilities to the two MCHIP supported HCs, Morsito and Homacho HC.



Locally made blood film slide drier, in Shelle HC



Locally manufactured screen in Homacho HC

SBM-R ignites creativity in MCHIP supported health facilities:

In Shelle HC the lab technician created a local blood film slide drier (see photo). This has reduced waiting time for clients to obtain blood test results as slides were previously air dried.

In Homacho HC staff made a screen using metal and shema, a locally made cotton fabric, to give clients privacy for during examinations. The facility also did not have installed tap water in the ANC and labor rooms, so to ensure proper hand washing practices, before and after examination, facility staff gave modified empty drug containers they found in their store as water containers. These containers have plastic taps and have become good alternative until tap water is fully installed.

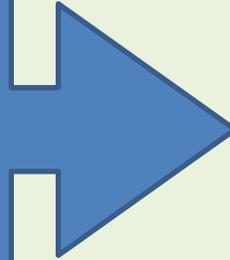
Client satisfaction assessment method to receive service feedback from illiterate clients

MCHIP supported sites have started assessing client satisfaction for illiterate mothers. Color coded cards have been developed to indicate level of service satisfaction. The health professionals who are providing the service at each service delivery point orient the client about different color cards in relation to their satisfaction level and then the clients put the cards in the box according to their satisfaction level. The following definition of colours:

Red Card- Service not good, needs considerable improvement

Yellow card- Service fairly good but needs improvement

Green Card- Very good, keep it up



Client satisfaction assessment method to receive service feedback from illiterate clients used in some MCHIP sites

Maternal, Newborn and Child Health (MNCH)

MCHIP supported sites have shown improvements in ANC and delivery services utilization provided at the supported health facilities. Improvements can in part be attributed to the improved quality of service. MCHIP has provided **BEmONC training for 64 health care providers** from MCHIP supported facilities to fill the knowledge and skill gaps identified in MNH care provision. This training helped health workers to improve their knowledge, skill and confidence in providing evidence based MNH care. Most of the MCHIP supported facilities have integrated respectful maternity care into their service provision. Examples include inviting pregnant women to tour the health facility prior to delivery to observe the facilities' preparedness, and to allay fears about delivering in a facility, re-organizing service outlets in the facility to have all MNH services in one part of the facility or one room where feasible, maintaining privacy, allowing women to deliver in positions of their choice, allowing companionship during labor and delivery, and designating areas where women in early labor and their families can stay and prepare coffee and traditional foods and hold religious rituals that play an important role in the birthing process (see photos below). These efforts are felt to contribute to the increases in utilization seen in MCHIP supported facilities. In Tigray region under the direction of the RHB, maternity waiting rooms have been established in HC for pregnant women who live far from the facility to stay when their pregnancy reaches term. During their stay the HC provides them with a place to sleep and basic materials to prepare their own food. While these are regional initiatives, they provide reinforcement to MCHIP's efforts to increase facility based birth.



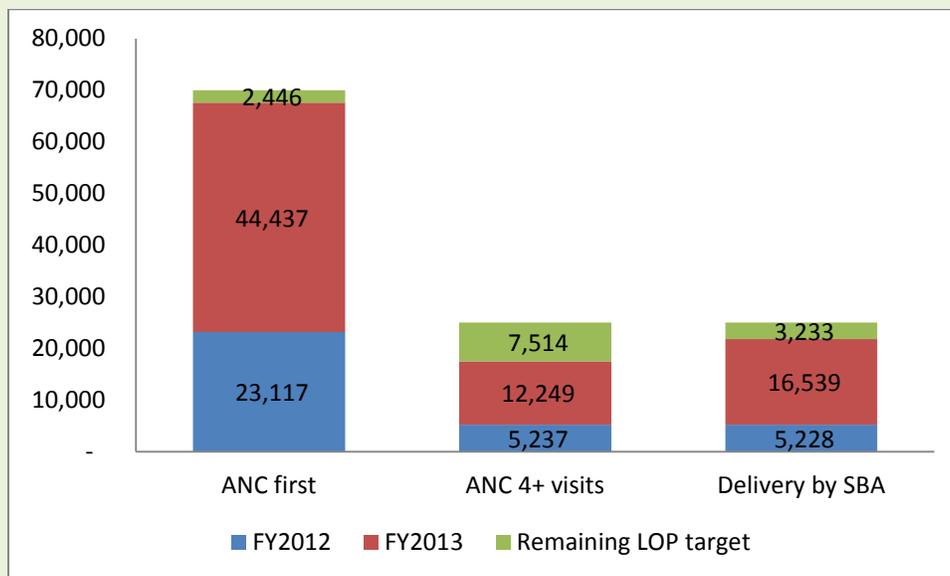
A woman in labor receiving prayer from her relatives during the coffee ceremony



Mother Mary is with you in the delivery room

Figure 2 show some of the achievements for ANC first visits and deliveries by a skilled attendant comparing achievements from FY13 with FY12, and the remaining targets for the length of project (LOP).

Figure 2: Key MNH Indicators Progress against LOP Targets, FY12-FY13



MCHIP has piloted innovative blended learning approaches for in-service training. Blended learning utilizes a combination of approaches including home study prior to the course, use of mobile technologies to facilitate learning and reducing the number of hours spent in the classroom. The aim is to shorten the number of days a provider is away from their work place. For BEmONC training, MCHIP piloted a blended learning course, and conducted two rounds of training for 28 providers (15 midwifery instructors and 13 clinical care providers). The blended BEmONC course is different in that participant knowledge is taken to them, rather than the usual knowledge they receive from presentations. The knowledge sharing is centered around key signal functions themes and is a reinforcement of key knowledge using a variety of knowledge tests e.g., case studies, small group discussions on case scenarios role plays and skill

demonstration and practice sessions using anatomic models. Participants then move to the skills practice, following the standard BEmONC training package but allowing more time for skills practice. At the end of the training participants receive an orientation on the follow up they will receive in the form of SMS: they will receive a daily SMS question related to the BEmONC training for 2 months; reminders are sent if they fail to respond and they will receive a response as to how they answered. If they answered incorrectly they will receive the correct answer and a reinforcement message. All of this is managed through frontline SMS from the MCHIP country office and runs automatically once set up. The course certificate is awarded *only after* completion of series of SMS which is considered part of the training and passed post training skill and knowledge assessment exams. This approach has reduced the BEmONC course from 18 days to 12 days, meaning providers are away from their facility for less time. MCHIP will continue to test this with one more training course in FY14 and will share experiences from the training with the FMOH and USAID. A detailed study on the effectiveness of the training may be taken up by the USAID funded Strengthening Human Resources for Health Project.

Facility Based Essential Newborn Care (ENC)

During year 3 of the project, MCHIP planned to ensure the effective integration of ENC follow up with the PQI follow up, post-training supportive supervision and on-site mentoring for providers trained on ENC. It continued to build upon the numbers of facilities in Tigray, Amhara, and Oromia that provide ENC, through training of health staff, provision of equipment and supplies such as bags and masks for neonatal resuscitation, and provision of registers.

To ensure key ENC standards and verification criteria are captured through the SBM-R process, an SBM-R standards review was conducted during the implementation period. The areas addressed by the revised tools now include essential newborn care, resuscitation, management of newborns with sepsis and thermal care for low birth weight babies.

Upon the request of the RHBs of the four regions, MCHIP facilitated the establishment of 110 ENC sites in 37 Woredas and trained 201 health care service providers in ENC including midwives, nurses and HC heads. ENC trained nurses and midwives were able to resuscitate successfully asphyxiated newborns. Besides the skills training on ENC, health service providers were also oriented and encouraged to locally analyze the data and act accordingly using the HMIS included indicators. Targeted post-training assessments were provided utilizing PQI approaches.

Supportive supervision was conducted to observe implementation of ENC, KMC and CKMC in five PHCUs of Tigray region. During the visit, ENC equipment and supplies were procured and distributed for the sites. The distributed materials includes baby hats, bag and masks, and job aids.

Helping Babies Breath (HBB)

Throughout the year, a total **2,090 asphyxiated babies were successfully resuscitated** from a total of 43,393 deliveries in 116 health facilities by health workers who received training with support from MCHIP. Although the HMIS does not capture the number of newborns

asphyxiated, MCHIP collected this information from Ethiopian Pediatrics Society (EPS) registers and from the comments section of HMIS registers. MCHIP is working with health facilities and the National Child Survival TWG to strengthen the recording and reporting of key indicators on newborn care including number of babies asphyxiated at birth and those that were successfully resuscitated.

Facility Based Kangaroo Mother Care (KMC)

During the year, almost all mothers who came for ANC services received KMC counseling during their visits, and from a total of 43,393 deliveries in 116 health facilities. **11,878 newborn babies** including those with low birth weight were provided with KMC following at birth. KMC units were integrated into the post-natal areas of the 116 health facilities.

PMTCT

MCHIP supported 44 health centers in 22 woredas of Amhara, 4 woredas of Oromia and 4 woredas of SNNP regions; all sites fulfill the PEPFAR Next Generation Indicator definition of a PMTCT site i.e. they provide Anti-retro Viral (ARV) prophylaxis.

At the request of SNNP and Oromia RHB to expand PMTCT services, MCHIP conducted a baseline assessment in 5 selected sites from SNNPR and 3 selected sites from Oromia and scaled-up PMTCT services in these new facilities. In addition MCHIP facilitated the distribution of PMTCT commodities from the Pharmaceuticals Fund Supply Agency (PFSA) regional hubs to nine facilities in SNNP and seven facilities in Oromia.

In response to the RHBs request for PMTCT site expansion and to address attrition of trained staff, MCHIP conducted basic PMTCT/MNCH training (Option A) in November and December 2012 for a total of 44 health care providers from MCHIP PMTCT sites. A one day technical update on the revised PMTCT guideline (Option A) and overview on Option B+, was provided to 63 health workers drawn from MCHIP supported zonal and Woreda Health offices. Action plans were developed to improve performance of key MNCH/PMTCT services in respective zones.

MCHIP conducted monthly phone follow-up with selected providers in MNCH/PMTCT implementing health centers. MCHIP was informed on the availability of HIV test kits in all MNCH units and on the integration of HIV Testing & Counseling in all MNCH units.

MCHIP conducted enhanced PMTCT supportive supervision in four selected health facilities in Amhara, Oromia and SNNP regions; during the supervision the following activities were performed:-

- Haphazardly situated MNCH rooms were re-arranged in such a way that mothers could receive all services in one place (“one-stop shop”) and one building for ANC, L&D, PNC, FP was allocated;
- Invitation letters for partners to be tested for HIV prepared and placed in ANC and PNC rooms;
- Some of the problems like weak demand creation efforts and absence of cotrimoxazole and the payment related to it, shortage of lab reagents were also reported to respective woreda health offices for collaborative effort;

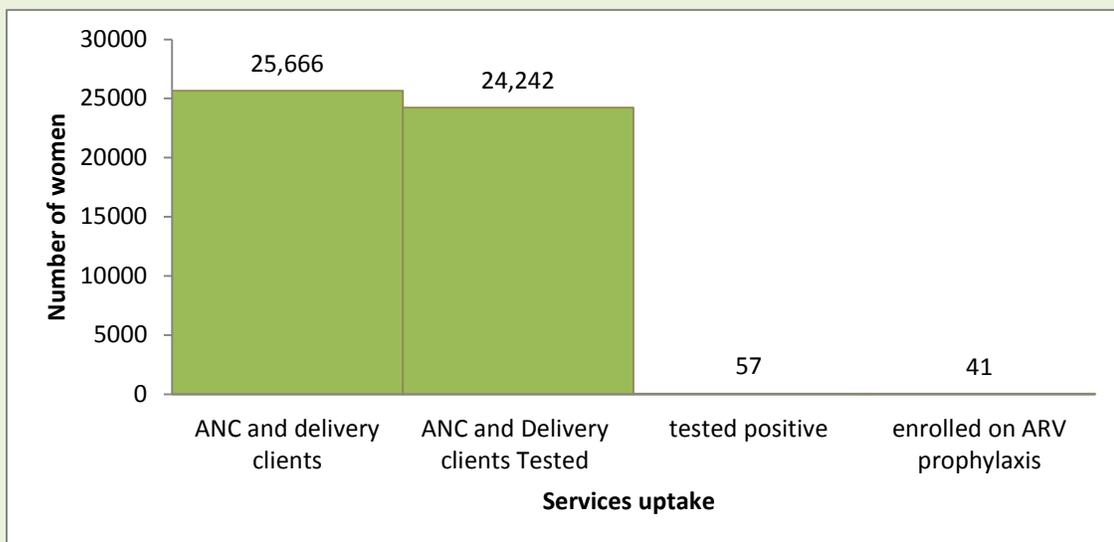
- Provision of cotrimoxazole prophylaxis for pregnant mothers tested HIV positive (WHO stage II and above) and TB screening at each Focused Antenatal Care (FANC) visit was done;

With the aim of ensuring knowledge retention and to improve quality, short text messages on basic PMTCT services packages were developed and send to PMTCT trained health care providers through their mobile phones. The aim of this SMS message was to reinforce the health care providers’ knowledge and skill and facilitate transfer of learning. Accordingly, 87.8% (65 of 74) of providers actively responded to the questions and received reinforcement messages; as observed through telephone follow up, the mechanism of SMS helped them to make reference to their training materials and share findings with other MNCH providers who are working in the unit.

A total of **24, 242** pregnant mothers were tested for HIV and received their results in ANC clinics and outreach programs in 44 MCHIP supported facilities; among these 8,446 (34.8%) were tested with their partners. Among the 24, 242 pregnant mothers, 89 HIV positive mothers get a minimum of one care service in MCHIP supported facilities; among the 89 HIV positives, 57 pregnant women were tested positive in ANC and L&D and 32 mothers were known HIV positive pregnant mothers respectively; after WHO clinical staging, 41 women were given ARV prophylaxis, 6 were newly initiated lifelong ART in current pregnancy, 25 were already on ART treatment and the remaining were referred to the nearby ART treatment for further follow up. TB screening was done for 57 newly identified HIV positive pregnant mothers.

A total of 37 HIV exposed infants were provided with a minimum of one care service; of these 26 were provided with NVP and 17 provided with cotrimoxazole prophylaxis.

Figure 3: PMTCT Service Cascade in 44 MCHIP Supported Sites in FY13



As part of HTC integration and primary prevention (*Prong 1 in PMTCT*), a total of 10,945 (53%) women were tested in the facility FP clinics; 7 mothers tested positive and were provided with

FP counseling particularly on dual protection and referred for pre-ART follow up to nearby ART sites.

MCHIP supported the FMOH to finalize the revised PMTCT training package for the Option B+ treatment approach and facilitated the national level training of trainers course held in April and August 2013 in collaboration with other USG partners (trainer participants were drawn from RHBs and facilities). MCHIP also supported regional level workshops to launch the Option B+ treatment approach in Amhara, SNNP and Oromia regions. The purpose of the workshops was for partners to share experiences, map out each partner's role in the implementation of the PMTCT option B+ approach as well as support the planning of trainings in the regions.

Post-partum family planning (PPFP)

MCHIP provided technical and financial support to the FMOH in organizing the first national FP symposium in November, 2012, where MCHIP had the opportunity to present its Post-Partum Family Planning or Post-Partum Intra Uterine Contraceptive Device (PPFP/PPIUCD) intervention at the symposium in an oral presentation titled "Introducing PPIUCD in Ethiopia: Experience of the Maternal and Child Health Integrated Program". The presentation ignited the interest of the FMOH to expand PPIUCD services in the country. The FMOH welcomed MCHIP request to initiate PP-IUCD services in additional facilities as it is in line with its own PP-FP expansion plan. MCHIP therefore conducted facility assessments in a number of additional hospital sites. MCHIP has now expanded PPIUCD implementation to an additional ten hospitals in Oromia, Amhara, SNNP and Tigray regions, bringing the total number of facilities that now have PPIUCD services from 8 to 18. Site selection was based on delivery caseloads and other prerequisites. 43 service providers from ANC and labor and delivery wards were trained in PPFP counseling with 25 of these providers who work in the labor and delivery wards then going on to receive further training in PPIUCD insertion skills. At the end of the PPIUCD insertion skills training, trainees were provided with PPIUCD insertion kits and essential infection prevention supplies to enable them to start PPIUCD insertion immediately upon return to their respective hospitals.

To support transfer of learning post-training, the MCHIP team brought the newly trained service providers from the ten new hospitals. Trained service providers were observed and provided with feedback during PPFP counseling sessions and PPIUCD skills practice using simulation and real situations.

Post-training follow-up and supportive supervision visits were also conducted in the PPFP/PPIUCD implementing health facilities that MCHIP initiated the PPIUCD insertion program in FY12. MCHIP conducted two follow-up meetings with 24 providers trained in PPFP counseling, and 26 trained in PPIUCD insertion skills from the initial 8 hospitals initiated in FY12. During the meetings, knowledge and skill updates were conducted, providers shared experiences and lessons and developed action plans to improve services. As this is a new program for the country, requiring strong linkages between ANC, and labour and delivery, MCHIP has placed much emphasis on working through providers and facility managers to ensure their support for the service and identifying gaps and solutions to improve service delivery. The frequent technical support from MCHIP through follow-up visits and meetings, has

assisted facilities to increase the number of PPIUCD clients, for example, Dessie Hospital, Amhara Region, initially had no clients after initiation of the service in FY12, but at the end of FY13 the hospital is performing nine to ten PPIUCD insertions a month.

In April 2013, MCHIP supported its FP Advisor, a PPIUCD service provider and the FP Program Officer from the FMOH to attend a meeting, “PPIUCD: Start-up to Scale-up” in Zambia to share experiences of PPIUCD implementation and design strategies for advocacy, demand creation and scale-up of PPIUCD services. At the end of the meeting, country teams developed action plans; the Ethiopia team comprising of the FMOH, PPIUCD service provider, MCHIP and Engender Health also developed their action plan. From the actions identified from this meeting a training of trainers’ course for PPIUCD has been conducted by MCHIP and site selection for PPIUCD implementation expansion by Engender Health has been accomplished.

In support of the Government’s plan to expand PPIUCD and permanent FP services, MCHIP has created a pool of national PPIUCD trainers by training 12 of the MCHIP trained PPIUCD service providers with a Clinical Training Skills course. In addition five service providers who had received training in long acting and permanent FP methods (trained by Engender Health or IPAS) participated in this trainer of trainer’s course.

At the end of FY13, **9,541** mothers were counseled on PPFp during ANC and **543** mothers had PPIUCD insertions within 48 hours postpartum from a total of 26 MCHIP health facilities (See *Table 1*).

Table 1: PPFp Counseling and PP-IUCD Insertion (October 2012 - September 2013)

Total no. of facilities implementing PP-FP counseling and PPIUCD insertion	No. of facilities providing PP-IUCD insertion	No. of facilities providing PPFp counseling only	PP-IUCD insertions (Oct 2012-Sep 2013)	No. of PP-FP counseled in ANC	No. mothers returned for 1st follow up visit (4-6 weeks after the PPIUCD insertion)	Reported spontaneous expulsion
26	18 (15 hospitals and 3 HCs)	08	543	9,541	207	13

MCHIP has also been providing technical and financial support to the FMOH in the organization of the 3rd International Conference on Family Planning that will be held in Addis Ababa in November 2013. MCHIP’s abstract entitled “Capturing a missed opportunity through PPIUCD in Ethiopia: Experience of MCHIP” has been accepted for oral presentation.

Support to the deployment of Integrated Emergency Surgical Officers (IESO)

This activity, added in year 2 of MCHIP implementation, was conducted in collaboration with the FMOH’s Human Resource Directorate. A specially established TWG was set up to support the new IESO graduates in their deployment. MCHIP supported the TWG by developing a supportive supervision tool to assess site level performance of the new IESO graduates (the tool

developed is based on MCHIP's own supportive supervision tool). MCHIP facilitated a session during the national consultative meeting on how to assess performance of deployed IESO's, and also participated in a two-day workshop organized by the FMOH with the goal of reviewing the terms of reference for the post-deployment follow-up of the new IESO graduates and their performance monitoring. An action plan for the upcoming performance monitoring the IESO graduates was also developed. The FMOH is leaning towards having the follow up led by the universities that provided the pre-service education, however the support to the universities to facilitate this supervision is yet to be clarified by the FMOH.

Intermediate Result 3: Care takers knowledge and behaviours on key MNH/Post-partum/FP/PMTCT household and care seeking behaviour

Community based Kangaroo Mother Care (CKMC)

MCHIP continued the evaluation to study the effectiveness of community based kangaroo mother care (CKMC) that is being implemented in 10 districts in the four regions. The specific objective of the study is to assess the coverage of CKMC and other neonatal health interventions related to MCHIP programming in Ethiopia. The survey will assess knowledge and acceptability of CKMC among postpartum mothers, compliance of KMC among mothers of LBW newborns, and the effect of HEWs' promotion of CKMC and other newborn care interventions on utilization of facility based delivery and newborn services, HEWs skills and knowledge for the promotion of KMC and providing newborn resuscitation in the community. The finding of the baseline survey conducted in January 2012, was presented in the Ethiopian Pediatrics Society (EPS) annual conference in November 2012. MCHIP has also submitted the baseline assessment and midline qualitative assessment to the BMC Pediatrics Journal, and is awaiting a response.

In support of implementation of CKMC, MCHIP had to conduct replacement training on KMC for 19 HEWs across 16 woredas in Amhara as previously trained HEWs have left their posts. Post training follow-up was conducted for CKMC implementing health posts in 10 PHCUs. The visits enabled MCHIP and zonal/woreda health officers staff to review CKMC implementation, identify key challenges and develop an action plan to address the challenges at different levels. For example in some health posts the family health cards were not available; through a discussion with the woreda and RHB and partners, MCHIP facilitated distribution of the family health cards to the health posts and health centers.

CKMC implementation monitoring data from HEWs' registers were collected from regions. MCHIP and zonal/woreda health offices staffs made on site visits to the health posts to review the recording of CKMC data and re-orient HEWs on registration of CKMC service data. In the reporting period a total of 2,074 deliveries were recorded by the HEWs in their catchment population under the 10 CKMC implementing health centers of which 1,071 (52 percent) received PNC visit by HEWs within the first 24 hours and 1,587 (77 percent) were cared for by KMC.

As part of feasibility study five out of the 10 PHCUs were supported to assess the coverage and quality of community MNCH services, including CKMC using lot quality assurance sampling (LQAS). Results showed that the coverage for key MNCH services in assessed households in the five PHCUs were much lower than what is reported by HEWs and the health centers. Following the assessment MCHIP shared the findings with the PHCUs, woreda health offices and HEWs and clarified that these findings were received from mothers expected to have received community MNCH services. The finding from the LQAS assessment helped PHCUs and woreda health offices to improve their support to HEWs and the HDAs agents to provide home visits as they are mandated to do and also strengthen postpartum care. As a result of the knowledge and experience acquired from this CKMC monitoring, some PHCUs have planned to conduct LQAS assessments themselves on a quarterly basis to identify if the interventions outlined in the health extension package are being carried out as reported.

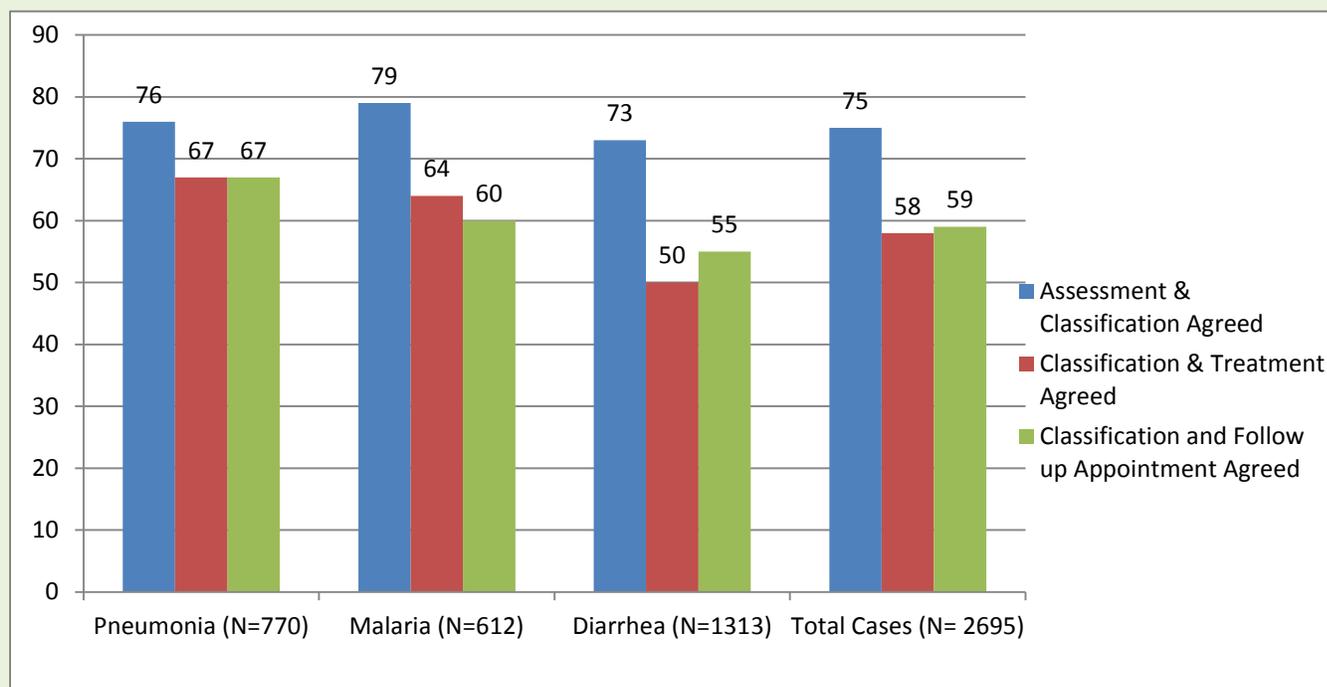
Integrated Community Case Management (ICCM)

ICCM in Oromia

MCHIP continued implementing ICCM in West Shoa and South-West Shoa Zones of Oromia Region. The Performance Review and Clinical Mentoring Meeting (PRCMM) is one of the strategies to follow up the implementation of ICCM to improve the knowledge and skill of HEWs. HEWs' supervisors, primary health care unit heads, woreda Health Extension Program focal persons and woreda health office heads also participated in the PRCMM. During the PRCMM registers of the catchment health posts are reviewed for completeness, consistency and case load. From a total 924 of health posts in West Shoa and South-West Shoa, 702 health posts (75%) participated in the review meeting; as seen in the PRCMM the total number of children under-5 cases that were managed/registered was 9,368; of the total cases managed 483 (5%) were infants of less than two months old.

As it is depicted in figure 2, facilitators of the PRCMM also reviewed registers of each health post for quality (completeness, consistency and referral of severe cases for advanced care); of a total 2,695 cases reviewed, 2,022 (75%) agreed between assessment and classification; 1,558 (58%) cases agreed between classification and treatment in accordance with the dose-schedule –duration (DSD) principle and 1,602 (59%) agreed between classifications and stated follow up.

Figure 4: Quality of HEWs Performance in ICCM, October 2012 – July 2013



Similarly PRCMM was conducted at 38 health centers in the region, 3,999 under five children were seen at the outpatient department of the health centers from Jan – March 2013. From the above cases 172 classifications were reviewed for quality; 144 cases (84%) were in agreement with the assessment and classify guideline and 110 cases (62%) received treatment according to the correct dose-schedule-duration principle. Some of the key findings from the supervision were:

- Close to half of the 38 HC visited had no functioning oral rehydration therapy (ORT) corners to provide care for children classified with dehydration. Woredas have agreed to procure the necessary materials to establish ORT corners in all their health centers/health posts.
- In some health centers the outpatient departments for under-fives and adults are shared which is not in accordance with the standard.
- Some facilities are still using the old registration book; the revised Integrated Management of Newborn and Child Illness (IMNCI) registration book (for young infants and children) has since been distributed to all HC.

Post training follow up and supportive supervision was provided to ICCM trained HEWs in 38 health posts to ensure that MCHIP donated supplies were properly used and to observe the status and challenges of services delivery at the health posts.

ICCM in Afar

In FY13, MCHIP was part of the initiation of ICCM services in Afar. MCHIP has introduced ICCM in the five woredas of two zones in the region selected by the RHB. As part of the introduction of ICCM, MCHIP facilitated a meeting to launch ICCM and ensure the support and commitment

of local government and other partners such as UNICEF and WHO. A baseline survey was conducted to assess the readiness of the HEWs and health posts to deliver ICCM service delivery.

In collaboration with Afar RHB and UNICEF a regional level ICCM training of trainers was conducted for 19 health professionals. The six day course which included content on skills of managing common childhood illnesses was cascaded to a total of 167 HEWs, front-line workers² and junior nurses. IMNCl training was also provided for 12 health center staff. During the clinical practice trainees were able to assess, classify, and identify cases with their appropriate treatment for each specific classification. 21 HEW supervisors were trained on basic ICCM roll-out and basic supervisory skills. These trained supervisors then participated with HC heads and MCHIP staff on post-training follow-up which were conducted in 45 health posts.



HEW Supervisors during supervision at the health post and reviewing registration book in ICCM training

The supportive supervision findings revealed the knowledge and skill gaps of HEWs, implementation challenges ICCM linked to logistic and supplies gaps and low utilization of ICCM services by the community.

Table 2: Quality of Case Management by HEWs, Front Line Health Workers and Junior Nurses, July-Sept 2013.

Diseases type	Number of HPs	Number of Classes	Correct Classification		Correct Treatment Rate (DSD)*		Correct Statement of Follow-up	
			Number	Percent	Number	Percent	Number	Percent
Pneumonia	28	54	42	78	41	76	49	91
Malaria	28	59	52	88	52	88	53	90
Diarrhea	28	61	49	80	43	70	51	83
SAM	28	38	35	92	36	95	37	97

**DSD refers to correct statement of dose, schedule, and duration of appropriate drug treatment. Correct treatment refers to fulfillment of all the three*

MCHIP organized district level community discussions in both zones to create awareness on ICCM and to generate strong commitment from woreda administrators and health offices, bureau of women affairs, religious leaders and the Afar regional Government. In the presence of project supported facilities, the four month ICCM program achievements and challenges were presented.

² Front line Health Workers are male health cadres deployed in Afar region by the Regional Health Bureau. They have similar roles to the Health Development Armies deployed in the highland areas.

Partnership and coordination

With the changes in leadership at the FMOH, and subsequent further restructuring in some directorates most notably for MCHIP the recent formation of the MCH Directorate, MCHIP has met with the newly appointed FMOH team leaders and directors to outline its program objectives, its priority interventions and appraise them of accomplishments to date.

As with previous years, MCHIP continues to be the leading partner with FMOH and RHBs in various MNCH areas. This includes taking the lead in the finalization of national BEmONC and FP training packages, being an active member of the technical advisory group for maternal death review and surveillance, Magnesium sulphate (MgSO₄) rollout to HC, and the Option B+ guidelines for PMTCT services, and initiating intra-partner collaborations on PPIUCD scale up and permanent methods This is also resulting in greater alignment of MCHIP's support to the regions by providing significant technical and financial support in organizing high level regional, national and international events such as the Safe motherhood campaigns and national and international FP conferences. MCHIP collaboration with the FMOH, RHBs and other health development partners has been substantial this year increased the project's visibility.

Technical assistance/STTA

Name	Travel dates	Summary of Scope of Work
Sheena Currie , Senior Maternal Health Advisor, Global Program Operations	October 19 – 27, 2012	To finalize the revision of MNCH PQI tools, conducted module 1 PQI training and field test the revised MNH PQI tools at Debre Berhan Hospital
Joseph De Graft Johnson , MCHIP Newborn Health Global Team leader	December 03 – 14, 2012	Conduct a program review of the newborn component of MCHIP/Ethiopia and provide technical assistance as needed
Abdullahi Baqui , Professor at JHU/IIP	December 5 – 8, 2012	To conduct review of the CKMC implementation and provide technical assistance to program staffs and investigators team
Tsige Pleah , Senior Reproductive Health Advisor, Technical Leadership, Jhpiego John Varallo , Senior Technical Advisor, FP/RH, Jhpiego	March 11 – 22, 2013	Knowledge sharing on the PPIUCD insertion skill training
Tsige Pleah Reproductive Health Advisor, Technical Leadership, Jhpiego	May 31– June 11, 2013	Assisted in transfer of learning follow up visits
Tsige Pleah Reproductive Health Advisor, Technical Leadership, Jhpiego	August 23 – Sep. 1, 2013	Facilitate TS training

Publications/reports

Conference Abstracts, Posters and Presentations

1. Oral presentation by Serawit Lisanework titled “Introducing PP-IUCD in Ethiopia: Experience of MCHIP” during the national Family Planning Symposium, November 2012, Ethiopia.
2. One abstract accepted to the third International Conference on Family Planning to be held in Ethiopia from November 12-15, 2013, entitled “Capturing a missed opportunity through PPIUCD in Ethiopia: Experience of MCHIP”.
3. One abstract accepted for the 1st FIGO Africa Conference, Ethiopia, October 3-5, 2013 entitled “Post-partum Intrauterine Contraceptive Device (PPIUCD) – Experience from starting a program in Ethiopia”.
4. Oral presentation by Alemnesh Tekleberhan entitled “Improving MNH nursing care through competency based Basic Emergency Obstetric and Newborn Care (BEmONC) training in Ethiopia” at the 25th Quadrennial Congress of the International Confederation of Nurses which was held on May 18-23, 2013 in Melbourne, Australia.
5. One abstract accepted for poster presentation on the 17th International Conference on Aids and STIs in Africa, South Africa, 2014 entitled: “Integrated PMTCT and maternal health services improves both HIV and maternal health indicators in rural Ethiopia”.
6. Two abstracts accepted to the 30th Triennial Congress of the International Confederations of Midwives to be held in Czechoslovakia, 2014. Entitled: “Experiences in Ethiopia: Building midwifery organizational capacity for stronger regulation” and “Improving skilled birth attendants’ service utilization through Performance Quality Improvement intervention”.

Reports

7. One report on literature review on cultural barriers to seeking MNH care titled “Cultural Barriers to Seeking Maternal Health Care: A review of the literature”, printed and distributed in December 2012.
8. One report on “Community based Kangaroo Mothers Care Monitoring: Findings of LQAS Rapid Assessment in five Primary Health Care Units in Ethiopia”, May 2013.
9. Printed and distributed two success stories booklets to document MCHIP’s accomplishments in Oromia and SNNP regions, May 2013.

International Travel

Name	Travel dates	Purpose of Travel
Dr. Jennifer Callaghan , Associate scientist, Johns Hopkins	November 22 – 25, 2012	To attended the KMC Conference in India
Dr. Tadele Bogale , Jhpiego Ethiopia Deputy Country Director	February 18 – 22, 2013	To attend the Elimination of Mother to Child Transmission (eMTCT) workshop held in Nairobi, Kenya

Serawit Lisanework , Family Planning Advisor, MCHIP Rahwa Belay , Family Planning Program Officer, FMOH Abdela Abdosh , Health Care Provider, Shashemene Hospital	April 8 – 13, 2013	To attend the PPIUCD Services: Start-up to Scale-up Regional Meeting in Lusaka, Zambia
Abiy Seifu , MCHIP Newborn Advisor	April 15 - 18, 2013	To attend the International Newborn Conference, Johannesburg, South Africa
Alemnesh Tekleberhan , MNCH Team Leader, MCHIP	May 18 – 23, 2013	To attend the 25th Quadrennial congress of the International Council of Nurses in Melbourne, Australia
Hannah Gibson , Program Director, MCHIP Belen Belayneh , Program Officer, MCHIP	May 26 – June 1, 2013	To attend the Women Deliver Conference in Kuala Lumpur, Malaysia

Monitoring Visits

MCHIP conducted integrated supportive supervision to 85 of the supported sites. Some facilities were not accessible due to the rainy season road challenges. This supervision visit covered MNCH, PMTCT, PQI technical areas. At the end of every visit de-briefing meetings were held with the respective zonal and woreda officials on action items were provided to facility staff and management. Major findings from the two integrated supportive supervisions were that most facilities:

- Had a functional PQI team;
- Began conducting monthly PHCU meetings which improved PHCU linkages with their respective health posts;
- 5 to 6 out of the 7 BEmONC signal functions are in place; gaps in reaching the full 7 signal functions are due to lack of or shortages of Magnesium Sulphate to manage eclampsia and parenteral antibiotics;
- Are providing ENC services according to the national newborn corner and neonatal care guidelines;
- Had introduced women friendly care in their facilities which includes: allowing a family member during delivery, setting up waiting areas for mothers and their waiting families, allowing the woman and her family to have religious, cultural and traditional practices that are important in child birth.

In addition guidance was given to facilities on the utilization of PMTCT job aids, the necessity of TB screening and the proper recording (avoiding double counting) of HIV tested mothers in ANC and Labor and Delivery.

It was also observed that MCHIP's support is well recognized by all supported zones and woredas. Examples of this are of Amhara South Wollo Zone health department vice head who expressed interest for MCHIP to expand PQI to other woredas in the zone. In SNNP region Hadiya Zonal health department head appreciated the BEmONC training MCHIP is conducting and how the PQI process is gaining improvements. In Tigray the Regional President even asked MCHIP to expand PQI to all woredas in the region.

Major constraints/challenges and actions to overcome them

The changes in leadership and restructuring within FMOH directorates has led to delays and uncertainty of approval for some activities. A number of the TWG or working groups did not meet during the restructuring or new ones were developed with new TORs. At the regional level frequent and sudden changes of planned activities with the RHB, due to their priority tasks has been in some instances a major reason for delays in implementation. .

MCHIP encountered considerable challenges in ensuring quality of locally procured supplies and had to reject a number of items that were provided by local vendors. As a result the procurement for all facilities has taken longer than anticipated.

Another major challenge was the shortage of supply in ARV, Cotrimoxazole prophylaxis, Dried Blood Spots (DBS) test kits, reagents for VDRL (Syphilis) and hematometer (used to test hemoglobin) test from PFSA. MCHIP reported the shortage to the national TWG meeting, but also advised its facilities to consider using their revenue from health care financing to purchase important reagents and Cotrimoxazole drugs.

In Afar Region ICCM implementation was challenged by under-utilization of health posts by communities who doubt the competence of HEWs. The regional and zonal level coordination of MNCH activities and supervision of health centers and is weak and there is recurrent stock out of some drugs.

High turnover of trained staff, inaccessibility of sites for supportive supervision, persistent basic infrastructural gaps as well as incompleteness ICCM kits and shortage of drugs remain to be constant challenges in some supported facilities.

Data quality issues

MCHIP conducted data quality audits for selected indicators to ensure that reported indicators are of good quality for reliable programmatic decisions. The selected indicators for data quality audit review included number of women tested, PNC visits within two days and Active Management of Third Stage of Labor (AMSTL). One of the indicators, "number of women tested", showed double counting where women were counted both in the ANC and the labor ward. Immediate feedback was provided to facilities to improve the documentation and reporting, MCHIP is stressing to health workers to count the number of women instead of the services. To assess the coverage of the indicators PNC within two days and active management

of the third stage of labour an LQAS sample of 19 was selected from each of 16 sample facilities; it was observed that the coverage was 80% and 95% respectively.

Major activities planned for next period

In the last implementation year, MCHIP will technically support the FMOH to roll-out important MNCH, PMTCT, FP policies and national training packages it helped develop in the past. Program learning documentation will be finalized and for some key areas the reports will be disseminated nationally and internationally. MCHIP will advocate for the integration of women friendly care at point of care, and work through the FMOH to advocate for the scale-up of selected promising practices. With a strong membership base, active chapter offices and strong network among partners, MCHIP will see the Ethiopian Midwives Association become more prominent and effectively advance the development of the midwifery profession in Ethiopia.

MCHIP will complete the SBM-R cycle by graduating high performing facilities in recognition of their achievement and commitment to improve MNCH services. MCHIP will pursue to have SBM-R approved by the FMOH. MCHIP will transfer ownership of PQI and MNCH, PMTCT and FP intervention to Zonal and Woreda offices to continue implementation and maintain progress beyond the life of the project. MCHIP will work with its head quarter and to complete project close out in a proper and time manner.

Environmental compliance

Standard infection prevention practices are integrated in all MCHIP training events to ensure environmental compliance. Waste disposal in health facilities is also included in the PQI standards. Health facility visits conducted by the MCHIP also include monitoring of health facilities waste disposal system.

Financial accomplishment

Life of project budget	Obligated to date	Expenditure to date (Accrual + Disbursement)	Remaining balance	Remark
(a)	(b)	(c)	(d)=(b)-(c)	
\$12,184,000.00	\$12,184,000.00	\$9,444,495	\$2,739,505	None

Issues requiring the attention of USAID management

MCHIP will end in FY14 with project implementation ceasing June 2014. MCHIP has identified a number of opportunities for sustainability beyond the life of the project and will outline these in a paper to be submitted to USAID in the coming quarter.

Data sharing with the host government

All data reported in this report were captured from the Federal MOH approved HMIS and in some instances remark sections were used to complement additional indicators. MCHIP shares reports to regional reports as per their specific templates at least semi-annually.

Appendices

1. MCHIP Performance Monitoring Plan
2. APR Success story
3. Summary of SBM-R Workshop for Performance and Quality Improvement
4. Summary of MCHIP Intervention Sites by Intervention and Facility Type
5. Distributed list of materials for MCHIP sites

Reports

6. "Community based Kangaroo Mothers Care Monitoring: Findings of LQAS Rapid Assessment in five Primary Health Care Units in Ethiopia", report, May 2013.
7. "Cultural Barriers to Seeking Maternal Health Care in Ethiopia: A review of the literature", report on literature review on cultural barriers to seeking MNH care, December 2012.
8. "Improving the quality of MNH Care; Oromia", success stories, May 2013
9. "Improving the quality of MNH Care; SNNPR", success stories, May 2013

Conference Abstracts, Posters and Presentations

10. "Introducing PP-IUCD in Ethiopia: Experience MCHIP", abstract and oral presentation at the National Family Planning Symposium, Ethiopia, November 2012.
11. "Improving MNH Nursing care through Competency based Basic Emergency Obstetric and Newborn Care (BEmONC) Training in Ethiopia", abstract, the 25th Quadrennial Congress of the International Confederation of Nurses, Australia, May 2013.
12. "Post-partum Intrauterine Contraceptive Device (PPIUCD) – Experience from starting a program in Ethiopia", abstract for oral presentation, 1st FIGO Africa Conference, Ethiopia, October 2013
13. "Capturing a missed opportunity through PPIUCD in Ethiopia", abstract accepted, 3rd International Conference on Family Planning, Ethiopia, November 2013.
14. "Experiences in Ethiopia: Building midwifery organizational capacity for stronger regulation" Abstracts accepted to the 30th Triennial Congress of the International Confederations of Midwives, Czechoslovakia, June 2014.

15. "Improving skilled birth attendants' service utilization through Performance Quality Improvement intervention", abstract accepted to the 30th Triennial Congress of the International Confederations of Midwives, Czechoslovakia, June 2014.
 16. "Integrated PMTCT and MNH services improves both HIV and maternal health indicators in rural Ethiopia", abstract accepted for poster presentation the 17th International Conference on Aids and STIs in Africa, South Africa, June 2014.
- Reports